



HHS Public Access

Author manuscript

Obstet Gynecol. Author manuscript; available in PMC 2021 May 01.

Published in final edited form as:

Obstet Gynecol. 2020 May ; 135(5): 1177–1183. doi:10.1097/AOG.0000000000003834.

Pregnancy Prevalence and Outcomes in U.S. Jails

Carolyn Sufrin, MD, PhD,

Johns Hopkins University School of Medicine, Department of Gynecology and Obstetrics

Johns Hopkins Bloomberg School of Public Health, Department of Health, Behavior and Society

Rachel K. Jones, PhD,

Guttmacher Institute

William D. Mosher, PhD,

Johns Hopkins Bloomberg School of Public Health, Department of Population, Family, and Reproductive Health

Lauren Beal, MPH

Johns Hopkins University School of Medicine, Department of Gynecology and Obstetrics

Abstract

Objective: To describe the number of admissions of pregnant people to U.S. jails and the outcomes of pregnancies that end in custody.

Methods: We prospectively collected pregnancy data from 6 U.S. jails, including the 5 largest jails, on a monthly basis for 12 months. Jails reported de-identified, aggregate numbers of pregnant people admitted, births, preterm births, cesarean deliveries, miscarriages, induced abortions, ectopics, and maternal and newborn deaths.

Results: There were 1622 admissions of pregnant people in 12 months in the selected jails. The highest one-day count of pregnant people at a single jail was 65. The majority of these admissions involved the release of a pregnant person. Of the 224 pregnancies that ended in jail, 144 (64%) were live births, 41 (18%) were miscarriages, 33 (15%) were induced abortions, and 4 were ectopics (1.8%). One third of the births were cesarean deliveries and 8% were preterm. There were 2 stillbirths, 1 newborn death, and no maternal deaths.

Conclusions: About 3% of admissions of females to U.S. jails are of pregnant people; extrapolating study results to national female jail admission rates suggests nearly 55,000 pregnancy admissions in 1 year. It is feasible to track pregnancy statistics about this overlooked group.

Precis

There are an estimated 55,000 annual admissions of pregnant people to U.S. jails; incarcerated women must be included in efforts to address pregnancy care inequities.

Corresponding author: Carolyn Sufrin, Johns Hopkins Bayview Hospital, Ob/Gyn, 4940 Eastern Ave., A121, Baltimore, MD 21224, 410-550-0337, csufrin@jhu.edu.

Financial Disclosure: Dr. Sufrin is an ex-officio member of ACOG's Committee on Health Care for Underserved Women, serving as ACOG's liaison to the board of the National Commission on Correctional Health Care; in this role, she reports receiving reimbursement for travel. The other authors did not report any potential conflicts of interest.

Introduction

In 2017, there were 113,700 women in jails in the U.S., a 6% increase from the prior year.¹ About 3 out of 4 incarcerated women in the U.S. are of childbearing age and many of them are mothers to young children.^{2,3} Up to 80% of women entering jails have been heterosexually active prior to arrest and nearly two-thirds are not using effective contraception.^{4,5} Therefore, some people will enter jail pregnant. A 2002 survey of 417 jails conducted by the Bureau of Justice Statistics found that 5% of women reported being pregnant at intake.⁶ In 2019, we published results from a study of pregnancy outcomes in state and federal prisons. We found that 4% of all newly admitted women were pregnant and that 753 people gave birth in custody, representing over 90% of all pregnancies that ended in prison.⁷

Yet we cannot assume similar trends in jails, as jails and prisons are distinct institutions. Unlike prisons, which imprison people who are convicted of felony level crimes and are serving sentences longer than 1 year, jails typically house people pre-trial and people who are sentenced to less than 1 year. The average jail stay in 2017 was 26 days;¹ so most people who enter jail pregnant will likely still be pregnant when they are released. A further distinction is that prisons are under state or federal control, whereas jails are under local jurisdictions. Jails are located in the communities where people are arrested. This local geography and the high turnover of jail mean that the pregnancy care people receive—or do not receive—in jail is inextricably tied to the care they need when they return to the community.

Data about pregnancy in jails are needed to help ensure that pregnant incarcerated people get appropriate care. When formerly incarcerated women come to hospitals in the community for birth, research shows that perinatal providers have limited knowledge about appropriate care for them⁸ Furthermore, black women are incarcerated at twice the rate of white women, reflecting the structural racism inherent to U.S. incarceration;¹ thus, having data about pregnancies in jails is part of a broader agenda to reduce racial disparities in maternal mortality and other negative outcomes. Prior to being arrested, many women experience racism, poverty, addiction, abuse, and limited access to health care—structural inequities that increase the risk of adverse pregnancy outcomes.^{9,10,11,12} This study prospectively collected 1 year of pregnancy admissions data and outcomes of pregnancies ending in jail from 6 county jails across the U.S, including the 5 largest jails, as a component of our previously reported prison pregnancy study.

Methods

This study was part of the larger “Pregnancy in Prisons Statistics” project, which collected pregnancy data from state and federal prisons in the U.S. While no comprehensive database of the number of jails exists, it is estimated that there are over 3000 to correspond with the over 3,000 counties in the U.S.¹³ The large number of U.S. jails creates methodological challenges involved in collecting data from a systematic and representative sample of these institutions. Given this large number and the uncatalogued locations of jails, we designed the

jail portion of our project as a smaller-scope study, with a small number of jails to assess feasibility of such data collection. Between May and December 2016, 6 jails housing females enrolled in the study.

Because of the intentionally limited sample size of jails, we wanted to have the largest possible number of women represented. Thus, we targeted recruitment on the 5 largest jails in the country: Los Angeles County (CA), Rikers Island (NY), Cook County (IL), Harris County (TX), and Dallas County (TX). We contacted administrators at each institution and all 5 of these recruited large jails agreed to participate. In addition, administrators at a small jail, Western Massachusetts Regional Women's Correctional Center, heard about the study and asked to participate. Since we were interested in feasibility of jails' data collection, we thought their participation would be helpful to illuminate if a small jail also could report pregnancy data. Therefore, this jail was also included in the study. These jails together account for about 5 percent of the 113,700 women in jails in the US in 2017.¹

We determined which monthly variables could be collected and the level of detail of the variables based on a 3-month exploratory study (with 4 prisons and one jail) in 2015. Our final monthly data collection tool was informed by feedback from prison and jail staff who reported data for this exploratory phase. The 6 study jails then reported the following aggregate, de-identified numbers each month: pregnant people admitted and total pregnant people in custody on the last day of the month; live births and stillbirths, stratified by term (>37 weeks), preterm (24–36 weeks, 6 days), and very early preterm (20–23 weeks, 6 days); preterm and cesarean deliveries; miscarriages; induced abortions; ectopic pregnancies; maternal deaths in custody (during pregnancy or within 6 weeks of the pregnancy ending); and newborn deaths within the first 3 days of life. While the standard definition of neonatal death is within the first 30 days, because jail systems do not have direct contact with the newborns, it was not feasible for sites to consistently know what happened to the infant beyond the time the mother was in the hospital for her postpartum recovery, typically 2–3 days. We asked sites to report if anyone became newly pregnant while in custody. No specific demographic characteristics about individual women, such as race and age, were gathered. We collected data for 13 months, and the first month was considered a trial period for the pregnancy tracking system at each site. We then analyzed data for months 2–13, a total of 12 months.

In addition, we asked jails to report baseline characteristics about their institutions, including whether their health care services were accredited by a voluntary accreditation program and when they administer urine pregnancy tests.

A designated reporter at each site—whose role varied from medical directors, other medical personnel, gender responsive advocate, and a detention lieutenant—tracked and reported aggregate, de-identified data at the end of each month. Two participating jails were already collecting some of these data before the study and their tracking systems were provided as examples for other jail sites, so that each jail could adapt a tracking system for their institution. Jails have electronic or paper medical records systems for care provided on site; these systems incorporate information from outside clinic visits and hospital admissions

occurring while people are in custody. Site reporters used these sources for pregnancy information, although we did not personally verify their internal records systems.

We asked jails to report on the women that their medical system recorded as pregnant; we presumed this was based on urine pregnancy testing, protocols which we asked about in the study, but we did not verify with reporters how each pregnancy was determined. Our study team provided guidance and was available to answer questions for site reporters about how to categorize the different subtypes of pregnancy outcomes, such as term or preterm births. However, since every jail has its own protocols and resources for obtaining dating ultrasounds, we could not verify exactly how the gestational age when someone gave birth was determined; we relied on the systems that each jail had for recording this information in their medical records and other health care tracking systems. Site reporters could indicate that they did not know the gestational age at delivery, but none reported this as an unknown in their monthly reports. Study staff reviewed data monthly to assess for discrepancies, for instance, if the number of preterm and term births did not add up to the total number of births in a given month. If we noted any inconsistencies, our study staff contacted site reporters to discuss and resolve these discrepancies. A final year long report was sent to study sites to confirm the accuracy of the data.

Some people in jail will be in custody for the duration of their pregnancies, but many will be released while still pregnant, and some may be re-arrested during that same pregnancy. We asked jails to report the number of *admissions* of pregnant people each month, recognizing that some individuals might be released and rearrested in a subsequent month, or even that month. Therefore, our measure of admissions of pregnant people likely does not reflect the number of unique individuals who entered jail pregnant. Our study was designed to track the outcomes of pregnancies that ended while people were in jail, aiming to shed light on their pregnancy care needs. We could not, however, track the outcomes of people who were released from jail while still pregnant.

In order to calculate a point prevalence of pregnancy, jails reported their overall female census on December 31, 2016, the same date used in the official Bureau of Justice Statistics reports.^{1,14} After the official 13 month reporting period, we determined it would be informative to have an additional point prevalence for seasonal comparison, as well as the proportion of admitted females who were pregnant in December 2016 and April 2017. We therefore re-contacted site reporters for the denominators of admitted females during these months and total female census on April 30, 2017. This additional census data was reported by 5 of the 6 jails (all but Dallas County).

We analyzed data for frequencies and other descriptive statistics for admissions of pregnant people and the outcomes of the pregnancies ended in jail. Proportions of each pregnancy outcome were calculated for pregnancies that ended in jail-- that is, not including women who were released from jail pregnant or those still pregnant and in jail at the end of the study time period. Because data represent complete counts from all participating jails, we could not calculate confidence intervals. Larger studies of more jails, based on probability samples, would be able to make formal national estimates with confidence intervals. Results are reported for all jails combined, and also by individual jails by state; results for Dallas

County and Harris County jails are reported in aggregate as “Texas jails.” Because of the small number of jails in this study and the variable conditions at each one, we did not conduct any statistical tests of association.

We collected and managed study data using the secure, web-based application Research Electronic Data Capture (REDCap) tools hosted at Johns Hopkins University School of Medicine.¹⁵ The study was approved as non-human subjects research by the Institutional Review Board at Johns Hopkins University School of Medicine, and we followed each jail’s system for research approval. Of note, the designation ‘non-human subjects’ research was based on the aggregate, de-identified nature of data collection. It is important to acknowledge, however, that each number reported for this study represents a person with a lived experience of being pregnant in custody.

Results

Five of the participating jails were large, holding a daily count of 502 to 1781 females; the small jail’s female census was 231. Half of the jails had received some form of voluntary health care accreditation (with one obtaining dual accreditation from 2 organizations); none of these jails contracted health care delivery to a private company. The one jail that did not routinely perform pregnancy testing at intake did so for all females within 2 weeks of their arrival to this jail. One jail had a program in place to release pregnant women with substance use disorders to a community-based treatment program under the Sheriff Department’s supervision.

In total, there were 1622 admissions of pregnant people to these 6 jails over 12 months, with a range of 2–58 admitted each month (Table 2). At the 5 jails that reported total female admissions, 84 of 2654 admitted females (3.2%) in December 2016 and 70 of 2936 (2.4%) in April 2017 were pregnant when they got to jail, with a range from 1.2% to 4.7% of admissions at individual jails (Tables 2 and 3). The 2016 year-end pregnancy prevalence at all jails in this study was 3.5%, and was 4% on April 30, 2017 (Table 2). The highest number of admissions of pregnant people to a jail in a single month was 50, at L.A. County jail, which also had the highest overall number of pregnant people on the last day of any month, at 65 people.. One jail indicated that one woman had a negative pregnancy test at intake that was then positive a few days later, and reported that it was most likely because she was too early to be detected at admission. Otherwise, sites reported that no women became pregnant while already in custody;

Two hundred twenty-four pregnancies ended in jail during the study time period. One hundred forty-four (64%) of these pregnancies ended in live births (Table 3). Of the live births, 12 (8%) were preterm and 2 were pre-viable preterm. One-third of live births were cesarean deliveries. All but 2 births occurred in a hospital; both of these in-jail deliveries were reported to be due to precipitous labor with jail nurses or emergency medical personnel in attendance. There were 41 miscarriages (18% of pregnancies that ended in jail), with 85% of them being first trimester. Thirty-three induced abortions occurred (15% of pregnancies that ended in jail). There were 4 ectopic pregnancies and 2 stillbirths, one of which was a

pre-viable gestation and the other was preterm. There were no maternal deaths, and 1 newborn death.

If we assume that all 224 of these outcomes were to women who were admitted to jail pregnant during the study period, then 1,398 of the 1,622 pregnant admissions (86%) resulted in a pregnant person being released while pregnant. It is possible that some of the pregnancies that ended in custody were to women who were already in jail continuously since the start of the study and therefore would not have been counted as admissions, which would result in an even higher proportion of admissions resulting in pregnant person getting released.

Discussion

In this study of 6 jails, 3% of women were pregnant at admission. If these jails are representative of all U.S. jails, then based on the over 1.7 million annual admissions of females to jail,¹⁶ we estimate there are nearly 55,000 admissions of pregnant people each year. While some of those admissions may be of the same people, this is a substantial number of times that jails need to provide comprehensive and urgent pregnancy care. The majority of admissions of pregnant people result in people getting released while still pregnant. Community providers should be aware that pregnant patients may have experienced incarceration; in turn, continuity of records from jail is essential for these patients.

The jail pregnancy admission incidence of 3% is similar to U.S. general population estimates,¹⁷ though slightly lower than the 5% jail estimate from 2002;⁶ one reason for this difference could be that the 2002 statistic was based on incarcerated people's self-reports of pregnancy, whereas our study elicited clinically verified pregnancies. Our data may slightly underestimate incidence of pregnancy at admission because some jails do not screen for pregnancy immediately, and some individuals may decline or may be released before screening. A national study is warranted to more fully assess jail pregnancy frequencies and to evaluate the effect of exposure to jail on pregnancy outcomes; our study shows that it is feasible for jails to track such data.

The 8% jail preterm birth rate is slightly lower than the 2016 U.S. national estimate of 9.9%.¹⁸ However, preterm birth rates ranged from 0–20% across the jails, with at least two jails reporting rates that were double the national rate. These patterns suggest that the context of the individual jail system and pre-incarceration conditions may play a role in the variable preterm birth rates. Rates of cesarean births and ectopic pregnancies among jailed women were also similar to national estimates.¹⁸ Approximately 15% of clinically recognized pregnancies end in miscarriage,¹⁹ similar to the 18% at these jails, which included 6 second trimester losses. Nationally, 18% of pregnancies end in induced abortion;²⁰ our study's induced abortion ratio is only slightly lower than this at 15%.

There were more admissions of pregnant people to these 6 jails than to 22 state prisons and all federal prisons examined in our prior study (1622 versus 1396).⁷ Conversely, there were more births in prisons in one year (753) than in the 6 jails (144). This difference likely

relates to the fact that people are in prison longer than in jail, with an average prison sentence length of 2.6 years versus average jail stay of 26 days.^{1,21} That hundreds of incarcerated people give birth, have miscarriages, or induced abortions each year should be examined within the complexities of pregnancy, birth, and postpartum care provided in custody, including the medically unsafe practice of shackling women in labor. Additionally, the majority of women in jail have been adversely affected by a number of social and structural determinants of health, such as limited access to medical care in the community, poverty, unstable housing, and disproportionate exposure to institutionalized racism.^{9,22,23} These conditions overlap with the high prevalence of histories of trauma, mental illness, and substance use disorders among incarcerated women.⁹ Caring for jailed people's pregnancies, then, also requires tending to these complex, intersecting health issues.

Health care service delivery in jails is based on policies and protocol as determined by local administrators. While the Supreme Court has ruled that jails are constitutionally required to provide health care,^{24,25} that ruling included no mandatory standards, oversight or requirements for data reporting. The American College of Obstetricians and Gynecologists provides recommendations for pregnancy care in custody, and voluntary accreditation programs exist.^{26–28} Still, the lack of mandatory standards and oversight leads to variability from jail to jail, even within the same state.^{9,29}

Our study has several shortcomings. We could not assess gestational age at entry, yet variations in gestational age could correlate to study outcomes. Selection bias may also influence study results, as jails that chose to participate may already be more attuned to the needs of pregnant incarcerated people. All but one of the study sites were large, urban jails that generally have greater health care resources, and outcomes might be different for jails with the least amount of resources. Finally, we could not collect individual-level data on race, socioeconomic status, pre-incarceration health, or pregnancy history, all factors that influence jail pregnancy outcomes.

The jails not included in this study vary not only by geography and female population size, but likely also by health policies, such as pregnancy testing protocols and, potentially, comprehensiveness of prenatal care. Additionally, other local or state-wide policies may influence how many pregnant people are incarcerated, such as policing practices sentences for drug-related charges.

These data are a critical first step in understanding the complex and interconnected needs of an overlooked group. This study makes it clear that larger and more in-depth studies of pregnant people in jail and upon release from jail, are needed—first to provide estimates at a larger and more diverse sample of jails; second, to give a richer and more detailed understanding of the pregnancy experiences of these people; third, to assess the impact of jail exposure on pregnancies that end either in the community or in jail; and fourth, to help jail health care providers and administrators optimize pregnancy care when pregnant people are in their custody.

Our study data should be viewed through the lens of the structural oppressions that adversely shape incarcerated women's lives. Jails must be understood not as institutions isolated from

society, but as ones that are located within communities. There is constant flux between jails and their surrounding communities, with people being arrested and released at frequent and often unpredictable intervals. Community health systems are therefore connected to jail health systems, as community providers care for people before incarceration and when people return to their communities.¹⁰ The pregnancy care people do or do not receive in custody will impact them and, for those who give birth, their infants, well after release. Identifying pregnancy outcomes among people in jail is, then, an essential part of broader strategies to address maternal health inequities.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments and Funding:

This research was supported by the Society of Family Planning Research Fund (SFPRF9-JI1) and the National Institute of Child Health and Development (grant NICHD-K12HD085845).

The authors thank Dr. Jennifer Clarke, Rhode Island Department of Corrections, for study design; Becki Ney from the National Resource Center on Justice Involved Women and Maureen Buell from the National Institute of Corrections for their assistance in recruitment; and the site reporters at the participating jails and the incarcerated women whose pregnancies are represented in these statistics.

References

1. Zeng Z Jail Inmates in 2017. NCJ 251774. Washington, DC Department of Justice, Bureau of Justice Statistics; 2019.
2. Glaze LE, Maruschak L. Parents in Prison and Their Minor Children. NCJ 222984. Washington, DC Department of Justice, Bureau of Justice Statistics; 2010.
3. Bronson J, Carson EA. Prisoners in 2017. NCJ 252156. Washington, DC Department of Justice, Bureau of Justice Statistics; 2019.
4. Clarke JG, Hebert MR, Rosengard C, Rose JS, DaSilva KM, Stein MD. Reproductive health care and family planning needs among incarcerated women. *Am J Public Health* 2006;96(5):834–9. [PubMed: 16571701]
5. Laroche F, Castro C, Goldenson J, et al. Contraceptive use and barriers to access among newly arrested women. *J Correct Health Care* 2012;18(2):111–9. [PubMed: 22419640]
6. Maruschak L Medical Problems of Jail Inmates. NCJ 210696. Washington, DC Department of Justice, Bureau of Justice Statistics; 2006.
7. Sufrin C, Beal L, Clarke J, Jones R, Mosher WD. Pregnancy Outcomes in US Prisons, 2016–2017. *Am J Public Health* 2019;109(5):799–805. [PubMed: 30897003]
8. Goshin LS. Humane Language for People in the Criminal Justice System. *JAMA* 2017;318(22):2258–9.
9. Hayes CM, Sufrin C, Perritt JB. Reproductive Justice Disrupted: Mass Incarceration as a Driver of Reproductive Oppression. *Am J Public Health* 2020;110(S1):S21–S24. [PubMed: 31967889]
10. Sufrin C Jailcare: Finding the Safety Net for Women Behind Bars. Oakland (CA): University of California Press; 2017.
11. Fogel CI. Pregnant inmates: risk factors and pregnancy outcomes. *J Obstet Gynecol Neonatal Nurs JOGNN* 1993;22(1):33–9.
12. Knight M, Plugge E. Risk factors for adverse perinatal outcomes in imprisoned pregnant women: a systematic review. *BMC Public Health* 2005;5:111. [PubMed: 16229740]
13. Mackun P, Wilson S. Population Distribution and Change: 2000 to 2010 United States Census Bureau. Washington, DC; 2011 Available at: <https://www.census.gov/library/publications/2011/dec/c2010br-01.html>. Retrieved December 17, 2019.

14. Zeng Zhen. Jail Inmates in 2016. NCJ 251210. Washington, DC Department of Justice, Bureau of Justice Statistics; 2018.
15. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)--a metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Inform* 2009;42(2):377–81. [PubMed: 18929686]
16. Federal Bureau of Investigation. Crime in the United States, 2017, Ten-Year Arrest Trends By Sex, 2008–2017. Available at: <https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/tables/table-33>. Retrieved February 10, 2020.
17. Daniels K, Abma JC. Current Contraceptive Status Among Women Aged 15–49: United States, 2015–2017 Data Brief No. 327 Hyattsville, MD National Center for Health Statistics; 2018.
18. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Drake P. National Vital Statistics Reports, Births: Final Data for 2016. Hyattsville, MD. National Center for Health Statistics 2018;67(1):55.
19. Horner-Johnson W, Kulkarni-Rajasekhara S, Darney BG, Dissanavake M, Caughey AB. Live Birth, Miscarriage, and Abortion among U.S. Women with and Without Disabilities. *Disabil Health J* 2017; 10(3): 382–386. [PubMed: 28431989]
20. Finer L, Zolna M. Declines in unintended pregnancy in the United States, 2008–2011. *N Engl J Med* 2016;374(9):843–852. [PubMed: 26962904]
21. Kaeble D, Cowhig M. Correctional Populations in the United States, 2016 NCJ 251211. Bureau of Justice Statistics Washington, DC 2018.
22. Rich JD, Chandler R, Williams BA, Dumont D, Wang EA, Taxman FS, Allen SA, Clarke JG, Griefinger RB, Wildeman C, Osher FC, Rosenberg S, Haney C, Mauer M, Western B. How Health Care Reform Can Transform the Health of Criminal-Justice Involved Individuals. *Health Aff* 2014; 33(3): 462–7.
23. Albertson EA, Scannell C, Ashtari N, Barnert E. Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration. *Am J Public Health* 2020; 110: 317–321. [PubMed: 31944846]
24. Estelle v. Gamble. 1976 1976. U.S. Supreme Court, 429 U.S. 97
25. Rold WJ. Thirty Years After Estelle v. Gamble: A Legal Retrospective. *J Correct Health Care* 2008;14(1):11–20.
26. American College of Obstetricians and Gynecologists. Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females. Committee Opinion No. 511. *Obstet Gynecol* 2011 (reaffirmed 2019);118:1198–202.
27. National Commission on Correctional Health Care, Accreditation Program. Available at: <https://www.ncchc.org/facility-accreditation>. Retrieved December 17, 2019.
28. American Correctional Association, Health Care Accreditation. Available at: http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Healthcare/Health_Accreditation/ACA_Member/Healthcare_Professional_Interest_Section/HC_AccreditationHome.aspx?hkey=5b21416b-fee4-47fd-9eed-2597879e7076. Retrieved December 17, 2019.
29. Kelsey CM, Medel N, Mullins C, Dallaire D, Forestell C. An Examination of Care Practices of Pregnant Women Incarcerated in Jail Facilities in the United States. *Matern Child Health J* 2017; 21(6): 1260–1266. [PubMed: 28236159]

Table 1.

Characteristics of participating U.S. jails, 2016–2017 (n=6)

Region of U.S.	No. (%)
Northeast	2 (33%)
Midwest	1 (17%)
South	2 (33%)
West	1 (17%)
Health care accreditation **	
None	3 (50%)
National Commission on Correctional Health Care	3 (50%)
American Correctional Association	1 (17%)
Pregnancy test performed on routine medical intake	5 (83%)
Jail may release some pregnant women to community-based treatment program	1 (17%)

** One jail had dual accreditation.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2. Pregnancy prevalence and admissions of pregnant people in U.S. jails, 2016–2017

Prison System	Total Female Census, 12/31/16	Pregnancy Prevalence, 12/31/16 No. (% of all females)	Total Female Census, 4/31/17	Pregnancy Prevalence, 4/31/17 No. (% of all females)	Total number of admissions of pregnant females, 12 months	Admitted females who were pregnant, December, 2016, No. (% of admitted females)	Admitted females who were pregnant, April, 2017, No. (% of admitted females)	Median admissions of pregnant females per month No. (range)	Median number of pregnant females, on the last day of the month No. (range)
Cook County	502	14 (2.8%)	539	28 (5.2%)	265	18 (3.9%)	16 (2.9%)	22.5 (11–32)	18.5 (11–39)
LA County	1781	54 (3.0%)	1963	60 (3.1%)	445	34 (2.4%)	30 (1.9%)	34.5 (22–50)	56 (48–65)
Rikers Island	545	6 (1.1%)	608	6 (1%)	117	11 (3.4%)	5 (1.3%)	9.5 (5–18)	8.5 (6–18)
Texas Jails	1851	87 (4.7%)	1119*	61 (5.5%)*	742	29 (4.7%)*	22 (3.4%)*	29.5 (2–58)	44.5 (26–69)
W. Mass	231	11 (4.8%)	258	5 (1.9%)	53	3 (1.7%)	2 (1.2%)	3.5 (2–9)	10 (5–17)
Total	4910	172 (3.5%)	4487	160 (3.6%)	1622	95 (3.2%)	75 (2.3%)	23 (2–52)	27.5 (5–69)

Numbers and percents are total counts (not samples) in the jails included in this study.

* Represents only one of the two Texas jails.

Table 3.

Select pregnancy outcomes of pregnancies that ended in U.S jails, 2016–2017

Jail	Total Female Census, No. 12/31/16	Total number of pregnancies that ended in custody*	Total Live Births, No. (% of known outcomes)	Preterm Births, No. (% of live births)	Cesarean Deliveries, No. (% of live births)	Total Miscarriages, No. (% of pregnancies that ended in custody)
Cook County	502	40	16 (40%)	0	3 (19%)	10 (25%)
LA County	1781	68	38 (56%)	5 (16%)	13 (34%)	11 (16%)
Rikers Island	545	10	5 (50%)	1 (20%)	4 (80%)	2 (20%)
Texas Jails	1851	97	80 (82%)	5 (8%)	24 (30%)	15 (15%)
W. Mass	231	9	5 (56%)	1 (20%)	2 (40%)	3 (33%)
Total, jails	4910	224	144 (64%)	12 (8.3%)	46 (32%)	41 (18%)

Numbers and percents are total counts (not samples) in the jails included in this study.

* Includes pregnancies that ended in jail by live birth, miscarriage, induced abortion, stillbirth, or ectopic pregnancy. Stillbirths and ectopic numbers are reported in text.