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Optimizing Obstetric Care in Incarcerated and Reentry Populations

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Abstract

Pregnancy during incarceration and reentry is shaped by the intersection of medical complexity, constrained autonomy, and fragmented systems of care. Although correctional settings may have procedures for pregnancy identification, treatment initiation, and stabilization of chronic conditions, these benefits are frequently limited by inconsistent intake screening, delayed evaluation of obstetric symptoms, incomplete prenatal care, underuse of medication treatment for opioid use disorder, and variable access to specialty consultation. Hospital-based labor and delivery may be affected by custody procedures that restrict mobility, privacy, support persons, and timely emergency response, while postpartum care is often compressed by rapid return to custody, early infant separation, and poorly coordinated transition planning. Reentry introduces additional vulnerability, as release may occur during pregnancy or shortly after birth, disrupting medication continuity, postpartum surveillance, behavioral health treatment, lactation support, and linkage to community obstetric care. For obstetricians, maternal-fetal medicine clinicians, and hospital systems, incarceration should function as a marker of high-risk care requiring verification, coordination, and proactive escalation. Intrapartum care should prioritize timely hospital transfer, restraint-free clinical assessment, access to analgesia and labor support, and clear communication among obstetric, anesthesia, neonatal, and custody staff. Postpartum discharge should be treated as a structured clinical handoff rather than a routine disposition, with explicit plans for medications, contraception if desired, lactation, mental health screening, infant caregiving arrangements, and follow-up after custody or release. This review synthesizes evidence on pregnancy identification, prenatal management, labor and delivery, postpartum recovery, and reentry care for incarcerated pregnant patients in the United States. It highlights practical, system-level approaches that can help apply established obstetric standards in settings where continuity, privacy, mobility, and follow-up are often unpredictable.

Keywords: Pregnant Incarcerated Women; Obstetric Care in Prisons and Jails; Standard of Care; Perinatal Care; Reentry Services; Algorithm for Obstetric and MFM Care

Abbreviations: DOL: Department of Labor; DV: Domestic Violence; GED: General Educational Development; MAT: Medication-Assisted Treatment; NICU: Neonatal Intensive Care Unit; NJRC: New Jersey Reentry Corporation; OB/GYN: obstetrics and gynecology; RR: risk ratio; SUD: Substance Use Disorder; WIARL: Women and Infants at Risk

Introduction

Pregnancy During Incarceration

Pregnant women in carceral settings represent a clinically complex population with distinct obstetric needs and variable access to care. In the United States, approximately 3-6% of individuals entering correctional facilities are pregnant at intake, and an estimated 55,000 pregnant individuals pass through jails annually [1,2]. These statistics reflect the high proportion of incarcerated women who are of reproductive age, with over 200,000 women incarcerated nationwide with the majority under age 45. Baseline health status in this population is frequently characterized by higher risk of substance use disorders, mental health conditions, prior trauma, and limited access to reproductive healthcare before incarceration [3] (Table 1). In a prospective surveillance study of pregnant people newly admitted to U.S. state prisons and local jails, hepatitis C was reported in 20.2% of prison admissions and 6.6% of jail admissions, HIV in 0.2% and 1.6%, high blood pressure in 2.7% and 4.1%, and diabetes in 1.6% and 2.1%, respectively [4].

These comorbidities in addition to the restricted autonomy, variable access to clinicians, and disrupted continuity of care

associated with incarceration compound the risk for adverse maternal and neonatal outcomes. The provision of obstetric care in carceral settings occurs within systems that are not uniformly required to adhere to clinical guidelines and standard of care. Although organizations such as the American College of Obstetricians and Gynecologists and the National Commission on Correctional Health Care [5] have published standards for perinatal care, implementation remains inconsistent across facilities due to the absence of mandatory oversight and variability in health care delivery models. Care may include delivering on site, through external referral systems, or via contracted providers, contributing to heterogeneity in access to prenatal screening, timely evaluation of obstetric symptoms, and postpartum follow up.

This variability is further heightened by the rapid turnover characteristic of jail settings, where a substantial proportion of individuals are released within months of admission, often during critical periods of pregnancy, limiting the ability to provide continuous concordant care. At the same time incarceration has been described as a setting in which some individuals may experience increased access to health care services relative to pre-incarceration conditions, including opportunities for screening, stabilization of substance use, and structured nutrition. However, access to care does not uniformly translate to quality or consistency of care delivery. Clinical encounters are frequently mediated by custody processes, and delays in evaluation or escalation of care may occur when nonmedical personnel serve as gatekeepers to clinical services.

In addition, practices that deviate from standard obstetric care such as limitations on mobility, variability in emergency response, and inconsistent support during labor and postpartum introduce additional clinical considerations that may adversely affect the mother and baby. Taken together, pregnancy during incarceration reflects a convergence of baseline medical and social risk factors with a care delivery environment often characterized by both access and resource variability. For maternal-fetal medicine (MFM) and obstetric clinicians, incarceration should be understood as high-risk care in which standard of care is frequently disrupted. This review examines how incarceration affects pregnancy identification, management of medical comorbidities, timely evaluation of obstetric complaints, and continuity of postpartum care, with emphasis on practical clinical approaches that can reduce maternal and neonatal morbidity.

Methods

This review was conducted using Ovid as the primary electronic database to identify relevant literature on obstetric care for incarcerated pregnant women, with a specific focus on care delivery across the prenatal, intrapartum, and postpartum periods of pregnancy. A keyword-based search strategy was implemented, combining keywords such as "incarcerated," "pregnancy," "prison," "jail," "prenatal care," "perinatal care," "opioid use disorder," "postpartum," and "reentry" using Boolean operators (and/or) to refine results. Included studies were selected based on their relevance to pregnancy identification, management of medical comorbidities, intrapartum and postpartum care under custody, and continuity of care during reentry. Preference was given to randomized controlled trials, systematic reviews, large observational studies, professional society guidelines, and descriptive evaluations of relevant care programs that provided data on comorbidity prevalence, maternal and neonatal outcomes, patterns of care delivery, and the effectiveness of coordinated care models. Geographic scope was limited to the United States, and all included studies were published in English. The search was not limited by year, although priority was given to literature from the last two decades to reflect contemporary clinical practice and policy.

Perinatal Outcomes

Perinatal outcomes among incarcerated women are closely linked to differences in care, timing of incarceration during pregnancy, and access to longitudinal support. Facility-level data demonstrate gaps in early identification and treatment, with only 37.7% of jails universally screening for pregnancy at intake and fewer than half initiating treatment for opioid use disorder during pregnancy [6]. In a longitudinal cohort study, only 40% of eligible pregnant patients received methadone and buprenorphine during incarceration and fewer than one-third were referred for ongoing treatment after release [7,8]. In addition, approximately one-third receive prenatal care that does not meet the recommended timing and visit frequency standards defined as 12 to 14 in person visits during the gestation, conveying incomplete implementation of established clinical guidelines [9]. Likewise, a recent systematic review and meta-analysis found higher odds of inadequate prenatal care (OR 2.99) and low birth weight (OR 1.66) among incarcerated compared with nonincarcerated pregnancies. National prison data report that 92% of pregnancies result in live birth, with 6% preterm delivery and 30% cesarean delivery; however, these outcomes differ by state, indicating that local practices influence results.

Some data suggest that individuals incarcerated during pregnancy may have similar or, in certain contexts, higher infant birth weight compared with socioeconomically similar populations, particularly when incarceration occurs earlier or for longer duration. These findings have been attributed to more consistent access to food, shelter, and reduced substance exposure. However, these observations are not consistent when evaluated in studies that account for baseline risk and timing of exposure. In a retrospective cohort study comparing 496 births among individuals with jail exposure during pregnancy to matched community controls, adjusted analyses demonstrated increased odds of low birth weight and preterm birth across most age groups, with maternal age modifying the association [10]. Similarly, a cross-sectional study examining exposure timing

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indicate that any observed increased in birth weight are limited to incarceration during early pregnancy with no measurable benefit when incarceration occurs later in [11]. Importantly, improved outcomes within these cohorts have been associated with better access to prenatal care and post release maternity case management.

These documented gaps establish a clear clinical rationale for targeted interventions to improve prenatal care delivery in carceral settings. Currently, the New Jersey Reentry Corporation (NJRC) Women's Project provides a coordinated community-based model that integrates medical care, behavioral health services, substance use treatment, and case management for incarcerated women, including those who are pregnant (NJRC, 2025a; (Table 2) [12]. Program data displays substantial engagement with health services including 3,366 individuals enrolled in Medicaid, 1,991 receiving medical treatment, and 1,091 receiving medical assisted treatment for substance use disorders – a known intervention associated with improved pregnancy outcomes and reduction in preterm birth. These data show that integrated care models that facilitate insurance coverage, treatment access, and coordination of services improve perinatal outcomes by addressing clinical risk during pregnancy. Additionally, continuous labor support has been associated with increased spontaneous vaginal delivery and reduced cesarean delivery (RR 0.79) [13].

Table 1: Prevalence of medical comorbidities among incarcerated pregnant women compared with the general United States pregnant population.

Condition	Prevalence in incarcerated pregnant womena		Prevalence in general U.S. pregnant population
	Prison (n = 445)	Jail (n = 243)	
Hepatitis C (HCV)	20.2% (n = 91)	6.6% (n = 16)	0.4% (>400% increase since 2000) (Ko et al., 2019) [37]
			1.1% by antibody screening (CDC, 2023) [38]
HIV	0.2% (1/445)b	1.6% (4/243)b	0.1% (≈1 per 1,000 deliveries; 3,500–4,600 annual births to people with diagnosed HIV) (Aslam et al., 2020; Nesheim et al., 2023) [39,40]
Chronic hypertension	2.70%	4.10%	2.0–2.3% (Bateman et al., 2012; Ford et al., 2022) [41,42]
Diabetes	1.6%c	2.1%c	Pregestational: 0.9%c (Deputy et al., 2018) [43]
			Gestational: 8.3%c (QuickStats, 2023) [44]
Mental health condition (any psychiatric diagnosis)	27.4% (n = 122)	17.7% (n = 43)	Perinatal depression: 13% (1 in 7) (Bauman et al., 2020) [45]
			Perinatal anxiety: 8–20% (ACOG, 2023a) [32]
Substance use disorder (SUD)	34.1% (n = 152)	23.5% (n = 57)	Any SUD at delivery: 2.4%
			Opioid use disorder: 0.65%
			Self-reported illicit drug use: 6%
Smoking (tobacco use in pregnancy)	54 – 66%d		4.6% (2021) (JA Martin & Osterman, 2023) [45]
			Up to 8.4% (any tobacco product) (JA Martin & Osterman, 2023) [46]

[a]Prison and jail prevalence's are from the Pregnancy in Prison Statistics (PIPS) prospective surveillance study of newly admitted pregnant people (20 state prisons and 3 local jails, 2016–2017) reported by Hendricks et al. (2024) [4] except smoking. "n" denotes the number of newly admitted pregnant people in each setting.

[b]HIV: 1 reported case among 445 prison admissions and 4 among 243 jail admissions; percentages reflect small case counts.

[c]Diabetes documented at admission most closely reflects pregestational (preexisting) diabetes. Gestational diabetes (~8.3% of U.S. pregnancies in 2021) develops later in gestation and is generally not captured at intake. The admission-documented and gestational figures are therefore not directly comparable.

[d]Estimates for incarcerated pregnant people derive from systematic reviews and observational studies (Fogel, 1993; Knight & Plugge, 2005; S. L. Martin et al., 1997) [4748,7].

Note: Estimates are drawn from differing data sources (medical-record review, administrative/claims data, and birth-certificate or survey data) and time periods, and case definitions vary. Formal statistical comparison between incarcerated and general-population estimates is not appropriate. Values are presented to convey relative magnitude and are rounded.

Building these current programs, enforceable strategies to improve perinatal outcomes include standardization of early pregnancy screening. Targeted intake protocols that incorporate menstrual history into existing medical history workflows with pregnancy testing triggered for all women of reproductive age can allow early identification without expanding beyond routine assessment. Once pregnancy

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is identified, incarceration facilities can implement scheduled prenatal care pathways aligned with established guidelines by partnering with local obstetric providers or health systems to deliver care either on site or through coordinated referral, ensuring appropriate visit frequency, screening, and management of comorbidities. These pathways should also include standardized obstetric escalation criteria for hypertension, diabetes, vaginal bleeding, suspected preterm labor, decreased fetal movement, and fetal growth concerns so that higher-risk pregnancies are referred promptly for obstetric or MFM evaluation [14]. At the systems level, consistent perinatal care requires state and federal policies that establish standards for management of obstetric care within prisons and integrate clinical training for staff. In parallel, routine data collection on pregnancy identification, prenatal care, and birth outcomes can be incorporated into existing reporting systems enabling monitoring of care delivery and identification of gaps without requiring new methods and practices.

Labor, Delivery, and Postpartum Care in Custody

Labor and delivery for incarcerated patients typically occur in community hospitals but hospital-based care is often modified by custody procedures. A clinical review of perinatal care in jail settings describes hospital transfer for labor as medically necessary, however many patients remain under constant officer supervision decreasing privacy during labor. Similarly, a pilot intervention study reported that women transferred from jail often arrive in early labor in handcuffs or leg irons and once admitted, cannot leave the room, receive visitors, or use the telephone. A national survey of 19 state prisons reported prenatal care and delivery arrangements varied substantially and psychosocial supports such as childbirth education and counseling were severely limited [15].

Current clinical guidance increasingly restrict the use of restraints during pregnancy and childbirth. The Association of Women's Health, Obstetric and Neonatal Nurses states that shackling during pregnancy should be limited to situations involving specific risk of harm or escape, and similarly identifies restraints during labor and delivery as incompatible with routine obstetric care except in necessary circumstances. Federal policy narrowed the practice through the First Step Act, and by 2020, 36 states had enacted some restrictions on restraints during labor and delivery. However, available data suggest that policy and practice remain misaligned. In a national survey of perinatal nurses, 74% reported caring for incarcerated pregnant patients in hospital units and among those clinicians, 82.9% reported that their patients were shackled sometimes to all of the time [16].

Despite the policy condemning shackling, "rule or protocol" was the most cited reason for restraint use. As of 2024, 45.1% of states lacked required documentation of restraint use, 54.9% did not authorize nurses or advanced practice nurses to remove shackles, and 41.2% did not prohibit waist restraints [17]. These gaps matter clinically because restricted movement may interfere with maternal positioning, delay urgent obstetric evaluation, and complicate response to hemorrhage or fetal heart rate abnormalities. The persistence of routine restraint use despite narrowing legal and professional standards suggests that implementation remains a major determinant of intrapartum care quality. Postpartum care in custody is also shaped by carceral settings that extend beyond routine medical care. currently recommends that individuals who give birth while in custody receive the same core postpartum elements as nonincarcerated patients, including time for parent-infant contact in the hospital, lactation support, mental health assessment, and early follow-up after discharge.

Further notes that nonmedical separation of the newborn during hospitalization or expedited postpartum discharge for correctional convenience can adversely affect bonding, breastfeeding, and psychological well-being. Available reports suggest that these departures from standard postpartum care remain common. In the King County doula program, mothers were usually returned to jail within 24 hours after birth while newborns were discharged to relatives or foster care. In a clinical review published by the Journal of the American Medical Association it was noted that a mother was discharged 36 hours postpartum, and she was unable to breastfeed because an officer remained in the room and her infant was not permitted to stay with her [18]. Qualitative work among 12 incarcerated postpartum mothers similarly found that women described a sharp shift in the postpartum period from connection during pregnancy to emptiness, grief, and avoidance of future oriented thinking once separated became imminent [19].

Some correctional policies frame restraints during labor and prompt postpartum return to custody as necessary to escape risk, ensure officer safety, and infant placement logistics. [20] policy allows restraint use only when an official identifies an immediate and credible flight risk or serious threat to harm and generally prohibits a newborn's return to the institution except through visiting or specific residential programs. However, outcome data does not suggest that routine use of these practices confers clear clinical benefit. In New York, 23 of 27 women (85%) surveyed after enactment of the anti-shackling law reported being shackled at least once in violation of the statue, including during transport to the hospital and postpartum recovery, indicating implementation failure remains common even when formal restrictions exist [21].

Additionally, the University of Chicago Law School Global Human Rights Clinic and American Civil Liberties Union (2014) [22] reported that jurisdictions that restricted routine shackling found no subsequent instances of women in labor escaping and harming officers or medical staff. Furthermore, evidence supporting less restrictive care shows more desirable clinical outcomes. Continuous support during childbirth is associated with lower cesarean delivery and higher rates of spontaneous vaginal birth. In the postpartum period, policies that separate the dyad shortly after birth may simplify custody management, but separation has been associated with increased anxiety and depression scores in children exposed to early maternal separation, whereas prison nursey co-residence provides greater developmental resilience.

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A systematic review similarly concluded that breastfeeding and postpartum care are better supported when programs delay or prevent mother-infant separation, provide immediate hospital-based lactation support, and create structured links for milk expression [23].

Solutions for Improving Intrapartum and Postpartum Outcomes

An additional model through the NJRC's Women's Project is one that approaches postpartum disruptions as both a legal and care coordination problem. In its 2025 report, the Women's Project notes that approximately 60% of incarcerated women are parents to minor children and are more than twice as likely as incarcerated fathers to have been their children's sole or primary caretaker before incarceration. In New Jersey, approximately 65,000 children experienced parental incarceration as of 2016. On that basis, the Women's Project has advanced a Survivors Justice Act and related diversionary options, including pretrial intervention, conditional discharge, conditional dismissal, and probation for eligible women with the aim of reducing avoidable separation of mothers and infants in the immediate postpartum period [24,25]. This legal framework is complemented by service based postpartum support.

Table 2: Existing care models for female incarcerated and reentry populations: structure, target population, and reported outcomes

Care model	Structure and key services	Target population	Reported outcomes and metrics
New Jersey Reentry Corporation (NJRC)	• A staged model that first stabilizes participants with benefits (state ID, SNAP, disability, housing), then connects them to health insurance and to medical, behavioral, and addiction care (including MAT), and finally moves them into workforce training and employment. [12,49]	• Court-involved and reentering individuals statewide; the Women's Project serves court-involved women, including pregnant and postpartum women [12,49]	• NJRC overall recidivism 14.01% (below state and national benchmarks; organization-wide, not women-specific) [12]
	• Free on-site care at the Francine A. LeFrak Wellness Center (partners: RWJBarnabas Health, Rutgers). [12]	• Women are 6.8% of the U.S. incarcerated population; NJ women's prison count rose >4-fold (176 in 1978 → 774 in 2017) and jail count ~7-fold (175 in 1970 → 1,268 in 2015) [12]	• Women's Project engagement (cumulative female participants): 3,366 Medicaid enrollments; 1,991 received medical treatment; 1,091 received MAT for SUD. [12]
	• 16 DOL-recognized workforce certifications, including the only national phlebotomy certification for court-involved women. [12]	• 72.5% of participants report addiction before or during incarceration [12]	• Two-year review: increased healthcare access and utilization; expanded mental-health and addiction treatment; improved employment and housing stability. [49]
	• Health Navigator model at Edna Mahan: medical director, navigator, and social workers link women to community OB/GYN, behavioral-health, addiction, and DV/sexual-assault services after release [24,25]	• 60% of incarcerated women are parents of minor children [12]	• Subgroup initiatives (Veterans Justice Outreach, Espíritu Latino) associated with reduced recidivism across New Jersey. (NJRC, 2025a) [12]
	• Legal advocacy (diversion, guardianship support) to reduce mother–infant separation. [24,25]	• 2× more likely than incarcerated fathers to be the sole/primary caregiver [12]	• MAT associated with improved pregnancy outcomes and lower preterm birth. [12]
	• Subgroup initiatives: Veterans Justice Outreach; Espíritu Latino.	• 65,000 NJ children had a parent incarcerated (2016) (12]	

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Women and Infants at Risk (WIAR), Michigan	• Pregnant, drug-dependent women transferred from prison to a residential house in Detroit. [50]	• Incarcerated pregnant women with substance use disorders [50]	• 45 infants (1991–1995): all drug-free at birth; 1 NICU admission; 1 fetal alcohol syndrome; 4 with anomalies or serious complications. [51]
	• Intensive prenatal care [50]		
	• Individual and group substance-use counseling [50]		• Birth outcomes compared favorably with pre-program imprisoned women. [51]
	• Life-skills and GED education [50]	• Must provide primary infant care, remain drug-free, and stay ≥4 months postpartum, regardless of sentence length. ([50]	
	• Mother–infant co-residence after birth [50]		• Improved psychosocial functioning during treatment; ~50% of completers discharged with depressive symptoms. (Kubiak et al., 2004) [52]
	• Housing, social services, and day care coordinated at reentry [50]		
Prison nursery programs	• Secure in-facility units [53]	• Incarcerated women who give birth during custody (Carlson, 2009) [53]	• Nebraska: 3-year recidivism fell from >30% (pre-nursery) to 9% (participants) [53].
(e.g., New York and Nebraska)	• Mothers live with and care for infants, typically 12–18 months (up to 36 months in some) [53]		• New York: 3-year recidivism 13% (participants) vs 25% (general female prison population). [55]
	• Prenatal and parenting education, infant care, and child-development support [53]		• Infant attachment security 75% among year-long co-residents (43% if <1 year), approximating low-risk community samples. [55]
	• Reentry linkage (Carlson, 2009) [53]	• Eligibility usually limited (e.g., non-violent offense; sentence compatible with the co-residence period) [53]	• At preschool age, co-resident children showed fewer anxious/depressed symptoms than peers separated by incarceration. [54]
	• Operate in ~8–9 U.S. states and 1 jail (Rose M. Singer Center, Rikers Island) [53]		

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Prison doula programs (e.g., Seattle/University of Washington & Minnesota Prison Doula Project)	• Trained doulas provide continuous one-on-one support across the prenatal, labor/birth, and postpartum periods [14]	• Pregnant incarcerated women, particularly those expected to give birth during custody [14]	• Continuous labor support: spontaneous vaginal birth RR 1.08; cesarean RR 0.79 (largest effect with a doula) [13]
	• Often paired with group pregnancy and parenting education [14]		• Prison-based programs logistically feasible. [57]
	• Partnerships among facilities, community doula organizations, public-health agencies, and delivering hospitals [14]		• Doula-delivered breastfeeding education linked to higher breastfeeding intention and initiation [27]
	• Birth planning, labor support within custody constraints, and early skin-to-skin and breastfeeding support [14]		• Participants reported empowerment, trust, and normalized birth experiences, including support through mother–infant separation [14]

Note: Programs differ in setting: NJRC and WIAR are community-based and span custody and reentry; prison nursery programs operate within correctional facilities; doula programs combine in-facility support with hospital-based birth care. Women's Project engagement figures are cumulative counts of female participants from NJRC case-management data; the 14.01% figure is NJRC's overall recidivism rate (below state and national benchmarks), not a Women's Project–specific or perinatal outcome. Incarceration-trend figures reflect NJRC-reported state and national data. Other outcomes derive from heterogeneous sources-cohort and descriptive studies, qualitative evaluations, and a systematic review of continuous labor support-across different facilities and time periods; comparisons are descriptive and are not the result of randomized comparison. Values are rounded as reported.

Through agreements with the New Jersey Department of Corrections, NJRC's Medical Director, Health Navigator, and social workers connect women at Edna Mahan Correctional Facility with community providers for behavioral health, addiction treatment, domestic violence and sexual assault services, mental health care, and OB/GYN follow up after release. Other obstetric and postpartum models have addressed these issues as well. Community based residential parenting programs allow mothers to remain with their infants while completing court-imposed sentences, and prison nursey programs have been associated with lower recidivism in Ohio (3% vs 38% in the general prison population). Residential programs such as the Women and Infants at Risk Program in Michigan extend this model further by combining nurse-midwifery care, Medicaid enrollment, substance use treatment, and postpartum follow-up in a structure setting [26].

Lastly, a prison-based pregnancy and parenting program in the Midwest combined a 12-week parenting support group with one-on-one doula care across the prenatal, intrapartum, and early postpartum periods, including skin to skin contact and breastfeeding support in the first hour of birth. Women who discussed breastfeeding with doulas were more likely to initiate breastfeeding, suggesting that even brief postpartum interventions may improve maternal and neonatal care trajectories [27]. These existing models confirm that several low burden changes could be incorporated into current medical and correctional workflows without requiring major expansion of services. One approach would be formal hospital-correctional agreements that specify officer location during postpartum care, documentation and clinical review of any restraint use, lactation access, and discharge planning responsibilities.

These measures can be incorporated into existing transfer protocols and maternal safety policies. Implementation would depend primarily on written policy revision and staff training rather than new infrastructure. A second approach would be a standardized postpartum care pathway for incarcerated patients that includes depression screening, breastfeeding or pumping assessment, medication if needed, scheduled follow up, and direct transfer of records to the receiving facility or community clinician. These elements mirror routine postpartum care and could be added to existing order sets and discharge workflows rather than requiring a separate clinical program. A third approach would be to create a standardized MFM-informed pathway that links pregnancy identification, comorbidity treatment, referrals, delivery planning, and postpartum care. This pathway would allow correctional facilities and hospitals to identify conditions requiring serial surveillance or specialty input before acute symptoms, transport barriers, or release disrupt care. In labor, care should prioritize maternal mobility when feasible, timely analgesia, unobstructed obstetric assessment, and access to continuous support (Figure 1).

Clinical Implications for Obstetricians and MFM Clinicians

Incarcerated pregnant patients present with medical and psychiatric comorbidities that are frequently under documented at intake. Surveillance of newly admitted pregnant women reported a psychiatric diagnosis in 27.4% and a substance use disorder in 34.1% of prison admissions, and chronic conditions such as hypertension are identified more often on clinical evaluations than by self-report ([28,29]. For obstetricians and MFM clinicians, the implication is consistent application of existing ACOG and Society for Maternal-Fetal Medicine (SMFM)

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guidelines to an under-resourced setting (ACOG, 2019) [30]. The guidelines advise opioid use disorder should be managed with continued medication rather than withdrawal [31]. Perinatal mental health conditions should be screened for and treated rather than deferred to release [32,33]. Patients with chronic hypertension, pregestational diabetes, or other high-risk factors should receive low-dose aspirin for preeclampsia prevention with blood pressure and glycemic management [34]. Because these conditions benefit from subspecialty input, identifying them early enables MFM consultation and risk-appropriate delivery planning before transport, release, or worsening symptoms interrupt care.

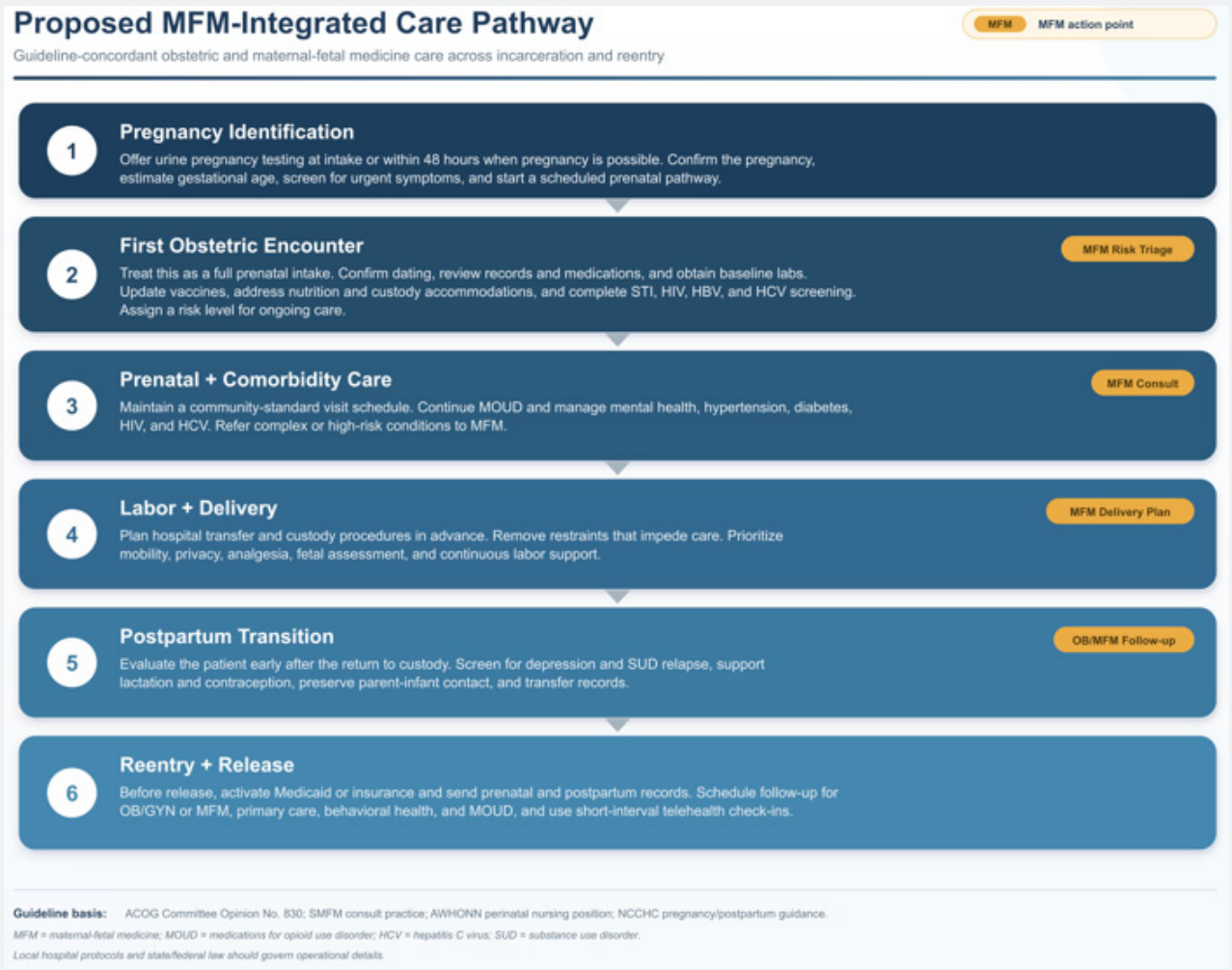

Figure 1: The algorithm operationalizes standard obstetric care within carceral settings by identifying points were custody procedures, record fragmentation, transport delays, release timing, or limited specialty access may interrupt guideline-concordant management. The sequence begins with early pregnancy identification and uses the first obstetric encounter as a corrective "catch-up" visit to complete deferred screening and identify comorbidities that may not have been fully documented at intake. Orange markers indicate MFM action points: risk triage at the initial obstetric encounter, formal MFM consultation for medical and fetal complexity, anticipatory delivering panning when custody procedures may affect intrapartum care, and OB/MFM follow-up after birth. The postpartum and reentry phases frame discharge as a high-risk transition requiring record transfer, medication and MOUD continuity, lactation and parent-infant support, contraception counseling, and linkage to community resources after release.

Incarceration or recent release should prompt clinicians to verify rather than assume the completeness of prior care. The first obstetric encounter should function as an prenatal intake and identify any preexisting comorbidities. Obstetricians should confirm gestational age, prior laboratory testing, vaccination status, current medications, and treatment for substance use disorders because screening, referral, and record transfer are not implemented consistently across facilities. Due to incomplete records, it is reasonable to confirm dating, repeat key prenatal labs, and reassess whether anatomy imaging, diabetes screening,

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Rh status, infectious disease testing, and fetal growth evaluation have been completed. Given the high prevalence of hepatitis C and HIV in this population, confirming HIV and hepatitis C status is a necessary priority. An HIV-positive pregnancy warrants antiretroviral therapy with coordinated MFM and infectious disease management to reduce perinatal transmission. Additionally, chronic hepatitis C warrants antenatal counseling and linkage to postpartum treatment [35].

A lower threshold for reassessment is also warranted when patients report bleeding, abdominal pain, headache, visual symptoms, leakage of fluid, reduced fetal movement, or possible labor, as evaluation may be delayed when symptoms are first filtered through custody staff rather than directly communicated to a clinician. On labor and delivery units, obstetricians, MFM clinicians and nurse midwives can reduce nonclinical barriers by clarifying custody procedures at admission. Practical questions include whether restraints are in place, who is authorized to remove them, whether an officer must remain in the room during examination, and how urgent transport to the operating room would occur if needed. In practice, obstetricians should request removal of restraints when they interfere with positioning, neuraxial analgesia, fetal assessment, or emergency response [36]. Early communication among obstetric, anesthesia, neonatology, and custody staff is important when patients have hypertensive disorders, suspected preterm labor or Preterm Prelabor Rupture of Membranes (PPROM), fetal growth restriction, gestational diabetes, placenta previa or accrete concern, multifetal gestation, or other conditions that may require rapid escalation.

Clinicians should also document explicitly when custody procedures delay evaluation, limit mobility, or alter recommended obstetric management [37-40]. Postpartum care should be approached as a planned clinical transition rather than a routine discharge. Before returning to custody or release, clinicians can complete depression screening, lactation counseling, prescribe any medications, contraception counseling if desired, and documented follow-up plan [41,42]. For MFM clinicians, that plan should be diagnosis specific when pregnancy was complicated by hypertensive disease, diabetes, cesarean delivery, hemorrhage, infection, or opioid use disorder, and should specify blood pressure checks, wound review, glucose follow-up, medication, and timing of obstetric follow-up rather than defaulting to general primary care. When infant caregiving arrangements are changing, early social involvement and anticipatory guardianship planning may make discharge safer and more predictable. Obstetricians can also improve continuity of care by identifying community follow-up resources before discharge, including reentry programs that help patients reconnect with Medicaid, behavioral health care, substance use treatment, and outpatient gynecologic or obstetric services [43-50].

This is relevant after release: in one reentry clinic cohort, all 11 live births involved pregnancy or delivery complications, yet only 4 of 10 women were placed in special obstetrics clinic. Beyond individual encounters, obstetricians, MFM clinicians, and nurse midwives can shape systems of care with relatively low burden changes. Hospital protocols for incarcerated pregnant patients can standardize points of contact at correctional facilities and community clinics [51-54]. Protocols should also define triggers for urgent obstetric evaluation and, when appropriate, MFM consultation for conditions such as gestational diabetes, chronic hypertension, superimposed preeclampsia, HIV, prior preterm birth, and fetal growth restriction. Guidelines should standardize transfer of prenatal laboratory results, ultrasound reports, medication lists, and postpartum plans back to custody or community clinicians. Because knowledge of correctional pregnancy policy remains inconsistent, clinician-led education on documentation, legal standards, and escalation pathways may improve consistently without requiring new clinical infrastructure[. In this setting, the central task is not to create a different standard of care, but to apply ordinary obstetric and MFM standards in a setting where access, privacy, mobility, and follow-up is less predictable [55-60].

Conclusion

Data shows that maternal and neonatal outcomes in carceral settings are influenced not only by baseline medical and social risk, but also by whether routine obstetric care can be delivered without interruption across prenatal, intrapartum, and postpartum periods. In this context, the most durable improvements are likely to come from systems that reduce fragmentation rather than from isolated clinical interventions. One practical next step would be the development of a designated obstetric liaison model, in which each correctional facility and referral hospital identifies a single clinical point person responsible for coordinating prenatal records, urgent evaluation, delivery planning, MFM referral for higher-risk pregnancies, and postpartum follow-up. A second strategy can be the use of trigger-based escalation protocols for common obstetric symptoms, such as bleeding, headache, decreased fetal movement, hypertension, and suspected labor, or the correctional staff have clear criteria for immediate clinical referral rather than relying on intermittent judgment. Because incarcerated patients carry a disproportionate burden of conditions within MFM scope, these pathways should also link higher-risk pregnancies to MFM consultation.

Additional progress may depend on quality improvement mechanisms that have not yet been widely applied to correctional obstetric care. State departments of corrections and affiliated hospitals could establish joint maternal case review processes for adverse pregnancy events, including preterm birth, delayed hospital transfer, postpartum readmission, and maternal morbidity, to identify recurrent systems failures and revise local protocols accordingly. Similarly, short interval telehealth obstetric follow-up after return to custody or release could offer a feasible way to maintain postpartum surveillance, medication continuity, and symptom assessment without substantially increasing

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transportation or staffing demands. These approaches do not require a separate standard of care, but rather, they apply standard obstetrical principles of care to incarcerated individuals.

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