

Pregnancy, Systematic Disregard and Degradation, and Carceral Institutions

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The majority of people incarcerated in U.S. women's jails and prisons are younger than 45; most of them are parents, and some will be pregnant behind bars. The ways that institutions of incarceration manage their reproductive bodies rely on overlapping legal, cultural, social, historical, and racialized foundations that allow reproductive oppressions to flourish behind bars. Yet, as we argue in this article, these dynamics of incarcerated reproduction manifest far beyond prison and jail walls, through criminalizing and restrictive discourses that devalue the reproductive wellbeing of marginalized people. We analyze the legal, clinical, and socio-political dimensions of carceral control of reproduction and reproductive health care in U.S. prisons and jails, including abortion access, prenatal and postpartum care, childbirth, and parenting. We describe violations of constitutional and clinical standards of reproductive care behind bars, showing how these reproductive coercions are grounded in historical legacies of slavery and the ongoing reproductive control of black and other marginalized bodies. This article makes the case that understanding reproduction behind bars and its legacies of racialized reproductive oppressions reveals the carceral dynamics of reproduction that are foundational to U.S. society.

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I. FOUNDATIONS OF CARCERALITY, CONTROL, AND REPRODUCTION IN THE U.S.

Jane Doe was in jail because she was pregnant. She was charged with “chemical endangerment of a child,” which the Alabama Supreme Court held applied to fetuses.¹ The criminalization of her pregnancy subjected her to the violence of detention and control at the hands of the state.² After a request for a first-trimester abortion was denied, she filed a lawsuit, then backed down after the district attorney told her that the county “might” stop prosecuting her on the child endangerment charge, allowing her to avoid prison, if she completed a drug-treatment program for pregnant people with substance abuse disorder.³ Jane Doe is one of a staggering number of pregnant people who have been civilly or criminally committed or forced to undergo unwanted medical treatment, in part because of their pregnancies.⁴ One study determined that at least 413 such cases occurred between 1973 and 2005 but concluded that this number “represent[s] a substantial undercount.”⁵

The people whose liberty was restricted as a result of their pregnancies were disproportionately likely to be in poverty and to be Black; Black people were also more likely to be reported to the police by hospital staff.⁶ Another study determined that in Alabama alone, nearly 500 pregnant and postpar-

¹ See Alan Blinder, *Inmate’s Suit Over Abortion Denial Ends with Her Decision to Have Child*, N.Y. TIMES (July 31, 2015), <https://www.nytimes.com/2015/08/01/us/inmates-suit-over-abortion-denial-ends-with-her-decision-to-have-child.html> [<https://perma.cc/Z3HP-24PZ>].

² See *id.*

³ *Id.*

⁴ See generally Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women’s Legal Status and Public Health*, 38 J. HEALTH POL. POL’Y & L. 299 (2013).

⁵ *Id.* at 304.

⁶ See *Executive Summary: Paltrow & Flavin, “Arrests of and Forced Interventions on Pregnant Women in the United States (1973-2005): The Implications for Women’s Legal Status and Public Health,” Journal of Health Politics, Policy and Law* (2013), NAT’L ADVOC. FOR PREGNANT WOMEN (Jan. 25, 2013), http://advocatesforpregnantwomen.org/main/publications/articles_and_reports/executive_summary_paltrow_flavin_jhplp_article.php [<https://perma.cc/J4JH-U6ZW>].

tum people were prosecuted under the same chemical endangerment law as Jane Doe between 2006 and 2015.⁷ And as Jane Doe's case illustrates, reproductive oppression continues inside institutions of incarceration. In this Article, we describe how forms of control of pregnancy that are foundational to U.S. society, law, and politics manifest in institutions of incarceration and argue that these violent state actions are driven by and perpetuate the systemic marginalization of pregnant people, particularly women of color.

Although Jane Doe stated that she was not "pressured" into changing her mind about abortion, it is hard to ignore that had she been convicted of a felony she would have been sent to Tutwiler Women's Prison, a facility that the Department of Justice found had astronomical rates of sexual violence, harassment, and retaliation against incarcerated people who attempted to report such abuse.⁸ The DOJ noted that there may also have been "systemic deficiencies" at the facility with regard to conditions of confinement generally, including inadequate medical care.⁹ Thus, the pregnant Jane Doe was faced with the prospect of a dangerous and sexually abusive environment if the state chose to prosecute her for child endangerment. The state therefore managed to constrain her reproductive choices not only by physically detaining her and denying her access to abortion, but also by using the implicit threat of harsh incarceration against her. Once she was in their custody, the state controlled her body and her access to reproductive health care.

Advocates across the country fight for reproductive rights, and many states have passed abortion-protecting legislation in the past years.¹⁰ Yet policy-makers have yet to address robustly the reproductive oppressions and reproductive health needs of people incarcerated in women's prisons and jails. From the lack of standards of health care for pregnant, incarcerated people, to unchecked abortion denials for them, to shackling during childbirth and other unsafe and undignified machinations of the reproductive bodies of confined individuals, sound policies and oversight of institutions of incarceration regarding the treatment of incarcerated pregnant people are inconsistent or non-existent. The systematic neglect of this group of confined people is, in and of itself, a form of violence: once the state chooses to incarcerate people and therefore deny them the ability to control and access their own health care, neglect of necessary care and choice is an active and destructive

⁷ See Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA (Sept. 23, 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene> [https://perma.cc/9867-939X].

⁸ See Letter from Jocelyn Samuels, Acting Assistant Att'y Gen., U.S. Dep't of Justice, to Robert Bentley, Governor, Alabama (Jan. 17, 2014), https://www.justice.gov/sites/default/files/crt/legacy/2014/01/23/tutwiler_findings_1-17-14.pdf [https://perma.cc/6KE2-ZYES].

⁹ *Id.* at 2.

¹⁰ See GUTTMACHER INST., ABORTION POLICY IN THE ABSENCE OF ROE (Nov. 1, 2019), <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe> [https://perma.cc/PER4-XNAP]; Sabrina Tavernise, *The Time is Now: States Are Rushing to Restrict Abortion, or to Protect It*, N.Y. TIMES (May 15, 2019), <https://www.nytimes.com/2019/05/15/us/abortion-laws-2019.html> [https://perma.cc/V23B-JS5B].

choice. This neglect allows the expansion of state control over the reproduction of people who are already historically subject to forms of state-sponsored reproductive oppressions, especially women of color.

In this article, we address the legal, clinical, and socio-political dimensions of carceral control of reproduction and reproductive health care in the U.S., specifically as they play out inside institutions of incarceration. Our discussion also necessarily tends to the ways that pregnancy itself has been criminalized, for that sheds light on and often leads to reproductive processes behind bars. First, we provide a demographic snapshot of incarcerated women in the U.S., especially in the age of mass incarceration, highlighting the continuing yet overlooked rise in numbers of women behind bars. We then briefly review the historical context of racialized control of reproduction in the U.S., as this background is foundational to understanding contemporary carceral control of reproduction. Next, we discuss the constitutional basis of health care provision within prisons, jails and detention centers—which we refer to throughout as “institutions of incarceration.”¹¹ The next sections apply these historical and legal foundations, along with clinical and social realities, to three aspects of reproduction as they occur behind bars: abortion access, prenatal care and childbirth, and postpartum

¹¹ Prisons, jails, and detention centers differ in several key areas. Prisons are under federal or state jurisdiction and confine people who have been convicted of felonies. See BUREAU OF JUSTICE STATISTICS, *What is the Difference Between Jails and Prisons?* (last visited Feb. 6, 2020), <https://www.bjs.gov/index.cfm?ty=qa&iid=322> [<https://perma.cc/6RQT-DEUZ>]. People in prison generally are serving sentences longer than 1 year. See *id.* A person is confined in a certain prison based on various classifications—security, gender, medical needs—not on geographic proximity to their home. See generally BUREAU OF PRISONS, Program Statement 5100.08 *Inmate Security Designation and Custody Classification* (Sept. 4, 2019) (explaining that prisoners are to be housed in facilities based on their “security designation” and other considerations and placed within 500 miles of their residence only if “practicable”); see also Bernadette Rabuy & Daniel Kopf, Report: Separation by Bars and Miles (Oct. 20, 2015), <https://www.prisonpolicy.org/reports/prisonvisits.html> [<https://perma.cc/SP9U-U3KX>] (using Bureau of Justice statistics to determine that the majority of people incarcerated in state prisons are held at least 100 miles from home). Jails, on the other hand, are under local county or city jurisdiction and therefore someone who is confined in a jail is typically closer to where they live. See Bureau of Justice Statistics, *Jail Inmates in 2017* 3 (Apr. 2019), <https://www.bjs.gov/content/pub/pdf/ji17.pdf> [<https://perma.cc/K2AL-UL9L>] (defining “jail”). The majority of people detained in jail are pre-trial and have not been convicted of a crime. See *id.* at 1 (65% of people confined in local jails are awaiting trial). Others in jail are serving shorter sentences for misdemeanors or probation violations. See *id.* Jail stays are of variable and unpredictable length, which can have implications for their health care. Institutions confining adolescents or immigrants are often called detention centers, though some of each group can be held in jails or, for adolescents who have been convicted of an offense, prisons. See Global Detention Project, *United States Immigration Detention* (May 2016), <https://www.globaldetentionproject.org/countries/americas/united-states> [<https://perma.cc/ALL8-93HN>] (immigration detention); Bureau of Justice Statistics, *Reported Number Of Inmates Under Age 18 Held In State Prisons, By Gender, Region, And Jurisdiction, June 30, 2007-2008* (Mar. 31, 2009), <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=1594> [<https://perma.cc/R9HE-9VQT>] (describing number of children under the age of 18 held in adult state prisons). It is common for these institutions to be called collectively “correctional facilities” or “correctional institutions.” However, we avoid this terminology for the sanitizing nature of that language and the problematic descriptor “correctional.”

care and parenting. Our analysis of abortion for incarcerated people is more detailed than the other sections because of the current sociopolitical interest in access to abortion, because there is comparatively more legal attention on abortion in prison compared to the other domains we discuss, and because abortion in incarcerated settings offers unique insights into abortion politics more broadly. These discussions center on pregnant people, acknowledging that cisgender women, transgender men, and nonbinary people could be pregnant in custody. While there are numerous, intersecting forms of oppression that incarcerated people experience, our analysis focuses on state control of incarcerated, pregnant people, especially women of color, because carceral treatment of pregnant people arises from a specific historical context of the exploitation of enslaved Black women in the U.S. We acknowledge the limitation that we do not explicitly attend to the unique reproductive experiences of LGBTQ+ community members, people with disabilities, immigrants, and other marginalized groups, and encourage future study into these connections.

The reproductive coercion that occurs within these institutions demonstrates the ways in which state intrusion into reproductive health care and choice reinforce state control over vulnerable and historically subjugated people. This control, whether manifested within institutions of incarceration or outside of them, reproduces racialized and gendered forms of oppression rather than expressing positive state values related to women's health.

II. INCARCERATED WOMEN ARE A GROWING YET OVERLOOKED GROUP IN THE U.S.

Although not often discussed, it is well documented that the rate at which women are being incarcerated¹² in the U.S. has outpaced that of men in the last four decades.¹³ And although the number of people behind bars has declined every year since 2007, this trend is only true for men: from 2016-2017, the number of incarcerated men dropped 1.3% while the number of women increased by 2.6%, with over 225,000 incarcerated women.¹⁴

¹² Incarcerated people are nearly always housed according to their sex as assigned at birth. Because statistics and other resources related to incarcerated people are so often sex-segregated, we will be referring to "women" throughout this article to include all people housed in women's facilities, even though this population includes some people who are not women and people housed in men's facilities include some women who are transgender. We acknowledge, however, the complexities and limitations of this language in fully encompassing the range of lived experiences.

¹³ See THE SENTENCING PROJECT, FACT SHEET: TRENDS IN U.S. CORRECTIONS 4 (2019), <https://sentencingproject.org/wp-content/uploads/2016/01/Trends-in-US-Corrections.pdf> [<https://perma.cc/2A2M-DPVM>].

¹⁴ See JENNIFER BRONSON & E. ANN CARSON, U.S. DEP'T OF JUSTICE, PRISONERS IN 2017 3 (2019), <https://www.bjs.gov/content/pub/pdf/p17.pdf> [<https://perma.cc/NV3G-VRB7>] (prisoners); ZHEN ZENG, U.S. DEP'T OF JUSTICE, JAIL INMATES IN 2017 4 (Apr. 2019), <https://www.bjs.gov/content/pub/pdf/ji17.pdf> [<https://perma.cc/8BLZ-DDNS>] (jail detainees).

Additionally, mass incarceration within women's prisons and jails, like that within men's, is profoundly racialized. In 2017, 53% of sentenced female prisoners were people of color, and Black women continue to be imprisoned at twice the rate of white women.¹⁵ While laws imposing long sentences have increased the rates and number of older women in prison, three-quarters of incarcerated women are younger than 45—that is, of reproductive age.¹⁶ These women have numerous sexual and reproductive health concerns that may arise during their incarceration. Also notable is that approximately two-thirds of women in state prisons are mothers and primary caregivers of young children.¹⁷

Research has shown that the majority of incarcerated women have been heterosexually active prior to arrest and plan to be sexually active upon release.¹⁸ Studies also report that less than one-third of these women were using contraception consistently before incarceration.¹⁹ Thus, it is undeniable that some people will enter institutions of incarceration pregnant. Some of these pregnant people will need abortions, and the rest will need other pregnancy care. Until 2019, there were no comprehensive statistics about pregnancy frequency and outcomes among incarcerated women available. The 2019 pregnancy outcomes study reported one year of pregnancy data from 22 state prison systems and all federal prisons. There were nearly 1400 admissions of pregnant people, 753 live births, 46 miscarriages, and 11 abortions.²⁰ While this study provides some data to fill the gap, we still do not have comprehensive pregnancy data from all 50 states or all jails.

Data omissions like this reflect the overall opacity of institutions of incarceration; without them being accountable, it is easier for abuses and neglectful care to occur. Furthermore, the failure of the state to track data about pregnant incarcerated people, as with the indifference with which the rise in female incarceration rates is treated, signals the general disregard for the profoundly gendered nature of our carceral system. That is, these elisions correspond to the presumption that males are the default prisoners and to the conflation of women's needs and experiences with men's. The shackling of

¹⁵ See BRONSON & CARSON, *supra* note 14, at 15 (comparing imprisonment rates of Black and white women); ZHEN, *supra* note 14, at 17 tbl.8 (comparing imprisonment rates by race).

¹⁶ See ZHEN, *supra* note 14, at 17 tbl.8.

¹⁷ See LAUREN E. GLAZE & LAURA M. MARUSCHAK, U.S. DEP'T OF JUSTICE, PARENTS IN PRISON AND THEIR MINOR CHILDREN 4 (2010), <https://www.bjs.gov/content/pub/pdf/pptmc.pdf> [<https://perma.cc/93UB-XBP9>].

¹⁸ See Jennifer G. Clarke et al., *Improving Birth Control Service Utilization by Offering Prerelease vs. Postincarceration*, 96 AM. J. PUB. HEALTH 840, 842 tbl.1 (2006) (prior to arrest and after release); Carolyn B. Sufirin et al., *Emergency Contraception for Newly Arrested Women: Evidence for an Unrecognized Public Health Opportunity*, 87 J. URB. HEALTH 244, 249 fig.1 (2009) (prior to arrest).

¹⁹ See Clarke et al., *supra* note 18, at 842 tbl.1; Flynn LaRochelle et al., *Contraceptive Use and Barriers to Access Among Newly Arrested Women*, 18 J. CORRECTIONAL HEALTH CARE 111, 114 (2012).

²⁰ See Carolyn Sufirin et al., *Pregnancy Outcomes in US Prisons, 2016–2017*, 109 AM. J. PUB. HEALTH 799, 801 (2019) [hereinafter Sufirin, *Pregnancy Outcomes*].

pregnant incarcerated people—which we address in detail below—exemplifies this notion that the carceral system is normatively male: shackling a pregnant person is medically unsafe and inhumane, yet it occurs because the default action is to restrain any incarcerated person when they are taken to a hospital or court, allegedly for public safety and flight-risk reasons. It then takes action to counter shackling in pregnancy, a physiological state that distinguishes presumptively male bodies from female bodies.

The lives of these women and their families are often negatively impacted by intersecting forms of oppression that include poverty, racism, unstable housing, histories of trauma and violence, untreated addiction and mental health conditions, and limited educational and employment opportunities. These factors also relate to both their overall health and to their pathways of involvement in the criminal justice system. The devaluation of the reproductive bodies of people whose lives are negatively impacted by these forms of oppression is then replicated in institutions of incarceration—in how institutions do or do not provide reproductive health care. We explore how such systematic disregard for reproductive health care in incarcerated settings manifests in legal and clinical terms below. While we are focused on the control of reproductive health and parenting behind bars, we emphasize that these practices follow predictable—and racialized—patterns that reflect and reinforce discourses of reproductive control in broader U.S. society.

III. HISTORICAL REGULATION OF BLACK WOMEN'S REPRODUCTION MANIFESTS IN CARCERAL SUBJUGATION

Women's reproduction²¹ and parenting have long been loci for state intrusion and control in the United States, particularly for women of color. Enslaved Black women "were dehumanized and distinguished from prevailing values of white womanhood" through "masculinization . . . devaluation . . . as mothers . . . the casting of Black women as dangerous, and . . . the construction of Black women as sexually deviant."²² Furthermore, Black women's reproduction, whether through rape or otherwise, and reproductive health was seen primarily as a method for increasing the slave labor force.²³ These various categorizations and capitalist structures justified sexual vio-

²¹ Throughout this paper, we use both gendered and non-gendered language in association with reproduction. It is essential to acknowledge that people with non-binary gender identities can reproduce in a variety of ways, including biologically. Using language such as "pregnant person" or "reproducing individuals" promotes this inclusivity. However, we also acknowledge that historically, women's bodies, because they are seen as women, have been subjected to specific oppressions. In collecting statistics about incarceration, agencies use the binary male and female to report demographics. Furthermore, the language of gender categories must be understood as unstable and socially contingent. For these reasons, we use both women and non-gendered language around reproduction.

²² Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CALIF. L. REV. 1239, 1259 (2012).

²³ See Deirdre Cooper Owens & Sharla M. Fett, *Black Maternal and Infant Health: Historical Legacies of Slavery*, 109 AM. J. PUB. HEALTH 1342, 1343 (Oct. 2019).

lence, forced reproduction, and the removal of parental rights of women who sought abortions after being raped by slave-owners.²⁴ The imposition of the male slave owner between the enslaved woman and her reproductive life course was mirrored in the similar imposition of the male prison officer after the Civil War.²⁵ After the system of chattel slavery was formally abolished, new laws punished formerly enslaved people through prohibitions on vagrancy, obscenity, and other acts.²⁶ Prisons engaged in so-called “convict leasing,” leasing out incarcerated people to private plantations, mines, and mills to engage in manual labor or ran their own plantations virtually indistinguishable from slave plantations.²⁷ Black women were subject to the same punishments as men, and their sentences and punishments could be intensified if they were pregnant.²⁸ “The punitive posture toward Black women’s pregnancies at sentencing and during incarceration served to devalue Black women as mothers and center their reproductive capacities as a cause for racial subordination.”²⁹ And just like enslaved people, Black incarcerated women were subject to “profound sexual abuses” at the hands of custody officers.³⁰

The control of Black women’s reproduction and its reflection of the moral and economic value U.S. society placed on their procreation continued throughout the 20th century. Such differential valuing of Black women’s reproduction increasingly became linked to understandings of deviance and then criminality. In 1965, the influential “Moynihan Report,” written on behalf of the United States Department of Labor, explicitly linked the Black family—seen by powerful white men as both matriarchal and broken—to Black criminality.³¹ The report opined that “the present tangle of pathology [in Black families] is capable of perpetuating itself without assistance from the white world.”³² The report therefore recommended that the federal government get involved in “enhancing the stability and resources of the Negro American family.”³³ While this statement may on the surface read as a call to improve safety net services for Black families who were often categorically excluded from accessing certain resources, it instead was mobilized as a justification to further interfere with Black women’s bodies and constrain their reproductive choices—for “wrong” choices that Black women made with re-

²⁴ See Ocen, *supra* note 22, at 1264, 1267.

²⁵ See *id.* at 1268.

²⁶ See Alexandria Gutierrez, *Sufferings Peculiarly Their Own: The Thirteenth Amendment, in Defense of Incarcerated Women’s Reproductive Rights*, 15 BERKELEY J. AFR.-AM. L. & POL’Y 117, 130 (2012).

²⁷ See *id.* at 131.

²⁸ See Ocen, *supra* note 22, at 1267–68.

²⁹ *Id.* at 1268.

³⁰ Gutierrez, *supra* note 26, at 133.

³¹ See generally DANIEL MOYNIHAN, U.S. DEP’T OF LAB., THE NEGRO FAMILY: THE CASE FOR NATIONAL ACTION (1965), <https://www.dol.gov/general/aboutdol/history/webid-moynihan> [<https://perma.cc/A7A4-XMWL>].

³² *Id.* at ch. V.

³³ *Id.*

spect to reproduction and parenting were therefore seen through the lens of criminality.³⁴ The incarceration and coercive reproductive control of the disproportionately Black pregnant people in Alabama explained above is evidence that the links between these moralizing judgments on Black women's reproduction, the state's oppressive claims to their bodies, and punishment persist.

Similarly, Native American women's reproductive autonomy and parenting have been sites of state oppression and control in ways that are foundational to this country. The United States long engaged in the practice of forcibly removing Native American children from their homes.³⁵ At the same time, Native American women receiving health care from the federal government were often sterilized, through force or coercion.³⁶ Yet they also lack access to abortion through mechanisms such as the Hyde Amendment, which prohibits the use of federal funding for abortions in most circumstances.³⁷ Thus, as with Black women, the state has interceded in various ways both to force Native American women to endure unwanted pregnancies and to prevent them from exercising the right to have and parent children—the core rights articulated by the reproductive justice framework.³⁸ People with disabilities, immigrant women, recipients of public aid and other systemically marginalized groups have experienced similar repro-

³⁴ See Stephen Steinberg, *The Moynihan Report at Fifty: The Long Reach of Intellectual Racism*, BOS. REV., July/Aug. 2015, at 1–2.

³⁵ In the nineteenth century, this removal took the form of forced boarding schools and other places in which children were prohibited from bonding with their families or practicing their own cultures or even languages. See Lorie M. Graham, *Reparations, Self-Determination, and the Seventh Generation*, 21 HARV. HUM. RTS. J. 47, 52 (2008). Later, this removal often took the form of “benevolently” removing children from Native American homes due to alleged abuse or neglect and then placing those children with white families. See *id.* at 56–57. These placements were based on the same idea: that the children would be better off without their Native American culture and the presumption of bad parenting on behalf of Native Americans. This practice continued until the passage of the ICWA in 1978. See *id.* at 90.

³⁶ See Jill E. Adams & Melissa Mikesell, *And Damned if They Don't: Prototype Theories to End Punitive Policies Against Pregnant People Living in Poverty*, 18 GEO. J. GENDER & L. 283, 294 n.62 (2017); Gemma Donofrio, *Exploring the Role of Lawyers in Supporting the Reproductive Justice Movement*, 42 N.Y.U. REV. L. & SOC. CHANGE 221, 229 (2018).

³⁷ See Rebecca A. Hart, *No Exceptions Made: Sexual Assault Against Native American Women and the Denial of Reproductive Healthcare Services*, 25 WIS. J.L. GENDER & SOC'Y 209, 216–17, 229–30 (2010).

³⁸ Reproductive justice is an intersectional theory and platform for action that emerged from and centers the experiences of women of color. See generally LORETTA J. ROSS & RICKIE SOLLINGER, *REPRODUCTIVE JUSTICE: AN INTRODUCTION* (2017). It advances reproduction in a human rights framework beyond the civil rights framing advanced by second-wave feminists and the pro-choice movement, which ignored the structural forces that differentially shape people's abilities to actualize their reproductive life goals. The core principles of reproductive justice include the right to have children, the right not to have children, and the right to parent one's children in safety and with dignity. See *id.* While reproductive justice emerged from a collective of black women, its principles are advanced for all groups whose reproduction has been devalued and marginalized, including based on immigration status, ability, and incarceration.

ductive oppressions.³⁹ It is this foundational history of state sanctioned reproductive control of certain groups in the U.S. that created the conditions of possibility for institutions of incarceration to then regulate and devalue the reproduction of people it confines.

IV. CRIMINALIZING BODIES AND THE RIGHT TO HEALTH CARE

The ongoing criminalization of abortion exemplifies how the state enacts control over pregnancy through carceral systems. From physician-led campaigns to successfully criminalize abortion in the late 19th century to a 2019 surge of punitive consequences for people who obtain and perform abortion, termination of pregnancy has long held a spot in U.S. criminal legal history.⁴⁰ Even though abortion remains legal in all fifty states, self-induced abortion is often illegal, and many states criminalize behavior that might harm a fetus or lead to miscarriage, including drug use.⁴¹ Pregnant people, abortion providers, and those who aid them may all be subject to incarceration, either currently or as abortion law develops.⁴² Contrary to arguments of anti-abortion advocates, abortion restrictions tend to oppress and control, not further health or protect pregnant people. As Judge Carlton Reeves explained in striking down a Mississippi abortion law,

the Mississippi Legislature’s professed interest in “women’s health” is pure gaslighting . . . The State “ranks as the state with the most [medical] challenges for women, infants, and children” but is silent on expanding Medicaid . . . Its leaders are proud to challenge Roe but choose not to lift a finger to address the tragedies lurking on

³⁹ See generally DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* (1997).

⁴⁰ See generally KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* (1984) (providing overview of the 19th century movement); Elizabeth Nash et al., *State Policy Trends Mid-Year 2019: States Race to Ban or Protect Abortion*, GUTTMACHER INST. (July 1, 2019), <https://www.guttmacher.org/article/2019/07/state-policy-trends-mid-year-2019-states-race-ban-or-protect-abortion> [<https://perma.cc/YDH5-9D7H>] (describing recent trends).

⁴¹ See Megan K. Donovan, *Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*, 21 GUTTMACHER POL’Y REV. 41, 45 (2018), https://www.guttmacher.org/sites/default/files/article_files/gpr2104118.pdf [<https://perma.cc/PH23-G33F>] (displaying map of states with laws that do or could criminalize self-managed abortion); NAT’L CONF. ST. LEGISLATURES, *State Laws on Fetal Homicide and Penalty-enhancement for Crimes Against Pregnant Women* (May 1, 2018), <http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx> [<https://perma.cc/XBW5-BKXM>] (listing state laws penalizing death or injury to a fetus); see also EXEC. BD., AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *DECriminalization of SELF-INDUCED ABORTION POSITION STATEMENT 1* (2017), <https://www.acog.org/-/media/17C77DCB90B84DCF8A60CEE731025117.pdf> [<https://perma.cc/99PG-TBYA>] (setting forth ACOG position statement supporting the decriminalization of self-induced abortion).

⁴² See ALA. CODE §§ 26-23H-1 to 26-23H-18 (West, Westlaw through Act 2019-540) (criminalizing the provision of abortion except in a medical emergency); *Robinson v. Marshall*, No. 2:19cv365-MHT, 2019 WL 5556198, at *5 (M.D. Ala. Oct. 29, 2019) (issuing preliminary injunction against enforcement of statute).

the other side of the delivery room: our alarming infant and maternal mortality rates. No, legislation like H.B. 1510 is closer to the old Mississippi—the Mississippi bent on controlling women and minorities. The Mississippi that, just a few decades ago, barred women from serving on juries “so they may continue their service as mothers, wives, and homemakers.” . . . The Mississippi that, in Fannie Lou Hamer’s reporting, sterilized six out of ten black women in Sunflower County at the local hospital—against their will . . . And the Mississippi that, in the early 1980s, was the last State to ratify the 19th Amendment—the authority guaranteeing women the right to vote.⁴³

Jane Doe was not originally incarcerated for seeking an abortion. Yet such criminalizing views on the procedure enabled the state to view itself as the protector of her fetus, both through the original violence of incarceration and through the denial of abortion, without regard to Jane Doe herself. Already a large number of people are currently incarcerated or have been prosecuted due to circumstances surrounding their miscarriages.⁴⁴ As abortion becomes more heavily regulated and criminalized, we must look to the ways that institutions of incarceration themselves are sites that punish and control reproductive choices and reproducing bodies. These institutions not only disproportionately confine people of color, but also internally restrict and control access to reproductive care.

Once in custody, incarcerated individuals are the only people the state is constitutionally obligated to provide medical care to, under the Eighth and Fourteenth amendments.⁴⁵ Justice Marshall in 1976 in *Estelle v. Gamble* declared that the “deliberate indifference to serious medical needs of prisoners” was cruel and unusual punishment “inconsistent with contemporary standards of decency.”⁴⁶ Since then, institutions of incarceration have been mandated to provide health care. However, the lack of specificity about what constitutes a “serious medical need” has allowed discretion, inconsistency, and moral judgment to flourish in the operationalizing of carceral health care systems.⁴⁷

Estelle has not resulted in a system of a required set of health care services to codify “serious medical needs” or oversight of health care delivery in institutions of incarceration. This lack of mandatory standardization results

⁴³ Jackson Women’s Health Org. v. Currier, 349 F. Supp. 3d 536, 541 n.22 (S.D. Miss. 2018) (citations omitted).

⁴⁴ See Mary Ziegler, *Some Form of Punishment: Penalizing Women for Abortion*, 26 WM. & MARY BILL RTS. J. 735, 772–75 (2018) (collecting cases).

⁴⁵ The Eighth Amendment, which prohibits cruel and unusual punishments, including denial of access to medical care, against convicted prisoners, is applied to the states through the Fourteenth Amendment. Pretrial detainees are entitled to the same services under the Due Process Clause of the Fourteenth Amendment. See *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983).

⁴⁶ *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

⁴⁷ See CAROLYN SUFRIN, *JAILCARE: FINDING THE SAFETY NET FOR WOMEN BEHIND BARS*, 41–61 (2017) [hereinafter Sufrin, *JAILCARE*].

in tremendous discretionary power on the part of each institution to determine what it deems a serious medical need and therefore what must be provided. Furthermore, without a formal, mandatory oversight system, the judicial system by default becomes the retroactive system for accountability when charges of deliberate indifference to serious medical needs are made in lawsuits. While hospitals must maintain accreditation by the Joint Commission in order to receive Medicaid and Medicare payments, there is no such structure in place to hold institutions of incarceration accountable for practicing standard health care.

This is certainly the case for reproductive health care. The Missouri Department of Corrections argued that the Fourteenth Amendment privacy right underlying the right to choose abortion “does not survive incarceration” because it is “inconsistent with imprisonment.”⁴⁸ The Department made this argument specifically about abortion, despite agreeing that the right to make “decisions about marriage” arises from the same privacy right and does survive incarceration.⁴⁹ This view, although it did not hold sway in the court,⁵⁰ demonstrates the belief that incarcerated people lose their right to make reproductive choices and must instead cede that control to the state.

The state has an obligation to provide health care precisely because of its complete control over those it detains. The obligation to provide care is therefore inextricably linked to the control over the body to which that care is provided. In the case of reproduction, the state incurs an obligation to provide reproductive care to those whom it punishes, including those it punishes for their reproductive choices, such as Jane Doe.⁵¹

The body in prison is an exemplary site of reproductive injustice,⁵² a site upon which the state may exercise nearly complete discretion and control over reproduction. This may occur through forced pregnancy via denial of abortion; or forced non-parenting through sterilization, through termination of parental rights, and through separation from one’s children. Reproductive control also manifests in the unqualified, dangerous prenatal and postpartum care that is often provided at institutions of incarceration, devaluing the safety and dignity of pregnant, incarcerated people. And since people cannot consensually conceive and procreate while behind bars, confining people

⁴⁸ *Roe v. Crawford*, 514 F.3d 789, 794 n.2 (8th Cir. 2008).

⁴⁹ *Id.*

⁵⁰ *See id.*

⁵¹ *See, e.g., Rachel Roth, “No New Babies?” Gender Inequality and Reproductive Control in the Criminal Justice and Prison Systems*, 12 AM. U. J. GENDER SOC. POL’Y & L. 391, 404–08 (2004) (describing cases in which criminal defendants were coerced into giving up reproductive choices under the threat of prison or other state control).

⁵² “Reproductive injustice” refers to the ways that institutions—like carceral institutions—fundamentally violate the core principles of reproductive justice as described earlier: the right to have children, the right not to have children, and the right to parent in safety and with dignity. *See generally* DANA-AIN DAVIS, REPRODUCTIVE INJUSTICE: RACISM, PREGNANCY, AND PREMATURE BIRTH (2019); *see generally* KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD (1984); Rachel Roth, “*She Doesn’t Deserve to be Treated Like This*”: Prisons as Sites of Reproductive Injustice, in RADICAL REPRODUCTIVE JUSTICE: FOUNDATIONS, THEORY, PRACTICE, CRITIQUE (Loretta J. Ross et al. eds., 2017).

during their prime childbearing years also sabotages their right to have children. That the people upon whom the state exercises these powers are among the most marginalized, through their race, economic status, mental health, addiction, and education, is a critical element of these practices. These are the very people whom the state has determined deserve no say in their own reproduction. The reproductive injustice enacted by and in institutions of incarceration can be particularly harrowing, but it portends danger for people who are free as well as those who are incarcerated, as it demonstrates what kind of coercion and control the state can get away with.

V. ABORTION DENIAL AS A METHOD OF CARCERAL CONTROL

A. Law permits forced pregnancy of incarcerated people

In theory, incarcerated people retain the constitutional right to access abortion, but most courts have upheld restrictions on abortion access under the Fourteenth Amendment even when they amount to complete denial in practice. Courts have reviewed abortion restrictions under both the Fourteenth Amendment, which *Roe v. Wade*⁵³ and *Planned Parenthood of Southeastern Pennsylvania v. Casey*⁵⁴ held protects the right to abortion in the free world,⁵⁵ and the Eighth Amendment, which *Estelle v. Gamble* held imposes affirmative obligations on institutions of incarceration to treat serious medical needs.⁵⁶ Every court to have considered the question has held that the right to abortion under the Fourteenth Amendment survives incarceration.⁵⁷ One court also upheld the right to access abortion under the Eighth Amendment.⁵⁸ Other courts have held that the desire for an “elective” abortion is not a “serious medical need” and therefore the Eighth Amendment does not require institutions of incarceration to provide access to or pay for it.⁵⁹ Therefore, although under the Fourteenth Amendment the institution of incarceration must provide access to abortion, it can require the person seek-

⁵³ 410 U.S. 113, 167 (1973).

⁵⁴ 505 U.S. 833, 833 (1992).

⁵⁵ See *Casey*, 505 U.S. at 167; *Roe*, 410 U.S. at 167.

⁵⁶ See *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

⁵⁷ See *Roe v. Crawford*, 514 F.3d 789, 794 (8th Cir. 2008); *Victoria W. v. Larpenter*, 369 F.3d 475, 483 (5th Cir. 2004); *Bryant v. Maffucci*, 923 F.2d 979, 979 (2d Cir. 1991); *Monmouth Cty. Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 335 (3rd Cir. 1987); *Roe v. Leis*, No. C-1-00-651, 2001 WL 1842459, at *2 (S.D. Ohio Jan. 10, 2001); *Doe v. Barron*, 92 F. Supp. 2d 694, 696 (S.D. Ohio 1999); *Doe v. Arpaio*, 150 P.3d 1258, 1262 (Ariz. Ct. App. 2007).

⁵⁸ See *Monmouth*, 834 F.2d at 349 (citing *Roe*, 410 U.S. at 153, for the damage that forced pregnancy can inflict).

⁵⁹ *Crawford*, 514 F.3d at 801; see also Samantha Laufer, *Reproductive Healthcare for Incarcerated Women: From “Rights” to “Dignity”*, 56 AM. CRIM. L. REV. 1785, 1788 (2019) (noting that “[c]ourts have been hesitant to classify certain reproductive issues [including pregnancy] as objectively serious”).

ing the abortion to pay not only for the abortion care itself but also for transportation and security costs.⁶⁰

Several national non-mandatory clinical guidelines affirm that institutions of incarceration should facilitate access to abortion as part of routine health care. The American College of Obstetricians and Gynecologists (ACOG), for instance, clearly outlines that institutions of incarceration should facilitate unbiased counseling about pregnancy options and access to abortion care, acknowledging that abortion is part of the spectrum of pregnancy care.⁶¹ Standards published by the American Public Health Association require the same services, although these have not been updated since 2003 and serve as non-mandatory guidelines only.⁶² The National Commission on Correctional Health Care is the leading organization in providing standards and accrediting health care systems within institutions of incarceration, although following those standards and acquiring accreditation is voluntary. The 2018⁶³ standards require that “counseling and assistance are provided and documented in accordance with the pregnant inmate’s expressed desires regarding her pregnancy, whether she elects to keep the child, use adoptive services, or have an abortion.”⁶⁴ The standard goes on to recommend that institutions should have a pre-existing arrangement with a community abortion provider, so that systems are in place to ensure abortion access when the need arises.⁶⁵

B. Systemic control by institutions of incarceration includes barriers to abortion

Regulations and practices within institutions of incarceration, together with obstacles to abortion outside of them, functionally limit or even eliminate the right to abortion access. Because incarcerated people cannot access

⁶⁰ See, e.g., PENN. DEP’T OF CORRS., POLICY No. 13.2.1, ACCESS TO HEALTH CARE, at 13–5 (2019), <https://www.cor.pa.gov/About%20Us/Documents/DOC%20Policies/13.02.01%20Access%20to%20Health%20Care.pdf> [<https://perma.cc/CHQ6-9BN4>] (requiring the incarcerated person to cover all security and transportation costs associated with “elective” abortion); FLA. ADMIN. CODE r. 33-401.601(3) (West, Westlaw through October 28, 2019) (making incarcerated people in Florida responsible for security and transportation for elective procedures); GA. COMP. R. & REGS. 125-4-4-.01(b)(2) (West, Westlaw through November 26, 2019) (Georgia DOC may deduct costs associated with medical treatment initiated by the incarcerated person).

⁶¹ See *Reproductive Health Care for Incarcerated Women and Adolescent Females*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-Health-Care-for-Incarcerated-Women-and-Adolescent-Females> [<https://perma.cc/HWB8-4BF9>].

⁶² See generally AM. PUB. HEALTH ASS’N, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS (2003).

⁶³ Of note, prior to NCCHC’s 2014 standards—the tenth revision of them since first being published in 1977—having access to counseling and abortion services was not categorized an essential standard that had to be met for accreditation.

⁶⁴ NAT’L COMM’N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JAIL 120 (2018).

⁶⁵ See *id.* at 119.

medical care or providers directly, they must go through the jail's or prison's internal system for accessing care. This process typically involves making a written request to see institutional medical staff and then relying on medical staff to coordinate scheduling outside appointments. Even in the best of circumstances, the process is still lengthy, involves many steps, and is not conducive to time sensitive requests like the ones abortion care might require.⁶⁶ Added to this logistical tangle is the variability in the existence of written policies.⁶⁷ Carceral policies may fail to mention or even prohibit abortion. The Federal Bureau of Prisons's (BOP) written policy states that pregnant people in federal custody can obtain an abortion, but regulations from the Hyde Amendment—which prohibits federal funding for abortion except in cases of rape, incest, or to save the life of the pregnant person—are built into the policy that prohibits BOP from paying for the abortion if it is “elective.”⁶⁸

The persistence of sporadic lawsuits on behalf of incarcerated patients actively seeking but being denied abortions illustrates this point,⁶⁹ and this is supported by existing research on abortion policies in jails and prisons. A 2004 survey of 44 state prison policies reported that only nine states clearly provided people with abortions.⁷⁰ Sixteen states had no official written policies, which in practice typically meant abortion was not available.⁷¹ Some states allowed and funded abortions if they were “medically necessary.”⁷² This policy variability means that discretion and inconsistency are the norm, which then makes it easy for prisons to deny people abortions. Another national study of health care providers in prisons and jails reported that 68% of respondents said that a pregnant person at their institution could obtain an abortion if they requested one.⁷³ However, when these providers were asked to delineate further logistics about scheduling, payment, transportation, and court orders, responses varied widely, suggesting that institutions might not be as practically equipped to provide pregnant people with abortion services as they claim.⁷⁴ These studies both highlight not only the absence of written policies on abortion for people in custody, but also other factors beyond a

⁶⁶ See FED. BUREAU OF PRISONS, U.S. DEP'T OF JUSTICE, PROGRAM STATEMENT NO. 5200.02, at 15 (2016), <https://www.bop.gov/policy/progstat/5200.02.pdf> [<https://perma.cc/DHM8-G3WB>]; Carolyn Sufirin, *When the Punishment is Pregnancy: Carceral Restriction of Abortion in the United States*, 34 CULTURAL ANTHROPOLOGY 34, 37 (2019) [hereinafter Sufirin, *When the Punishment is Pregnancy*].

⁶⁷ See Rachel Roth, *Do Prisoners Have Abortion Rights?*, 30 FEMINIST STUD. 353, 365 tbl.1 (2004).

⁶⁸ FED. BUREAU OF PRISONS, U.S. DEP'T OF JUSTICE, *supra* note 66, at 13.

⁶⁹ See *infra* notes 80 and 120–21 and accompanying text.

⁷⁰ See Roth, *supra* note 67, at 365 tbl.1.

⁷¹ See *id.*

⁷² *Id.*

⁷³ See Carolyn Sufirin et al., *Incarcerated Women and Abortion Provision: A Survey of Correctional Health Providers*, 41 PERSP. ON SEXUAL & REPROD. HEALTH 6, 8 (2009).

⁷⁴ See *id.* at 8–9. Interviews conducted in 2016 demonstrate that this problem is ongoing. One jail in Massachusetts paid for one incarcerated person's abortion but required another to pay for it herself. See Lauren Kuhlik, *Pregnancy Behind Bars: The Constitutional Argument for Reproductive Healthcare Access in Prison*, 52 HARV. C.R.-C.L. L. REV. 501, 515 (2017).

policy that might allow or disallow abortion that would functionally restrict a person's ability to actually get an abortion. This assertion is also suggested by the 2019 prison pregnancy outcomes study in which only 1% of the pregnancies that ended in prisons ended in abortion, a much lower proportion than expected based on national abortion rates.⁷⁵

Abortion restrictions enacted in the free world likely have a disproportionate impact on incarcerated people in multiple intersecting ways. Laws targeting abortion providers that have led to the closure of abortion clinics exacerbate this access barrier for incarcerated people. Six states have only one clinic that provides abortion, and 8% of women of reproductive age live more than 90 miles from the nearest clinic.⁷⁶ Incarcerated people are particularly at risk for being far from clinics, since many prisons are in rural areas and most abortion clinics in urban ones.⁷⁷

Some institutions, including BOP, give officers the choice to decline transporting a woman for an abortion if they have moral opposition to it.⁷⁸ This too could contribute to delays. While affiliates of the National Network of Abortion Funds can help with some costs of the abortion procedure, these funds are limited, and they cannot cover things like officer overtime.⁷⁹ Furthermore, if a clinic is extremely far away, and if the abortion must be a two-day procedure either due to state restrictions or the medical steps involved, institutions of incarceration might be unwilling to approve a procedure that requires either two long round trips or facilitating an overnight stay closer to the clinic. Laws in the free world outside institutions of incarceration that require waiting periods compound this issue by increasing the amount of time, and therefore the cost, of travel, and again they may necessitate an overnight stay near the clinic that a prison or jail might refuse to allow.⁸⁰

⁷⁵ See Sufrin, *Pregnancy Outcomes*, *supra* note 20, at 801.

⁷⁶ See Jessica Arons, *The Last Clinics Standing*, AM. C.L. UNION, <https://www.aclu.org/issues/reproductive-freedom/abortion/last-clinics-standing> [<https://perma.cc/97JW-32J5>]; Rebecca Wind, *Although Many U.S. Women of Reproductive Age Live Close to an Abortion Clinic, a Substantial Minority Would Need to Travel Far to Access Services*, GUTTMACHER INST. (Oct. 3, 2017), <https://www.guttmacher.org/news-release/2017/although-many-us-women-reproductive-age-live-close-abortion-clinic-substantial> [<https://perma.cc/H6FG-MH9L>].

⁷⁷ See generally Julia Gips et al., *Does Distance Decrease Healthcare Options for Pregnant, Incarcerated People? Mapping the Distance between Abortion Providers and Prisons*, CONTRACEPTION (Jan. 23, 2020), <https://doi.org/10.1016/j.contraception.2020.01.005> [<https://perma.cc/46BK-65C9>]; See generally John Eason et al., *Mass Imprisonment Across the Rural-Urban Interface*, 672 ANNALS AM. ACAD. POL. & SOC. SCI. 202, (2017) (explaining that most prisons are located in rural areas); Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, J. WOMEN'S HEALTH 1, 4 tbl.2 (2019) (explaining that people living in metropolitan areas traveled less distance to get to abortion clinics than those living outside of metropolitan areas).

⁷⁸ See FED. BUREAU OF PRISONS, U.S. DEP'T OF JUSTICE, *supra* note 66, at 15; Sufrin, *When the Punishment is Pregnancy*, *supra* note 66, at 37.

⁷⁹ See FED. BUREAU OF PRISONS, U.S. DEP'T OF JUSTICE, *supra* note 66, at 15; see also ABOUT, NAT'L NETWORK ABORTION FUNDS, <https://abortionfunds.org/about/> [<https://perma.cc/24KJ-CPNU>].

⁸⁰ Fourteen states require two separate trips to an abortion facility; thirteen others do not require in-person counseling but do have a waiting period between a counseling session and the abortion, which, for incarcerated people, amounts to the same two-visit requirement. See *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST., <https://www.guttmacher>

Many clinics also only perform abortions up to a certain point in pregnancy, such as 15 weeks, even though no state forbids “elective” abortion before viability.⁸¹ Because of the slow process of scheduling medical appointments in institutions of incarceration,⁸² such a cut-off might make abortion practically unavailable to someone who would otherwise have been able to access it.

Amid these regulatory and practical barriers to abortion, there are other clinical factors to consider. First, a person has to know they are pregnant. Research has documented that some people first learn of a pregnancy upon arrival to jail or prison,⁸³ in part related to limitations in their community access to health care and to high rates of irregularities in their menstrual cycles.⁸⁴ Some institutions routinely offer pregnancy tests at intake, some routinely do pregnancy tests within a given time period on arrival, and some only do them upon request or at medical providers’ discretion.⁸⁵

Additionally, incarcerated people denied medical care must go through lengthy grievance processes before requesting judicial relief.⁸⁶ Given the urgency of request for medical care, especially time-sensitive abortion care, “[r]equiring such a prisoner to exhaust all administrative options is effectively to deny him or her relief.”⁸⁷ Even if the pregnancy is still pre-viability at the end of the grievance process, the length of time of this process itself can render abortion practically inaccessible for the reasons explained above. People seeking abortion are even worse off if the facility does not conduct routine pregnancy tests, requiring them to go through the grievance process for

.org/state-policy/explore/counseling-and-waiting-periods-abortion [https://perma.cc/FVF2-3XRA].

⁸¹ See Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 4 AM. J. PUB. HEALTH 623, 624 (2009).

⁸² See, e.g., *Brown v. Plata*, 563 U.S. 493, 519 (2011) (describing “severe” delays in scheduling medical appointments in the California prison system, including urgent specialty referrals that “had been pending for six months to a year”).

⁸³ See Sufrin, *JAILCARE*, *supra* note 47, at 74-75.

⁸⁴ See Jenifer E. Allsworth et al., *The Influence of Stress on the Menstrual Cycle Among Newly Incarcerated Women*, 17 WOMEN’S HEALTH ISSUES 202, 207-08 (2007).

⁸⁵ See, e.g., Ginette G. Ferzst & Jennifer G. Clarke, *Health Care of Pregnant Women in U.S. State Prisons*, 23 J. HEALTH CARE FOR POOR & UNDERSERVED 557, Table 2, 564 (2012); C. M. Kelsey et al., *An Examination of Care Practices of Pregnant Women Incarcerated in Jail Facilities in the United States*, 21 MATERNAL & CHILD HEALTH J. 1260, 1261-63 (2017); Sufrin, *Pregnancy Outcomes*, *supra* note 20 at 801. There are some that force women to give a urine sample for a pregnancy test, not offering them a choice, which is also problematic. See *ACLU Settles Lawsuit with Alameda County Jails over Pregnancy Testing*, AM. C.L. UNION NORTHERN CAL. (Oct. 28, 2015), <https://www.aclunc.org/news/aclu-settles-lawsuit-alameda-county-jails-over-pregnancy-testing> [https://perma.cc/MKC5-6EZC].

⁸⁶ See, e.g., N.J. ADMIN. CODE § 10A:1-4.4 (West, Westlaw through amendments included in the N.J. Reg., Vol. 51, Issue 21, dated November 4, 2019) (describing multi-step grievance procedure in New Jersey in which staff has fifteen to thirty days to respond at each step); OHIO ADMIN. CODE. 5120-9-31 (West, Westlaw through September 6, 2019) (explaining the three-step grievance process in Ohio, where imprisoned people have to wait 7-30 days to receive a response at each step); 37 TEX. ADMIN. CODE § 283.3 (West, Westlaw through 44 Tex. Reg. No. 5954, dated October 11, 2019, as effective on or before October 18, 2019) (providing staff in Texas jails with up to 60 days to respond to detainee grievances).

⁸⁷ Antonieta Pimienta, *Overcoming Administrative Silence in Prisoner Litigation: Grievance Specificity and the “Object Intelligibly” Standard*, 114 COLUM. L. REV. 1209, 1219 (2014).

the pregnancy test and then for the abortion. Yet even though the institutions themselves impose these barriers, incarcerated people who are unable to access abortion because of the lengthiness of the request and grievance processes may not be entitled to judicial relief.⁸⁸

All of these barriers for a person just to get to an abortion clinic can prevent incarcerated people from actually getting the care they need. Additionally, the option of medication abortion is also less realistic for incarcerated people. The bleeding that is standard with medication abortion may be difficult for people to experience in a setting where they do not consistently have access to menstrual products,⁸⁹ or where staff may be unresponsive to their concerns of excessive bleeding.⁹⁰ Pain, too, is common with medication abortion, but incarcerated people have constrained abilities to address their own pain—in part due to the “pill call” systems that only deliver medications at designated times, rather than having pain medications at one’s side;⁹¹ this would be especially pronounced for a short-lived process like medication abortion.

Once an incarcerated person decides they need an abortion, the experiential reality on the ground is variable and may depend on custody officers’ individual beliefs and actions. Pregnant people should receive non-biased assessment and counseling from health care providers as to their thoughts and plans for the pregnancies.⁹² While there is little research exploring the nature of carceral-provided options counseling, there is some evidence of directive counseling.⁹³ A pregnant person might also endure judgmental or discriminatory comments from custody officers or other incarcerated people about her abortion decision, which is difficult to keep private while in custody.⁹⁴ Because of the immense power differential between custody officers and incarcerated people, there is also the danger that the “counseling” could

⁸⁸ See, e.g., *Gibson v. Matthews*, 926 F.2d 532, 534–35 (6th Cir. 1991) (stating that “[a]lthough it may appear from the facts that Gibson was a victim of the bureaucracy as a whole . . . this theory cannot suffice to affix personal liability on any of the defendants”); *Bryant v. Maffucci*, 923 F.2d 979, 984–85 (2d Cir. 1991) (stating that “the effect of the delay” that ultimately prevented the plaintiff from accessing an abortion “did not then deprive [her] of her rights”).

⁸⁹ See AM. CIVIL LIBERTIES UNION, *THE UNEQUAL PRICE OF PERIODS: MENSTRUAL EQUITY IN THE UNITED STATES* 3–4 (2019), https://www.aclu.org/sites/default/files/field_document/111219-sj-periodequity.pdf [<https://perma.cc/9HKW-FXER>].

⁹⁰ While no research documents how often officers and medical staff ignore labor complaints, there is evidence that this happens in cases where women have birthed in their jail cells, after requesting medical attention for bleeding and other labor signs. The case of Diana Sanchez in 2018 is notable for video surveillance of her labor, ignored requests, and jail cell birth. See Allyson Chiu, “*Nobody Cared*: A Woman Gave Birth Alone in a Jail Cell After Her Cries for Help Were Ignored, Lawsuit Says,” WASH. POST (Aug. 29, 2019), <https://www.washingtonpost.com/nation/2019/08/29/pregnant-woman-diana-sanchez-birth-alone-jail-cell-denver/> [<https://perma.cc/R6B7-BXPK>].

⁹¹ See Sufirin, *JAILCARE*, *supra* note 47, at 109–10.

⁹² See *supra* notes 84–87 and accompanying text.

⁹³ See Rachel Roth, *Obstructing Justice: Prisons as Barriers to Medical Care for Pregnant Women*, 18 UCLA WOMEN’S L.J. 79, 84 (2010).

⁹⁴ See generally Sufirin, *JAILCARE*, *supra* note 47.

come across as an implicit threat—and retaliation for engaging in constitutionally protected behavior is difficult to prove.⁹⁵

One of the authors of this paper, an abortion provider, has personally cared for an incarcerated patient to whom custody officers were verbally abusive, telling her she was “murdering her baby” as they were en route transporting her for the abortion. The other author is aware of a case in which both a custody officer and a medical staff person informed the woman that she was killing her baby. The medical staff person did so while forcing her to view an image of an ultrasound. People across the country have fought back against laws forcing people to view ultrasounds before being allowed to access abortion, and advocacy organizations have sometimes been successful in getting such laws overturned on state or federal grounds.⁹⁶ But what happens inside jail walls is invisible to the outside world and therefore can be far more insidious—a woman told she’s murdering her baby cannot call up a sympathetic reporter or find another provider. She is stuck with the staff members at the jail and must endure verbal abuse without recourse. Although institutions of incarceration cannot legally ban abortion entirely (though some do either by default or inappropriately claiming it is an elective procedure), the authors are not aware of any cases in which such abuse was held to violate the Constitution.⁹⁷ This derision also resonates with the judgment that incarcerated people who continue pregnancies face being labelled “bad mothers;” ultimately, these poles of reproductive judgement signal the ways that women’s reproductive bodies and capacities, especially those who are marginalized, are differentially valued and controlled.⁹⁸

⁹⁵ See, e.g., *Cooper v. Duncan*, No. 7:16CV00578, 2017 WL 2271501, at *2 (W.D. Va. May 23, 2017) (explaining that courts are skeptical of claims that prison discipline was retaliatory and summarily dismissing a claim of retaliation for reporting sexual assault as unsupported); CTR. FOR AM. PROGRESS ET AL., UNJUST: HOW THE BROKEN CRIMINAL JUSTICE SYSTEM FAILS LGBT PEOPLE 113 (2016), <http://www.lgbtmap.org/file/lgbt-criminal-justice.pdf> [<https://perma.cc/8AKA-42LK>] (describing lack of protection from retaliation for reporting sexual abuse).

⁹⁶ See *Forced Ultrasound*, REWIRE.NEWS, <https://rewire.news/legislative-tracker/law-topic/forced-ultrasound/> [<https://perma.cc/6LHF-39MB>] (last updated Sept. 12, 2018).

⁹⁷ In general, verbal abuse and even verbal threats from custody officers are constitutionally permissible. See, e.g., *Jackson v. Holley*, 666 F. App’x 242, 244 (4th Cir. 2016) (holding that allegation of sexual harassment failed to state a constitutional claim); *Randolph v. London*, 400 F. App’x 894, 896 (5th Cir. 2010) (holding that retaliatory verbal abuse did not violate the Constitution); *Richardson v. Sherrer*, 344 F. App’x 755, 757 (3d Cir. 2009) (concluding verbal harassment and threats to the plaintiff to “shut [him] up” did not violate the Constitution); *Johnson v. Dellatifa*, 357 F.3d 539, 545–46 (6th Cir. 2004) (concluding racially prejudicial remarks and harassment were not a constitutional violation); *Rivera v. Hassler*, 79 F. App’x 392, 394 (10th Cir. 2003) (dismissing prisoner’s claim that he was harassed, teased, and falsely reported by a custody officer).

⁹⁸ See Shelle Colen, “*With Respect and Feelings*”: *Voices of West Indian Child Care Workers in New York City*, in ALL AMERICAN WOMEN: LINES THAT DIVIDE, TIES THAT BIND 46, 46–70 (Johnnetta B. Cole ed., 1986), for seminal discussion of “stratified reproduction,” the processes through which some women’s reproduction is valued and promoted and others’ is devalued and suppressed. See also Carolyn Sufrin, *Making Mothers in Jail: Carceral Reproduction of Normative Motherhood*, 7 REPROD. BIOMEDICINE & SOC’Y ONLINE 55, 60 (2018) [hereinafter Sufrin, *Making Mothers*].

Other cases also demonstrate the variability of access. For example, one Tennessee judge denied a woman's request to go out of state to access abortion; another judge rebuked him sharply and granted the woman's request, and the woman was able to get her abortion.⁹⁹ Other people seeking abortion have been less lucky: multiple jails have completely blocked access to abortion, forcing people to carry pregnancies to term or wait until their release to access this medical care.¹⁰⁰ Ultimately, we do not know how many such cases are out there, because few carceral facilities keep track of pregnancy outcomes, much less requests for abortion that were not realized—another manifestation of the general invisibility of people incarcerated in women's facilities.

C. Carceral forced pregnancy as site of punishment and control

Institutions of incarceration are a core part of the “repressive state apparatus”¹⁰¹ that act as forms of social control not only of the people confined inside, but also for all of society in expressing the state's values by orchestrating who is locked up. Drawing on the work of Michel Foucault,¹⁰² we also understand that the coercion and regulatory control of bodies within carceral institutions is a form of state-sanctioned violence, and this daily violence compounds the underlying violence of the racially biased iteration of mass incarceration within the U.S. When considering such forms of carceral state power and violence in terms of control over pregnancy and reproduction within institutions of incarceration, we see how these processes serve to further oppress and marginalize people who are already marginalized by race and gender.

State violence within institutions of incarceration, combined with state power and control over certain pregnant bodies outside of these institutions, serve to curtail real access to abortion for incarcerated people, forcing them to endure pregnancy and thereby become more susceptible to state control. Reproductive control by carceral institutions constitutes a form of state-sanctioned violence, in continuity with numerous other forms of the state's coercive regulation of reproductive bodies. The prevailing assumption among

⁹⁹ See *Tennessee Judge Rebuked for Nixing Out-of-State Abortion*, ASSOCIATED PRESS (Mar. 15, 2019), <https://www.apnews.com/b6b8b8d4dddc4521aec5665c90feb97> [<https://perma.cc/VRJ6-M4PL>].

¹⁰⁰ See Kay Winston, “*Roe v. Wade* Must Include Abortion Access for Women in Prison,” Bitch Media (Jan. 22, 2018), <https://www.bitchmedia.org/article/roe-v-wade/abortion-in-prison> [<https://perma.cc/X4MF-86Q9>] (describing her own experience being denied abortion while in jail); Kristine Phillips, *A Woman Claims She Was Denied an Abortion While in Jail. Now She's Suing for \$1.5 Million*, Washington Post (Jan. 11, 2017), <https://www.washingtonpost.com/news/post-nation/wp/2017/01/11/a-woman-claims-she-was-denied-an-abortion-while-in-jail-now-shes-suing-for-1-5-million/> [<https://perma.cc/P9QR-9XK6>] (describing multiple cases in which jails refused to provide access to abortion care).

¹⁰¹ See generally Louis Althusser, *Ideology and Ideological State Apparatuses*, in *THE ANTHROPOLOGY OF THE STATE: A READER* (Aradhana Sharma & Akhil Gupta eds., 2006).

¹⁰² See generally MICHEL FOUCAULT, *DISCIPLINE AND PUNISH: THE BIRTH OF THE PRISON* (Alan Sheridan trans., Vintage Books 2d ed. 1995) (1977).

institutions of incarceration and courts alike is that abortion is not a “serious medical need,” in the language of *Estelle*.¹⁰³ This declaration that abortion is not essential health care has also been documented in qualitative research.¹⁰⁴ The work that the reproductive rights movement has advanced to ground abortion in individual choice—rather than the collective and structural forces of justice—has been complicit in enabling carceral administrators to thus see abortion as an elective medical procedure.¹⁰⁵ That is, abortion rights discourses that center discussing motherhood as a choice, and abortion as a tool to facilitate that choice, presume that the individual self can act through a set of unconstrained choices. For example, an amicus brief filed on behalf of the appellants in *Roe v. Wade* by prominent women’s organizations began its argument, under the heading “The Nature of the Woman’s Right[,]” with the assertion that “[t]he personal, constitutional right of a woman to . . . determine whether to bear a particular child . . . evolves inevitably from” previous Supreme Court recognition of various “constitutionally protected interests” in the area of “marriage, sex, the family and the raising of children.”¹⁰⁶ The amici argued that the Court should hold “that one of the individual rights protected by the United States Constitution is the woman’s right to determine the spacing of her children and to decide whether to carry a particular pregnancy to term.”¹⁰⁷

But this laser focus on bodily autonomy and a pregnant person’s “right to choose” is incongruous in an environment—prison or jail—that intentionally restricts one’s bodily autonomy and everyday choices, where one cannot choose when or what to eat, where one must get permission to use the bathroom.¹⁰⁸ Health care professionals, too, can subtly promote hierarchies between legitimate abortions—those where abortion is necessary to preserve the pregnant person’s physical body or where there is a lethal fetal abnormality, often called “medically indicated”—and illegitimate abortions—when abortions are not done for an immediate, physical health reason, often called “elective.”¹⁰⁹ The trivializing language of “elective” enables carceral administrators to consider abortion as they would cosmetic surgery for an incarcerated individual.

An “elective” procedure in health care is one that can be delayed or deferred without significant effect on someone’s life or health.¹¹⁰ This is cer-

¹⁰³ *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

¹⁰⁴ See e.g., FED. BUREAU OF PRISONS, U.S. DEP’T OF JUSTICE, *supra* note 66, at 15; Suffrin, *When the Punishment is Pregnancy*, *supra* note 66 at 37.

¹⁰⁵ See FED. BUREAU OF PRISONS, U.S. DEP’T OF JUSTICE, *supra* note 66, at 15.

¹⁰⁶ Motion for Leave to File Brief Amici Curiae on Behalf of Women’s Organizations and Named Women in Support of Appellants in Each Case, and Brief Amici Curiae, *Roe v. Wade*, 410 U.S. 113 (1971) (Nos. 70–18, 70–40), 1971 WL 128048, at *8.

¹⁰⁷ *Id.* at *16.

¹⁰⁸ *Id.* at *25 (describing denial of the “right to choose” as restrictive in the same degree as “long term imprisonment”).

¹⁰⁹ Katrina Kimport et al., *The Stratified Legitimacy of Abortions*, 57 J. HEALTH & SOC. BEHAV. 503, 507–08 (2016).

¹¹⁰ See e.g., FED. BUREAU OF PRISONS, U.S. DEP’T OF JUSTICE, *supra* note 66, at 15; Suffrin, *When the Punishment is Pregnancy*, *supra* note 66 at 34, 37.

tainly not the case with pregnancy and abortion, since they are time-dependent and since reproduction is a core part of many people's entire life courses.¹¹¹ Therefore, understanding abortion not solely in an individual, rights-based framework and instead in the broader structural rubric theorized by reproductive justice scholars and activists is essential¹¹²—for the consequences of not doing so for incarcerated pregnant people mean that carceral administrators can deny them abortions.

Forced pregnancy and birth can render incarcerated people especially vulnerable to state control. In the free world, people who are denied abortion are disadvantaged in several ways compared to those who are able to access abortion. They are less likely to bond with their children or to continue or find full-time employment, and their children are more likely to live in poverty.¹¹³ These individuals and their families are consequently more dependent on the state for their livelihood and for the protection of their children.

Many of these concerns are magnified for incarcerated people enduring forced pregnancy. Incarcerated people were generally more impoverished prior to their incarceration than non-incarcerated people.¹¹⁴ Post-release, the poverty and dependency are exacerbated by laws limiting where formerly incarcerated people can live and work.¹¹⁵ This forced dependency and exclusion from mainstream economy and social services then increases state coercion and control, since access to government aid is often conditioned on permitting ongoing state intrusion into one's personal decision-making.¹¹⁶ Lack of abortion access can therefore lead to state control that continues long after a prison sentence ends.

Incarcerated people have to contend with numerous other forms of coercion and control while pregnant as well. They may be shackled, placed into solitary confinement, denied adequate prenatal care or food, or denied necessary access to medical care. Pregnancy is a site of "particularized punishment

¹¹¹ FED. BUREAU OF PRISONS, U.S. DEP'T OF JUSTICE, *supra* note 66, at 15.

¹¹² See generally LORETTA ROSS & RICKIE SOLLINGER, *REPRODUCTIVE JUSTICE* (2017).

¹¹³ See Diana Greene Foster et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs. After Pregnancies Subsequent to an Abortion*, 172 JAMA PEDIATRICS 1053, 1056–57 (2018) (poor maternal bonding and poverty); Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortion in the United States*, 108 AM. J. PUBLIC HEALTH 407, 409 (2018) (unemployment).

¹¹⁴ See generally LOIC WACQUANT, *PRISONS OF POVERTY* (2009).

¹¹⁵ See generally MARIE CLAIRE TRAN-LEUNG, *WHEN DISCRETION MEANS DENIAL: A NATIONAL PERSPECTIVE ON CRIMINAL RECORDS BARRIERS TO FEDERALLY SUBSIDIZED HOUSING* (2015) (explaining that many public housing assistance programs go beyond mandatory federal regulations to ban people with past convictions); Ryan Cramer et al., *State Policies in the United States Impacting Drug-Related Convictions and Their Consequences in 2015*, 5 DRUG SCI., POLY & L. 1 (2019) (exploring limitations on collecting public assistance, becoming professionally licensed, and accessing jobs for formerly incarcerated people).

¹¹⁶ See *Wyman v. James*, 400 U.S. 309, 326 (1971) (upholding a state law requiring public assistance beneficiaries to allow unscheduled home visits made without probable cause); Khiara Bridges, *Privacy Rights and Public Families*, 34 HARV. J.L. & GENDER 113, 124–25 (2011) (explaining how, in exchange for enrollment in prenatal care assistance in New York, people are "obliged to divulge a broad swath of information about their lives" and to consult with a number of educators, counselors, and others).

. . . in penal institutions across the country.”¹¹⁷ Denial of access to abortion and the attendant harms incarcerated people must endure due to forced pregnancy permits the state to exert special control over and to punish these people.

As a systemic practice, denial of abortion access for incarcerated people is not about individual administrators’—or system-wide—“pro-life” values, as demonstrated by conflicting reproductive coercions across the system. Rather, the unwanted pregnancy of the incarcerated person is seen as proof of her diminished value in society as a woman.¹¹⁸ Indeed, the positioning of a judge or custody officer as a barrier between an incarcerated person or criminal defendant and reproductive health care serves to underscore this point.¹¹⁹ The state makes the reproductive choices and in doing so, asserts and maintains control over the reproductive autonomy of the people it incarcerates.

VI. CARCERAL STATE DEVALUES AND PUNISHES PREGNANCY AND CHILDBIRTH

A. Barriers to prenatal and postpartum care function to oppress and control

When considering the implications of prenatal care—or its absence—in carceral settings, we must ground it in two overlapping phenomena of racial disparities: maternal mortality and incarceration. That is, Black women are 3-4 times more likely to die in childbirth than white women;¹²⁰ and Black women are incarcerated at twice the rate of white women.¹²¹ Thus, prenatal care behind bars ties these two racialized facts together. As with carceral abortion discretion, the lack of mandatory standards and oversight for health care in institutions of incarceration translates into tremendous variability in provision of prenatal care services. A 2010 report from the Rebecca Project found that 38 state prison systems had inadequate prenatal care, sometimes

¹¹⁷ Ocen, *supra* note 22, at 1254.

¹¹⁸ See *id.* at 1266–67; see also Sufrin, *Making Mothers*, *supra* note 98, at 60 (arguing that the “carceral system envisions the default prisoner to be male” and imputes violence even to pregnant incarcerated people, thereby permitting it to degrade them through practices such as shackling and denial of abortion).

¹¹⁹ See *Doe v. Arpaio*, 150 P.3d 1258, 1266 (2007) (explicitly referring to a judge as an unconstitutional “gate-keeper” while striking down court order requirement as unconstitutional abortion restriction).

¹²⁰ See Monica R. McLemore, *To Prevent Women from Dying in Childbirth, First Stop Blaming Them*, *SCI. AM.* (May 1, 2019), <https://www.scientificamerican.com/article/to-prevent-women-from-dying-in-childbirth-first-stop-blaming-them/> [<https://perma.cc/7T4Y-446T>]; *Pregnancy Mortality Surveillance System*, *CTR. FOR DISEASE CONTROL & PREVENTION* (Jan. 16, 2016), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm> [<https://perma.cc/6T9V-7XFX>].

¹²¹ JENNIFER BRONSON & E. ANN CARSON, *U.S. DEP’T OF JUSTICE, PRISONERS IN 2017*, at 15 (2019), <https://www.bjs.gov/content/pub/pdf/p17.pdf> [<https://perma.cc/CV3V-DRAT>].

consisting only of a periodic blood pressure check.¹²² Research studies of prison and jail policies have similarly documented inconsistencies in terms of access to qualified prenatal care providers, routine availability of standard nutritional and other care recommendations in pregnancy, and mental health and substance use disorder care.¹²³ Despite well-established recommendations that pregnant people with opioid use disorder be on pharmacologic treatment for their addiction, and not undergo withdrawal, the drugs methadone and buprenorphine are not consistently available in carceral settings.¹²⁴ Forcing pregnant people to go through opioid withdrawal poses significant risks for them and their developing fetuses.¹²⁵ To the extent that institutions of incarceration provide pregnant people with this medication-assisted treatment, it might be done to “prevent . . . fetal harm rather than [to respond to] the inmate’s medical needs.”¹²⁶

An incarcerated pregnant person must, by default, rely on custody officers to triage any pregnancy related symptoms requiring medical attention, including possible labor symptoms. A pregnant person in custody does not have the freedom to call their health care provider or an ambulance or to go to a hospital, but must instead notify a custody officer who serves, functionally, as the gatekeeper to a pregnant person accessing medical personnel. The response of a custody officer, who is not a medical professional and typically has had no training from the institution on proper pregnancy care or warning signs, should always be to contact medical staff.¹²⁷ This need is particularly salient in pregnancy because concerning signs in pregnancy or labor symptoms may often be subtle, such as light bleeding, cramping, or even a headache. In reality, however, custody officers may make their own, unqualified assessments as to whether a pregnant person’s symptoms warrant medical attention, or whether they are “really” in labor—leading to delays and neglect in care.¹²⁸ Custody officers’ gatekeeping position allows them not

¹²² THE REBECCA PROJECT FOR HUMAN RIGHTS & NAT’L WOMEN’S LAW CTR., *MOTHERS BEHIND BARS* 6 (2010), <https://www.nwlc.org/sites/default/files/pdfs/mother-behindbars2010.pdf> [<https://perma.cc/XED9-R2PX>].

¹²³ See Ginette G. Ferszt & Jennifer G. Clarke, *Health Care of Pregnant Women in U.S. State Prisons*, 23 J. HEALTH CARE FOR POOR & UNDERSERVED 557, 567 (2012); C. M. Kelsey et al., *An Examination of Care Practices of Pregnant Women Incarcerated in Jail Facilities in the United States*, 21 MATERNAL CHILD HEALTH J. 1260, 1265–66 (2017).

¹²⁴ See Kelsey et al., *supra* note 124, at 1265–66; Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey*, 105 DRUG & ALCOHOL DEPENDENCE 83, 86–88 (2009).

¹²⁵ See Mishka Terplian et al., *Opioid Detoxification During Pregnancy: A Systematic Review*, 131 OBSTETRICS & GYNECOLOGY 803, 812–13 (2018).

¹²⁶ *Smith v. Aroostook City*, 376 F. Supp. 3d 146, 156 (D. Me. 2019).

¹²⁷ Some custody officers who guard incarcerated pregnant people are female and some are male. There are no data on responsiveness to concerns based on officer gender, and it therefore is difficult to assess whether female custody officers would be more responsive to pregnant people’s symptoms than male officers. While it may seem intuitive that women officers, who may have been pregnant themselves, might be more knowledgeable about concerning pregnancy signs, it is also possible that male officers might be more quick to call for help with pregnant people since they have no framework for triaging.

¹²⁸ See, e.g., Victoria Law, *Pregnant and Behind Bars: How the US Prison System Abuses Mothers-to-Be*, *GUARDIAN*, (Oct. 20, 2015), <https://www.theguardian.com/us-news/2015/oct/>

only to exercise their lack of clinical judgment, but also to exercise potential punitive, moral judgments about pregnant incarcerated people.¹²⁹

Institutions of incarceration are rarely held accountable for failing to provide prenatal care except when that failure results in an adverse pregnancy outcome. ACOG recommends that incarcerated pregnant people should receive the same prenatal care services—including regular visits with a qualified provider and certain laboratory and ultrasound tests—that are standard in the community. The federal district court of the District of Columbia held that failure to provide routine prenatal care is illegal but analyzed that failure in the context of local law, not the Eighth Amendment.¹³⁰ Analyzing the claims under state law, the court required the prison to establish a clinic and provide prenatal care on a schedule recommended by ACOG.¹³¹ The appellate court overturned that portion of the opinion, holding that the district court had improperly exercised its discretion in analyzing claims under local, non-federal law.¹³² To date, no court has held that failure to provide routine prenatal care violates the Eighth Amendment.¹³³

When courts have held that failure to provide prenatal care is unconstitutional, they have generally done so in the context of a specific and obvious medical need arising from an abnormality in pregnancy or in failure to respond to an incarcerated person going into labor. Case law demonstrates that institutions of incarceration are required to provide prenatal care only when they are aware of circumstances demonstrating a substantial risk of serious harm to the pregnant person and/or the pregnancy.¹³⁴ Many of the cases deal with horrific situations that custody officers entirely ignored, including bleeding or other significant discharge,¹³⁵ significant pain and

20/pregnant-women-prison-system-abuse-medical-neglect [https://perma.cc/LEX5-UH4P]; Mariel Padilla, *Woman Gave Birth in Denver Jail Cell Alone, Lawsuit Says*, N.Y. TIMES (Sept. 1, 2019), <https://www.nytimes.com/2019/09/01/us/diana-sanchez-birth-denver-jail.html> [https://perma.cc/BHQ3-FBRA]; Eric Balaban & Lauren Kuhlik, *No One Should Be Forced to Give Birth Alone in a Jail Cell*, AM. C.L. UNION (May 9, 2019), <https://www.acu.org/blog/prisoners-rights/women-prison/no-one-should-be-forced-give-birth-alone-jail-cell> [https://perma.cc/65FQ-SF3Z].

¹²⁹ See generally Sufrin, JAILCARE, *supra* note 47; Sufrin, *Making Mothers*, *supra* note 96, at 55–65.

¹³⁰ See *Women Prisoners of the D.C. Dep't of Corr. v. District of Columbia*, 877 F. Supp. 634, 667–68 (D.D.C. 1994).

¹³¹ *Id.* at 682–83.

¹³² See *Women Prisoners of the D.C. Dep't of Corr. v. District of Columbia*, 93 F.3d 910, 923 (D.C. Cir. 1996).

¹³³ However, courts have deemed the complete failure to provide routine medical care to violate the Eighth Amendment. See, e.g., *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982), *abrogated on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980); *Todaro v. Ward*, 565 F.2d 48, 52 (2nd Cir. 1977). Under this case law, a pregnant person completely denied access to regular prenatal care may state a constitutional claim.

¹³⁴ See, e.g., *Patterson v. Carroll Cty. Det. Ctr.*, No. 2:05-cv-00101-DLB, 2006 WL 3780552, at *4 (E.D. Ky. Dec. 20, 2006) (issuing summary judgment for jail where COs ignored cramping and then the next day, the woman went into early labor and lost the pregnancy).

¹³⁵ See *Castro v. Melchor*, 414 P.3d 53, 57 (Haw. 2018) (noting woman had stillbirth after prison staff ignored significant bleeding and did not timely transport her to hospital).

cramping,¹³⁶ and other signs of miscarriage, early labor, or other serious pregnancy issues.¹³⁷

A number of state laws go further than the courts have, mandating that prisons provide prenatal care to pregnant incarcerated individuals.¹³⁸ However, these statutes do not undermine the carceral institutions' ability to limit the amount or quality of care received. Institutions have the final say in determining who gets care, when they get care, and from where they get care. Custody officers remain positioned between the pregnant incarcerated person and actual access to care.

B. State oppression during childbirth demonstrates devaluation and control of certain pregnancies

Unlike pregnancy in general, in which limited or no access to abortion and prenatal care has been legitimized, labor is considered a "serious medical need." Specifically, institutions of incarceration are constitutionally obligated to take people in labor to the hospital.¹³⁹ However, this categorization of labor as a serious medical need certainly does not result in consistent or high-quality health care. First, there is the issue of appropriately assessing if someone is in labor, which custody staff, as non-medical professionals, are not qualified to do. Therefore, if a person has symptoms that suggest labor or if they request evaluation for labor, the response should always be to refer to medical staff; and jail or prison medical staff, if they are not trained in obstetrical care, should always refer such a person to a hospital or other provider who can assess. Yet, as reports of people who birthed in their jail cells demonstrate, these steps to ensure appropriate evaluation for labor are not consistently taken.¹⁴⁰

¹³⁶ See *Calloway v. City of New Orleans*, 524 So. 2d 182, 187 (La. Ct. App. 1988).

¹³⁷ See *Turner v. Knox Cty. Det. Facility*, No. 3:15-CV-266-TAV-CCS, 2016 WL 6775431, at *4 (E.D. Tenn. Nov. 15, 2016) (declining to dismiss woman's claim that she had a high-risk pregnancy requiring regimen of medications that was not provided, leading to miscarriage).

¹³⁸ See, e.g., CAL. PENAL CODE § 3406 (West, Westlaw through Ch. 870 of 2019 Reg. Sess.); CONN. GEN. STAT. ANN. § 18-69c (West, Westlaw through the 2019 January Reg. Sess. and the 2019 July Spec. Sess.).

¹³⁹ See, e.g., *Boswell v. Sherburne Cty.*, 849 F.2d 1117, 1119, 1123 (declining to issue summary judgment to defendants where 6.5-month pregnant pretrial detainee passed blood clots, had abnormal discharge, and had fainted; she had a history of fast delivery but was not brought to the hospital despite labor symptoms; when she finally got to the hospital, her baby died shortly after birth).

¹⁴⁰ There is no systematic information about how many incarcerated people give birth inside prison or jail. Sufirin, *Pregnancy Outcomes*, *supra* note 20, at 801, reported that 6 of the 753 births in their study occurred in prisons. Likewise, several media accounts report on lawsuits of women who gave birth in their jail cells after their calls for help were ignored. See Ashley Southall, *She Was Forced to Give Birth in Handcuffs. Now Her Case is Changing Police Rules.*, N.Y. TIMES (July 3, 2019), <https://www.nytimes.com/2019/07/03/nyregion/nypd-pregnant-women-handcuffs.html> [<https://perma.cc/WZY6-BBSQ>], among others. The publicity around Ms. Sanchez's case is notable for its inclusion of surveillance video of her labor symptoms, requesting medical attention, being ignored, and then delivering her own baby in her jail cell.

Furthermore, the use of restraints in labor and childbirth comes with numerous medical risks for the pregnant person and the fetus, not to mention the long-term traumatic effects.¹⁴¹ In deliberations over laws and policies restricting the shackling of pregnant people, one issue that frequently arises in discussion is how to know when a person is in labor and therefore when a custody officer should not place them in restraints.¹⁴² Likewise, various laws and policies addressing shackling among pregnant incarcerated people differentiate between restraints in labor, childbirth, at other non-labor points in pregnancy, and during transport.¹⁴³

Such attention to these distinctions makes it seem as though labor and delivery are the only dangerous time to shackle, when in fact shackling is dangerous for different reasons throughout the pregnancy: during labor and delivery, shackles restrict the ability of the health care team to provide emergency care, such as during a hemorrhage, if an emergency Cesarean section is warranted, or if the baby gets stuck in the birth canal; shackles can also injure the pregnant person's body as they move to relieve contraction pain or push the baby out; and at non-labor points in pregnancy, shackles are also dangerous because they could increase the risk that a pregnant person could fall and not be able to break their fall, which can cause the placenta to separate, leading to hemorrhage and stillbirth.¹⁴⁴ Distinguishing between labor and delivery versus other points in pregnancy also suggests that diagnosing labor is a clear-cut activity, when it is not, especially as evidenced by jail staff's neglect that has facilitated jail cell births. Furthermore, effort invested into such distinctions promotes the default condition that all pregnant people should be restrained, and the task is to figure out the exceptions to when restraints should be applied, when, in fact, it should be the reverse.

¹⁴¹ See *Reproductive Health Care for Incarcerated Women and Adolescent Females*, *supra* note 61.

¹⁴² One author has given numerous presentations to custody and policy audiences and legislators on the topic of shackling of pregnant people. As an Ob/Gyn, she is frequently asked "how do you know when a woman is really in labor?" And as an Ob/Gyn, she responds that it can be a difficult diagnosis to make and that it usually requires more than one sequential pelvic examinations—that is, a non-trained individual cannot simply look at a woman and determine whether or not she's in labor. See generally NATIONAL TASK FORCE ON THE USE OF RESTRAINTS WITH PREGNANT WOMEN UNDER CORRECTIONAL CUSTODY, BEST PRACTICES IN THE USE OF RESTRAINTS WITH PREGNANT WOMEN AND GIRLS UNDER CORRECTIONAL CUSTODY (2014), https://www.nasmhpd.org/sites/default/files/Best_Practices_Use_of_Restraints_Pregnant%282%29.pdf [<https://perma.cc/S3YX-6NUD>].

¹⁴³ See Appendix I.

¹⁴⁴ Other dangers of shackles at non-labor points of pregnancy include the fact that obstetrical emergencies can arise at any point, and restraints impair the ability of health care providers to deliver necessary care; shackles impair mobility, and prolonged immobility increases pregnant people's risk of blood clots; pregnant people, especially those with nausea and vomiting, may be more prone to passing out, and this can be dangerous if they are also shackled. For a full discussion of the dangers of shackling pregnant people, see *Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Pregnant-and-Postpartum-Incarcerated-Women-and-Adolescent-Females> [<https://perma.cc/393V-8NVQ>].

Beyond the medical risks, courts have also held that shackling of wrists and ankles may be unconstitutional during labor, at least in some cases.¹⁴⁵ For example, the Ninth Circuit held that a jury could reasonably conclude that a woman shackled during labor and postpartum recovery was “exposed . . . to a substantial risk of serious harm” because of the risk of injury such restraint poses and the “chorus of organizations that have warned of the danger of restraining women in labor.”¹⁴⁶ However, the court recognized that “[t]hese same organizations” warning of the danger of shackling “acknowledge, however, that shackles may be necessary, despite the risks, when an inmate poses a flight or safety risk.”¹⁴⁷ It was therefore relevant to the court’s analysis that the defendants “failed to show that [the plaintiff] was a danger to others[,] . . . that [she] was a flight risk” and that she had been “arrested for a nonviolent crime.”¹⁴⁸ Similarly, the Eighth Circuit held that “a factfinder could draw the inference that [the defendant] recognized that the shackles interfered with [the plaintiff]’s medical care, could be an obstacle in the event of a medical emergency, and caused unnecessary suffering” when the plaintiff was shackled by her ankles to her hospital bed during labor.¹⁴⁹ Again, it was relevant to the holding that there was evidence that the incarcerated woman “did not present a flight risk” and therefore there was no “competing penological interest in shackling her . . .”¹⁵⁰ Therefore, the right to be free from shackling, even during childbirth, is qualified by presumptions about incarcerated people’s danger and risk of escape, presumptions that are absurd when applied to someone who is delivering a child. Holdings affirming the (qualified) right to be free from shackling may have been motivated by devastating fact patterns.¹⁵¹ However, even incidents of shackling during labor do not always rouse courts’ sympathy.¹⁵²

Due to the advocacy work of impacted people and on-the-ground advocates, the use of restraints on pregnant, incarcerated people has garnered some legislative and media attention.¹⁵³ As detailed in the Appendix, as of May 2020, 30 states, the District of Columbia, and the federal government have passed laws prohibiting the practice at least during labor. Many of these anti-shackling laws, however, include explicit exceptions allowing custody officers to shackle even people in the midst of delivering their babies,

¹⁴⁵ See, e.g., *Women Prisoners of the D.C. Dep’t of Corr. v. District of Columbia*, 899 F. Supp. 659, 678 (D.D.C. 1995) (noting that an exception might be made for incarcerated people with a “history of assaultive behavior” or escaping).

¹⁴⁶ *Mediola-Martinez v. Arpaio*, 836 F.3d 1239, 1254 (9th Cir. 2016).

¹⁴⁷ *Id.* at 1253.

¹⁴⁸ *Id.* at 1255.

¹⁴⁹ *Nelson v. Corr. Med. Servs.*, 583 F.3d 522, 530 (8th Cir. 2009) (en banc).

¹⁵⁰ *Id.* at 530–31.

¹⁵¹ See, e.g., *id.* at 526 (finding pregnant woman shackled during labor suffered “extreme mental anguish and pain, permanent hip injury, torn stomach muscles, and an umbilical hernia requiring surgical repair.”).

¹⁵² See, e.g., *Fain v. Rappahannock Reg’l Jail*, No. 3:12cv293–JAG, 2013 WL 3148145, at *6 (E.D. Va. June 19, 2013) (holding that officers who shackled a woman during labor were entitled to qualified immunity).

¹⁵³ See, e.g., Southall, *supra* note 140. .

whether by vaginal birth or cesarean delivery, even with an epidural, which limits one's ability to walk, if a custody officer deems that there are legitimate security risks.¹⁵⁴ The laws presume that incarcerated people are so dangerous that they may escape or assault someone even while giving birth.¹⁵⁵ While many laws have provisions that authorize health care professionals to have custody officers remove restraints, some laws and hospital policies also make health care providers complicit by enabling them to request that restraints be applied or determine when it is or is not safe—when it is, by medical standards, always an unsafe practice.¹⁵⁶ That this practice of shackling pregnant people—deemed medically unsafe and a human rights violation by all major medical professional societies in the U.S. and by international standards¹⁵⁷—even requires legislative regulation signals the inherent inhumanity at the intersection of incarceration and reproduction.

Even when a law is in place, it by no means precludes the shackling of pregnant incarcerated people, either in pregnancy in general or in labor. Notably, only Rhode Island's law includes a private right of action allowing a person illegally shackled to sue for damages.¹⁵⁸ Weak or non-existent enforcement provisions demonstrate that even legislators opposed to the practice still believe the state, not the pregnant person, should be allowed to vindicate the rights of those subject to reproductive oppression.¹⁵⁹ Several reports from states with anti-shackling laws demonstrate that the practice still occurs.¹⁶⁰ Officers continue to apply restraints as the default practice, presuming pregnant people taken off site to be public safety and flight risks, either in ignorance of the laws' intent or flagrantly violating their terms. Furthermore, police officers may not even feel that the laws apply to them, and therefore may continue to shackle pregnant people even after anti-

¹⁵⁴ See Appendix I.

¹⁵⁵ See Laufer, *supra* note 59, at 1798–99; see also Appendix I, Column 3, “Exceptions.”

¹⁵⁶ See *Reproductive Health Care for Incarcerated Women and Adolescent Females*, *supra* note 61.

¹⁵⁷ See United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules), Rule 24 (adopted Mar. 16, 2011), <https://cdn.penalreform.org/wp-content/uploads/2016/07/BangkokRules-Updated-2016-with-renumbering-SMR.pdf> [<https://perma.cc/H9NG-RFHQ>]; AM. MED. ASS'N HOUSE OF DELEGATES, RESOLUTION 203 (A-10), SHACKLING OF PREGNANT WOMEN IN LABOR 1 (2010), <https://www.prisonlegalnews.org/news/publications/american-medical-association-house-of-delegates-resolution-203-a-10-shackling-of-pregnant-women-in-labor-2010/> [<https://perma.cc/3HKV-NL8Z>]; see also *Reproductive Health Care for Incarcerated Women and Adolescent Females*, *supra* note 61.

¹⁵⁸ See Appendix I.

¹⁵⁹ See *id.*

¹⁶⁰ See TAMAR KRAFT-STOLAR, CORR. ASS'N OF N.Y., REPRODUCTIVE INJUSTICE: THE STATE OF REPRODUCTIVE HEALTH CARE FOR WOMEN IN NEW YORK STATE PRISONS 6, 137 (2015), <https://static1.squarespace.com/static/5b2c07e2a9e02851fb387477/t/5c4f5d01758d466ad39b0a97/1548705033102/2015+Reproductive+Injustice+n+New+Yorks+Prisons.pdf> [<https://perma.cc/6FQL-G427>]; THE PRISON BIRTH PROJECT & PRISONERS' LEGAL SERVS. OF MASS., BREAKING PROMISES: VIOLATIONS OF THE MASSACHUSETTS PREGNANCY STANDARDS & ANTI-SHACKLING LAW 10 (2016), <https://www.prisonlegalnews.org/media/publications/Breaking%20Promises%20-%20Violation%20sof%20the%20MA%20Pregnancy%20Standards%20%26%20Anti-Shackling%20Law%2C%20Prison%20Birth%20Project%2C%202016.pdf> [<https://perma.cc/2E7M-86SZ>].

shackling laws are implemented.¹⁶¹ Medical personnel at hospitals may also be complicit in shackling pregnant people. A survey of nearly 700 perinatal nurses found that only seven percent of them correctly identified whether their states had a law.¹⁶² Hospital policies do not always align with laws or safe, ethical practice, and health care providers may not understand their role in advocating for patients.¹⁶³

Even when a medical provider is aware of an anti-shackling law and attempts to ensure it is enforced, illegal shackling during labor still occurs. In 2017, a medical student in California explained the anti-shackling law—which was passed in 2005 and then improved on in a 2012 law—to a custody officer who nonetheless still refused to remove the restraints from a woman in labor. He based his refusal on the fact that the labor was not “active,” not on any danger or flight risk. As soon as his shift ended, the next custody officer allowed the woman’s handcuffs to be removed.¹⁶⁴

In addition to shackling, another way in which incarcerated birthing people are denied dignity is in their isolation—that is, not having a trust support person in the room with them; while in labor or giving birth in hospital settings, incarcerated people are typically not permitted to have support people beyond the hospital health care staff in their rooms.¹⁶⁵ Some carceral systems may allow visitation at designated hospital visiting times, but such limited windows do not necessarily align with the time when a person is giving birth.¹⁶⁶ Birth support can be essential for someone’s psychological wellbeing during labor, and improves people’s satisfaction with their birth experience.¹⁶⁷ Instead, a custody officer is often stationed inside a laboring patient’s room. Some carceral institutions attempt to have the custody staff be female, but this is not always the case. Regardless of the gender of the guarding person, they are still a law enforcement officer inserted into a person’s birthing experience. In some cases, a pregnant person may surprisingly find support from this individual,¹⁶⁸ but in other cases the officer may insult the patient or stare intently as the patient undergoes pelvic examina-

¹⁶¹ See, e.g., Southall, *supra* note 138.

¹⁶² See Lorie S. Goshin et al., *Perinatal Nurses’ Experiences with and Knowledge of the Care of Incarcerated Women During Pregnancy and the Postpartum Period*, J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 27, 32 (2018).

¹⁶³ See *id.* at 33.

¹⁶⁴ Author’s interview with anonymous medical student (June 2017).

¹⁶⁵ See Stephanie Fritz & Kevin Whiteacre, *Prison nurseries: Experiences of incarcerated women during pregnancy*, 55 J. OFFENDER REHABILITATION 1, 9–10 (2016); cf Rebecca J. Schlafer et al., *Reproductive Justice for Incarcerated Mothers and Advocacy for Their Infants and Young Children*, 40 INFANT MENTAL HEALTH J. 725, 731 (2019).

¹⁶⁶ See generally Sufirin, JAILCARE, *supra* note 47.

¹⁶⁷ See Mary Ann Stark et al., *Importance of the Birth Environment to Support Physiologic Birth*, 45 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 285, 285 (2016). Although not formally documented in official institution policies, one author (CS) is aware of a practice at several state prisons where the institution works with the local hospital to schedule non-medically indicated labor inductions—and in some cases cesarean sections routinely at 39 weeks, for the convenience of the institution to minimize the chances of having to deal with the unpredictability of labor timing.

¹⁶⁸ See Sufirin, JAILCARE, *supra* note 47, at 121–153.

tions. Incarcerated people, particularly women, are disproportionately likely to have experienced sexual or physical abuse.¹⁶⁹ The presence of having a threatening officer in the room during the intimate experience of giving birth could plausibly be re-traumatizing for people with those experiences.

Several state prison systems and county jails allow doulas to support people throughout the pregnancy while they are in custody, during childbirth in the hospital, and postpartum in the hospital and at the prison or jail.¹⁷⁰ Research on these specialized doula services demonstrates that they are feasible and provide benefits for the pregnant person including emotional support, knowledge, and increased breastfeeding.¹⁷¹ Three states have even passed legislation to ensure that pregnant incarcerated people have access to doula services.¹⁷² While such legislative validation underscores the importance of non-carceral support systems for confined pregnant and postpartum people, these laws do not provide funding for prison and jail doula programs.¹⁷³ This often means that doulas provide volunteer services, reinforcing exploitative anti-feminist ideologies of uncompensated labor.¹⁷⁴

¹⁶⁹ See CAROLINE WOLF HARLOW, U.S. DEP'T OF JUSTICE, PRIOR ABUSE REPORTED BY INMATES AND PROBATIONERS 1 (1999), <https://www.bjs.gov/content/pub/pdf/parip.pdf> [<https://perma.cc/5FDE-NA5N>] ("Just under half of the women in correctional populations and a tenth of the men indicated past abuse."); EVALUATION & INSPECTIONS DIV., U.S. DEP'T OF JUSTICE, REVIEW OF THE FEDERAL BUREAU OF PRISONS' MANAGEMENT OF ITS FEMALE INMATE POPULATION 19 (2018), <https://oig.justice.gov/reports/2018/e1805.pdf> [<https://perma.cc/D2NH-2RHT>] (estimating that 90% of women in federal Bureau of Prisons custody have experienced past trauma, including sexual abuse and domestic violence).

¹⁷⁰ For an example of one such program, see *Our Mission*, MINN. PRISON DOULA PROJECT, <https://www.mnprisondoula.org/about> [<https://perma.cc/EAG6-PWY5>]. After a thorough review of the literature, the authors could find no systematic information about how many prison and jail doula programs exist. However, one author is aware of programs in Alabama, New York City, Connecticut, Georgia, and San Francisco. She is aware of a doula program in Maryland that has been attempted for several years but held up by bureaucratic hurdles. There are likely programs in other states and cities, but this is not something that has been cataloged or researched at this time.

¹⁷¹ See Rebecca J. Shlafer et al., *Doulas' Perspectives About Providing Support to Incarcerated Women: A Feasibility Study*, 32 PUB. HEALTH NURSING 316, 325–26 (2015); Rebecca J. Shlafer et al., *Intention and Initiation of Breastfeeding Among Women Who Are Incarcerated*, 22 NURSING FOR WOMEN'S HEALTH 64, 72 (2018).

¹⁷² See MINN. STAT. § 241.89(4) (West, Westlaw through January 1, 2020 from the 2019 Reg. and First Spec. Sess.) (permitting incarcerated pregnant people to access doula services, but only if those services are offered for free or the incarcerated person pays); OKLA. STAT. tit. 57, § 4.2(E)(3) (West, Westlaw through the First Reg. Sess. of the 57th Leg. (2019)) (requiring institutions of incarceration to provide access to a doula during delivery, provided that "the doula services are furnished by a certified doula without charge to the" institution); WASH. STAT. § 70.48.135 (West, Westlaw through the 2019 Reg. Sess. of the Washington Leg.) (requiring jails to make reasonable accommodations for the provision of, but not to pay for, doula services).

¹⁷³ See *supra* note 172 and accompanying text.

¹⁷⁴ See Jennifer M. C. Torres, *Expertise and Sliding Scales: Lactation Consultants, Doulas, and the Relational Work of Breastfeeding and Labor Support*, 29 GENDER & SOC'Y 244, 247 (2015) (Because "caring is constructed as belonging to the private sphere of the home[,] [doulas' work] is . . . linked to femininity and believed to be an innate characteristic of women. . . . [Therefore,] people commonly expect that [this labor] will be provided out of love, kinship, or obligation. This creates difficulty in negotiating paid caring relationships.") (internal citations omitted); see also Sarah Jaffe, *The Factor in the Family*, THE NATION (Apr. 9, 2018), <https://www.thenation.com/article/archive/wages-for-houseworks-radical-vision/> [<https://perma.cc/>

After delivery, policies and practices vary around allowing parents to be with their infants in the hospital. There are no data documenting these hospital-based visitation practices after birth, as this falls in the liminal space between hospital and custody policies.¹⁷⁵ That is, the postpartum person is both a patient and incarcerated person, and this status creates ambiguity as to which policies of rooming-in with one's infant (hospital) or punitive isolation (custody) apply; it also raises ambiguity as to the status of the infant, who is not incarcerated, but incidentally punished when they are not allowed to be with their parent. In this space of ambiguity, discretion flourishes and inconsistency is the norm. One of the authors who has worked in several hospitals in different states that care for incarcerated people who have given birth has witnessed some situations where mothers can have their babies in their postpartum recovery room with them the entire time; other situations where babies are whisked away to the nursery within hours after birth, with only limited visiting times for the mother—and often in shackles no less;¹⁷⁶ and others where the postpartum person is discharged from the hospital in a truncated time period so she can return to the carceral institution as soon as possible.

While there are health benefits of enabling immediate parent-infant bonding, from psychological to facilitating breastfeeding, the mechanics of how and how long a parent can be with their newborn do not clearly fall under the domain of a health care practice or a custody practice—leaving it up to discretion and interpretation of custody officers, and, as is often the case, enabling subtly punitive gestures such as not allowing the infant to be in the hospital room with the parent, requiring early discharge from the hospital 24 hours after birth, and not allowing breastfeeding even in the hospital.

There are numerous medical and mental health issues that may arise for postpartum incarcerated people, yet there is little codified knowledge about postpartum care in custody, and a dearth of case law involving postpartum medical care, much less mental health care.¹⁷⁷ For instance, it is likely that postpartum depression is common for people who give birth while incarcerated, due to the synergistic effects of the baseline high rates of mental illness

DZN2-KVQ3] (describing the feminist campaign Wages for Housework, which highlighted gender inequality inherent in the idea of unpaid women's work).

¹⁷⁵ There is no central national repository of hospital policies or academic study reporting post-labor visitation policies.

¹⁷⁶ See Carolyn Sufryn et al., *Reproductive Justice, Health Disparities, and Incarcerated Women in the U.S.*, 47 PERSP. ON SEXUAL & REPROD. HEALTH 213, 216 (2015).

¹⁷⁷ Even more so than with prenatal care, as a finding of unconstitutionally deficient postpartum care requires an abnormal and egregious situation. In one case, the plaintiff had a stillbirth, after which she had a severe fever, pain, and shaking. See *Fogell v. Ryan*, No. 01-611-SLR, 2003 WL 21756096, at *2-3 (D. Del. July 30, 2003). The prison doctor, who also delivered the stillbirth, dismissed her symptoms; it was later determined that the prison doctor had failed to remove the fragments, causing permanent damage. See *id.* at *3. The court denied the doctor's and the correctional medical service's motion for summary judgment. See *id.* at *6. The case does not address the severe mental anguish that surely followed the stillbirth or require routine postpartum care in the absence of severe and acute symptoms.

combined with the psychological trauma of being forcibly separated from one's newborn.¹⁷⁸

Yet there are no data documenting frequency of postpartum depression in incarcerated settings and little to indicate whether carceral health care providers even screen for postpartum depression. Even if an institution of incarceration provides standard treatment in pregnancy for opioid use disorder by providing methadone or buprenorphine—since opioid withdrawal is dangerous in pregnancy—it is common for prisons and jails to discontinue the medication as soon as the pregnancy has ended;¹⁷⁹ this practice reveals that the carceral institution was providing the medication out of concern for the fetus, not for the pregnant or postpartum person, failing to recognize that the parent's long-term health and opioid treatment are important for them and their baby. And for people who do not express breast milk in custody—either by choice or by default because the institution does not allow it—they are potentially at risk for breast conditions like plugged ducts or even infections if they cannot empty their breasts. Another postpartum constraint in this setting is the inconsistent and often limited access to adequate menstrual products;¹⁸⁰ this is not only a problem in custody for menstruating people, but also postpartum people who typically have vaginal bleeding for several weeks.

C. *Carceral state as barrier between pregnant person and care and dignity*

These incidents establish the regularity with which custody officers and policies, health care institutions, and legislative practices place themselves between pregnant people and necessary care: lack of access to care and shackling are dehumanizing as well as physically dangerous. Presumptions about incarcerated women serve to fuel the idea that they are lying about their pain or their labor and do not deserve to be treated with the same dignity as “good” mothers or non-incarcerated women. Just as they do not get to choose whether to remain pregnant, these people do not get to choose when to go to the hospital or where to give birth. Instead, the state makes those decisions.

Given that some of the people denied prenatal care may well be incarcerated due to reproductive choices,¹⁸¹ it is particularly egregious that institu-

¹⁷⁸ One of the authors had heard anecdotal reports of increased use of solitary confinement on people who have just given birth due to perceived “acting out” by parents who have endured the trauma of giving birth while incarcerated and then having their infant separated within twenty-four to forty-eight hours. However, this phenomenon has not been officially studied, nor do institutions of incarcerated document it.

¹⁷⁹ In a survey conducted by one author, thirty-one jail administrators representing ninety-four counties in eighteen states responded to questions about provision of medication treatment to pregnant and postpartum people with opioid use disorder. See Carolyn Sufrin, Address at the Addiction Health Services Research Conference (Oct. 17, 2019). 92% of respondents who provided treatment during pregnancy indicated that they discontinued treatment when the pregnancy ended. *See id.*

¹⁸⁰ *See* AM. CIVIL LIBERTIES UNION, *supra* note 89, at 3–4.

¹⁸¹ *See supra* Part IV.

tions of incarceration would punish them with inadequate care or shackling. Only a view of these incarcerated people as “bad mothers” would justify a regime that so regularly punishes and harms them. Even when case law or legislation prohibits shackling someone who is in labor, there are exceptions built in. These exceptions then position custody officers between pregnant people and access to dignity and care, presuming that the state should determine who “deserves” to be free from such awful punishment. This view necessarily “rests on an assumption that incarcerated women are dangerous as individuals and as mothers” which further “rests on stereotypes of female incarcerated people informed by prior regimes of racialized punishments that viewed Black women as lacking in maternal instincts, driven by sexual desires, and physically threatening.”¹⁸² Ideas of “dangerousness, deviance, and control of bodily integrity” have come to harm all incarcerated people—even though they were “once attached only to Black women’s bodies”—through the process of mass incarceration.¹⁸³

VII. STATE OPPRESSION VIA DENIAL OF RIGHT TO PARENT

A. *The law legitimizes family separation and destruction*

Legal protections for postpartum people and incarcerated parents are scarce due to a dearth of both legislation and litigation on behalf of postpartum people and incarcerated parents. Most carceral policies only allow a postpartum parent to spend 24–48 hours with their newborn before separating them and bringing the parent back to the prison.¹⁸⁴ Institutions of incarceration are constitutionally permitted to restrict visits significantly, even if doing so has the practical effect of curtailing or even eliminating parent-child visitation.¹⁸⁵ The importance of maternal-infant bonding is well established and the absence of early bonding opportunities can have a negative impact on a child’s psychological development.¹⁸⁶ Additionally, there is no recognized constitutional right to pump breast milk, even though being denied the ability to pump may cause pain and infection.¹⁸⁷ The Federal Bureau of Prisons allows incarcerated people to pump breast milk, but then

¹⁸² Ocen, *supra* note 22, at 1258.

¹⁸³ *Id.* at 1273.

¹⁸⁴ See Emily Halter, *Parental Prisoners: The Incarcerated Mother’s Constitutional Right to Parent*, 108 J. CRIM. L. & CRIMINOLOGY 539, 541 (2018).

¹⁸⁵ See *Overton v. Bazzeta*, 539 U.S. 126, 133 (2003) (upholding regulation eliminating visits between parents and children when the parental rights had been terminated); cf. *Shallowhorn v. Molina*, 572 Fed. Appx. 545, 547–48 (9th Cir. 2014) (affirming dismissal of constitutional claims regarding six-month prohibition on all visitation with minors, including the plaintiff’s child because there is “no constitutional right to contact visitation” and any right to a parent-child relationship “can be significantly curtailed during incarceration”).

¹⁸⁶ See Jeanne Alhusen et al., *A Longitudinal Study of Maternal Attachment and Infant Development Outcomes*, 16 ARCHIVES WOMEN’S MENTAL HEALTH 521, 527 (2013).

¹⁸⁷ See *Villegas v. Metro. Gov’t of Nashville*, 709 F.3d 563, 579–80 (6th Cir. 2013).

discards the milk rather than storing it and allowing an infant's caretaker to pick it up.¹⁸⁸

Recent statutory provisions may strengthen postpartum incarcerated people's legal rights. For example, a number of states prohibit or limit the use of shackling and solitary confinement for 30 days after an incarcerated person gives birth.¹⁸⁹ A California law requires jails to keep breastmilk and allow infants' caretakers to pick it up.¹⁹⁰ A number of "Dignity for Incarcerated Women" bills have been introduced or enacted that would provide for more robust parent-child visitation practices and allow new parents to remain with their infants for slightly longer after giving birth.¹⁹¹ If implemented fully, these laws will have the effect of easing the transition back into incarceration after birth and creating and maintaining a parent-child connection. However, forcible parent-infant separation can cause lasting damage to both parties and their bond, even if that damage is mitigated by later visitation.¹⁹²

Additionally, any legal rights that purport to strengthen the parent-child relationship are undermined by laws that provide for the termination of parental rights of incarcerated people. Specifically, federal and state laws often combine with judicial discretion to sever the families of incarcerated people without just cause. The federal Adoption and Safe Families Act requires states to begin termination proceedings in most cases if a child has lived in foster care for 15 of the previous 22 months.¹⁹³ The law does not

¹⁸⁸ See FED. BUREAU OF PRISONS, *supra* note 66, at 19.

¹⁸⁹ See Appendix I.

¹⁹⁰ See CAL. PENAL CODE §4002.5 (West, Westlaw, current with urgency legislation through Ch. 3 of 2020 Reg. Sess.). Prison policies vary by jurisdiction. Illinois recently ended its ban on breastfeeding in response to a demand letter issued by the ACLU. See Shannon Heffernan, *Small Change in Illinois Prisons a Big Deal for Some New Moms Behind Bars*, WBEZ NEWS (July 18, 2019), <https://www.wbez.org/shows/wbez-news/small-change-in-illinois-prisons-a-big-deal-for-some-new-moms-behind-bars/d1877180-d581-44ba-b812-80bc6dc64f82> [<https://perma.cc/V8PB-DXTU>].

¹⁹¹ See *e.g.*, TEX. GOV'T CODE ANN. § 501.0667 (West, Westlaw through the end of the 2019 Reg. Sess. of the 86th Legis.); Dignity for Incarcerated Women Act, S. 1358, 54th Leg., 1st Reg. Sess. (Ariz. 2019).

¹⁹² Significant attention has been paid to the lasting damage done by the family separation policy at the border. See, *e.g.*, ALISON L. MILLER ET AL., RESEARCH AND POLICY PERSPECTIVES ON SEPARATING (AND RECONNECTING) CHILDREN AND PARENTS: IMPLICATIONS FOR FAMILIES ON THE BORDER (2018), https://medicine.umich.edu/sites/default/files/content/downloads/Rapid%20Response%20Talk_Research%20and%20Policy%20Perspectives%20on%20Separating%20Children%20and%20Parents.pdf [<https://perma.cc/MKL8-L22R>]. Given that children of incarcerated parents are more likely to live in conditions that cause extreme stress and trauma, they may be subject to the same lifelong harms. See NAT'L RES. CTR. ON CHILDREN & FAMILIES OF THE INCARCERATED, RUTGERS UNIV., CHILDREN AND FAMILIES OF THE INCARCERATED FACT SHEET 1–2 (2014), <https://nrccfi.camden.rutgers.edu/files/nrccfi-fact-sheet-2014.pdf> [<https://perma.cc/N4CA-RBJQ>] (finding children of incarcerated parents represent 15–20% of children entering foster care, and that children who witness their parents' arrest are more likely to experience trauma and PTSD). Studies of children of incarcerated parents have also demonstrated that incarceration of a parent itself causes lasting harm to children. See LEILA MORSY & RICHARD ROTHSTEIN, MASS INCARCERATION AND CHILDREN'S OUTCOMES 8–9 (2016), <https://www.epi.org/files/pdf/118615.pdf> [<https://perma.cc/AW4L-QMER>].

¹⁹³ 42 U.S.C. § 675(5)(E) (2018).

include an exception for incarcerated parents, though a state agency can approve an exception for an incarcerated parent if it determines that doing so is in the best interest of the child. State laws generally allow judges to take a parent's incarceration into account when deciding whether to terminate parental rights, often regardless of whether the underlying crime is relevant to their fitness to parent.¹⁹⁴

B. Incarceration allows the state to control family relationships

Incarcerated women are far likelier than incarcerated men to have been primary and single parents prior to incarceration.¹⁹⁵ Additionally, only people incarcerated in women's facilities have to undergo the damaging indignities of being separated from their infants, shackled and placed into solitary confinement immediately after giving birth. The male-standardized policies and practices that give rise to these harms are forms of particularly gendered oppression. The view that mothers in institutions of incarceration can be treated just like men and are not deserving of the accommodation free-world mothers need can be traced back to slavery and to the post-Civil War rise of the prison system.¹⁹⁶ As a society, we generally recognize the incredible harms of parent-child separation, but because of those historical gendered and racialized views of incarcerated women, those concerns are not taken seriously when applied to parent-child separation resulting from incarceration.¹⁹⁷

Although evidence demonstrates that children of incarcerated parents are likely to languish in foster care, judges often terminate parental rights of incarcerated women.¹⁹⁸ Long drug sentences and poverty, both of which have disproportionate impact on women of color, combine to allow the state to terminate the parental rights of women who have committed low-level drug offenses, including selling drugs to make ends meet, on the basis of the length of their sentences.¹⁹⁹ Termination of parental rights is an area in which the state has explicitly positioned itself between parent and child, es-

¹⁹⁴ See Desiree Kennedy, *Children, Parents, and the State: The Construction of a New Family Ideology*, 26 BERKELEY J. GENDER, L. & JUST. 78, 98–99 (2011).

¹⁹⁵ See LAUREN E. GLAZE & LAURA M. MARUSCHAK, PARENTS IN PRISON AND THEIR MINOR CHILDREN 5 (2010), <https://www.bjs.gov/content/pub/pdf/pptmc.pdf> [<https://perma.cc/U8BR-TX75>].

¹⁹⁶ Gutierrez, *supra* note 26, at 155; Ocen, *supra* note 22, at 1243–44.

¹⁹⁷ See Shailla Dewan, *Family Separations: It's a Problem for U.S. Citizens, Too*, N.Y. TIMES (June 22, 2018), <https://www.nytimes.com/2018/06/22/us/family-separation-americans-prison-jail.html> [<https://perma.cc/5QKM-7RJU>].

¹⁹⁸ According to one author, the number of termination proceedings involving incarcerated parents increased from 260 in 1997 (the year AFSA was passed) to 909 in 2002. See Philip M. Genty, *Damage to Family Relationships as a Collateral Consequence of Parental Incarceration*, 30 FORDHAM URB. L.J. 1671, 1678 (2003). As explained in note 194, *supra*, and the accompanying text, AFSA requires the state to begin termination proceedings if the child has not lived with the parent for 15 of the previous 22 months.

¹⁹⁹ See Paula C. Johnson, *At the Intersection of Injustice: Experiences of African American Women in Crime and Sentencing*, 4 AM. U. J. GENDER & L. 1, 42–43 (1995) (“[P]overty is the major correlative in African American women’s involvement in criminality . . . [and the “war

pecially for racially marginalized groups, on the basis that the parent is unfit. In the carceral context, the implicit assumption that incarcerated women are “bad mothers” and unfit to parent is particularly damaging.²⁰⁰ Incarcerated parents who have not neglected or abused their children are *more* likely to lose custody than non-incarcerated parents who have neglected or abused their children.²⁰¹ This outcome makes sense only if incarcerated women are seen as failing to live up to particular ideas of womanhood and motherhood, as demonstrated by their incarceration and reproductive choices.

The state’s presumption of incarcerated women’s unfitness to parent and make reproductive choices has a hugely disproportionate impact on people and communities of color. This outcome is not coincidental, as the government has long viewed many women of color as improper parents and unable to make their own reproductive choices.²⁰² White women are also harmed by these policies, perhaps because they are seen as failing to live up to white womanhood standards and therefore are not fit to propagate or parent²⁰³ or because they are “blackened” by their incarceration.²⁰⁴ The setting of incarceration allows implicit negative views about some women’s capacity to parent to become particularly dangerous in undermining their families.

CONCLUSION

Pregnant people who are confined in institutions of incarceration in the U.S. tell us much about the intricate ways that the state manages reproductive bodies in ways that both reflect and produce the differential value of various reproductive bodies. While shackling in labor is just one instance, this spectral display of state power on incarcerated reproductive bodies is exemplary of the ways that carcerality can so facilely devalue the reproduction of people who have already been marginalized by systems of oppression and then further degrade them by denying them dignity during childbirth. As feminist historian Laura Briggs has succinctly summarized, all politics have become reproductive politics.²⁰⁵ The systematic neglect of pregnant

on drugs” has had] a devastating impact on African American women who are receiving the severe punishments.”)

²⁰⁰ See Kennedy, *supra* note 194, at 98.

²⁰¹ See Eli Hager & Anna Flagg, *How Incarcerated Parents Are Losing Their Children Forever*, MARSHALL PROJECT (Dec. 2, 2018, 10:00 PM), <https://www.themarshallproject.org/2018/12/03/how-incarcerated-parents-are-losing-their-children-forever> [<https://perma.cc/DQ36-C6VF>].

²⁰² See *supra* Part III; see also Elizabeth Bartholet, *Differential Response: A Dangerous Experiment in Child Welfare*, 42 FLA. ST. UNIV. L. REV. 573, 585 (2015) (accepting the premise that children of color are disproportionately in foster care because parents of color are disproportionately abusive); MOYNIHAN, *supra* note 31, at 29 (connecting black mothering with criminality in a section entitled “The Tangle of Pathology”).

²⁰³ See Khiara Bridges, *White Privilege and White Disadvantage*, 105 VA. L. REV. 449, 465 (2019).

²⁰⁴ See Ocen, *supra* note 22, at 1274.

²⁰⁵ See generally LAURA BRIGGS, *HOW ALL POLITICS BECAME REPRODUCTIVE POLITICS* (2017).

people behind bars allows abuses and reproductive oppressions to flourish. Even when laws are passed that prohibit mistreatment like shackling in labor, custody officials still shackle pregnant people. Even when national standards for pregnancy care exist, following those standards is optional and there is no oversight of health care services in institutions of incarceration. Even when incarcerated people's rights to abortion have been upheld under the Constitution, incarcerated individuals are forced to carry unwanted pregnancies because carceral institutions do not permit them to obtain abortion care—a condition partly enabled by progressive pro-choice language that has allowed abortion to be viewed as “elective.”

Examining social, legal, and clinical perspectives on pregnancy related health care that is provided—or not—to incarcerated people highlights the ways that pregnancy provides a canvas for contemporary U.S. politics to work through the most pressing issues of our society. From poverty to white supremacy and their historical foundations, to unequally distributed physical and psychic suffering from inadequate and unjust health care systems, to the differential ability of people to fulfill the reproductive life they want, the management of reproduction behind bars is an exemplar of reproductive injustice. State control over reproduction in institutions of incarceration demonstrates a society that has taken the opacity of prison walls to mean that we can systematically disregard the health, value, and flourishing of certain lives.

LAWS RESTRICTING SHACKLING OF PREGNANT PEOPLE²⁰⁶

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
Federal (Bureau of Prisons and Marshals Service) ²⁰⁷	No restraints throughout pregnancy	No restraints in labor or post-partum recovery	Immediate and credible flight risk or risk of harm to self or others that cannot reasonably be otherwise prevented, or if health professional deems it appropriate for the health and safety of the patient to apply restraints; restraints must be removed if requested by health professional	If restraints are used in pregnancy, report must be sent within 30 days to director and to health care professional responsible for the pregnant person
AR ²⁰⁸	No restraints throughout pregnancy	No restraints in labor or post-partum recovery	Individualized determination of substantial flight or security risk, except the restraints shall be removed if requested by a health professional during labor and delivery	Facility shall make written findings about application of restraints under the exception, which shall be maintained for 5 years and made available for public inspection; department shall report the use of restraints to the Board of Corrections and to the Attorney General

²⁰⁶ In May 2020, South Carolina passed a law (Act No. 136) prohibiting the use of restraints in pregnant, incarcerated people, and bringing the total number of states with anti-shackling laws to 30.

²⁰⁷ United States Congress, H.R.5682 - FIRST STEP Act 115th Congress (2017-2018).

²⁰⁸ Ark. Stat. § 12-32-102 (2019).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
AZ ²⁰⁹	No	No restraints for transport to hospital for delivery, during labor and delivery, or immediate postpartum recovery	Attending medical staff requests use of restraints; corrections official makes an individualized determination that the incarcerated person presents an extraordinary circumstance	Written findings for each instance of shackling must be made public for at least two years
CA ²¹⁰	During all of pregnancy, except handcuffs in front of the body	No restraints at all during pregnancy, delivery, or recovery after delivery	None	Prisoner must be advised of the relevant standards and policies
CO ²¹¹	Least restrictive restraints necessary to ensure safety	No restraints at all during labor and delivery, and least restrictive during postpartum recovery and transport	Medical necessity; immediate and serious risk of harm; substantial risk of escape	Written record of use of restraints during labor and delivery must be made available for public inspection; adequate training required
CT ²¹²	No leg or waist restraints	No restraints during any stage of labor or delivery, and no leg or waist restraints during the postpartum period	None for labor and delivery; immediate and serious threat of harm or substantial flight risk during pregnancy	Pregnant prisoners provided with written materials on law; restraints used under exception must be documented in writing

²⁰⁹ Ariz. Stat. § 31-601 (2012).

²¹⁰ Cal. Pen. Code § 3407 (2013). Note: separate statutes for jails, juvenile

²¹¹ Colo. Stat. § 17-1-113.7 (2011).

²¹² Conn. Gen. Stat. Ann. § 18-69c (2018).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
DC ²¹³	First and second trimester: least restrictive available; third trimester: no restraints	No restraints during labor and delivery or postpartum recover, including transport	Individualized determination that extraordinary circumstances apply and restraints are necessary to prevent injury, unless removal medically necessary and never during labor	Written statement whenever restraints are applied under exception to the Director of Department of Corrections, and that information provided to the Council; notice must be provided to pregnant people in their third trimester as well as relevant staff
DE ²¹⁴	No restraints during pregnancy	No restraints during labor, delivery, or postpartum recovery	Extraordinary circumstance, unless health professional requests restraints not be used and leg or waist restraints can never be used during labor and delivery	Written findings whenever restraints are applied under the exception, which must be kept on file for at least 5 years
FL ²¹⁵	During third trimester, only front handcuffs may be used and least restrictive restraints during all of pregnancy	No restraints during labor, delivery, and postpartum recovery	Extraordinary circumstances: correctional officer may apply restraints even if medical staff requests restraints not be used	Written findings of extraordinary circumstances must be kept for at least 5 years; prisoner may file a grievance; notice must be provided upon admission and policies must be posted in the institution

²¹³ D.C. Stat. § 24-276.02 et seq. (2015).

²¹⁴ 11 Del. Code § 6603 (2012).

²¹⁵ Fla. Stat. Ann. § 944.241 (2012).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
GA ²¹⁶	None in second or third trimester, except medical restraints applied by a licensed health care professional	None during labor, delivery, or immediate postpartum period	Wrist handcuffs in front only during postpartum period if immediate and serious threat of harm or substantial flight risk	Restraints applied under exception must be documented, reviewed by the officer in charge, and retained by the institution for reporting purposes
HI ²¹⁷	No leg irons or waist chains during pregnancy; least restrictive available throughout; no restraints in transportation during third trimester, or throughout if ordered by physician	No restraints during labor or childbirth except if requested for medical safety by treating physician; no restraints during transportation in postpartum recovery	Extraordinary circumstances (not applicable during labor and delivery): necessary to stop the person from escaping or injuring herself or others	Restraints applied under exception must be fully documented in writing; director must provide information to any staff involved in transportation or supervision of pregnant prisoners; notice must be provided to pregnant and postpartum prisoners and posted in conspicuous areas; treating physicians, midwives, and nurses must be informed

²¹⁶ Ga. Code Ann. § 42-1-11.3 (2019).

²¹⁷ Haw. Stat. § 353-122 (2011). NOTE separate enforcement.

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
ID ²¹⁸	No restraints during pregnancy	No restraints during labor and delivery, and never leg or waist restraints even if extraordinary circumstances	Individualized determination that restraints are necessary to prevent escape or injury, unless health professional requests they not be used	Written findings must be made for all restraints applied under exception, and kept for at least five years and made available for public inspection; prisoners must receive notice upon admission and notice must be posted in an accessible location
IL ²¹⁹	No	No restraints during transport to hospital for delivery; no leg irons or shackles or waist shackles during labor	None	None
KY ²²⁰	Handcuffs in front of the body only during all of pregnancy	No restraints during transport for delivery, during labor, or during postpartum recovery	Reasonable grounds to believe they present an immediate and credible serious threat of hurting themselves or others or risk of escape	None

²¹⁸ Ida. Code § 20-902 (2011). NOTE separate enforcement.

²¹⁹ 730 ILCS 125/17.5 (2019). Note: separate for jails.

²²⁰ Ken. Stat. § 196.173 (2018).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
LA ²²¹	Least restrictive restraints during second and third trimester, and no cuffing behind back, electronic restraint belt, or leg irons; no restraints during pregnancy-related medical distress	No restraints during transport for and during labor and delivery except therapeutic restraints ordered by medical staff or during postpartum recovery	Exception applies only to transport, postpartum, and medical distress: immediate and serious threat of physical harm; substantial flight risk. No restraints if health professional requests they not be used.	Written record of restraints applied to pregnant person must be kept for five years and made available for public inspection; all potentially affected prisoners must be advised upon admission and when known to be pregnant
MD ²²²	No restraints throughout pregnancy	No restraints during labor, delivery, except as determined by treating medical professional, or during postpartum recovery	Exception not applicable to labor and delivery: individualized determination that restraint required to ensure safety and security, except that restraints must be removed upon health professional's request	Department and local facilities must develop implementing policies; policies must be provided to pregnant person at time of positive pregnancy test; Maryland Commission on Correctional Standards shall review each policy during regular inspections

²²¹ 15 La. Stat. § 744.2 et seq. (2012).

²²² Md. Code, Corr. Servs. § 9-601 (2019). Note: separate for prisons.

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
ME ²²³	No restraints during pregnancy	No restraints during transport for delivery, during labor and delivery, or during postpartum recovery	Chief administrative officer or designee determines substantial flight risk or other extraordinary circumstance, unless health professional requests removal, and never in labor or childbirth	Chief administrative officer/designee must make written findings of all restraints applied under exception, kept for five years, and made available for public inspection; female prisoners must be informed upon admission and notice provided in handbook
MA ²²⁴	Handcuffs in front only during second and third trimesters; all restraints must be removed upon request of treating physician or nurse	No restraints during any stage of labor or post-delivery recuperation	For post-delivery recuperation only: extraordinary circumstances of serious threat to self or others or credible risk of escape	Restraints applied under exception must document in writing and approved by a superintendent
MN ²²⁵	No restraints throughout pregnancy	No restraints during labor and delivery or three days after giving birth	Individualized determination for legitimate safety and security needs; nothing behind the back or waist chains during transport; restraints in labor or postpartum only allowed if no objection from treating medical care provider	Head of each facility must ensure relevant staff trained; commissioner shall report to legislature on the use of restraints on pregnant/postpartum people, except for handcuffs in the front of the body

²²³ 34 Me. Stat. § 3102 (2015). NOTE: separate for notice.

²²⁴ 127 Mass. Gen. Laws Ann. § 118 (2014).

²²⁵ Minn. Stat. Ann. § 241.88 (2015).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
MO ²²⁶	No restraints during third trimester during transport or medical appointments and examinations; only handcuffs in front of body during third trimester	No restraints during labor, delivery, or 48 hours postdelivery	Extraordinary circumstances, except that all restraints must be removed from the person in third trimester or postpartum if requested by health provider	Restraints applied under exception must be documented and kept on file for 10 years; chief administrative officer must ensure relevant employees receive adequate training; prisoners must be informed upon admission and policies must be in handbook and posted where they will be seen
NE ²²⁷	No restraints during pregnancy	No restraints during labor, delivery, postpartum recovery	Individualized determination of substantial flight risk or other extraordinary medical or security circumstance; restraints must be removed if requested by health professional	If restraints applied under exception, administrator must make written findings, kept for 5 years and available for public inspection; administrator shall submit a report to the Inspector General every year describing use of restraints on pregnant prisoners, available for public inspection
NV ²²⁸	No	No restraints during labor, delivery, or recuperating from delivery	Compelling reasons to believe prisoner presents serious and immediate threat of harm or substantial flight risk	None

²²⁶ Mo. Ann. Stat. § 217.151 (2018).

²²⁷ Neb. Rev. Stat. § 47-1004 (2019). NOTE report separate

²²⁸ Nev. Rev. Stat. Ann. § 209.376 (2011).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
NM	Least restrictive restraints during second and third trimester	No restraints during labor, delivery, or recuperating from delivery	Compelling grounds to believe the prisoner presents an immediate and serious threat of harm or substantial flight risk	None
NY ²²⁹	No restraints during pregnancy	No restraints within 8 weeks of delivery or pregnancy outcome	Superintendent or sheriff or designee, in conjunction with medical professional, makes individualized determination that restraints are necessary to prevent injury, and then only wrist restraints in front of body, and never during labor, admitted for delivery, or recovering after birth	Restraints applied under exception must be documented; department shall report annually to governor and legislature concerning every use of restraints on pregnant/postpartum person, and report must be posted on website
OK ²³⁰	Least restrictive restraints throughout pregnancy	Presumption that no restraints shall be used unless otherwise directed by physician during transportation of person in labor, any phase of labor or delivery, or postpartum recuperation. Restraints never allowed during labor.	Compelling grounds to believe that there is an immediate and serious threat of harm or substantial flight risk	Correctional officers who use violate the law are subject to imprisonment and/or fine; Female prisoners receive notice in writing about the restraint requirements upon admission and again when the person is known to be pregnant, and notice must be posted in prominent locations

²²⁹ NY Corr. Law § 611 (2016).

²³⁰ Okla. Stat. Ann. § 4.2 (2018).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
PA ²³¹	No restraints during pregnancy-related medical distress	No restraints during any stage of labor, delivery, or postpartum (before being discharged from a medical facility)	Individualized determination of substantial flight risk or other extraordinary medical or security circumstance, except that restraints must be removed upon request of health care professional	Annual report must be submitted to governor containing information regarding the use of restraints on any pregnant person and circumstances under which restraints were applied.
RI ²³²	Only medically appropriate restraints during second and third trimester	No restraints during transport to a medical facility, labor, delivery, or postpartum recovery	Exception applies only to the labor/delivery/postpartum requirement: immediate and serious threat of physical harm or substantial flight risk, except that restraints must be removed upon request of health professional	Findings on restraints used under exception must be kept on file and made available for public inspection; any person illegally restrained may file a civil action for damages and equitable relief; department must report to the legislature on all shackling during pregnancy, and the findings shall be made available for public inspection
TX ²³³	No ankle, leg, or waist restraints during pregnancy	Nothing specific to labor/delivery	Director, designee, or medical professional determines restraints necessary to prevent harm (to self, fetus or other person) or will attempt escape	None

²³¹ Penn. Stat. § 5905 (2010).

²³² R.I. Gen. Laws § 42-56.3-3 et seq. (2011).

²³³ Tex. Gov't Code § 501.066 (2019). Written record separate.

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
UT ²³⁴	Least restrictive restraints during pregnancy, including transport	No restraints during labor and childbirth, least restrictive during postpartum recovery, never shackles, leg restraints or waist restraints during labor and childbirth or postpartum recovery in the medical facility	Restriction applies to labor and childbirth: individualized determination of immediate and serious risk of harm or substantial risk of escape	Written record of decision shall be made, retained for five years, and available for public inspection
VT ²³⁵	No	No restraints during “active labor” or while in recovery at the hospital after delivery	To prevent escape or ensure safety	Commissioner of corrections must make written findings as to why restraints were necessary
WA ²³⁶	No restraints of any kind during third trimester of pregnancy during transportation to and from medical visits and court proceedings	No restraints of any kind during labor or childbirth or during postpartum recovery	Exception does not apply during labor and delivery: individualized determination that restraints are necessary to prevent escape or injury, except that restraints must be removed upon health professional’s request	Reasons for application of restraints under exception must be fully documented; relevant staff and pregnant people must be notified and notice must be posted in facilities

²³⁴ Utah Code § 64-13-46 (2019).

²³⁵ Vt. Stat. Ann. § 801a (2005).

²³⁶ Wash. Rev. Code Ann. § 72.09.651 et seq. (2010).

State	Shackling Prohibited During Pregnancy	Labor and Delivery	Exceptions	Enforcement Mechanisms
WV ²³⁷	Reasonable measures must be taken to assure pregnant people not restrained after reaching second trimester of pregnancy	Nothing specific about labor/delivery/postpartum	Reasonably necessary restraints may be applied if necessary based on person's classification, discipline history, or other factors relevant to determining if there is a threat of escape or safety	None

²³⁷ W. Va. Code § 15A-4-5 (2018).