STRUCTURED FOR PUNISHMENT, NOT FOR PREGNANCY: HOW AND WHY NEW JERSEY SHOULD ADDRESS THE PARADOXICAL ISSUE OF PREGNANCY CARE IN STATE PRISONS

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* J.D. Candidate, Rutgers Law School, Camden, 2026. I would like to give my sincerest thanks to Professor Kimberly Mutcherson for her invaluable guidance in writing this Note, to the whole staff of the *Women's Rights Law Reporter* for their tireless dedication to this publication, and to my amazing parents for their unwavering support throughout my entire law school journey.

I. INTRODUCTION

In 2021, Hayley was incarcerated in Georgia when she was discovered to be pregnant during a routine medical exam.[1] She was not immediately told she was pregnant, but rather that she was being sent to a different facility.[2] Even once informed of her pregnancy, the only information that she received was a dictionary to look up pregnancy-related terms.[3] She was not even told her due date until around twenty-two weeks.[4] Inmates at Hayley's facility did not receive any pillows for sleeping, and pregnant inmates were only given one extra sleeping mat.[5] She later stated that the uncomfortable bed seriously inhibited her sleep, especially during her third trimester.[6] When Hayley went into labor, she was taken to a nearby hospital, where an armed guard was stationed at the end of her bed, with a full view of the birth.[7] After three days, Hayley's baby was taken by the hospital nurses, and Hayley was transported back to prison, with nothing but menstrual pads.[8]

Hayley's story is just one of many from incarcerated women[9] who face a lack of care, education, and counseling when pregnant and incarcerated. Stories like hers are demonstrative of a serious gap in the law to protect some of the most vulnerable people in the custody of state and federal governments. Especially given the rapid growth of women's prison populations, with a 525% increase since 1980, it is imperative that states give increased focus to the needs of incarcerated women.[10] This issue represents an important, but frequently overlooked, intersection between public health,

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[1] Danielle Campoamor, *What Giving Birth in Prison is Really Like: One Mom's Story*, TODAY, https://www.today.com/parents/pregnancy/pregnancy-birth-prison-rcna59152 [https://perma.cc/3VLG-WJR6] (last updated Feb. 28, 2023, at 18:47 ET).

[2] *Id.*

[3] *Id.*

[4] *Id.*; *see* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NO. 700, METHODS FOR ESTIMATING DUE DATE (2017) (explaining that ultrasound measurement to determine gestational age and calculate a pregnancy's due date is most accurate when performed in the first trimester, or within the 14 weeks).

[5] Campoamor, *supra* note 2.

[6] *Id.*

[7] *Id.*

[8] *Id.*

[9] I would like to note that pregnancy is not limited to people who identify as women. People of all gender identities may become pregnant, such as transgender men and intersex or non-binary people. Deconstructing the rigid constraints of the gender and sex binaries in relation to pregnancy is essential to achieving equal access of the law, including for those in incarceration. However, most laws do not reflect this. Jessica A. Clarke, *Pregnant People?*, 119 COLUM. L. REV. 173, 177-83 (2019). Most correctional facilities today are separated by sex assigned at birth and many laws, reports, and articles that will be discussed here refer explicitly to women and the female sex, but please keep in mind that this is not the reality for many. Due to the reality that pregnancy care in prisons is only provided to the female incarcerated population, feminine language will be used throughout this paper, while maintaining that rigid binaries frequently do not serve principles of intersectional feminism.

[10] Riley Smith et al., *Correctional Facilities*, 25 GEO. J. GENDER & L. 437, 438 (2024).

criminal justice, and women's rights that this Note seeks to address. In order to begin dismantling the issues seen in each of these movements, and move towards a safer, healthier, and more equitable society, incarcerated women capable of pregnancy must be given the same (if not better) care as those who are not incarcerated, and further, care that is tailored to address the unique demographics of incarcerated populations, which as this Note will show, is not currently being provided.

Important to this discussion is that people outside of incarceration frequently do not have access to adequate healthcare, including pregnancy care, either. Given the overrepresentation of people of color and low-income individuals in prisons–communities that have historically lacked access to public health resources–some people may receive healthcare for the first time while incarcerated.[11] These populations are also more vulnerable to health issues like substance abuse disorders, chronic health conditions, and infectious diseases, which may be diagnosed for the first time in a prison.[12]

As to pregnancy, the U.S. has the highest maternal mortality rate among similarly economically developed countries in the world, and has the fourth highest infant mortality rate.[13] New Jersey (N.J.), in particular, has the fourth highest rate of maternal mortality among the fifty states and sees stark racial disparities in pregnancy outcomes.[14] Black women have a pregnancy-associated death rate seven times higher than their white counterparts, and a three and a half times higher rate of infant mortality.[15]

In response to these findings, N.J. launched the "Nurture NJ" program in 2019 to combat maternal and infant mortality and address these glaring racial disparities.[16] Nurture NJ found that women of color frequently face issues such as lower quality care being provided in their neighborhoods, having their concerns ignored by healthcare professionals, and a lack of access to basic needs like housing and food.[17] These issues all exacerbate vulnerability to poor pregnancy outcomes.[18] The program identified action areas such as building infrastructure for racial equity, strengthening and expanding public health policy, and improving the overall quality of care in the state.[19]

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[11] Shanoor Seervai, *Health Behind Bars - How the U.S. Could Improve Care for Incarcerated People*, THE COMMONWEALTH FUND (Apr. 8, 2022), https://www.commonwealthfund.org/publications/podcast/2022/apr/health-behind-bars-improve-care-incarcerated [https://perma.cc/HP79-MFYS].

[12] *Id.*

[13] V.K. HOGAN ET AL., NURTURE NEW JERSEY 2021 STRATEGIC PLAN, 9 (Jan. 2021).

[14] *Id.*

[15] *Id.*

[16] *Id.* at 10.

[17] *Id.* at 32-33.

[18] *Id.*

[19] *Id.* at 13-14.

In Nurture NJ's strategic plan, the N.J. Department of Corrections (NJDOC) is already a designated partner, and the plan includes specific recommendations concerning maternal health in incarceration.[20] Relevant recommendations include developing an "advised procedure" for how prosecutors work with pregnant women, including the possibility of delaying sentencing until three months postpartum, ensuring "pregnancy and childbirth education" for incarcerated parents, in addition to other counseling, and developing training for corrections officers to "ensure that incarcerated pregnant women receive care that promotes their health and safety."[21] Although these are important recommendations, the results of the program's efforts are yet to be seen and more could be done to expand the partnership with NJDOC.

Focusing on pregnancy care in prison will inevitably improve pregnancy care and outcomes outside of prison. Firstly, although healthcare is mandated in prisons, healthcare in incarceration paradoxically fails to give inmates the knowledge they need to manage health issues.[22] Overcrowded and unsanitary conditions inside prison contribute to the spread of disease and the stress of incarceration itself can exacerbate health issues.[23] So, when inmates are released and the state fails to provide transitional support, like housing and employment, any healthcare that was provided in incarceration is stripped away and former inmates return to communities characterized by the same poverty and lack of resources that they were incarcerated from.[24]

On a greater level, given the high flow of individuals in and out of prison in our age of mass incarceration,[25] when health needs go unaddressed in prison, the state places those burdens of care on already underserved communities upon release, leading to even higher disease transmission among those communities, increased recidivism, and crippled public health systems.[26] This jeopardizes the wellbeing of entire populations, in and out of

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[20] *Id.* at 5, 18, 68.

[21] *Id.* at 56, 68.

[22] Lindsay A. Pearce et al., *Prison Health Data Collection: Transforming Public Health Risks to Opportunities for Global Health Equity*, 388 SOC. SCI. & MED. 118793 (2026).

[23] *Id.*

[24] *Id.*

[25] The U.S. has the highest rate of incarceration in the world, at approximately 750 per 750,000 people. The expansion of the U.S. prison population occurred largely in the 1980's and 90's, increasing by the millions in as little as thirty years, which some scholars attribute to the "War on Drugs," launched by Ronald Raegan in 1982. This phenomenon, labelled by many as "mass incarceration," or "mass imprisonment" as first coined by David Garland, is defined by both the sheer numbers of the prison population and the "systematic imprisonment of whole groups of the population." The group most affected by this phenomenon is black Americans, with black people being eight times more likely to spend time in prison than white people. MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS (2010); MASS IMPRISONMENT: SOCIAL CAUSES AND CONSEQUENCES (David Garland ed., 2001); Dorothy E. Roberts, *The Social and Moral Costs of Mass Incarceration in African American Communities*, 56 STAN. L. REV. 1271 (Apr. 2004).

[26] Pearce et al., *supra* note 22.

incarceration.[27] Therefore, prison health *is* public health, and, given the stated interests of N.J., pregnancy care should be at the top of the list of public health issues to address.

In light of recent social and political developments, including the Nurture NJ program, in addition to the closing and reformation of N.J.'s Edna Mahan Correctional Facility for Women (EMCF) and the federal Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, it is an opportune time for N.J. to be a trailblazer state in creating and adopting legal protections and programs for those who are pregnant in its state correctional facilities. This would be an important step in recognizing both women's rights and the rights of individuals in state custody that correctional facilities are mandated to provide and care for.

This Note will first lay out the current landscape of pregnancy in prisons. By addressing who is in prison and how they ended up there, we get a clearer picture of the needs that they may have. Recent developments in N.J., with the investigations of abuse and eventual closing of the Edna Mahan Correctional Facility for Women, also frame the discussion of N.J.'s current approach to healthcare in women's prisons.

Next, this Note will review the recommended standards for pregnancy care in prisons. Federal agencies like the Bureau of Prisons (BOP) and U.S. Marshals Service (USMS) provide recommendations for state prisons in how to care for pregnant inmates. However, these standards are largely permissive and there is little to no data on how they are enforced. In contrast, professional organizations, like the American College of Obstetricians and Gynecologists (ACOG), provide much more in-depth recommendations for pregnancy care in prisons and pregnancy care generally. These standards should serve as a guide for all prisons in providing the best pregnancy care possible.

Next, this Note will look to the legal landscape governing pregnancy care in prisons, including current federal and N.J. laws and both federal and N.J. caselaw. Federal law, although frequently not binding on the states, helps us to understand national legal trends that influence public sentiment towards feminist and criminal justice issues and impact the priorities of state legislators. The research shows that such laws are largely vague, permissively enforced, and lack many of the recommended standards from professional organizations. Furthermore, this Note demonstrates how the prison infrastructure is not set up to provide the care that pregnant inmates truly need, demanding imaginative legislative solutions.

Reproductive issues today also cannot be discussed without addressing the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*. The Note will discuss how the *Dobbs* decision implicates

[27] *Id.*

pregnancy care in prisons, due to its minimization of women's rights and autonomy. Although the Note does not focus on abortion rights, a woman's right to privacy and choice is not limited to abortion, and any Supreme Court decision that influences such has an inherent impact on all women's issues, including pregnancy care.

Next, this Note attempts to answer the question of what N.J. can do to address the reality that state prisons lack the necessary mandates and resources to provide expansive pregnancy care that would aid in increasing positive pregnancy and health outcomes. The section first reviews a failed piece of federal legislation, the Pregnant Women in Custody Act, that would have made a significant step towards aligning pregnancy care in prisons with the recommendations of professional organizations. Although the Act fails to address how prisons are not currently structured to provide the appropriate care, it still serves as an important guide for the kind of care that needs to be provided and may be a strong model for future state legislation.

In contrast, more radical programs that operate outside of criminal justice norms have been successfully enacted in other states, like Minnesota's Healthy Start Act and prison nursery programs. The successes of these programs, as in their ability to produce positive pregnancy outcomes and reduce recidivism, should serve as strong encouragement for N.J. to adopt similar programs and provide further guidance for future state legislation. N.J. itself has introduced bills pertaining to pregnancy care in prison in the state legislature in recent years, but those bills have repeatedly failed to be signed into law. Still, they serve as important guides for future legislation and reflect the state legislature's willingness to address such important issues.

Lastly, the Note concludes with a concrete recommendation for legislation N.J. should adopt to address the issues outlined in the note, combining the recommendations and models from professional agencies, federal bills and standards, and legislation in both N.J. and other states. It is the hope that this Note serves as a model and starting-off point for future state legislation and N.J.'s overall work towards gender equity and criminal justice reform.

II. THE CURRENT LANDSCAPE

When creating laws guiding pregnancy care in prisons, it is important to note who exactly will be affected by such provisions. Incarcerated individuals face unique challenges, especially when it comes to healthcare. Demographics such as race, age, and socioeconomic background are correlated with both a vulnerability to incarceration and a vulnerability to certain health issues, like substance abuse and poor mental health, which

contribute to poor pregnancy outcomes.[28] Incarcerated individuals also face unique challenges due solely to the fact that they are incarcerated, including limited access to healthcare and the physiological effects of being in confinement.[29] The law, then, must reflect an intersectional view of the needs of pregnant inmates.

A. Who is in Prison and Why?

Between 1980 and 2021, the number of incarcerated women in the U.S. has increased 525%,[30] and yet very little has been done to address the unique concerns of this population. Although women still represent a small portion of the prison population, "women's prison populations have seen much higher relative growth than men's since 1978…more than double the pace of the growth among men."[31] Women in prison face issues separate from those facing men, given that they are more likely than men to enter prison with histories of abuse, trauma, and mental health problems,[32] with one study finding that 66% of women in prisons and jails having histories of mental health problems, in contrast to 35% of men.[33] In addition, women have the unique need for reproductive healthcare, and 62% of women in prison are the primary caretakers of minor children.[34] And yet, prisons remain structured for men and lack consideration of these variabilities.[35]

The quick growth of women's prison populations means that criminal justice reforms and efforts to decarcerate are ultimately benefitting men more than women, with the total number of incarcerated men in state prisons falling over 5% between 2009 and 2015, and the total number of incarcerated women falling only 0.29% in that same time period.[36]

The 2023 annual report from NJDOC stated that female inmates represent approximately 3.5% of its total population, with the majority race being black, and the median age being thirty-six.[37] A study from the Prison Policy Initiative found that, as of 2015, women in N.J. are incarcerated at a

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[28] *See* discussion *infra* Section II(a).

[29] *Id.*

[30] Smith et al., *supra* note 10, at 438.

[31] Wendy Sawyer, *The Gender Divide: Tracking Women's State Prison Growth*, PRISON POL'Y INITIATIVE (Jan. 9, 2018), https://www.prisonpolicy.org/reports/women_overtime.html [https://perma.cc/FT2M-XD5Y].

[32] Smith et al., *supra* note 10, at 453.

[33] Jennifer Bronson & Marcus Berzofsky, *Special Report: Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12*, BUREAU OF JUST. STAT. (June 2017).

[34] Sawyer, *supra* note 31.

[35] *See generally id.* ("Women's incarceration demands more attention because of the distinct ways in which prisons and jails fail women and their families. Research consistently shows that incarcerated women face different problems than men—and prisons often make those problems worse.").

[36] *Id.*

[37] STATE OF NEW JERSEY DEP'T OF CORR., 2023 ANNUAL REP. 22, 28 (2023).

rate of 20 per 100,000 female residents.[38] Notably, NJDOC's annual reports before 2022 lack any statistics regarding its female population, separate from its male population,[39] which leads to the conclusion that N.J. is in line with the national trend of women's rates of incarceration outpacing those of men.

Women, generally, are more likely to be serving time for drug and property crimes than men, rather than violent crimes.[40] Violent crimes are more likely to be committed by men, and, even when women commit violent crimes, they are often found to be accomplices or acting in self-defense.[41] For drug and property crimes, those who are convicted of such are "more likely to be experiencing homelessness at the time of their arrest and conviction, which is typically exacerbated upon reentry once they are labeled as 'convict.'"[42] These "severe collateral consequences," of incarceration that disproportionately impact women, like homelessness, in addition to trauma from abuse, with 86% of women in prisons identified as sexual violence survivors, can manifest into mental health and behavioral issues that "demand unique solutions."[43]

B. Pregnancy Rates and Outcomes in Prison

According to one study from 2016-2017, four percent of women entering state prisons were pregnant.[44] Other studies show that up to 25% of women in prisons are or have become pregnant, sometimes as a result of rape by prisons guards.[45] Furthermore, female prisoners who become pregnant without having outside contact, like conjugal visits or furloughs, are often subject to solitary confinement or other punishment for having had sexual contact.[46] In contrast, guards who perpetuate such contact or engage in rape

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[38] *New Jersey Prison Incarceration Rates: Women*, PRISON POL'Y INITIATIVE, https://www.prisonpolicy.org/graphs/NJ_Women_Rates_1978_2015.html[https://perma.cc/F56V-VTZE] (last visited Feb. 21, 2025).

[39] NEW JERSEY DEP'T OF CORR., 2022 ANNUAL REP. (2022)*; see, e.g.*, *N.J. Dep't of Corr. Annual Report*, N.J. STATE LIBR., https://hdl.handle.net/10929/113329 [https://perma.cc/64VL-PRWT] (last visited Mar. 18, 2025) (containing archive of annual reports from NJDOC, each show no separate statistics on the women's population until 2022).

[40] Lex Haris, *Lopsided Liability: Analyzing the Constitutional and Statutory Implications of the BOP's Failure to Meet Programming Duties for Incarcerated Individuals in Female Prisons*, 7 ADMIN. L. REV. 183, 194-96 (2022).

[41] *See, e.g.*, *id.* at 195 ("In North Carolina, seventy-five percent of cases where women are convicted of homicide result from a confrontation with their abuser.").

[42] *Id.*

[43] *Id.* at 196.

[44] *Pregnancy in Prisons Statistics (PIPS) Project*, ADVOC. AND RSCH. ON REPROD. WELLNESS OF INCARCERATED PEOPLE, https://arrwip.org/projects/pregnancy-in-prison-statistics-pips-project/ [https://perma.cc/9BL9-4K7R] (last visited Nov. 20, 2024).

[45] Smith et al., *supra* note 10, at 449 (A 2009-2011 statistical report of prison rape found that, where women constitute 7% of prisoners, 32.6% of victims of staff-on prisoner sexual violence were women, with 45.7% of perpetrators being male guards).

[46] *Id.* at 449-450.

of inmates are rarely successfully prosecuted for sexual abuse, despite the criminalization of sexual conduct between guards and prisoners.[47] This is demonstrative of the low regard prison officials hold for the inmates they are meant to protect, especially when comparing the consequences correctional employees face when they similarly violate the law.

N.J., specifically, lacks an official monitoring system for pregnancy and pregnancy outcomes within state correctional facilities, making statistics difficult to ascertain.[48] However, we can look to general pregnancy rates and outcomes in the state to get a picture of how pregnancy may look inside state prisons. In 2023, the general fertility rate in the N.J. was 57.4 per 1,000 women, aged 15-44.[49] In 2024, the preterm birth rate in New Jersey was 9.3%, the infant mortality rate was 3.6 deaths per 1,000 births, and the maternal mortality rate was 26 deaths per 100,000 births.[50] Notably, according to this study, the infant mortality rate amongst black birthing people is 2.4 times the overall state rate, and black birthing people are more likely to experience preterm birth than their white counterparts in N.J.[51] In comparison to other states, though, N.J. has the eighth lowest rate of preterm birth and has adopted all of the policies March of Dimes recognizes as "critical to improve and sustain maternal and infant health," with the exception of a midwifery policy.[52]

Other sources, however, emphasize that access to pregnancy care and positive pregnancy outcomes in N.J. is extremely variable, when considering factors like race and geographic location. In a 2021 study, women reported receiving good care in suburban areas, but women in low-income, urban areas reported low quality care and stated that they faced stigmatization for being black or brown and/or having state-issued health insurance.[53] Another study found that a mother's race and ethnicity accounted for 45.1% of variation in severe maternal morbidity across municipalities, emphasizing

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[47] *Id.* at 450; *see* Prison Rape Elimination Act of 2003, 108 P.L. 79, at § 3 (established a "zero-tolerance" policy for prison rape in the U.S. and implemented national standards for the "detection, prevention, reduction, and punishment of prison rape").

[48] The following official reports from the N.J. Department of Corrections lack any mention of pregnancy: NEW JERSEY OFF. OF CORR. OMBUDSPERSON, 2024 ANNUAL REP. (2024); NEW JERSEY DEP'T OF CORR., POPULATION CHARACTERISTICS REP. (Jan. 1, 2024); NEW JERSEY OFF. OF CORR. OMBUDSPERSON, 2022 ANNUAL REP. (2022).

[49] *Births: Data for New Jersey*, MARCH OF DIMES: PERISTATS, https://www.marchofdimes.org/peristats/data?reg=34&top=2&stop=1&lev=1&slev=4&obj=1&sreg=34 [https://perma.cc/K8J8-BEUY] (last visited Feb. 21, 2025).

[50] *2024 March of Dimes Report Card: New Jersey*, MARCH OF DIMES: PERISTATS, https://www.marchofdimes.org/peristats/reports/new-jersey/report-card [https://perma.cc/7F5Y-57J7] (last visited Feb. 21, 2025).

[51] *Id.*

[52] *Id.*

[53] NURTURE NEW JERSEY STRATEGIC PLAN COMPANION DOCUMENT: A DEEPER DIVE INTO DATA AND KEY CONCEPTS, OFFICE OF THE FIRST LADY OF NEW JERSEY, 8-10 (2021).

the correlation between structural racism and pregnancy-associated deaths.[54] Women living in areas with low access to pregnancy care in N.J. must travel 1.4 times further than women living in full-access areas, increasing financial strain, prenatal stress, and the risk of "maternal morbidity and adverse infant outcomes, such as stillbirth."[55]

These seem to be the issues that Nurture NJ aims to address.[56] Especially given the high flow of people in and out of prisons and low-income, low-access communities, there should be increased focus on how these variabilities in care impact N.J.'s prison population.[57] Statistics show that the number of people capable of pregnancy in N.J. prisons is increasing, according to gender and age, and low-income women of color in N.J. are far more vulnerable to poor pregnancy outcomes. The fact that the majority of incarcerated women are black and brown, then, also means that the majority of incarcerated women are inherently more susceptible to maternal morbidity, infant mortality, and preterm birth, and, even if released from prison, they will not get the care that they need. So, if N.J. is seeking to improve its overall landscape of maternal health, pregnancy care for its female prison population—which is arguably the most vulnerable to adverse outcomes—must be part of the conversation.

C. Issues in New Jersey's Women's Correctional Facility

N.J. has recently seen scandal concerning its women's correctional facility that has ignited a wave of changes and increased protections for incarcerated women. In June of 2021, former N.J. Governor Phil Murphy announced the closing of the EMCF, the state's only all-women correctional facility, in response to an investigative report that revealed a history and pattern of sexual and physical abuse against inmates at the hands of staff.[58] The investigation was spurred by an incident on January 11, 2021, when the correctional facility staff performed a series of violent "cell extractions," where they forcibly removed inmates from their cells, shackled them, and subjected them to unwarranted strip searches.[59] The report details video and

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[54] Felix M. Mochumba et al., *Municipality-Level Variation in Severe Maternal Morbidity and Association with Municipal Expenditures in New Jersey*, 4 JAMA NETWORK OPEN 1, 8 (2021).

[55] WHERE YOU LIVE MATTERS: MATERNITY CARE IN NEW JERSEY (2023) [hereinafter Where You Live Matters], https://www.marchofdimes.org/peristats/reports/new-jersey/maternity-care-deserts [https://perma.cc/JQD6-MYV9].

[56] *See supra* discussion in Section I.

[57] *Id.*

[58] *Murphy Announces Intention to Close the Edna Mahan Correctional Facility for Women,* INSIDER NJ (June 7, 2021, at 09:47 ET), https://www.insidernj.com/murphy-announces-intention-close-edna-mahan-correctional-facility-women/ [https://perma.cc/94E7-8NN2].

[59] LOWENSTEIN SANDLER LLP, REPORT OF INVESTIGATION: JANUARY 11, 2021 CELL EXTRACTIONS AT THE EDNA MAHAN CORRECTIONAL FACILITY FOR WOMEN (June 3, 2021).

testamentary evidence of the officers' conduct in the cell extractions, which included ripping and cutting inmates' clothes off, using pepper spray on noncompliant inmates, and repeatedly beating the inmates with their fists.[60] The resulting injuries of the inmates ranged from superficial bruises to sprains, breaks, and concussions.[61]

The report made several conclusions regarding the incident, including that staff failed to establish a proper basis for conducting the cell extractions, staff used excessive force, staff filed false reports of the incident, and staff failed to prevent male-viewing of inmate strip searches, resulting from unclear and informal authorization protocols and delays in implementing remedial measures.[62] The report further recommended an increase in independent oversight, clarifications of authorization policies for cell extractions, increasing the number of female staff and gender-restricted posts, and ultimately closing the physical facility while the issues are addressed.[63] The cell extraction incident was also preceded by criminal charges for over a dozen EMCF officers for sexually abusing inmates.[64]

The State of N.J. and the U.S. Department of Justice entered into a settlement agreement in August of 2021, and, according to a Federal Monitor report from 2024, there has been significant progress and a "robust commitment" on the part of the state and EMCF to execute the agreement and improve conditions for all female inmates in the state.[65] Steps taken include moving the minimum security population to a Satellite building, increasing language translation services, performing independent audits of prison rape, and making plans for the creation of a new, gender-informed facility.[66]

In the most recent Federal Monitor report from December of 2025, the Monitor reported that progress in those areas has remained at a steady increase and highlighted several new programs that have been implemented,

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[60] *Id.* at 35-43.

[61] *Id.*

[62] *Id.* at 50-62.

[63] *Id.* at 62-73.

[64] S.P. Sullivan, *N.J. is Closing its Scandal-Plagued Women's Prison. Its Replacement Will Cost at Least $90M*, NJ (June 15, 2024, at 09:06 ET), https://www.nj.com/news/2024/06/nj-is-closing-its-scandal-plagued-womens-prison-its-replacement-will-cost-at-least-90m.html [https://perma.cc/J28R-WTCV].

[65] JANE PARNELL, FIFTH MONITOR'S REPORT: THE UNITED STATES OF AMERICA V. THE STATE OF NEW JERSEY AND THE NEW JERSEY DEPARTMENT OF CORRECTIONS 27 (2024) [hereinafter FIFTH MONITOR'S REPORT].

[66] *Id.* at 6-14. Although not detailed in the Fifth Monitor's report, a "gender informed facility," presumably refers to gender-responsive policies, practices, and programs, that, as defined by the Council of State Governments, "recognize that women have distinct histories, pathways to offending, and experiences in the criminal justice system." ELIZABETH FLEMING, ET AL., ADOPTING A GENDER-RESPONSIVE APPROACH FOR WOMEN IN THE JUSTICE SYSTEM: A RESOURCE GUIDE 3 (2021).

such as industrial training and library programs.[67] All inmates in "minimum custody status" have now been moved to the Satellite building, while "higher-security" inmates remain in the original EMCF building, which will continue to be the arrangement until the new facility becomes operational.[68] Importantly, the report noted that construction of the new facility is expected to have its first areas completed in 2027 and is projected for full completion in 2028.[69] Construction actually began in October of 2025 and the state has dedicated $310 million towards the project.[70]

The criminal indictments against the EMCF officers concerning sexual abuse of inmates, however, were dismissed with prejudice as "unconstitutionally vague," shortly before construction of the new EMCF began, also in October of 2025.[71] With the avenue of criminal redress against individual actors now closed, it is up to the current administrators of EMCF, NJDOC, and the state to ensure that the structural issues that led to such widespread abuse in the past are not present in the new facility.

The scandals at EMCF are representative of the culmination of issues that results when the unique needs of female inmates are not taken into consideration. Given that the protection of female inmates and pregnant women appear to be a priority for N.J., considering the Nurture N.J. program and the new women's facility being constructed within the next few years, it seems to be an opportune moment to bring the need for appropriate pregnancy care into the conversation.

III. WHAT SHOULD THE STANDARD OF PREGNANCY CARE IN PRISONS BE?

Incarcerated individuals are dependent on the carceral institution to provide for their healthcare needs. As discussed, prison health *is* public health in our age of mass incarceration, so any efforts to improve conditions outside of prisons must be mirrored within prisons to reach maximum efficacy. There are several resources available to such institutions to help formulate policies and practices for pregnancy care, as recommended by both licensed physicians and federal agencies. The reality, though, is that

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[67] JANE PARNELL, EIGHTH MONITOR'S REPORT: THE UNITED STATES OF AMERICA V. THE STATE OF NEW JERSEY AND THE NEW JERSEY DEPARTMENT OF CORRECTIONS 12-13 (2024) [hereinafter EIGHTH MONITOR'S REPORT].

[68] FIFTH MONITOR'S REPORT, *supra* note 65, at 6.

[69] EIGHTH MONITOR'S REPORT, *supra* note 67, at 10.

[70] Dana DiFilippo, *Construction to Start on $310M NJ Prison for Women*, N.J. MONITOR (Oct. 15, 2025, at 16:17 ET), https://newjerseymonitor.com/2025/10/15/nj-new-womens-prison/ [https://perma.cc/9B9R-753F].

[71] Dana DiFilippo, *Judge Tosses Indictment Against NJ Prison Guards Accused of Assaulting Inmates*, N.J. MONITOR (Oct. 3, 2025, at 15:51 ET), https://newjerseymonitor.com/2025/10/03/judge-indictment-prison-guards-new-jersey/ [https://perma.cc/ZQ64-8RNR].

recommendations are just that—recommendations, not mandates—so their effects may be minimal.

From federal agencies, both the BOP and USMS provide some guidance. In 2022, the BOP updated its "Female Offender Manual" to include recommendations and special considerations for the care of pregnant inmates in federal facilities.[72] The manual strongly discourages the use of restrictive housing,[73] but still permits it as a temporary response, so long as in consultation with senior officials.[74] Medical staff are permitted to authorize additional nutritional or commissary items, or assign a lower bunk for safety reasons.[75] Inmates must be evaluated for limits to activity post-birth and must be referred to a social worker.[76] Prison staff may also consider giving the inmate additional family visits or telephone calls around the time of the birth.[77]

The USMS, which assumes responsibility for prisoners charged with federal offenses, regardless of their placement in state or federal facilities,[78] also outlines policies for obstetric and gynecological (OB/GYN) care of inmates. As it pertains to pregnancy, USMS recommends tests to confirm pregnancy diagnoses, prenatal care—including prenatal vitamins, routine lab visits, and at least one ultrasound—hospital and delivery care for the mother, with a maximum of 48 hours of hospitalization after vaginal delivery, and 72 hours after a cesarean section, and postpartum follow-up.[79]

Although these policies outline important facets of pregnancy care, they are largely vague and simply permissive recommendations, not mandatory, so implementation will inevitably vary between different institutions. Even if the recommended care is provided, these policies fail to address several essential aspects of pregnancy care, like how to address pregnancy complications if they arise, maintaining health during pregnancy through

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[72] U.S. DEPARTMENT OF JUSTICE, CHANGE NOTICE FEMALE OFFENDER MANUAL No. 5200.07 CN-1 (July 8, 2022).

[73] "Restrictive Housing," as defined by the Federal Bureau of Prisons, means housing that involves: "1) Removal from the general inmate population, whether voluntary or involuntary, 2) Placement in a locked room or cell, whether alone or with another inmate, [and] 3) Inability to leave the room or cell for the majority of the day," and may be imposed when an inmate's "presence in the general population poses a threat to life, property, self, staff, other inmates, the public, or to the security or orderly running of the institution." U.S. DEP'T OF JUSTICE, PROGRAM STATEMENT: SPECIAL HOUSING UNITS NO. 5270.12 (Mar. 5, 2024).

[74] CHANGE NOTICE TO FEMALE OFFENDER MANUAL, *supra* note 72, at 21.

[75] *Id.* at 21-22.

[76] *Id.*

[77] *Id.*

[78] *Custody of Prisoners*, U.S. MARSHALS SERV., https://www.usmarshals.gov/what-we-do/prisoners [https://perma.cc/6XCM-HPXS] (last visited Feb. 21, 2025).

[79] *Obstetrics/Gynecology (OB/GYN)*, U.S. MARSHALS SERV., https://www.usmarshals.gov/what-we-do/prisoners/operation/prisoner-health-care/obstetrics-gynecology [https://perma.cc/8ERV-H5BZ] (last visited Feb. 21, 2025).

exercise and nutrition, and ongoing monitoring during the postpartum period.

In contrast, ACOG outlines specific and medically informed recommendations for policies regarding pregnancy care of incarcerated individuals. As stated in a 2021 committee opinion, reaffirmed in 2024, "reproductive health care for incarcerated individuals should be provided in accordance with the same guidelines and recommendations as for those who are not incarcerated, with attention to the increased risk of infectious diseases and mental health conditions common to incarcerated populations."[80] Under these recommendations, upon entry to incarceration, "every individual of childbearing age should be assessed for pregnancy" and offered testing, in order to enable the provision of care.[81] Those who are found to be pregnant and choose to continue their pregnancies (if they are in fact imprisoned in a state where abortion services are provided to inmates and have that choice) should have access to "readily available and regularly scheduled obstetric care, beginning in early pregnancy and continuing through the postpartum period," in addition to emergency visits accessible 24 hours a day.[82]

ACOG states that pregnant inmates should be assessed for alcohol and other substance abuse disorders.[83] In the case of opioid use, inmates should not undergo withdrawal, but rather receive the appropriate medications and counseling to ease withdrawal symptoms, which can be dangerous for a pregnant person and her fetus.[84] A separate ACOG opinion that addressed opioid use disorders in pregnancy emphasized that opioid use disorder is a chronic, but treatable disease, defined as, "a pattern of opioid use characterized by tolerance, craving, inability to control use, and continued use despite adverse consequences."[85] It has been found that the risk of certain birth defects associated with opioid use during pregnancy are extremely rare, but pregnant women with opioid use disorder also often suffer "co-occurring mental health conditions," like depression and post-traumatic stress disorder, and a higher likelihood of other high-risk behaviors, which must be screened for and addressed as part of pregnancy care.[86] ACOG stresses that "opioid agonist pharmacotherapy," also known as medication-assisted treatment, is highly preferable to medically-assisted withdrawal because of the high relapse rates associated with withdrawal, and the further risks to pregnancy

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[80] AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NO. 830 REPRODUCTIVE HEALTHCARE FOR INCARCERATED PREGNANT, POSTPARTUM, AND NONPREGNANT INDIVIDUALS 27 (2021) [hereinafter ACOG Committee Opinion].

[81] *Id.* at 28.

[82] *Id.*

[83] *Id.* at 29.

[84] *Id.*

[85] AM. COLL. OBSTETRICIANS & GYNECOLOGISTS & AM. SOC'Y ADDICTION MED., COMMITTEE OPINION NO. 711 OPIOID USE AND OPIOID USE DISORDER IN PREGNANCY 2 (2017).

[86] *Id.* at 4.

in relapse, like accidental overdose and obstetric complications.[87] As people in prison are more likely to suffer from substance abuse disorders,[88] appropriate care for such must be a part of the conversation.

The obstetric care provided to inmates should be in accordance with the guidelines of the American Academy of Pediatrics and ACOG.[89] These guidelines echo the need for routine obstetric visits, and, although frequency should be individualized to the pregnant person and their particular needs and vulnerabilities, the typical frequency for an uncomplicated first pregnancy is every 4 weeks during the first 28 weeks of pregnancy, every 2 weeks until 36 weeks, and weekly thereafter.[90] Regular visits should include evaluation of the pregnant person's blood pressure, weight, and uterine size, the presence of fetal heart activity, routine lab testing for sexually transmitted infections, antibodies, blood count, and other diseases, and appropriate immunizations.[91] Pregnant individuals should also receive information about a well-balanced diet, "consistent with her access to food and food preferences."[92] Nutritional supplements should include iron, Vitamin D, and folic acid.[93]

Pregnancy should also be taken into consideration when assigning work positions and bunk assignments in prisons, and pregnant inmates should be given the opportunity for daily, moderate exercise.[94] Correctional staff and clinicians should be trained to identify symptoms of pregnancy complications, such as miscarriage and preterm labor, which should not be dismissed, but evaluated in a timely fashion.[95] Correctional officers do not need to be present when a pregnant inmate is being examined, and delivery should occur in a licensed hospital with facilities for high-risk pregnancies, when possible.[96]

When it comes to postpartum care, ACOG emphasizes the need for maximizing parent-infant bonding while in the hospital after delivery, and continuing bonding with frequent visits when the inmate returns to the detention facility.[97] The opinion also encourages the possibility of prison

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[87] *Id.* at 6-7.

[88] *See* discussion *supra* Section II(A).

[89] ACOG Committee Opinion, *supra* note 80, at 29.

[90] AM. ACAD. PEDIATRICS & AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 150 (8th ed. 2017).

[91] *Id.* at 153-166.

[92] *Id.* at 185-188.

[93] *Id.*

[94] ACOG Committee Opinion, *supra* note 80, at 29.

[95] *Id.*

[96] *Id.* All pregnancies that occur in prison are arguably high risk, due to the population's predispositions to chronic health conditions, substance use disorders, and mental health issues, in addition to the general lack of access to immediate care in a prison setting. Nicolette Wolfrey, *Incarceration Harms Moms and Babies*, NAT'L P'SHIP FOR WOMEN & FAMS. (June 2021).

[97] ACOG Committee Opinion, *supra* note 80, at 29-30.

nursery programs that would allow inmates to have their newborns with them for periods of time or community-based alternatives to incarceration, where individuals could be with their children under community supervision.[98] After birth, inmates should have frequent postpartum clinical visits to ensure appropriate medical care and early detection of conditions like postpartum depression.[99] Breastfeeding is also strongly encouraged, so individuals who wish to do so should be able to breastfeed directly to their infants, or, alternatively, be given accommodations to have a safe and private space to pump, safely store breastmilk, and transport the breastmilk to the infant's caregiver.[100]

Lastly, the ACOG opinion states concerns about the use of restraints and solitary confinement during pregnancy, labor, and the postpartum period.[101] The use of restraints, or "shackling," interferes with physicians' abilities to safely assess and evaluate the pregnant patient and fetus, increases the risk of falls, and is psychologically demeaning to the inmate.[102] ACOG notes the widespread adoption of anti-shackling laws, but recognizes that "passing a law does not always ensure compliance," so OB/GYN's and other women's healthcare providers should advocate for and work with custody staff to ensure policies are being followed.[103] Physical restraints should not be used on pregnant women or within 6 weeks of postpartum, and, if needed, should be the least restrictive restraints possible, ensuring that they do not interfere with leg movement or the ability to break a fall.[104] Pregnant women should not be placed in solitary confinement because it limits access to timely healthcare, results in harmful bedrest, and has profound mental health effects.[105]

The recommendations set out by ACOG here are extremely clear about what correctional facilities can do to protect and care for their pregnant populations. Despite clear guidance, however, the laws we will see below are extremely vague and open to discretion, or entirely silent on the kind of pregnancy care that is mandated in carceral institutions.

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[98] *Id.*
[99] *Id.* at 30.
[100] *Id.*
[101] *Id.*
[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.* at 31.

IV. WHAT DOES THE LAW SAY?

There is extreme variability in the kinds of medical care that incarcerated people receive in both federal and state institutions.[106] Although mandated to provide health care to inmates by the U.S. and most state Constitutions, there is no single standard that carceral facilities must follow, and very little oversight.[107] Without clear legal standards, as will be demonstrated in this review of the law, inmates are unable to articulate and advocate for the appropriate and necessary pregnancy care that ought to be included in their entitlement of healthcare.

As noted by Jason Schnittker and his colleagues, the idea of providing healthcare in prions is a "paradox."[108] Prisons are "bound up with a variety of coexisting and often incompatible goals," as these institutions are charged with inflicting some sort of "punishment" or reformation on their inmates, but are also mandated to keep them safe and healthy, and the same personnel are often charged with serving all of these goals.[109] When incarceration itself is harmful—whether that be from the spread of infectious diseases, physical and mental abuse at the hands of prison officials or fellow inmates, or general mental health problems associated with confinement[110]—penal institutions are charged with a seemingly impossible task of balancing such competing interests.[111]

A. Federal Law

Laws governing federal prisons are not binding on state prisons, but they serve as a model and guide for the entire country. Most statutes, both on a state and federal level, do not start from scratch, but rather "incorporate and build upon existing laws," which allows legislatures to rely on the experience and research of others when crafting their own legislation.[112] This method of

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[106] Jonathan Lambert, *Pregnant Behind Bars: What We Do and Don't Know About Pregnancy and Incarceration*, NPR (Mar. 21, 2019).

[107] *Id.*

[108] Jason Schnittker et al., *The 'Paradox' of Receiving Health Care in Prison*, PENN TODAY (Jan. 6, 2023), https://penntoday.upenn.edu/news/Penn-sociologist-Jason-Schnittker-paradox-receiving-health-care-prison [https://perma.cc/J4ML-3KXZ].

[109] *Id.*

[110] *See, e.g.*, Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health*, PRISON POLICY INITIATIVE (May 13, 2021), https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/ [https://perma.cc/7A3V-6DC5] ("Many of the defining features of incarceration are linked to negative mental health outcomes, including disconnection from family, loss of autonomy, boredom and lack of purpose, and unpredictability of surroundings.").

[111] Schnittker et al., *supra* note 108.

[112] Joshua M. Devine, *Statutory Federalism and Criminal Law*, 106 VA. L. REV. 127, 133-34 (Mar. 2020).

"dynamic incorporation" means that state and federal laws develop and evolve alongside each other.[113] A review of federal law governing pregnancy in prisons, then, is appropriate to illustrate general trends and sentiments across the country.

The U.S. Code provides some governance for the treatment of pregnant inmates in federal prisons.[114] However, it is limited to the single issue of shackling of pregnant prisoners.[115] The Code generally prohibits the use of shackles on pregnant women in the BOP and USMS custody.[116] This provision was enacted with the passing of the First Step Act of 2018, which addressed various issues within the criminal justice system, including healthcare.[117]

The Act states that prisoners in BOP or USMS custody shall not be placed in restraints from the time pregnancy is confirmed until the end of postpartum recovery,[118] which is defined as the 12-week period following delivery or longer, if determined by a healthcare professional.[119] However, the statute also includes two major exceptions: 1) If a correctional officer makes a determination that the prisoner is either an immediate and credible flight risk or poses an immediate threat of harm to herself or others, neither of which can be reasonably prevented by other means,[120] and 2) If a healthcare professional determines that the use of restraints is appropriate for the medical safety of the prisoner.[121] If using restraints under either of the exceptions, only the least restrictive restraints are permitted,[122] and a corrections official must submit a written report describing the facts and circumstances warranting the restraints.[123]

Other than the shackling provisions, the lack of clear and mandatory policies for handling pregnancy-related health issues raises serious concerns about the safety of an inmate and her pregnancy. Inmates do not have the luxury of calling 9-1-1 or driving themselves to the hospital when they have a medical emergency. Instead, to access medical care in incarceration, an inmate must first bring her concerns to a correctional officer, who then

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[113] *Id.* at 143-44.
[114] 18 U.S.C. § 4322.
[115] *Id.* at § 4322(a).
[116] *Id.*
[117] First Step Act of 2018, 115 P.L. 391 § 301.
[118] 18 U.S.C. § 4322(a).
[119] *Id.* at § 4322(g)(1).
[120] *Id.* at § 4322(b)(1)(A)
[121] *Id.* at § 4322(b)(1)(B)
[122] Least restrictive restraints exclude restraints around the ankles, legs or waist of the prisoner, restraining the prisoner behind their back, using 4-point restraints, or attaching the prisoner to another prisoner. *Id.* § 4322(b)(2); *Id.* § 4322(b)(3)(A)(1)(i)-(iv).
[123] *Id.* § 4322(a).

evaluates the severity of the situation and schedules a medical appointment.[124]

Proper training for identifying and assessing pregnancy-related issues then becomes essential. Standard C-04 from the National Commission on Correctional Health Care recommends that correctional officers receive "healthcare related" training every two years.[125] The training should enable officers to recognize when they need to refer an inmate to a healthcare professional and how to provide emergency care in the interim.[126] The First Step Act also mandates certain training guidelines be developed for the use of restraints on pregnant prisoners.[127] The Directors of BOP and USMS are required to promulgate guidelines, in consultation with healthcare professionals, "with expertise in caring for women during the period of pregnancy and postpartum recovery."[128] The guidelines must include how to identify symptoms of pregnancy that would require immediate referral to a healthcare professional, when it is appropriate to apply the exceptions described above, how to apply restraints in a way that is not harmful to the prisoner or the fetus, the process for reporting, and the right of a healthcare professional to request restraints not be used.[129] Again, however, there are little to no statistics on whether and how these guidelines are implemented.

B. Federal Litigation

When the law lacks adequate protection or laws are not followed by correctional officials, inmates may turn to litigation. The rights enumerated in the Eighth and Fourteenth Amendments are essential to the fair and just treatment of incarcerated people.[130] When these rights are violated, one course of action for plaintiffs is to initiate a civil action for deprivation of rights under 42 U.S.C. § 1983.[131] Through this provision of law, many pregnant, incarcerated women have been able to challenge the treatment they

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[124] Sojourner Ahébéé, *40% of Incarcerated People Have Chronic Conditions—How Good is the Health Care They Get Behind Bars*?, WHYY (Apr. 9, 2021), https://whyy.org/segments/why-good-health-care-in-u-s-prisons-may-be-hard-to-come-by/ [https://perma.cc/6GAK-BJN4].

[125] *Health Training for Correctional Officers*, NAT'L COMM'N ON CORR. HEALTH CARE, https://www.ncchc.org/spotlight-on-the-standards/health-training-for-correctional-officers/ [https://perma.cc/45J5-BY7E] (last visited Jan. 31, 2025).

[126] *Id.*

[127] § 4322(f).

[128] § 4322(f)(2).

[129] § 4322(f)(1)(A)-(E); *see also* § 3261(b); § 3624(c)(2); First Step Act § 602, (There are provisions from the First Step Act that are not specific to pregnant prisoners, but may be helpful to them, like placing them as close as possible to their residence or allowing home confinement, as to increase parent-infant bonding, and the expansion of medication-assisted treatment for opioid use, as to aid pregnant inmates in addressing substance abuse).

[130] U.S. CONST. amend. IV; *id.* amend. XIV, § 1.

[131] 42 U.S.C. § 1983.

receive in prisons. However, the determination of a constitutional violation is ultimately left to the subjective interpretation of whichever court the inmate ends up in front of, if they are even fortunate enough to have the time, money, and opportunity to be heard.

Although the need for money and resources to fund litigation is not unique to inmates, studies show that only 14% of prisoner civil rights suits reach settlement, compared to 75% of civil rights suits, excluding prisoner claims.[132] Of those claims that go to trial, only 1% of prisoner plaintiffs won relief in court.[133] Notably, 78% of prisoners litigate *pro se*, or without counsel, and in those cases where relief was won in court, the plaintiff was always represented by counsel.[134]

The leading case applying § 1983 to health care in prison is *Estelle v. Gamble*.[135] The *Estelle* Court established that the government has an obligation to provide medical care for those it is punishing through the incarceration system.[136] "Cruel and unusual punishment" is not limited to "barbarous torture" as the founders imagined, but rather includes any method of punishment that would be incompatible with "evolving standards of decency."[137] The Court found that a denial of medical care may cause unnecessary suffering that serves no legitimate penological purpose.[138] Therefore, "deliberate indifference" to the serious medical needs of inmates is a violation of the Eighth Amendment, and constitutes a cause of action under § 1983.[139]

Turning to the application to pregnant inmates, *Archer v. Dutcher* applied the standard in *Estelle* to find that an inmate who suffered a miscarriage due to lack of medical attention properly stated a cause of action.[140] Here, the pregnant inmate experienced a beating while in custody and subsequently reported cramps and pain in her stomach multiple times, but was

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[132] Nicole Einbinder & Hannah Beckler, *The 1%: Original Data Analysis Shows It's Exceedingly Rare for Prisoners to Win Lawsuits Claiming "Cruel and Unusual Punishments,"* BUS. INSIDER (Dec. 26, 2024), https://www.businessinsider.com/prisoner-lawsuit-win-settlement-statistics-2024-12 [https://perma.cc/9PCY-GD44].

[133] *Id.*

[134] *Id.*

[135] Estelle v. Gamble, 429 U.S. 97 (1976).

[136] *Id.* at 103.

[137] *Id.* at 102.

[138] *Id.* at 103.

[139] *Id.* at 104; *see also*, Van Horn v. Hornbeak, Civ. A. No. CV F 08-1622 LJO DLB, 2010 U.S. Dist. LEXIS 14321, at *15-17 (E.D. Cal. Feb. 18, 2010) (discussing the "two-prong" test of deliberate indifference to a serious medical need: the objective prong being whether the prisoner's medical need is serious, as in the failure to address would result in further significant injury or unnecessary and wanton infliction of pain, and the subjective prong being deliberate indifference by prison officials, as in the official was subjectively aware that serious harm would likely result from a failure to provide medical care).

[140] Archer v. Dutcher, 733 F.2d 14 (2d Cir. 1984).

continuously refused a hospital visit.[141] Eventually, she began vaginal bleeding, but correctional officials still refused to take her to the hospital, and told her, "If she was going to miscarry it would happen regardless whether she was in the hospital or the prison."[142] The court discussed how the standards of medical care at a prison are not equal to that of a hospital, and held that it should be left to the finder of fact to determine whether this was an instance of deliberate indifference to serious medical issues.[143]

In *Havard v. Wayne Cty.*, the court clarified that adequate medical care means, "the appropriate standard of care under the circumstances."[144] In the context of a pregnant inmate in labor, this means birth should occur in a place, "equipped with the personnel and resources to handle pregnancy-related emergencies," which the prison in this case seriously lacked.[145] Here, the detainee informed the correctional officers that she was experiencing contractions, yet they waited several hours to take her to the nurse's station, and, even then, performed no medical assessment, and, rather than taking her to the hospital, called emergency medical services (EMS).[146] By the time EMS arrived, the baby was already crowning and had to be resuscitated upon birth, which caused the baby to suffer severe intellectual disabilities and cerebral palsy.[147] The court concluded that, given the correctional officers' knowledge of the detainee's medical condition, and knowing that both the prison and EMS lacked the necessary equipment for childbirth, the subjective component of deliberate indifference was satisfied.[148]

As we can see from the federal landscape of laws and litigation concerning pregnancy care in federal institutions, experiences of pregnant individuals and the outcomes they receive in the courts are extremely varied, and, in many cases, we see a general lack of proper care and consideration for this vulnerable population. Although state law differs, we can expect to see similar themes within individual states.

C. New Jersey Law

N.J. sets out standards for the care of pregnant women in prisons in its state code.[149] NJDOC is required to provide a pregnant inmate with medical and social services, including prenatal medical evaluation and care, nutritional supplements and diet as prescribed by a physician, counseling

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[141] *Id.* at 15.
[142] *Id.* at 17.
[143] *Id.*
[144] Havard v. Wayne Cty, 436 Fed. App'x. 451, 454 (6th Cir. 2011).
[145] *Id.*
[146] *Id.* at 452.
[147] *Id.*
[148] *Id.* at 455.
[149] N.J. ADMIN. CODE § 10A:16-6.1 to 6.7 (2026).

regarding family planning, birth control, test results, termination of pregnancy, child placement services, religious counseling, if desired, and appropriate postpartum care.[150] If a pregnant inmate decides to carry the pregnancy to term, arrangements for labor at an appropriate medical facility shall be scheduled in advance by NJDOC officials.[151] The pregnant inmate will be provided with suitable maternity clothes, reasonable housing assignments, appropriate exercise, and reduced work schedules.[152] The non-gestational parent may be present in the delivery room during birth, contingent upon approval by NJDOC authorities, the hospital, and attending physicians.[153] A social worker will also counsel the inmate on the placement of the child, "well in advance of delivery."[154] The social worker will determine whether the inmate wants to keep the child and grant temporary custody to a family member, or, if the mother is contemplating adoption or foster home placement, the social worker will contact the Division of Child Protection and Permanency.[155]

The law here is strong because it requires both physical components, like nutritional supplements and work accommodations, and psychological components, like counseling and social work services.[156] Pregnant inmates are often deprived of important nutrients to guard against neural tube defects, low birth weight, and preterm labor.[157] The food in prisons already lacks sufficient nutritional value, with a lack of Vitamin-C and Omega-3 fatty acids, on top of which pregnant inmates are usually not given proper prenatal vitamins, like folic acid.[158] Furthermore, pregnant inmates need access to education, support, and counseling, because they are more likely to experience high-risk pregnancies, due to their heightened likelihood of histories of "drug and alcohol abuse, high-risk sexual histories, and related diseases."[159] The need for social and emotional support is great when these individuals are isolated from their family and communities during such a vulnerable time, and it's been shown that pregnant inmates who receive counseling have better pregnancy outcomes.[160] In these aspects, N.J. is on the right track.

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[150] *Id.* at § 10A:16-6.1.
[151] *Id.* at § 10A:16-6.2.
[152] *Id.* at § 10A:16-6.3.
[153] *Id.* at § 10A:16-6.5.
[154] *Id.* at § 10A:16-6.6.
[155] *Id.*
[156] *Id.* at § § 10A:16-6.1 to -6.4.
[157] Sarah B. Bondar, *Hurt, Hungry and Handcuffed: How the Prison Systems Fails Pregnant Women and Their Newborns*, 25 MARQ. BENEFITS & SOC. WELFARE L. R. 248, 252-53 (2024).
[158] *Id.*
[159] Somayah Alirezaei & Robab Latifnejad Roudsari, *The Needs of Incarcerated Pregnant Women: A Systematic Review of Literature*, 10 INT. J. COMMUNITY BASED NURS. MIDWIFERY 2, 12 (2022).
[160] *Id.* at 13.

N.J. also provides rather expansive provisions for the termination of pregnancy.[161] As soon as possible, after pregnancy is diagnosed, the correctional facility's healthcare provider must provide the inmate with "medical care" and offer religious and social counseling on whether to continue or terminate her pregnancy.[162] If electing to terminate, arrangements to schedule and complete the procedure will be made by a health care provider without undue delay, unless the physician determines the pregnancy is not able to be terminated.[163] Termination can only occur at a state-licensed medical facility, and follow-up medical care shall be provided at the correctional facility.[164]

In addition, N.J.'s Dignity for Incarcerated Primary Caretakers Act, signed into law in 2020, affirmed the prohibition of isolated confinement and the use of restraints on pregnant women.[165] Although shackling of pregnant inmates is a particularly harmful and dehumanizing practice that is rightly addressed by the law, the struggles that they face are certainly not limited to that issue. To truly improve the treatment of pregnant inmates, states need not only negative mandates, like the prohibition of shackling, but also positive mandates requiring certain care be provided. In a review of pregnancy care in state prisons, it was found that, "thirty-eight states had insufficient or no prenatal care, or inadequate arrangements for childbirth."[166] The prenatal care provided, although mandated in N.J., is not necessarily comprehensive, sometimes consisting only of checking the inmate's blood pressure and weight, and often not by a prenatal care provider.[167] Subtle symptoms of pregnancy complications, like cramping and bleeding, are often ignored by prison staff, although they can indicate miscarriage, preterm labor, or other serious conditions.[168]

The Dignity for Incarcerated Primary Caretakers Act also allows pregnant women and primary caretaker parents to enroll in residential drug abuse and mental health programs.[169] Research shows that N.J. has experienced positive trends in openings of substance abuse treatment facilities, over closings of such facilities.[170] However, most of those facilities

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[161] N.J. ADMIN. CODE § 10A:16-6.4.

[162] *Id.*

[163] *Id.*

[164] *Id.*

[165] *Governor Murphy Signs Dignity for Incarcerated Primary Caretaker Parents Act*, THE STATE OF NEW JERSEY (Jan. 9, 2020), https://www.nj.gov/governor/news/news/562020/20200109b.shtml [https://perma.cc/XA6N-FMM9]; N.J. STAT. ANN. § 30:1B-6.5 (West 2024).

[166] CAROLYN SUFRIN, JAILCARE: FINDING THE SAFETY NET FOR WOMEN BEHIND BARS 125 (2017) [hereinafter JAILCARE].

[167] *Id.*

[168] *Id.* at 126.

[169] N.J. STAT. ANN. § 30:1B-6.8.

[170] Adrianna Corredor-Waldron & Janet M. Curie, *Tackling the Substance Abuse Crisis: The Role of Access to Treatment Facilities*, (Nat'l Bureau of Econ. Rsch., Working Paper No. 28862, 2021),

are out-patient clinics, rather than residential facilities, and very few offer medication-assisted treatment.[171] Access to substance abuse facilities is extremely effective in reducing drug-related emergency room visits, but, with an increase in openings, new centers "may take some time to reach their full capacity."[172] As access to such facilities is already restricted by geography, availability, and types of services,[173] it is difficult to quantify how effective a program allowing pregnant inmates to spend time in a residential facility may be.

Although N.J. laws are progressive in theory, issues are exacerbated by the fact that prisons are often overcrowded, and inmates must always be accounted for and monitored, so scheduling and oversight can pose significant barriers to accessing care, even when mandated.[174] Incarcerated people are more likely to come from impoverished communities, where they have historically lacked access to healthcare, are more susceptible to chronic diseases, and may have developed a general distrust of healthcare providers, discouraging them from advocating for themselves.[175] Furthermore, facilities are not prohibited from charging co-payments for medical visits, including maternal health care, which can even further discourage pregnant inmates from seeking care in the first place, for fear of incurring costs they are unable to pay.[176]

On-site medical care is also often limited to primary care and outpatient services, with limited resources.[177] Using these limited on-site services, correctional clinicians must then evaluate whether hospitalization is needed.[178] Especially in the case of non-emergent health issues, the hospital visit must also be authorized by a prison administrator, usually the medical director of the institution.[179] Prisons are not required to have an on-site OB/GYN, so this decision may not even be made by a pregnancy specialist in the case of a pregnant inmate, especially in smaller facilities.[180] Even once a hospital visit is approved, prisons are often located far from civilian

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https://economics.princeton.edu/working-papers/tackling-the-substance-abuse-crisis-the-role-of-access-to-treatment-facilities/ [https://perma.cc/2TTV-Y5MV].

[171] *Id.* at 5.

[172] *Id.* at 17.

[173] *Id.*

[174] Ahébéé, *supra* note 124.

[175] *Id.*

[176] U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-106404 PREGNANT WOMEN IN STATE PRISONS AND LOCAL JAILS 38 (2024) [hereinafter GAO REPORT].

[177] THE PEW CHARITABLE TRUSTS, STATE PRISONS AND THE DELIVERY OF HOSPITAL CARE: HOW STATES SET UP AND FINANCE OFF-SITE CARE FOR INCARCERATED INDIVIDUALS 2 (July 2018), https://www.pewtrusts.org/en/research-and-analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care [https://perma.cc/R6R4-3XC6].

[178] *Id.* at 6.

[179] *Id.*

[180] GAO REPORT, *supra* note 176, at 38.

populations and hospitals, and inmates may be taken to facilities that are under contract with the institution, rather than the closest facility, which further delays care.[181]

In N.J., the prenatal care provided in incarceration is largely a mystery. In an interview with officials representing nine state prisons and nine local jails from across 12 states, including N.J., the Government Accountability Office (GAO) concluded that, "comprehensive national data on pregnant women incarcerated in state prisons and local jails do not exist."[182] Although about 4% of women in state prisons are pregnant, as of 2016, state departments of justice did not report on the demographics or pregnancy outcomes of such inmates.[183] Of the inmates in state prisons surveyed at that time, 91% reported they received an obstetric exam, but only 50% reported they received other forms of prenatal care.[184] All of the state prisons and local jails that the GAO spoke to reported collecting "some information" on incarcerated pregnant women, but none said that they routinely report this information or are required to do so.[185] The collection of information and statistics is essential for policy and change-makers, and, without it, we are left to assume the worst.

D. New Jersey Litigation

Again, where the law fails to protect individuals, they may turn to the courts for a remedy. The N.J. Constitution has a similar provision to that of the federal Eighth Amendment, stating that, "cruel and unusual punishments shall not be inflicted."[186] Courts in N.J. have construed the state's Civil Rights Act "nearly identical to its federal counterpart: § 1983,"[187] meaning that a claim of a violation of the N.J. cruel and unusual punishment provision brought under the N.J. Civil Rights Act (NJCRA) will be analyzed the same as a claim of an Eighth Amendment violation under § 1983. However, there is no evidence of cases arising under the N.J. Constitution and the NJCRA that pertain to the care of pregnant people in N.J. prisons.

Looking at the general treatment of pregnant people in the criminal justice system, though, N.J. courts have not been sympathetic to pregnant

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[181] Marc Shalit & Matthew R. Lewin, *Medical Care of Prisoners in the USA*, 364 THE LANCET (SPECIAL ISSUE) 34, 34 (2004), https://www.thelancet.com/journals/lancet/article/PIIS0140673604176332/fulltext [https://perma.cc/Z5QH-EGDH].

[182] GAO REPORT, *supra* note 176, at 11-12.

[183] *Id.*

[184] *Id.*

[185] *Id.* at 15.

[186] N.J. CONST. art. 1, § 12.

[187] Szemple v. Corr. Med. Servs., No. 07-4809, 2012 U.S. Dist. LEXIS 6037 at *28-29 (D.N.J. Jan. 18, 2012).

detainees and fail to consider pregnancy as a mitigating factor to sentencing or pretrial detention. In *State v. Williams*, the Superior Court found that the trial court abused its discretion when it gave "undue weight to defendant's pregnancy," in denying the State pretrial detention of the defendant.[188] The court stated that the trial judge improperly elevated the defendant's condition of pregnancy because all applicable factors must be weighed equally in determining pretrial detention, the judge's concerns about the pregnancy were purely speculative, and there was no "indication that the jail is unable to provide appropriate prenatal medical care to defendant."[189] However, the court did leave open the possibility that a defendant's pregnancy could be a determining factor if there is evidence that the pregnancy is classified as high-risk or presents unusual medical complications that would require specialized treatment.[190]

In *State v. Michaels*, a defendant attempted to appeal her sentence for the trial judge's failure to find the mitigating factor of "excessive hardship," due to her pregnancy.[191] The court affirmed that, "The effect a mother's incarceration has on minor children does not amount to a 'serious injustice' to overcome a presumption of imprisonment,"[192] in comparison to a defendant who was diagnosed with a brain tumor.[193] Further, the court stated that there was "no reason to believe defendant would not receive appropriate prenatal care while incarcerated."[194] However, as discussed above, there is no proof that "appropriate" prenatal care is actually being provided in incarceration, perhaps negating the court's assessment that no serious injustices are occurring.

E. Abortion Access and the *Dobbs* Decision

As discussed, N.J.'s constitutional prohibition on "cruel and unusual punishment" and civil rights statute operates essentially the same as the federal Eighth Amendment and § 1983, so development of federal caselaw is likely to mirror that of state litigation. As progressive as N.J. may appear when it comes to healthcare and gender equity, it would be naïve to believe

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[188] State v. Williams, 170 A.3d 966, 969 (N.J. Super. Ct. App. Div. 2017).

[189] *Id.*

[190] *Id. But cf.* State v. Ikerd, 850 A.2d 516, 520-22 (N.J. Super. Ct. App. Div. 2004) (rejecting the trial judge's determination that the defendant's status as a pregnant addict mandated rehabilitation and parole ineligibility, as it bore no relationship to the offense she committed and accomplished no legitimate penological purpose).

[191] State v. Michaels, No. A-5190-10T2, 2012 N.J. Super. LEXIS 2321, at *49 (App. Div. Oct. 15, 2012).

[192] *Id.* at *51 (citing State v. Roth, 95 N.J. 334, 358 (1984)).

[193] *Id.* (citing State v. Lebra, 357 N.J. Super. 500, 511-12 (App. Div. 2003)).

[194] *Id.*

that the state cannot be impacted by federal legal sentiment and general trends in social attitudes.

Abortion access for incarcerated individuals, just like non-incarcerated individuals, has always been complex and often lacking. Before *Dobbs v. Jackson Women's Health Organization*, the policy for federal prisons was to provide access to "elective" abortions,[195] under the frameworks of *Roe v. Wade* and *Planned Parenthood v. Casey*, after the inmate receives "medical, religious, and social counseling."[196] The inmate would then submit a written statement requesting the abortion and the prison's medical director was charged with arranging for the procedure to take place.[197] However, the BOP was only required to pay for "medically necessary" abortions, whereas inmates seeking "elective" abortions had to cover costs themselves, which is not feasible for all inmates.[198] Further, the exact process for facilitating an abortion procedure was extremely varying among institutions and subject to subjective decision-making and discrimination.[199] Many institutions did not have official policies regarding the process and there were inconsistencies "surrounding transportation, help arranging appointments, and other logistical assistance," often delineated by whether the abortion was "medically necessary" or "elective."[200] Some institutions flat-out denied inmates access to abortions, despite legal mandates that the right to an abortion was maintained in incarceration.[201]

Under the framework of *Estelle*, it has been held that the deprivation of an abortion to an inmate could be an Eighth Amendment violation, but the circuit courts do not always apply the standard equally.[202] Because an *Estelle* claim rests on whether the inmate had a "serious medical need," courts have been far more likely to find an Eighth Amendment violation where the abortion is sought for purely medical reasons, rather than "non-emergent, elective" abortions.[203] Some courts, in contrast, have held that denying prisoners their right to abortion, regardless of their reason for doing so, or

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[195] Every abortion in some way is "elective," and the choice to have one always involves at least some consideration of the medical risks involved with pregnancy. Distinguishing between "elective" and "medically necessary" abortions, then, merely serves to assign a moral judgment to the pregnant person's reasons for terminating the pregnancy. Unfortunately, these terms are still prevalent in medical and legal scholarship. *See* Katie Watson, *Why We Should Stop Using the Term "Elective Abortion,"* 20 AMA J. OF ETHICS 1175, 1176-77(Dec. 2018), https://journalofethics.ama-assn.org/article/why-we-should-stop-using-term-elective-abortion/2018-12 (on file with the WRLR).

[196] Smith et al., *supra* note 10, at 457.

[197] *Id.*

[198] *Id.*

[199] Carolyn B. Sufrin et al., *Incarcerated Women and Abortion Provision: A Survey of Correctional Health Providers*, 41 PERSPS. ON SEXUAL AND REPROD. HEALTH 6, 6-7 (2009).

[200] *Id.* at 9, 10.

[201] JAILCARE, *supra* note 166, at 126.

[202] *Estelle*, 429 U.S. at 106; *see* Smith et al., *supra* note 10, at 458-59.

[203] Smith et al., *supra* note 10, at 458-59.

failing to provide transportation for such, *is* an Eighth Amendment violation.[204] Still, the results in the courts are varying and, again, often dependent on an inmate's ability to initiate litigation in the first place.

The *Dobbs* decision, in overruling the frameworks of *Roe* and *Casey*,[205] will only exacerbate the obstacles inmates will face in asserting their right to an abortion. The significant upheaval of abortion protections and variances in rules across the country are very likely to cause a chilling effect on providing women's health care in all respects,[206] and New Jersey is not immune to such effects.

Dobbs is ultimately detrimental to maternal health, in and out of prisons.[207] Many states' abortion bans are at odds with medical standards of care and fail to provide guidance on exceptions to protect the health of the mother.[208] It is unclear and exceptionally difficult to calculate when exactly a mother's life is in immediate danger and abortion is absolutely necessary, which deters physicians from acting, in fear of criminal prosecution, and has resulted in serious delays of healthcare in situations such as miscarriages and ectopic pregnancies.[209]

This equally applies to physicians caring for incarcerated people, and incarcerated individuals do not have the freedom that others may have to travel to another state to obtain potentially life-saving healthcare.[210] The impacts of pregnancy in prisons are widespread and seriously harmful. Lack of social support causes stress associated with maternal depression, pre-term delivery, and low birth weights, and incarcerated individuals are far more likely to experience postpartum depression.[211] One can only imagine how these effects are magnified when the pregnancy is unwanted.

Incarcerated women are already much more susceptible to mental illness and come from lower socioeconomic statuses, both of which complicate

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[204] *Id.*; *see* Monmouth Cnty. Corr. Inst. Inmates v. Lanzaro, 834 F.2d 326, 351 (3d Cir. 1987).

[205] Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022). In this case the Supreme Court definitively overruled *Roe* and *Casey*, which previously conferred a federal constitutional right to abortion. In order to form this basis, the Court concluded that a right to abortion is not "deeply rooted in the Nation's history and traditions," largely due to the fact that states have historically criminalized abortion after "quickening," or movement of the fetus. Weighing these findings with principles of stare decisis, the Court found that the tests imposed by *Roe* and *Casey* were ambiguous and unworkable, in addition to the cases being "egregiously wrong and deeply damaging," warranting an overruling. Consequently, the issue of abortion has been returned to the states and future regulations will be subject to rational basis review.

[206] *See id.* at 404-11 (Breyer, J., dissenting).

[207] *See id.*

[208] Sonia M. Suter, *Alito is Wrong: We Can Assess the Impact of Dobbs, and It Is Bad for Women's Health*, 53 SETON HALL L. REV. 1477, 1497-99 (2023).

[209] *Id.* at 1499-1502.

[210] Elena LeVan, *Fruit of the Poisonous Tree: Potential Eighth Amendment Projections for Inmates Subject to Sexual Victimization in the Post-Dobbs World*, 101 WASH. U.L. REV. 589, 603 (2023).

[211] *Id.* at 600-01.

pregnancy and make childbirth more dangerous.[212] By returning the issue of abortion to the states and eliminating the federal right to terminate a pregnancy pre-viability, incarcerated individuals are likely to be forced to remain in states that are hostile towards abortion, without access to travel across state lines.[213] As of now, California is the only state that has enacted a statute reaffirming incarcerated women's right to access abortion care.[214]

Lastly, the *Dobbs* decision exacerbates the rhetoric that certain women are "unfit" to make their own decisions about their bodies, which disproportionately impacts already marginalized populations, like women of color and disabled women.[215] From this perspective, incarcerated women are deemed as "unfit" to mother, which makes them more vulnerable to reproductive control and less likely to receive sympathy from the public.[216] The health care needs of incarcerated women have always been an "afterthought."[217] As shown, many care provisions for pregnant inmates are highly discretionary and/or followed inconsistently, and a lack of federal protections for abortion reasserts the idea that there are no consequences for controlling a woman's reproductive decisions, falling hardest on those who are already subject to governmental control, like incarcerated individuals.[218]

V. WHAT CAN NEW JERSEY DO?

Given the current federal landscape, it appears unlikely at this time that any sort of federal standard for pregnancy care in prisons will be passed. What then can pregnant incarcerated individuals do to address the challenges they face? That is where state law comes in, as it is up to state legislators and the democratic process to address these gaps. N.J. has the opportunity to join other progressive states in establishing a much-needed body of law to ensure that pregnant incarcerated women are given the care that they deserve.

A. A Map: The Pregnant Women in Custody Act

The Pregnant Women in Custody Act was first introduced in the House of Representatives in September of 2018 by Karen Bass, a Democratic

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[212] *Id.*

[213] *Id.* at 603.

[214] Allanah Colley, *"Unfit" Women Across the Atlantic: Reproductive Control of Incarcerated Women in the US and UK*, 25 GEO. J. GENDER & L. 1, 19 (2023).

[215] *Id.* at 12.

[216] *Id.*

[217] Renuka Rayasam, *Pregnancy Care Was Always Lacking in Jails. It Could Get Worse*, KFF HEALTH NEWS (Feb. 23, 2024), https://kffhealthnews.org/news/article/pregnancy-care-jails-prisons-incarcerated-women/ [https://perma.cc/B2QA-KKNQ].

[218] *See id.*

representative from California.[219] Despite being passed in the House of Representatives in 2022, the Act stalled in the Senate Committee on the Judiciary and, as of now, has not been passed.[220] The Act, as will be discussed, is not revolutionary, but rather contains simple steps that carceral institutions can take to protect pregnant women in their custody.[221] Therefore, it serves as an appropriate model for state legislation, addressing several essential aspects of protecting pregnant incarcerated women, such as required data collection, explicit standards of care, limitations on the use of restrictive housing, and caring for inmates with high-risk pregnancies.[222]

Firstly, the Act sets out that the Director of the Bureau of Justice Statistics must conduct an annual survey to collect statistics relating to the health needs of incarcerated pregnant women.[223] The statistics should include demographics, provisions of care, the location of the nearest hospital with a licensed OB/GYN, the number of incarcerated pregnant women, and the number of pregnant women put in restrictive housing.[224] Statistics and independent oversight are essential to allow policy-makers, scholars, and advocates to engage with important issues.[225] Because imprisonment and deprivation of liberty is one of the most severe expressions of government power, scholars argue that it deserves the most "extensive scrutiny," which demands the regular collection of information to monitor and identify problems within prison systems.[226]

Next, the Act sets out pregnancy and childbirth standards of care for incarcerated women.[227] The Director of the BOP must ensure that every woman of reproductive age in custody is administered a pregnancy test when she enters the facility, which she may decline.[228] Upon confirmation of a pregnancy, the woman shall be provided with a summary of the relevant

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[219] Pregnant Women in Custody Act, H.R. 6805, 115th Cong. (2018), https://www.congress.gov/bill/115th-congress/house-bill/6805/all-info [https://perma.cc/XH5B-HCWY].

[220] *Id.* The initial version of the Act was referred to the House Committee on the Judiciary but received no subsequent action. Bass tried again in July of 2020, and the Act was reported on by the Committee on the Judiciary, the House engaged in debate, and it was eventually passed in the House that October, but no action was taken in the Senate. The 2022 version was again passed in the House and referred to the Senate Committee on the Judiciary. Protecting the Health and Wellness of Babies and Pregnant Women in Custody Act, H.R. 7718, 116th Cong. (2020), https://www.congress.gov/bill/116th-congress/house-bill/7718 [https://perma.cc/4RCU-KQFF]; Pregnant Women in Custody Act, H.R. 6878, 117th Cong. (2022), https://www.congress.gov/bill/117th-congress/house-bill/6878/text [https://perma.cc/7LM8-UMXF].

[221] H.R. 6878 § 4(a).

[222] H.R. 6878.

[223] *Id.* at § 3(a).

[224] *Id.* § 3(a)(1)-(7).

[225] Michele Deitch, *Opening Up a Closed World: A Sourcebook on Prison Oversight*, 30 PACE L. REV. 1687, 1690-92 (2010).

[226] *Id.*

[227] H.R. 6878 § 4.

[228] *Id.* at § 4(b)(1)(B).

protocols, such as transfer to a lower bunk, regular access to water and bathrooms, and access to prenatal vitamins and dietary supplements.[229] No later than 14 days after confirmation, the woman will receive prenatal education, counseling, and birth support services by a provider trained to provide such services, including information about parental rights and the health and safety risks of pregnancy.[230] Any woman who gives birth in custody or gave birth within the six-month period before intake shall receive counseling from a licensed provider and be evaluated for substance use and mental health conditions.[231]

The Act also sets out standards for the use of restrictive housing on pregnant inmates.[232] Restrictive housing is defined as removal from the general prison population, placement in a locked room or cell, and an inability to leave the room or cell for the vast majority of the day.[233] Use of restrictive housing is prohibited during pregnancy, labor, and postpartum recovery.[234] The Act provides an exception if the Director, in consultation with senior health officials, makes an individualized determination that restrictive housing is required as a temporary response to behavior that poses a serious and immediate risk of physical harm.[235] If restrictive housing is used, prison officials must conduct a daily review, develop a plan to move the inmate to less restrictive housing, and make an official report to the BOP or USMS.[236] Solitary confinement is also excluded, without exception, if the woman is in her third trimester.[237]

Lastly, the Act mandates certain care be taken for inmates with high-risk pregnancies.[238] The Director must ensure that every pregnant inmate receives an evaluation to determine if her pregnancy is high-risk, and, if so, ensure the incarcerated inmate receives the appropriate OB/GYN care.[239] The Director shall transfer a woman who is determined by a health care professional to have a high-risk pregnancy to a residential reentry center with

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[229] *Id.* at § 4(b)(2)(C).
[230] *Id.* at § 4(b)(3)(A).
[231] *Id.* at § 4(b)(3)(B)
[232] H.R. 6878 § 5.
[233] *Id.* at § 5(i).
[234] *Id.* at § 5(a).
[235] *Id.* at § 5(b)(1).
[236] *Id.* at § 5(b)(2)-(3), (c).
[237] H.R. 6878 § 5(b)(4).
[238] *Id.* at § 6.
[239] *Id.* at § 6(a).

adequate health care.[240] The inmate shall receive priority to be placed in a center that is geographically close to her family.[241]

The Pregnant Women in Custody Act can serve as a tool for future legislation because of how thoroughly it reviews the provision of care for a pregnant inmate throughout her pregnancy and postpartum care. If pregnancy care must be provided within a conventional prison setting, these kinds of laws, with specific and mandatory provisions should be the standard. Strengths of the bill include the provision of medical care and counseling by physicians specifically trained to treat pregnancy-related issues, inmate education on their needs during pregnancy and their rights to demand accommodations, the assessment and treatment of substance use and mental health disorders, and the collection of data.

The Act could still be improved by expanding the option of residential reentry centers beyond just "high-risk" pregnancies, especially considering the argument that all pregnancies in prison are high-risk,[242] and the provision could align even more closely with standards from medical professional agencies, like ACOG.[243] As will be discussed below, other states have implemented programs that utilize residential reentry centers and acknowledge that traditional prison settings are not well-suited for any pregnancy.

B. Progressive Programs in Other States

A few states have attempted to take measures to address the needs of pregnant incarcerated women.[244] One type of program that has existed in several states since the 1990's is a prison nursery program.[245] These programs, currently available in eight different states, including Illinois, New York, and Washington, allow inmates to keep their newborns with them

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[240] *Id.* at § 6(b)(1); Residential reentry centers are also known as halfway houses. These centers are a form of supervised housing, where inmates are permitted to leave for certain approved activities. They frequently offer services like employment and mental health counseling and increase opportunities to receive medical care, *Residential Reentry Management Centers*, FED. BUREAU OF PRISONS, https://www.bop.gov/about/facilities/residential_reentry_management_centers.jsp [https://perma.cc/TL6R-J2MT] (last visited Jan. 6, 2025).

[241] H.R. 6878 at § 6(b)(2).

[242] *See supra* text accompanying note 96.

[243] *See* discussion *supra* Section III.

[244] *See, e.g.*, Bob Egelko, *Bill to Ban Solitary Confinement for Pregnant Inmates Now Allows it. Its Backers Want a Veto*, S.F. CHRON. (Sep. 3, 2024), https://www.disabilityrightsca.org/system/files/file-attachments/Bill_to_ban%20solitary_confinement_for_pregnant_inmates_now_allows_it.pdf [https://perma.cc/GN9D-KN73] (California attempted to pass a bill banning solitary confinement for pregnant inmates, but after it was amended to allow up to 5 days of confinement, the bill lost support).

[245] Hendrick DeBoer, *Prison Nursery Programs in Other States*, CONN. GEN. ASSEMB., OFF. OF LEGIS. RSCH. (Mar. 30, 2012), https://www.cga.ct.gov/2012/rpt/2012-R-0157.htm [https://perma.cc/K49M-VWBA].

inside the correctional facility for a certain amount of time.[246] There are variations in the requirements to be in the program.[247] Each state has different medical and mental health screenings and may or may not consider the crime the person has been convicted of and/or the length of her sentence.[248] States also vary in the length of time the newborn is allowed to stay with the inmate, with some limits being as short as 30 days, and others being as long as 30 months—but the overall objective is the same: to form bonds between mother and child during infancy.[249]

Importantly, one study shows that women who participate in prison nursery programs have a "low likelihood of recidivism within three years of release."[250] Only 4.3% of the prison population in the study residing in prison nursery programs between 2001-2007 returned to prison, whereas three-year recidivism rates across the U.S. range from 24-66%.[251] The study noted that such programs take a "strength-based approach," as in they help women to identify and mobilize support systems that prevent reincarceration and provide a social safety net.[252] When women are able to adjust to parenting in a supportive environment and form secure attachments with their newborns and support systems, they are better equipped to re-enter society and are less likely to commit parole violations.[253]

Different from prison nursery programs, in 2021, Minnesota passed the Healthy Start Act, which allows pregnant women to serve their sentences in community-based alternatives to incarceration, such as halfway houses or rehabilitation centers.[254] It allows mothers to spend up to one year with their newborns and apply for a conditional release, which is reviewed on a case-by-case basis.[255] This type of legislation is revolutionary in that it is the first to offer the possibility of conditional release for pregnant inmates.[256] The program further allows for mothers to be placed where they can receive the proper pre- and post-natal care and counseling and create a healthier mother-child bond.[257] The Minnesota Department of Corrections also works closely

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[246] *Id.*
[247] *Id.*
[248] *Id.*
[249] *Id.*
[250] Lorie S. Goshin et al., *Recidivism After Release From a Prison Nursery Program*, 31 PUB. HEALTH NURSING 109, 113 (2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3942796/ [https://perma.cc/5P7H-NVUB].
[251] *Id.* at 113-14.
[252] *Id.* at 114.
[253] *Id.* at 110.
[254] Patrice Gaines, *One State is Trying to Make Pregnancy in Prison Slightly More Bearable*, NBC NEWS (Aug. 5, 2021, at 10:35 ET), https://www.nbcnews.com/news/nbcblk/one-state-trying-make-pregnancy-prison-slightly-bearable-rcna1578 [https://perma.cc/XPG5-XSBJ].
[255] *Id.*
[256] *Id.*
[257] *Id.*

with the Minnesota Prison Doula Project to provide doula and other delivery specialists for the program.[258] The Commissioner of the Department recognized, "The healthier the bond is between mother and child, the more likely these women will be successful."[259]

The kind of mother-infant attachment allowed by these programs is, "critical for the infant's psychological development and the mother's mental health."[260] A lack of regular contact visits between the parent and the baby and suppression of the ability to breastfeed can hinder the baby's development and further contribute to the mental health issues that inmates face postpartum.[261] Post-partum care itself, like regular check-ups, psychotherapy, and the use of anti-depressants, that could be provided in a nursery program or in a reentry center, is needed to mitigate the risk of psychiatric illness, exacerbated by hormonal fluctuations and fatigue experienced during the postpartum period.[262]

Such programs may also aid in establishing and maintaining custody between the inmate and newborn. Under federal law, "parental rights are terminated after children have lived in foster care for fifteen months, a time period shorter than many prison sentences."[263] If prison officials fail to assist women in making arrangements for their newborns, like identifying a family member or other responsible party to care for them, the state will assume custody and responsibility for the child's placement.[264]

It is important to note the successes in other states when drafting legislation in N.J. Progressive programs that work outside the norms of the criminal justice system provide better results for the physical and mental health of both the mother and the baby, and improves society overall, with less recidivism and parole violations. These programs are not entirely novel and there is a strong framework for N.J. to base its laws upon.

C. Previous and Pending New Jersey Bills

Like the federal legislature and other states, the N.J. legislature has attempted to further expand pregnancy care and protections in prisons, but the legislation has generally failed to move through the legislature and be signed into law. In 2020, the legislature introduced a bill that would require NJDOC to "provide prenatal and post-partum education and services to

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[258] *Id.*

[259] *Id.*

[260] Carolyn Sufrin, *Pregnancy and Postpartum Care in Correctional Settings*, NAT'L CMM'N ON CORR. HEALTH CARE 5 (Jan. 2018), https://www.ncchc.org/wp-content/uploads/Pregnancy-and-Postpartum-Care-2018.pdf [https://perma.cc/DD9J-348D].

[261] *Id.*

[262] *Id.* at 6.

[263] JAILCARE, *supra* note 166, at 9.

[264] *Id.*

certain inmates."[265] Under the bill, every female inmate under 60 years old would be required to be tested for pregnancy upon entering a state correctional facility, and, if pregnancy is confirmed, the Commissioner of Corrections must provide the "appropriate" prenatal and post-partum services.[266] The bill enumerates a non-exhaustive list of such services, including prenatal education, medical evaluation and care, nutritional care and supplements "as prescribed by a physician," and counseling on family planning, birth control, test results, termination, child placement, and religious counseling, if desired.[267] Lastly, if the inmate elects to carry the pregnancy to term, she shall be provided "ongoing prenatal care and support," including obstetrical services, maternity clothes, reasonable housing assignments, appropriate exercise, and reduced work scheduling, "as deemed medically advisable by the treating physician."[268]

In 2021, the N.J. legislature attempted to establish the Female Inmates' Rights Protections Act.[269] Although not limited to pregnancy care, the Act would have established a nursery program, "allowing newborn children to remain with their incarcerated mothers," if the inmate gave birth while incarcerated.[270] There are exceptions to participation in the program, such as if the inmate has substantiated claims of child abuse against them, has outstanding warrants, or has committed any serious disciplinary infraction.[271] If the inmate is eligible, though, they would be transferred to a residential community release program, and the child would remain with the mother until the child is two years old or the inmate is released, whichever is sooner, and the inmate would be able to participate in prenatal and parenting classes.[272] Further, the Commissioner of Corrections would be required to provide "doula services" to pregnant inmates, and the service provider and an additional "support person" would be permitted to be with the inmate during labor and childbirth.[273] The Act defines "doula services" as, "services provided by a trained doula for physical, emotional, or informational support to a pregnant woman before, during, and after the delivery of a child."[274]

Both bills have carried into successive sessions, but neither have made it out of their respective bodies' committees.[275] The fact that these bills have

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[265] Assemb. 4953, 219th Leg. Reg. Sess. (N.J. 2020).
[266] *Id.* at § 1(a).
[267] *Id.* at § 1(a)(1)-(5).
[268] *Id.* at § 5(b).
[269] S. 4180, 219th Leg. Reg. Sess. (N.J. 2021).
[270] *Id.* at § 3.
[271] *Id.* at § 3(b)(1)-(6).
[272] *Id.* at § 3(d)-(e).
[273] *Id.* at § 4(a)-(b).
[274] *Id.* at § 4(c).
[275] S. 2223, 221st Leg., Reg. Sess. (N.J. 2024), Assemb. 1412, 221st Leg., Reg. Sess. (N.J. 2024).

been continuously introduced throughout consecutive sessions still affirms that there are legislators in N.J. that care about this issue and are willing and able to continue the fight for real change.

In a conversation with Assemblywoman Carol Murphy, one of such legislators and a former co-sponsor of the bill that would have mandated prenatal and postpartum education and services to pregnant inmates, she affirmed that pregnancy care in prisons is an important topic that needs to be discussed more within the N.J. legislature.[276] She stated that the bill came about after reports from ACOG about the rising percentages of pregnant women in state prisons, which she agreed heightened the need for care and counseling on things like nutrition, access to medical treatment, child placement services, and religious counseling, if desired by the inmate.[277] With the large volume of legislation that comes before the N.J. legislature, the Assemblywoman acknowledged that the bill has not yet been a big topic of discussion, but that change begins with conversation, research, and awareness, which is not out of reach, especially considering the conversations currently ongoing about the issues at EMCF.[278] The Assemblywoman stated that this is not just an issue of public safety, but of general access to healthcare and women's rights, underscoring its importance.[279] The conversation was imbued with the hope that legislation that truly addresses the needs of pregnant women in incarceration is a possibility in N.J.

VI. CALL TO ACTION: PROPOSED LEGISLATION

Pregnancy and pregnancy care are fundamentally at odds with the workings of our systems of incarceration. People in prison are much more susceptible to pregnancy complications, due to increased risk factors like mental health issues, substance abuse disorders, and predisposition to preterm birth, infant mortality, and maternal morbidity.[280] The continuous and emergent needs of women experiencing pregnancy in prison are often incompatible with the way healthcare is provided in incarceration, like a lack of regular access to medical care and barriers posed by correctional officers and administration.[281] Given the complex profiles of people in incarceration, the pregnancy care that is provided to them must be tailored to serve their specific needs.

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[276] Telephone Interview with Carol A. Murphy, Assemblywoman & Majority Whip, Dist. 7, N.J. Gen. Assemb. (Mar. 11, 2025).

[277] *Id.*

[278] *Id.*

[279] *Id.*

[280] *See* discussion *supra* Section II.

[281] *See* discussion *supra* Sections III, IV.

Although there have been trends in the law providing further protections for pregnant inmates, such laws are largely discretionary and there is an alarming lack of oversight and reporting on pregnancy and pregnancy outcomes in state prisons, on top of the hostility towards such populations within the federal government and limited access to litigation for inmates to address constitutional violations.[282] This presents a unique problem that demands creative and progressive solutions.

Luckily, though, such solutions are not entirely novel and there is a wealth of information from medical experts and other legislatures to guide N.J. in creating new laws. The standards outlined from ACOG and other medical professional groups, legislation like Minnesota's Healthy Start Act, other states' prison nursery programs, and the federal Pregnant Women in Custody Act, serve as guideposts for N.J. to work towards the necessary and equitable treatment of pregnant women in incarceration. The needs of this population are already known, and it is simply a matter of implementation.

Now is the perfect time for N.J. to implement legislation addressing the needs of pregnant inmates. As discussed, there is only one all-women prison in N.J., the new facility for which is currently being constructed and expected to be completed in 2028. So, the impact of the legislation would be limited to a single facility, around which there is already ongoing, robust conversation about the unique needs of incarcerated women. N.J. is also already engaged in research and advocacy for the health of pregnant women and their children with the Nurture NJ program, which has an existing partnership with NJDOC, and could easily be utilized to implement specific policies concerning pregnancy care at EMCF.

This Note recommends that N.J. legislators draft and introduce a bill that would model Minnesota's Healthy Start Act and require NJDOC to implement a policy of transferring pregnant inmates to residential reentry centers for the duration of their pregnancy and allow them to remain there, with their infants, for a minimum of one year, or until release, in addition to mandating construction of additional reentry centers. Organizations like the New Jersey Reentry Corporation,[283] the New Jersey Association on Correction,[284] and the WOW Center[285] have existing agreements with NJDOC, specifically the Offices of Transitional Services and Community Programs, to operate reentry centers. These existing agreements may be altered and expanded to accommodate a program for pregnant inmates,

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[282] *See* discussion *supra* Section IV.

[283] *See About*, N.J. REENTRY CORP., https://njreentry.org/about/ [https://perma.cc/UM9U-FEKT] (last visited Apr. 18, 2026).

[284] *See Reintegration*, N.J. ASS'N OF CORR., https://njaconline.org/services/reintegration [https://perma.cc/5M6B-6NPA] (last visited Apr. 18, 2026).

[285] *See Reentry Services,* THE WOW CTR., https://www.thewowcenternj.org/reentry-services [https://perma.cc/LC6G-U39X] (last visited Apr. 18, 2026).

allowing for easier access to medical care, counseling, and opportunities for mother-infant bonding, helping to increase positive pregnancy outcomes and set pregnant women and babies up for healthy lives going forward.

In the absence of a residential reentry program for pregnant inmates, this Note recommends N.J. adopt a bill that mirrors the Pregnant Women in Custody Act and includes provisions for a prison nursery program. If pregnant women in prison must remain in a traditional prison setting during pregnancy and postpartum, NJDOC, including the Healthcare Compliance Unit and the Office of Educational Services, must be mandated to provide comprehensive care and counseling, like that recommended by ACOG, and a nursery program would address many of the concerns raised in this Note about the need for mother-infant bonding and the retention of custody.

This Note strongly recommends increased collaboration between Nurture NJ, NJDOC, and the Administrator of EMCF, in addition to legislators, to implement these solutions. Lastly, regardless of the chosen policy, NJDOC's Office of Compliance and Strategic Planning should be required to collect data on pregnancy in state prison annually, including the number of pregnant women in custody, the care they are provided, and the outcomes of the pregnancies.

VII. CONCLUSION

In April of 2021, the N.J. Assembly Judiciary Committee and Assembly Women and Children Committee held a joint meeting and hearing to address the allegations and need for reform at EMCF.[286] Two former inmates and survivors of abuse at EMCF, Nafeesah Goldsmith and Lydia Thornton, testified to the joint committees.[287] Thornton spoke about the culture at EMCF, saying, "We talk about a culture; the culture is of, 'Oh, well, they're just criminals.' 'Oh, well, they'll be back anyway.' I was told that as I left: 'You'll be back.'"[288] Thornton emphasized how this culture is impenetrable for women, in particular, because of their lack of choice, stating, "Women. . .don't have much of a choice, because there's no other choice but Edna Mahan that they can be confined in; they can't be moved to a facility closer to their children. Men can."[289] Goldsmith, after describing her experiences with sexual abuse and medical neglect at EMCF, said:

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[286] *Recent Allegations and Needed Reforms at the Edna Mahan Corr. Facility for Women and Other Related Issues: Hearing Before the Assemb. Judiciary Comm. and Assemb. Women and Child. Comm.*, N.J. Leg. Sess. (2021), https://dspace.njstatelib.org/server/api/core/bitstreams/632fda1c-44d3-4b35-998e-3fd454a72ae3/content [https://perma.cc/CM2H-C7Y6].

[287] *Id.* at 125-37, 158-68.

[288] *Id.* at 161-62.

[289] *Id.* at 167.

> Until this night—I've been home almost six years—I sleep with my bedroom door locked. It is traumatic. My sisters and my brothers have been suffering abuses at the hands of the New Jersey Department of Corrections, and it has to stop. This system—this creation—breeds nothing but a culture of abuse.[290]

These two women's experiences and the issues outlined in this Note only serve as a snapshot of the experiences of women in incarceration. The stories of many are extremely varied, and unfortunately, tragic. The experience of carrying a pregnancy to term and giving birth to a baby is one of the most complicated and sensitive experiences a woman will have in her life, and all of the stress and danger associated with pregnancy is inevitably amplified by conditions of confinement, social isolation, and limited access to healthcare. If N.J. is truly dedicated to improving the welfare of moms and babies in the state, healthcare in prison must be part of the conversation. The next logical step is to create legislation that protects some of the most vulnerable women in our society: pregnant women in incarceration. Let us affirm N.J. as a state dedicated to gender equity, criminal justice reform, and public health, and serve as a model for progress and hope.

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[290] *Id.* at 126-27.