Healthcare Disparities Among Incarcerated Pregnant Women

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Introduction

Incarcerated pregnant women face a lack of access to standard perinatal care. These individuals are considered to be at a higher risk for poor pregnancy outcomes and these prospects are increased due to systematic insufficiencies (Dallaire et al., 2017). Prisons are ill-equipped to cater to the perinatal needs of these incarcerated pregnant women. A report found that 38 states in the US had inadequate or no prenatal care in their prisons, and a 2008 report from the US Department of Justice noted that 46% of imprison pregnant women reported that they had had no prenatal care (Bard et al., 2016). Incarcerated women are largely deprived of educational resources and clarification regarding their pregnancy healthcare options (Dallaire et al., 2017). This population is subjected to inhumane treatment, such as shackling during delivery, and the omnipresent stigmas some healthcare workers associate with incarcerated patients (Goshin et al., 2020). Not only is there substantial data highlighting the disparity in healthcare received by this populace, but the lived experiences of these women and their journey through pregnancy, while incarcerated, speaks volumes (Fritz and Whiteacre, 2016). It is through direct training regarding specific treatment needs, such as dietary necessities, and an increased understanding of the intersectional struggles incarcerated pregnant women endure, that a higher quality of patient centered care can be ensured for these individuals.

Background & Significance

Incarcerated pregnant women are exposed to many stressors that can harm them and their fetuses, such as social isolation, psychological stress, overcrowding and communicable diseases (Leeper et al., 2018). Although there is limited research about parental incarceration and child health in the United States, one study highlighted the varied outcomes of maternal incarceration on child health and well-being, with positive effects reported in some studies, negative effects in others, and null effects in others (Wildeman et al., 2018). Research emphasizes the need for incarcerated pregnant women to receive additional medical care, nutritional care, and screenings for STDs, along with assessments of the mother and the fetus, in an effort to decrease the likelihood of negative health effects for the mother and the baby (Alirezaei & Roudsari, 2020). Furthermore, there is evidence to suggest a lack of educational counselling and adequate health interventions within the pregnant incarcerated community. For example, Mukherjee et al. (2014) found tobacco use among pregnant inmates exceeded 50%, with some studies reporting as high as 84%; 36% of inmates abused illicit drugs; and depression was reported among 80% of inmates. There are also factors such as race, economic class, substance dependency, infectious disease, and depreciating mental health that influence incarcerated pregnant women (Kotler et al., 2015). Surfin, Molinas, and Roth (2015) highlighted the significant increase in incarceration from 1980 to 2013, with rates rising from 501,886 inmates to 2,287,949 inmates in the United States. These incarceration rates have been even more dramatic for women of color, with Black women being incarcerated 2.3 times the rate of white women and Hispanic women incarcerated at 1.5 times the rate of white women (Surfin et al., 2015). Sufrin et al. (2019) reported that within the incarcerated community, "There were 753 live births (92% of outcomes), 46 miscarriages (6%), 11 abortions (1%), 4 stillbirths (0.5%), 3 newborn deaths, and no maternal deaths. Six percent of live births were preterm and 30% were cesarean deliveries. Distributions of outcomes varied by state." The majority of prison births either result in live births or miscarriages. The women incarcerated while pregnant are constitutionally required to have health assistance, but that does not mean that there are mandatory standards (Sufrin et al. 2019). Although there are volunteer programs that help these women receive higher levels of care, the overall lack of healthcare in correctional institutions results in a lack of care for the pregnant women and their unborn children. Nurses must be aware of the laws surrounding the care of incarcerated pregnant women and advocate for them when the need rises.

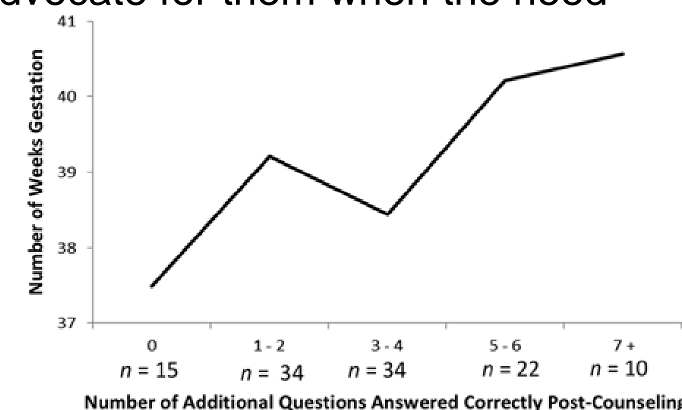
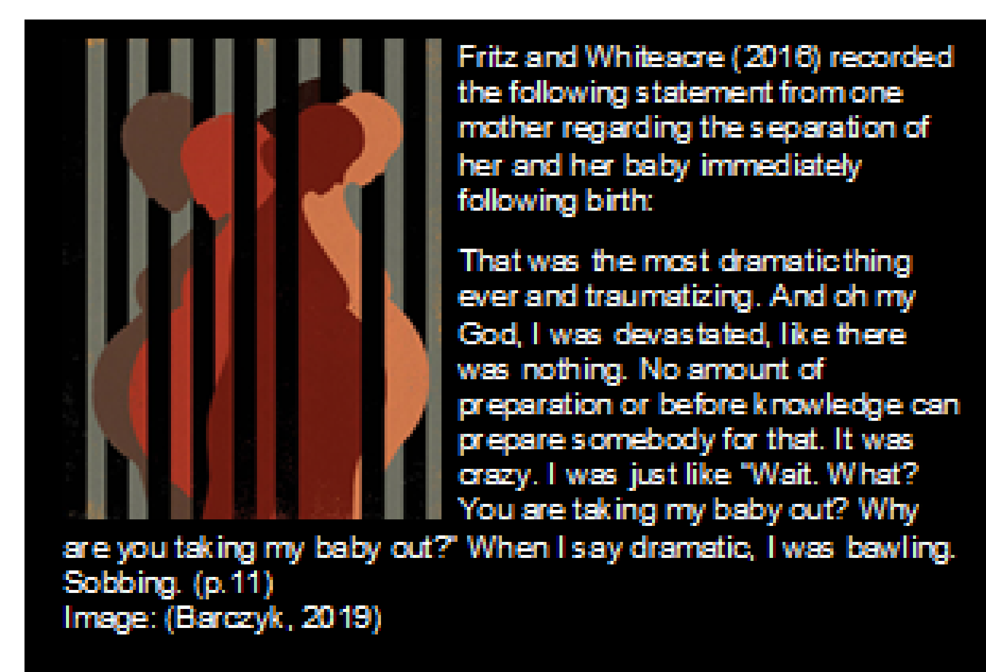


Figure 1: Pregnancy gains following nutritional counseling (Dallaire et al., 2017).



Literature Review & Methods

We searched several databases, including ETSU Sherrod Library's Database and PubMed, using keywords including incarcerated, pregnant, and healthcare to select twenty studies that highlight the status of maternal healthcare standards. Sources were narrowed down through publication date (2015 to current), source reputability (peer-reviewed), and the applicability of their data. We then critically analyzed the available research to produce this literature review.

Findings

This review found numerous disparities faced by incarcerated pregnant women including a shortage of educational resources and quality patient-centered care. One study highlighted the racial and ethnic disparities linked to pregnant incarcerated women and how these women are more likely to have a chronic health condition (Bronson & Surfin, 2019). These discrepancies in the standard of care are further influenced by potential stigmas held by healthcare workers surrounding these patients. Goshin et al. (2019) determined there were critical gaps in nurses' knowledge of professional standards and protective laws regarding the care of incarcerated women during pregnancy. Later in a 2020 study, Goshin et al. determined that less than 1 in 5 of the Association of Women's Health, Obstetrics, and Neonatal Nurses' (AWHONN) members, who were participants in this study, were aware of AWHONN's perinatal care standards for incarcerated women.

Less than 10% of participants knew whether their states had or did not have shackling laws (Goshin et al., 2020). In a bivariate statistical analysis, Goshin et al. (2020) depicted that prior knowledge of the AWHONN position statements was significantly associated with a better quality of care ($p=0.001$). This emphasizes the role personal biases and stigmas have among healthcare workers and their incarcerated patients, and how this can negatively influence patient care. Another study analyzed the importance of nutritional counseling and access to educational resources. Dallaire et al. (2017) discovered that incarcerated women who completed nutritional programming did have significantly higher birth weights ($p=0.03$) and longer gestations ($p=0.01$), than those who did not complete the programming (see Figure 1). This exhibits the effectiveness and positive influence nutrition-based programs have on birth outcomes among incarcerated pregnant women (Dallaire et al., 2017). This analysis further stresses the critical role of healthcare providers and nurses working in jails and their duty to educate patients regarding appropriate nutrition during gestation, as well as ensuring patients have access to these nutritional standards.

Conclusions & Implications

This study emphasizes the importance of equitable standards of care for pregnant incarcerated women. Through instituting, programs surrounding maternal health education and promotion of positive health habits, the inequitable treatment of this populace may be rectified. This strategy must not stop at providing greater access for incarcerated patients, but also include routine training for healthcare and criminal justice employees. These individuals must be knowledgeable in the particular stressors incarcerated pregnant women endure and aim to provide quality evidence-based care.

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