An Exploration of Pregnancy and Postpartum Healthcare in Washington State Jails

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Abstract

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Background: The number of women incarcerated in local jails has been steadily increasing for decades. Jails, originally designed to house mainly men and treat men's health issues, are now responsible for handling the healthcare needs of pregnant and postpartum women. Despite the large and growing number of women in local jails, this facet of jail healthcare remains understudied. We know very little about how many women are pregnant or have recently given birth when they are taken into custody, nor about the care they receive.

Research aim: This thesis was exploratory and formative in nature, aiming to learn more about pregnancy and postpartum healthcare in jail in Washington State. Specifically, this project focused on the policy that dictates healthcare, how that policy is decided, and what its implementation looks like.

Methods: I conducted semi-structured in-depth interviews with jail administrators, jail healthcare providers, and pregnant and postpartum incarcerated women in four jails in Washington State. I then conducted a qualitative analysis on the interview data using the constant comparative method.

Results: All jail administrators and healthcare providers had interacted with pregnant women in custody before and recognized the group's unique health needs. Jails were all controlled by the city or the county in which they were located, and as such they had a large degree of freedom

when making and implementing policy. All jails were motivated to provide adequate care to women in their custody, but they encountered constraints such as financial and staffing resource shortages. The jails were all interconnected with the larger community, utilizing outside specialized services or trying to provide linkages to care for women. Women reported adequate care that met most established guidelines, but there are areas with potential for improvement and optimization.

Conclusion: Providing healthcare in jail is different than providing it in a typical clinical setting. There are additional challenges that must be considered when developing potential interventional programs. However, these programs have been shown to work for pregnancy and other health issues within jails when implemented thoughtfully. More research on the topic and a greater focus on this important issue is necessary.

Introduction

Over the last 50 years, the number of people incarcerated in the United States has grown dramatically, to the point of the US having the highest rate of imprisonment in the world (BBC, 2020). In step with this trend, the number of women in jails has increased exponentially: In 1970, an estimated 8,000 women were held in jail facilities nationwide (Vera Institute of Justice, 2016, p.6). By 2019, that number had risen to 101,000[1] (Kajstura, 2019). The number of jailed women in Washington State has also increased significantly, from 197 in 1980 to 1,494 in 2015 (Vera Institute of Justice, 2019). Jails function as the *de facto* healthcare providers for the people in their custody and are responsible for their charges' wellbeing (Cooney, 2017). However, jails are not required to record or share even basic information like how many incarcerated women are pregnant[2]: there are no surveillance systems in place to monitor this critical public health issue. Estimates on the number of women who are pregnant when they enter jail range from 5.2%-10% (Maruschak, 2006, p.1; The American College of Obstetricians and Gynecologists, 2012, p.425). There are thousands of jails around the country, and 65 of them are located in Washington State (Grande and Stern, 2018). They are operated by the city, county, or tribe in which they are located, and there are "no formal external…oversight mechanisms" on the state level monitoring their healthcare practices or pregnancy trends (Office of Financial Management, 2014, p.2; Deitch, 2010, p. 1923). This lack of information makes it nearly impossible to comprehensively characterize the practices happening within jails or the effectiveness of those practices in the US or Washington State.

Pregnancy and the postpartum period come with unique health concerns, and women who are incarcerated are more likely to have high-risk pregnancies than the non-incarcerated population because they are disproportionately vulnerable to myriad physical and mental health issues. Studies have shown that women who are incarcerated during pregnancy are at high risk for adverse outcomes such as pre-term birth and low fetal birth weight (Bell et al., 2004; Dyer et al., 2019). Due to centuries of systemic discrimination, the demographics of these women do not reflect the general population. Women of color are overrepresented in jail and prison populations in the United States and Washington (Kajstura, 2019; WASPC, 2019). Studies of women in prison specifically show that "women offenders are clearly sicker than their male counterparts. They have higher rates of diabetes, HIV, and other STDs than male inmates. They also have higher rates of serious mental illness, drug use, depression, [post-traumatic stress disorder] and other emotional problems…" (Anno, 2001, p.243). An estimated 72% of women in jail suffer from substance use disorder, significantly higher than the non-incarcerated population *and* the prison-incarcerated female population (Bello et al., 2019; Fazel et al., 2017). Further compounding this inequity, studies show that on average "people in jail are even poorer than people in prison and are drastically poorer than their non-incarcerated counterparts" (Rabuy and Kopf, 2016). Women who have spent time in jail often have poor access to care, are housing-insecure, and rely heavily on social safety nets (Kelsey et al., 2018). Based on what is known about the women who are incarcerated in jail or prison, it is likely that the burden of disease and need for pregnancy- and postpartum-related care is greater within jails.

[1] Excluding immigration detention facilities.

[2] "Women" or "female" is used throughout this paper to refer to people who experience pregnancy in custody. I acknowledge that this terminology is imperfect and does not capture the experiences of transgender individuals in custody. More research and advocacy is desperately needed for this hyper-vulnerable population.

Although healthcare provided in jail cannot undo the effects of systemic inequity, time in custody is a potential opportunity to stabilize women's basic mental and physical needs and link them to care in the community. However, this intersection of punishment and care is a complicated one that public health practitioners must be cautious in exploiting. As Dr. Carolyn Sufrin explains in *Jailcare*, "Jail and the broader system of incarceration…have become an integral part of our society's social and medical safety net" (Sufrin, 2017, p.5). She goes on to list the "various forms of violence" associated with jails, including structural violence and the "subtle violence" of surveillance (Sufrin, 2017, p.5). Improving healthcare in jails and performing interventions for pregnant women must be coupled with efforts to reduce women's interaction with the carceral system as a whole. Despite the complexities of this issue, there is an ethical public health imperative to leverage this time and provide quality, term-appropriate care to women while they are in custody. Although providing care in this arena does present unique challenges, it is possible.

At least a dozen large prisons in the US have successfully implemented programs for pregnant and postpartum women (Corley, 2018). These programs are aimed at maintaining women's health during and after pregnancy, as well as equipping them with parenting skills and information through interactive programs and dialectical classes. In Gig Harbor, Washington, the Washington Corrections Center for Women operates the Residential Parenting Program so that women can spend time with their infants during their term. These programs have been demonstrated to work, potentially decreasing recidivism rates and increasing how invested mothers are in their child's wellbeing (Dodson et al., 2019; Shlafer et al., 2015). Numerous prisons have also allowed researchers to study birth outcomes, the demographics of pregnant incarcerated women, and the effectiveness of programs administered within the prison. However, very little of this kind of vital research has been conducted in jails. There are a handful of studies specifically designed to gather information about jail healthcare policies and the prevalence of pregnancy within jails, and there have been multiple studies measuring birth outcomes of jailed women (Mertens, 2001; Kelsey et al., 2017; Clarke et al., 2010; Sufrin et al., 2020a; Bell et al., 2004). The pioneering Pregnancy in Prison Statistics (PIPS) Project, started in 2018 by experts who also recognized the need for research on this topic, has since expanded to cover jails as well. They have conducted studies to gather baseline information about pregnant and postpartum women in jail; their findings indicate that a significant number of pregnant women pass through jails, many of whom are dealing with comorbid conditions such as SUD (Sufrin et al., 2020b). The research strongly suggests that administering pregnancy and postpartum care in jails could be a leverage point for a high-need population, with great potential for implementing novel programs and improving outcomes for women with evidence-based policy modifications. Although this has been a blind spot in research for decades, interest in the topic is growing. The combination of increasing focus on preventive care, momentum for social movements focused on justice for marginalized population, and interest in carceral reform provide an ideal opportunity to engage in formative research aimed at understanding the unique healthcare needs of incarcerated women, and the barriers to delivering care in this setting.

Research Objectives and Study Design

The goal of the research was to determine factors within each jail that affect healthcare policy and delivery, and to compare themes across the four participating jails. Because of the scarcity of

prior research, the goal of this study was exploratory in nature. I aimed to collect data to illuminate healthcare policies and practices in jails and to develop appropriate concepts, rather than to test a hypothesis. Initially, the aims of the project centered around determining whether care provided in jails aligned with the American College of Obstetricians and Gynecologists (ACOG) guidelines for providing care to incarcerated women. However, as the research progressed, it became apparent that the participating jails were not readily familiar with ACOG, and that analyzing findings along those lines was less informative than approaching the project with a systems- and intervention-focused lens. After making that adjustment, the research objectives shifted to understanding the healthcare delivered in each jail; the factors internal and external to the jail that drive healthcare decisions and delivery; and the challenges involved in providing that care.

This research utilized a case study design and consisted of in-depth semi-structured interviews with jail administrators, jail healthcare providers, and incarcerated pregnant or postpartum women.

Methods

The literature search initially consisted of searches across only PubMed, but grew to include three databases (PubMed, Project Muse, and Criminal Justice Abstracts) and a search of the grey literature.

In order to learn about this topic from multiple perspectives, three types of participants were recruited (administrator, healthcare provider, or incarcerated woman) to be interviewed. Jail administrators had to have an official rank within the jail and be familiar with their jail's policymaking procedures. Healthcare providers had to work directly and consistently with the jail—hospital or clinic employees who treated incarcerated patients by chance were not eligible for participation. Incarcerated interviewees were women in custody at the time of the interview. They had to either be pregnant (confirmed by jail staff) or have given birth within the past 12 weeks.

Institutional Review and Informed Consent

Institutional Review Board (IRB) approval was granted by the University of Washington (UW) prior to recruiting any jails. Informed consent was obtained from all participants. Names and identifying characteristics of participants were not recorded. During recruitment, jail administrators were informed that the jail identity would not be disclosed. The UW IRB approved a standard informed consent for jail administrators and healthcare providers, and a short form for incarcerated women. Because the study was considered low risk, signed consent was not required from any participants.

Informed consent was obtained prior to all interviews. Incarcerated participants were asked if they preferred to read the informed consent themselves, have me read it, or read along while I read aloud. All women preferred to have me read the informed consent document to them. I read the informed consent document verbatim, encouraging them to stop me at any time if they had a

question. None of the incarcerated women had questions or concerns about the informed consent. No interviewees declined to answer any questions or ended the interview early.

The IRB considers both pregnant women and institutionalized people as vulnerable populations "that may need special protections or considerations" (N.A., 2020). This study was designed so that participating incarcerated women felt comfortable and appreciated, with the informed consent making it clear that they were autonomous individuals sharing their important experiences.

Sampling and Recruitment

The study utilized a purposive sampling method to select potential jails for participation (Lavrakas, 2008). Purposive sampling was employed in order to have representation from a variety of jails based on location (urban or non-urban); size (small, medium, or large); geography (Eastern, Western, or Mid-Washington); and type of jurisdiction (city, county, or tribal). In order to be eligible for participation, jails had to be within Washington State and had to accept females at their facility. At the participating jails, convenience sampling was used to select interviewees. Once selected as potential participants, jails were recruited using a cold-call approach. Contact information was obtained from the jail or jurisdiction websites. If an email address was provided, a standard recruitment email was sent (Appendix 5). If an email address was not provided, jails were contacted via telephone. For telephone calls, the same recruitment document was adapted for oral communication. In order to recruit incarcerated women for this project, jail administrators were provided with an IRB-approved document that laid out the goals of the project and what participation would entail. On the morning of the interview a jail administrator approached any eligible women and informed them about the study so that they had time to consider participation. Upon my arrival, jail staff asked the women if they wanted to participate. No women declined.

Interview Questionnaire Development

I developed interview questionnaires for each role (Appendices 2-4). The questionnaires were designed to maximize the information gained from each group according to their expertise and experiences. Questions for participants in an administrative role were primarily focused on jail healthcare policies and policymaking procedures, funding, and the challenges of administering care to the jail population. Healthcare providers were also asked about the facility's healthcare policies, with emphasis on how those policies are put into practice. Finally, the questionnaire for incarcerated women included questions about their pregnancy, how they would rate the care they received at the facility, and how the care compared to care they may have received in the past in any setting; if participants had been pregnant more than once, they were asked where they had received care for each pregnancy. After interviews at the first jail were complete, I added questions to capture emerging themes. These questions included more detailed probing about policymaking procedures and funding mechanisms, and a checklist for incarcerated women covering each of the American College of Obstetricians and Gynecologists (ACOG) recommendations (The American College of Obstetricians and Gynecologists, 2012; Appendix 1).

Interviews

Interviews were conducted from October 2019 to February 2020. I conducted all interviews. When possible, interviews took place in-person and onsite. Interviews with jail administrators and healthcare providers ranged from approximately 30 minutes to one hour; interviews with incarcerated women lasted approximately ten to 15 minutes. To maintain confidentiality and adhere to jail policies regarding electronic devices, interviews were not recorded electronically. I took extensive field notes during the interviews, writing down participants' answers to the questionnaire. Responses recorded verbatim were clearly marked in the hand-written notes. The field notes also included descriptions of the jail environment. Field notes were transcribed into an electronic format the day they were conducted. The original written field notes were kept in a locked file cabinet, and electronic transcriptions of notes were stored in a password-secured file.

Qualitative Analysis

A constant comparative method was used to analyze the interview notes. The constant comparative method allows for systematic analysis of qualitative data as well as for the generation of new theories that emerge from the data during analysis (Glaser, 1965, p.437). I conducted the analysis, as well as the interviews. This approach has several strengths and weaknesses. One advantage in this particular project is the preservation of participant anonymity. Bias and overlooked thematic connections are two potential downsides.

To begin, transcribed field notes were uploaded to the encrypted Dedoose web application. Dedoose was selected because it is robust enough to record and organize a large number of distinct codes. Open coding—the process of identifying and defining relevant words, phrases, and ideas in the data—was used to uncover themes within and across interview categories. For the first iteration of coding, interview data were divided into three categories: administrators, healthcare providers, and incarcerated women. This delineation of participants was used to identify themes within the specific roles the participants play in the carceral healthcare system and to determine similarities and differences between each of them. I looked for information about the specific care provided or received in accordance with ACOG guidelines, and the things that motivated or hindered that care. In the second iteration of coding, interviews were coded by jail. The goal of this portion of the analysis was to determine factors specific to each jail that affect healthcare policy, and to compare themes across the four participating jails. In this stage of coding, I was looking for either confirmations or discrepancies within jails based on their stated policies compared to the care they provided to women. A total of 53 codes (17 root codes and 36 nested "child codes") were formulated. The codes consist of words, phrases, and ideas that recurred throughout the interviews.

A Note on Ensuring Anonymity

As participant anonymity is critical for this research, I took several steps to ensure it in the Results section below. First and foremost, names and obvious identifying characteristics of jails have been removed or anonymized. This includes not only county and city names but also the specific ranks of jail administrators; the names of privately contracted organizations that provide healthcare; and the specific number of beds in each facility. Second, although Table 1 provides information about each of the four participating jails and who was interviewed at each, direct quotes are not coupled with an attribution. Sacrificing some cross-jail comparisons for enhanced privacy protection is a trade-off I decided to make because the sample is so small that such

comparisons would not yield significant data, but the risk of compromising participant identity is a significant one.

Results

Overview

This model (Figure 1) illustrates the dynamics of how healthcare is provided to women within the jail setting, and how what happens in jail can continue to affect women's healthcare upon and after release. The model shows that the motivations and goals of staff and incarcerated women and the constraints limiting how completely those goals can be realized plays out entirely within the jail; however, the jail setting is influenced by the greater community in which it exists. The constraints (described in greater detail in the following section) interrupt the ideal healthcare that would be administered to women in jail, and the impacts of those constraints can influence the trajectory of women's healthcare-seeking behaviors and ability to access care once they are released.

The three domains included in the model are the jail setting, the motivators and goals of incarcerated women, and constraints. The jail setting includes the characteristics of the jail that make it distinct from other healthcare providers and health setting in the community. The motivators and goals of the staff and incarcerated women differed within each group, but the primary aim of most participants was to administer or receive appropriate, quality care. What constituted such care varied by participant. The constraints include challenges such as inadequate funding, staff shortages, and tension between incarcerated women and the people responsible for their healthcare while they are in custody. As shown in the model, all of these factors complicate the task of providing healthcare to incarcerated pregnant and postpartum women. Understanding the relationship between these three domains is important when examining the healthcare that women receive while in jail and after release.

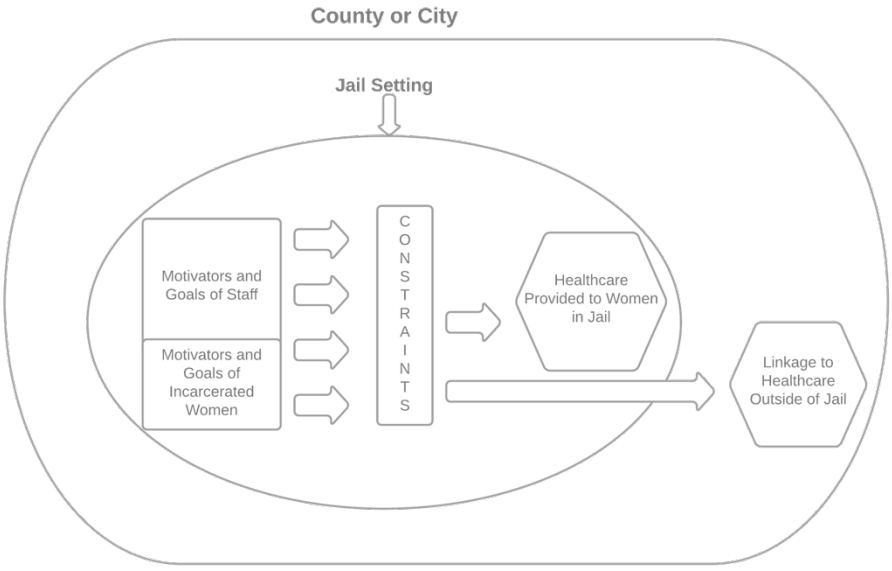

Figure 1: The three domains of healthcare in jail (Setting, Motivators, and Constraints) that lead to the outcome, the healthcare provided to women.

Interviews and Interview Environment

Within these four jails, ten administrators and healthcare providers participated. The jail administrators interviewed included three Lieutenants, one Senior Corrections Officer, and one Chief. The healthcare providers interviewed included one medical doctor, one physician's assistant, two Health Services Administrators, and one Director of Nursing. Of the ten jail administrators and healthcare providers interviewed, only two were women. Interviews with administrators and healthcare providers were conducted in person; three took place over the phone. I visited three out of four participating jails in person. At the first jail, the interview with the administrator took place in their office; the interviews with the healthcare providers were conducted at a nearby clinic where they worked, since the jail did not have an on-site clinic. At the second jail, the interview with the healthcare provider took place in a large office room. I conducted two follow-up interviews via phone with two administrators who were not at the jail on the day I visited. At the third jail, the interview with the jail administrator took place during a walking tour and concluded in their office; the interviews with the healthcare providers were conducted in their office in the medical area. The administrator of the fourth jail informed reported that they were unlikely to have any pregnant females in custody, so they were interviewed over the phone.

All incarcerated women were interviewed in person. One woman was interviewed at a semi-private seating area with a table. Two women were interviewed outside of their medical pods, each of us seated in a plastic chair facing one another with no table. During all three interviews, a corrections officer was seated approximately 10-20 feet away, within listening and watching distance but appearing to give us privacy for the duration of the interviews.

Table 1. Summary of interview participant role and interview setting

Jail	Role	Interview Setting
#1 (total interviews = 5)	Administrator	Office
	Healthcare Provider	Office within clinic
	Healthcare Provider	Office within clinic
	Incarcerated Woman (pregnant)	Clinic, outside pod
	Incarcerated Woman (pregnant)	Clinic, outside pod
#2 (total interviews = 4)	Administrator	Phone
	Administrator	Phone
	Healthcare Provider	Office
	Incarcerated Woman (postpartum)	Meeting area
#3 (total interviews = 3)	Administrator	Office
	Healthcare Provider	Clinic, separate from jail
	Healthcare Provider	Clinic, separate from jail
#4 (total interviews = 1)	Administrator	Phone

Domain 1: Characteristics of the jail setting.
Each jail in Washington is distinctly different, but they all share characteristics that differentiate them from other institutions like prisons or psychiatric hospitals. Jails function more like fiefdoms than uniform facilities; because the Revised Code of Washington's (RCW) few statutes about providing healthcare in jail facilities do not include many concrete rules about what healthcare must entail, the day-to-day operational policies are largely decided by the county, tribe, or city responsible for the facility (RCW, 2020). Taking people into custody in jail was described as a "revolving door" because the average stay is so short, usually between two to three weeks. Understanding the jail healthcare setting is a foundational first step for any research or intervention, because with the jails' unique characteristics come unique public health issues and concerns.

1a. Temporality
The average jail stay in Washington across all facilities is 14.98 days (Washington Association of Sheriffs and Police Chiefs, 2019). At the jails that participated in this project, the average stay ranged from 8.5 – 19 days. This is a very limited window of time to provide healthcare. In interviews with jail administrators and healthcare providers, the time crunch was a recurring theme and something that multiple people emphasized.

"Most incarcerated women do not stay in jail long enough to be connected to prenatal or postpartum healthcare with [the privately contracted provider]."

"Women generally are not incarcerated long enough to get postpartum care…"

"The average stay is nine days."

However, even though the average individual stay is short, many people do pass through the same jail multiple times. The complex intersection of care and carceral punishment leads to situations like the one described by a veteran jail administrator, reporting that now there is "*the third generation coming through jails. You get to know these people and their stories…*" The challenging relationship dynamics between inmates and staff is discussed further in Domain 3.

1b. Discretion
During analysis of the interviews, one word kept recurring: "prefer." Jail administrators and healthcare providers at all four facilities told me that they were free to make decisions about healthcare as they preferred. This of course affects the healthcare provided to incarcerated people—as put by one interviewee, if a woman is arrested 100 yards on either side of a county line, their care could be entirely different. Within jails, critical healthcare decisions for pregnant and postpartum women are almost always left up to the preference of the responsible party (with the exception of the few strict statewide rules, such as no shackling during labor):

"The jail shows a preference for EHM (electronic home monitoring) for this population when appropriate."

"If a woman is pregnant and out of control, we prefer a chemical sedative to physical."

"With MAT (medication-assisted treatment), we prefer to use buprenorphine."

"Sometimes [other facilities] will let high-needs cases go on personal recognizance. They try not to do elective procedures when someone is in custody, so they might let them out to pursue that procedure. Some jails would just put it off and put it off, but [we] prefer to use our method."

For the most part, interviewees felt comfortable responsibly wielding this power. Giving so much discretion to individuals in the system leads to uneven and inconsistent provision of services within and across facilities, such as some facilities using the Clinical Opioid Withdrawal Scale (COWS) and some not; some testing for HIV and some not; some isolating pregnant women and some not; some providing breast milk pump equipment and some not.

1c. Atomization

Although jail authorities do exercise a significant amount of discretion in their jobs, they are accountable to the jurisdiction and have to follow policies handed down by governing officials. Usually, representatives from the jails are involved in this decision-making and their concerns are addressed. This kind of decision-making happens all over Washington State, with dozens of separate counties, cities, and tribes making policies within their area. There are several often-overlapping concerns among the primary stakeholders involved in running the jail. Usually the relationship is harmonious, but it can result in complicated bureaucratic bottlenecks and disagreements. If a jail is using privately contracted healthcare services, the company's policies will also be in effect within the jail.

"Elected officials are responsible for determining the budget. There are three county commissioners; one definitely understands, but two, I'm unsure."

"The contract was first presented to the Board of County Commissioners, then the legal team, then the correctional officers and lieutenant. They had process discussions and eventually went with [the current privately contracted organization's] bid."

"[We use a] private contract. The county sought them out, they put in a bid."

1d. Collaboration

While jails do not operate under a shared set of policies or authorities, they nonetheless communicate and work together to address shared concerns and to stay updated on trends and innovations.

"The networking is vital; what we're experiencing, others are experiencing."

Jail administrators recognize that their facilities cannot always meet the needs of pregnant incarcerated women, so they utilize resources outside the jail to supplement their existing healthcare programs. All four jails mentioned the involvement of local community clinics and programs, ranging from the city to the state level. This mainly applied to treating substance

abuse disorders and healthcare issues that they are not equipped to handle, and helping incarcerated people have a smooth re-entry after they are released from custody.

"We communicate with [a] clinic in town, and the staff sets up an appointment prior to release, provides the prescription to continue MAT, and takes care of transportation hurdles…We can actually refer inmates to [several local programs and clinics]. [At one], they have a 'navigator' to help reactivate Medicaid."

"If the woman is pregnant, she is referred to the local rural health clinic and a Nurse Practitioner will come to the jail to administer pre-natal vitamins, etc."

"The jail supports the care, but in the end, it's the local clinic that provides it. It is the same with pregnant women and non-pregnant inmates alike."

"*The jail is one of the biggest treatment centers-slash-clinics in the county. We got funding to implement our own MAT program and it has been a great success. Formerly, we just did detox."*

Domain 2: Factors influencing decision-making among administrators and healthcare providers: motivators, goals, and concerns.

Just as jails are similar to typical healthcare settings in some ways and vastly different in others, so are the things that motivate and inform the choices made by administrators and healthcare providers who work there. Interviewees wanted to provide quality care for the people in their custody. But because it is not always possible to provide everything to everyone, they have to weigh the costs, benefits, and risks when making policy or day-to-day decisions.

2a. Protection from liability

The biggest perceived risk to most jails is liability. Although none of the participating jails have been subject to any major lawsuits regarding healthcare within the last few years, all interviewees were aware of ongoing litigation against facilities across the state. Pregnant women especially are a liability because so much can go wrong.

"Our role is to make sure they finish the sentence healthy…"

"*We always err on the side of believing them—in the mindset of administration, there is a cost-benefit analysis to erring on the side of caution—but sometimes women are not honest."*

"The mindset of the command staff is that they want to do their best to ensure the woman and fetus are safe…They get treatment, but they are also responsible for what got them in jail. But still, the staff want the best care for them."

Policies—on the level of the jail and the privately-contracted healthcare provider organization, when applicable—are designed with liability in mind.

*"We follow Prison Legal News. We used to use LexiPol but switched to Power DMS."**

"We have an 'inmates first' perspective. We take on the liability for the jail…[we] ensure that we maintain NCCHC accreditation and compliance and meet contractual obligations to [the facility]…[Pregnant and postpartum women] are screened for suicidality et cetera and if they score above six, corporate is notified—potential liability issues."

"If someone is putting themselves or others in danger, and we think medical sedation is necessary, we have to have two separate people sign off on administering the medicine just in case."

"Usually we do pump and dump; there are liability issues about the safety of breastmilk."

"We revise the policies every few years, adding more questionnaires. About eight or nine years ago we added mental health questions and Prison Rape Elimination Act components."

"Staff has to read and sign off on every new [policy] update, and all staff also have to sign off on a training form. If a female comes in and she is close to labor, we advise the staff to take complaints about pain or blood seriously."

If possible, the participating administrators reported that they do not want to book pregnant women into custody at all. Interviewees acknowledged that this group was both high risk and expensive to care for. Providing accommodations like lower bunks, no stairs, or isolated cells is necessary but increases the workload for staff.

"[This facility] does not take females who are in their third trimester, as policy: 'Third trimester, they're out of here.'"

2b. Perceived urgency and/or cost-effectiveness of healthcare procedure

Upon booking, many people need medical treatment of some kind. Life-threatening or very serious conditions are prioritized for immediate treatment. Potential opiate withdrawal, especially among pregnant women, is one such condition. However, other pregnancy- or postpartum-related issues like mental health treatment, prenatal exams, and contraception are given much less attention. Although all three examples listed do have serious long-term ramifications for a woman's health and wellbeing, long-term problems are generally not the jail staff's priority. All jails did test women for pregnancy, perform an initial mental health screening, manage withdrawals, and provide prenatal vitamins. No jails provided contraception.

"No, there is no psychiatric care in the contract with [the privately contracted organization]."

"[We] do emergent care only. There is no dental, et cetera."

* *LexiPol and Power DMS are two services that offer software, consulting, and educational resources for groups such as law enforcement, business, and fire & rescue. The goal of these services is to ensure compliance and reduce risk and liability for paying subscribers.*

"If a woman reports [a mental health crisis], mental health will meet her sooner rather than later. Staff might also report behavior. Then the provider can give a prescription. Lots of them just want to talk. But with mental health, we have to triage. A lot of times, you're reacting."

"Contraception is not provided in custody; we can give a care referral but to us, that is going above and beyond and the cost is not justified."

"We do not test for Hep C, because the average stay is so short and it is so expensive to treat."

Domain 3: Constraints

The challenges that jails report facing are not something that jail administrators and healthcare providers can overcome on their own, as most are rooted in inadequate resources resulting from policies decided on the local or federal level. Participants reported that resource constraints stand in the way between jail staff and the ideal care that they would like to provide to incarcerated pregnant and postpartum women. Interpersonal interactions can also prove challenging in a carceral setting; this topic came up in almost all interviews with both staff and incarcerated women.

3a. Financial challenges

Three out of four jails reported that they did not have adequate funding for healthcare. Administrators at those three jails said that they do their best to remain within the budget, often coming up with creative solutions to save money, but sometimes the cost goes over the limit or they cannot provide non-essential care.

"The funding is never enough, but we do our best to make it go as far as possible and cover what we need to."

"Every year, the medical budget goes way over what is projected and funded by the county."

"[Our county] is a poorer county and can't accommodate things like on-site methadone treatment."

"It can be tough. You can always want more, but in this milieu it is adequate"

3b. The Medicaid Inmate Exclusion Policy (MIEP)

People who are on public insurance—the majority of incarcerated people—lose their insurance coverage when they are taken into custody. This creates challenges for administrators and incarcerated women alike. At every participating jail, insurance was a topic of discussion. Specifically, administrators talked about how federal regulations, MIEP, require public insurance to be suspended immediately when someone is booked into custody. Women might fail to request or even refuse care while in custody due to the cost. Jails try to do what they can to reduce the financial burden on women. Furthermore, it can take several days for insurance coverage to be reinstated, which frequently compromises women's wellbeing post-release. Multiple administrators and healthcare providers discussed the difficulty women face accessing

care and medicine upon release, especially continuing the MAT programs they participated in while incarcerated.

"Nearly 80% of the inmate population has healthcare issues, a large amount. The question we have to deal with is how much the inmates should foot for their healthcare costs versus how much the taxpayers should foot, since all state benefits end when someone is incarcerated—a federal law."

"Almost everyone is on Medicaid, upwards of 90%. At one point [the administrative staff] conducted a survey and only three people out of several hundred were not on Medicaid."

"Medicaid suspension is an issue for everyone. The logistics are challenging…"

***"**For people with chronic or urgent conditions, the reinstatement waiting period could be problematic."*

3c. Staffing shortages

As shared by interviewees, finding enough staff members to carry out all of the medical needs for incarcerated people is difficult for several reasons. First, of course, is the financial aspect. Providers working in carceral health might be paid less, and in counties and cities that are already strapped for funds, offering higher salaries as an incentive is not feasible. Second, it is a challenging work environment; although healthcare providers do not get as much verbal abuse as corrections officers and they encounter virtually no physical danger, interviewees reported that the conditions and patients they see can be distressing.

"We tell the medical and mental health staff that they will see everything."
"[Jail leadership] would be interested in providing long-acting reversible contraceptives or utilizing a mobile medicine van, but this requires more funding, more staffing of nurses and officers, et cetera."

"The obstetrician outlines the care. We follow the plan as much as possible, tailoring it to the capabilities of the jail. For example, if someone needs physical therapy three times per week, we will have them go three times for the first two weeks, learn how to administer it themselves, then cut it down to once per week because we don't always have enough staff for transportation. We want to do what is realistically optimal."

"Formerly we used [another privately contracted organization], but they were not satisfactory. There were discrepancies, theft, and it was difficult to have good staff."

3d. The inherently (but not always) adversarial relationship between incarcerated people and jail staff

As referenced above, and seen in several excerpts from interviews, there is some mistrust of incarcerated people by jail administrators and healthcare providers. Women in custody are there against their will, and they must rely entirely on jail staff to meet their needs during an intense period of heightened health risk. They have different ideas of success, and do not always agree on what is fair or right in terms of treatment—both interpersonal and medical.

"There are many intersecting issues like manipulation, recognizance, and trust. Administering care in this setting is challenging in many ways but rewarding too. It is difficult not to become somewhat cynical over time."

Incarcerated women reported negative experiences with staff and care as well.

"I would give the detox a 5, the housing a 0… I've been pregnant nine times, this is the tenth. I was pregnant in [another jail]. I wasn't locked down [there]. I'm stressed out enough. Here I'm being isolated, depressed, not able to talk to anyone, no exercise, confined to my cell."

"[I] feel like they don't go out of their way to be mean but some staff are nicer than others. Being pregnant can cause them to treat you different…Sometimes the staff make fun of me or put me down. I'm unsure of my resources as a pregnant person here."

"I wish they would be more thorough about my pregnancy."

But the relationship between incarcerated women and jail staff is not always outwardly contentious. Both staff and incarcerated women recognize that time in custody is an opportunity to provide and access care, respectively. Additionally, over time, staff get to know the people in custody. This is a complex, multifaceted issue and in no way means that the system is working as it is—but, it is more complicated than it may seem to outsiders.

Illustrative Quotes

This table shows examples of quotes that fit each specific domain. This table is included to provide additional insight into the qualitative analysis process, as well as to highlight some disagreements in certain domains between different interviewees.

Domain	Illustrative Quote	Notes
1. Characteristics of the Jail Setting		
1a. Temporality	*Most incarcerated women do not stay in jail long enough to be connected to prenatal/postpartum healthcare with [the contracted provider].*	
1b. Discretion	*I feel more free without contracted services. They would not fit our needs…I don't feel they're necessary.*	This administrator was in the minority, as most other participants preferred contracted services.
1c. Atomization	*All of the shares of [the contracted healthcare provider] are owned by the company, not traded publicly. Policies are internal and*	A healthcare provider described how the company they have a contract with operates in a relatively

	employees have to agree to a certain non-disclosure agreement.	private way, largely shielded from public prying.
1d. Collaboration	*We aren't in communication directly with other jails about healthcare. However, the Washington State Association of Sheriffs and Police Chiefs has a liaison who keeps the jail administration and chiefs up to date; he is the hub of all jails in Washington. We all meet in the Spring and Fall every year, and the liaison prepares an agenda of what our most pressing topics are.*	
2. Factors influencing decision-making among administrators and healthcare providers: motivators, goals, and concerns.		
2a. Protection from liability	*We take on liability for the jail.*	A healthcare provider with a privately contracted company explaining that their organization takes on liability, a feature that is attractive to administrators who are concerned about liability risks.
2b. Perceived urgency and/or cost-effectiveness of healthcare procedure	*Everyone is depressed in jail.*	This was said in response to a question about screening for postpartum depression, and why it is not prioritized.
3. Constraints		
3a. Financial challenges	*Even then, when [the cost charged by the contracted provider] was decreased, it took time and education to get it past the [local policymaking body]. We educated them about liability, and how spending money up front saves money in the long run.*	A jail administrator described the negotiation process with the local policymakers when the facility switched to a different contracted provider. The policymakers wanted to spend as little as possible on the jail, but eventually reached a compromise.

3b. MIEP	*[Members of state-run health organizations] met and discussed ways to reduce barriers for MAT further. It turns out that pharmacies can be retroactively repaid after someone's insurance is reinstated. They were not willing to take IOUs from us, but once they talked to the [state-run organization], they were willing to be paid retroactively. We now have, on average, a 24-hour activation period for Medicaid reactivation.*	This administrator described working with public health and state employees to try to reduce the barrier faced by people who are uninsured upon release.
	I do want to continue the methadone when I'm out.	One of the incarcerated women shared her desire to continue her MAT program upon release. MIEP complicates that.
3c. Staffing shortages	*Lots of [people who request mental health treatment] just want to talk. But with mental health, we have to triage. A lot of times, you're reacting. The provider can only see approximately ten people per day, so people might have to be bumped if there's an emergency. We tell the medical and mental health staff that they will see everything.*	This was a common challenge for administrators and healthcare providers. Simply put, the demand for care—especially mental health treatment—often overwhelmed the supply.
	I am still waiting for a second surgery for hemorrhoids.	An incarcerated woman described the pain and discomfort caused by her condition, and the healthcare staff is aware as well, but at the time of the interview she was still waiting for treatment.
3d. The relationship between incarcerated people and jail staff	*In some ways, when people are here they are a captive audience. They have free will, and we give them options.*	

Discussion

All interviewees shared valuable information and their combined responses painted a picture of a fragmented yet interconnected system. It is difficult to work in a jail, and of course it is challenging to be incarcerated within one. Providing healthcare for pregnant and postpartum women in Washington jails is made even more challenging by myriad factors. Some of these are unique to specific counties or cities while some are shared by all participating jails. As shown in the model (Figure 1), the characteristics of the jail setting, motivators and goals of both jail staff and incarcerated women, and the constraints faced within jail combined result in the care women receive within the facility and outside its walls. When making healthcare decisions for people in their custody, healthcare providers and administrators across participating jails had many of the same motivations driving their actions. While many healthcare decisions are made in the moment within jails, policy is decided on the county or city level with input from multiple, sometimes disagreeing, stakeholders; the issue is further complicated when jails have privately contracted healthcare providers who also exercise control over jail policy. The relationships between jail staff and incarcerated women are complex and, although there are many valid and critically important criticisms of jails in general, the administrators and providers do genuinely want to do what they understand to be best for the women in their care, to the greatest of their ability.

One of the reasons that jail healthcare was chosen as the focus for this thesis was because a relatively substantial amount of research has already been conducted on this issue in prison settings. This research revealed that there is far less uniformity in the care that participating jails provide to women than there is within state or federal prisons. Additionally, while some jails did track the number of pregnant women who passed through their facility, existing research reviewed in the Introduction suggests that prisons tend to collect more data about pregnancy within their walls. This is likely due to the fact that prison sentences are generally at least one year in length, so the time constraints that pose a challenge for jail staff when housing pregnant and postpartum women simply do not exist in a prison setting. Participating jails also tried to avoid performing elective procedures, thereby completely avoiding the controversial issue of sterilization in custody.

The number of pregnant and postpartum women within the four participating jails was also lower than I expected based on the existing, albeit scarce, data on pregnancy in other jails. Two of the jails had zero pregnant or postpartum women in custody; while that was not surprising in the smallest jail, the second-smallest jail had about 10-15 women in custody at the time of the interview, meaning that at that moment in time their numbers aligned more with the recent findings of Bronson and Sufrin (2019) than ACOG estimates (2012). However, jail administrators and healthcare providers did frequently remind me that that number could change at a moment's notice without warning. All administrators were considerate in warning me of this before I visited, making sure I understood that they could not promise any interviews with incarcerated pregnant or postpartum women. The rate of unplanned pregnancy in Washington State is significantly lower than many other states, potentially affecting the number of pregnant and postpartum women in custody (Guttmacher Institute, 2016).

Geography is important to consider for other reasons when discussing these findings—Washington State is more progressive in its approach to incarceration than many other states. For example, in the survey conducted by Kelsey et al. (2017) of jails across the US, the authors found that fewer than half of the participating facilities screened women for pregnancy, and 56.7% reported the use of physical restraints during or shortly after birth. While screening for pregnancy is not mandatory in Washington, all four participating jails reported screening any woman who could be pregnant. Shackling women during labor is illegal in Washington, and all participants reported that they never do it: One healthcare provider made it very clear that they do not even *condone* shackling during labor, and an administrator found the idea that a woman in active labor would be dangerous or escape-oriented laughable.

There were several limitations to this study. The most important is the small, geographically limited sample. The participating jails are potentially not representative of jails as a whole in Washington State. Only two of the four jails were housing pregnant or postpartum women at the time of the interview, which made it impossible to compare the term-specific experiences of women across jails. Additionally, there are pregnant and postpartum incarcerated people whose experiences are not reflected in this small sample. One group is transgender or gender non-conforming people. While they make up a small percentage of an already-small population, making it impossible to include them in this small study, their experiences matter and providing them appropriate treatment is likely even more challenging than providing it to cisgender women. I am happy that none of the incarcerated women I interviewed reported serious medical harm. However, medical harm does happen to pregnant and postpartum women (and gender non-conforming people) in jail; numerous lawsuits have been filed in recent years against jails across the country alleging serious negligence, such as a woman who was forced to give birth alone in her cell in Niantic, Connecticut, and five women at the same Allegheny, Pennsylvania jail who were placed in solitary confinement while pregnant with no access to prenatal care (Kovner, 2019; Ward, 2016). There are likely even more cases that are never reported. And while there is limited research on pregnant adult jail populations, there is even less regarding youth in detention centers. One report shows that 4.8% of female minors admitted to a Los Angeles county jail were pregnant upon booking (Los Angeles County Board of Supervisors, 2018). Further research on these specific topics is crucially needed.

Adding to the limitations, all statements included in this paper were self-reported by interviewees. I did not verify these responses or review documents to check their accuracy. The data collection would be strengthened by having audio recordings of the interviews. Another limitation was the lack of additional coders contributing to the thematic analysis. I did not triangulate the development of the codes with others for several reasons, including time constraints and concerns about participant anonymity. Since I conducted both the interviews and the analysis, my perspective could have biased the qualitative analysis; a second coder who did not conduct the interviews might have analyzed the "cultural meanings" of the qualitative data differently, and would have a different perspective as they were not involved in "the interview as a social situation" (Neuman, 2015, p. 353).

Despite the limitations, this formative research project yielded information that can be useful to future researchers. First and foremost, it highlights the need for increased research on this topic as a whole. There must be more research on how many pregnant women pass through the jail

system, and what the current healthcare practices are in jails in Washington and across the US. Additionally, this is fertile ground for implementation science research. Implementing programs in jails for pregnant and postpartum women could significantly improve outcomes for these women. But because the jail setting does involve challenges atypical of most public health settings, research is needed on how to best implement such programs within jails. Interventions such as a diabetes and HIV education programs, opt-out (rather than opt-in) screening, and of course the MAT programs in Washington State demonstrate that successful implementation of health-focused programs in jails is possible (Davoust et al., 2016; Magura et al., 1994; Malek et al., 2011; Grande and Stern, 2018). It is possible to adapt and draw on what has already been done; researchers can learn from non-pregnancy-focused health interventions that have already been shown to work in jails and modify them to target prenatal and postpartum healthcare instead. Additionally, energy should be focused on how to increase community collaboration with jails. As reported by interviewees, jails can end up being some of the largest healthcare providers in certain counties. Ensuring that people are linked to care, that they have access to what they need with guaranteed continuity, is a public health goal worth working towards. Finally, this research demonstrates the need for policy analyses focused on MIEP, a harmful and inhumane policy designed to strip insurance coverage from the people with the greatest need for it.

While this thesis project is small in scope and merely formative in its goals, it is part of a growing field of research on the increasingly relevant topic of pregnancy and postpartum healthcare in jails. It is my hope that this body of research continues to expand, and that healthcare for incarcerated people becomes a larger focus in the field of public health as a whole. There are many ways to move forward. To begin, in addition to the next steps for research described above, Washington State should incentivize public health professionals and jail administrators to collect and share surveillance data on the pregnant incarcerated population across the state. Washington could consider adopting a statute that establishes mandatory standards for pregnancy and postpartum care that implements existing best-practice guidelines. In tandem with that recommendation, the State could provide funding to jails for policy training programs and establish a statewide fund specifically for medical care for pregnant and postpartum women in jail, so that jails do not have to strain budgets to provide adequate care and so that women do not have to pay out of pocket. While these participating jail administrators and healthcare providers all genuinely seemed to be trying their best for the people in their custody, the care received by incarcerated people compared to the non-incarcerated population is, on average, still deeply inequitable. Systemic change is necessary, and that change can start with small legal and research-based steps—even ones as small as this thesis.

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Appendix 1: ACOG Recommendations Table, adapted from ACOG online statement.

Table 1. Recommended Care for Incarcerated Women and Adolescent Females

Type of Care	Adult Jail or Prison*	Juvenile Facilities
Entering facilities	Ask about any current medical problems and care and safety of minor children at home.	Same as in adults, but also screen for eating disorders
	Obtain a medical history—immunization status; sexual activity, contraceptive use, and menstrual cycle to assess the need for a pregnancy test; number of pregnancies and outcomes; history of medical problems, chronic illness, hospitalizations, breast disease, and gynecologic problems; and domestic violence, sexual abuse, and physical abuse	Same as in adults
	Mental health assessment	Same as in adults, bearing in mind that adolescents in correctional facilities are at higher risk of suicide than those in the general population
	Physical examination†—pelvic and breast, Pap test, and baseline mammography based on College guidelines In a jail setting, Pap test and mammography should only be done if there is enough time to obtain results before release.	Same as in adults, except mammography and Pap test are unlikely to be needed. Pap test should be performed on adolescents according to College recommendations.
	Laboratory work—STIs, HIV, pregnancy, hepatitis, and tuberculin skin tests based on College guidelines In a jail setting, tuberculin skin tests should only be done if incarceration is expected to be for at least 48 hours to see if any reaction occurs.	Same as in adults
Pregnancy care	Pregnancy counseling, perinatal care, and abortion services should be offered based on College guidelines	Same as in adults
Preventive care	Any additional tests, examinations, and care based on College guidelines	Same as in adults
	Health education on contraception and pregnancy; tobacco, alcohol, and substance abuse cessation; and parenting	Same as in adults
	Comprehensive HIV and STI treatment and prevention programs	Same as in adults, bearing in mind that adolescents are at higher risk of STIs than the adult population
	Contraceptive services, including emergency contraception, based on medical need or potential risk of pregnancy	Same as in adults
	Provide immunizations as necessary based on College guidelines, with particular focus on influenza and pneumococcal vaccination	Same as in adults, but with particular focus on HPV, meningococcal, and influenza vaccination
Care for older women	Hormone therapy, if indicated	Not applicable
	Screening, treatment, and prevention programs for osteoporosis	Osteoporosis prevention programs may be useful
	Screening for depression and dementia	Screening for depression
Mental health care	Medication management, suicide prevention, crisis intervention, substance abuse programs, and linkage to social services and community substance abuse programs upon release	Same as in adults, noting that incarceration is a risk factor for suicide among adolescents

Abbreviations: College, American College of Obstetricians and Gynecologists; STIs, sexually transmitted infections; HIV, human immunodeficiency virus; HPV, human papillomavirus.

*If a juvenile is housed in an adult prison or jail, the recommendations under the juvenile facilities column should be followed.

†The request by either a patient or a physician to have a chaperone present during a physical examination should be accommodated regardless of the physician's sex.

Data from Anno BJ. Correctional health care: guidelines for the management of an adequate delivery system. Chicago (IL): National Commission on Correctional Health Care; 2001. Available at: http://static.nicic.gov/Library/017521.pdf. Retrieved April 16, 2012; American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 6th ed. Elk Grove Village (IL): AAP; Washington, DC: ACOG; 2007; American College of Obstetricians and Gynecologists. Guidelines for adolescent health care. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2011; American College of Obstetricians and Gynecologists. Guidelines for women's health care: a resource manual. 3rd ed. Washington, DC: ACOG; 2007; American College of Obstetricians and Gynecologists. Well-woman care: assessments and recommendations. Washington, DC: American College of Obstetricians and Gynecologists; 2012. Available at: http://www.acog.org/~/media/Departments/Annual%20Womens%20Health%20Care/PrimaryAndPreventiveCare.pdf?dmc=1&ts=20120419T1033428879. Retrieved April 19, 2012; American Public Health Association. Standards for health services in correctional institutions. 3rd ed. Washington, DC: APHA; 2003; Cervical cancer in adolescents: screening, evaluation, and management. Committee Opinion No. 463. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;116:469–72; Health care for pregnant and postpartum incarcerated women and adolescent females. Committee Opinion No. 511. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:1198–1202; National Commission on Correctional Health Care. Standards for health services in jails. Chicago (IL): NCCHC; 2008; National Commission on Correctional Health Care. Standards for health services in juvenile detention and confinement facilities. Chicago (IL): NCCHC; 2004; National Commission on Correctional Health Care. Standards for health services in prisons. Chicago (IL): NCCHC; 2008; *and* Health care for youth in the juvenile justice system. Policy Statement. American Academy of Pediatrics. Pediatrics 2011;128:1219–35.

Appendix 2: Questionnaire for Jail Administrators

1. Please tell me about your position and responsibilities at the jail.

2. If possible, could you please tell me how many women are currently in your care and how many of them are pregnant?

3. Does this jail currently have policies related specifically to prenatal and postpartum care for inmates?
    a. If so, how were they decided?
        i. How often are they revised?
        ii. How is the staff trained in these policies?
        iii. How is policy adherence monitored?
    b. If not, why not?

4. How is health care at the jail funded?
    a. Does the funding level feel sufficient to meet the jail's needs?

5. Is care is contracted out?
    a. If so, how was that organization chosen?
    b. If not, why not?

6. Who is in charge of overseeing the healthcare at your jail?
    a. Who manages it on a day-to-day basis?
    b. Who has control when policy changes are needed? When difficult situations arise?

7. Are you familiar with the American College of Obstetricians and Gynecologists' recommendations for care for incarcerated pregnant women?

8. Are all women screened for pregnancy upon entry?
    a. How was that decision made?

9. Are all women screened for sexually transmitted infections upon entry?
    a. How was that decision made?

10. If a woman is less than 24 weeks pregnant, is she able to get an abortion?
    a. If so, how is that handled?

11. Does the jail have any policies regarding how to manage opioid withdrawal during pregnancy?

12. Is there a policy for procedure when an inmate goes into labor?
    a. Transportation to hospital
    b. Presence of jail custodians during birth
    c. Family visitors
13. Are restraints are used on inmates when they are in labor?
    a. What kind?
    b. Is this decided based on policy, personal judgment, or both?

14. What is the policy for procedures after birth?
    a. How long does the inmate remain in the hospital?
    b. What kind of care does she receive once she returns to jail?

15. Does the jail have a policy to monitor women for postpartum depression after they give birth?

16. Are women guaranteed access to contraception through the jail after they give birth, or upon release?

17. In your experience, if a woman is pregnant, does that change her experience at the jail compared to non-pregnant women in custody?

18. How are your experiences here different from places you have worked in the past?

19. Does your jail communicate with other jails regarding their healthcare policies?

20. Thank you so much for your time. Is there anything you would like to add before we wrap up the interview?

Appendix 3: Questionnaire for Jail Healthcare Providers

1. Please tell me about your position and responsibilities at the jail.

2. If possible, could you please tell me how many women are currently in your care and how many of them are pregnant?

3. Do you work for the jail itself, county/city/tribe, or private organization?

4. Do you screen women for pregnancy and STIs upon admission?

5. What is the procedure when an inmate has a miscarriage? (turned into umbrella question about avoiding or terminating pregnancy)
    a. Have you dealt with / heard about this happening at your jail?
    b. If this is something you've witnessed or had to provide care for, would you tell me how the jail handled it?

6. How do you manage opioid withdrawal during pregnancy?

7. What tests are conducted to determine if a woman has a high-risk pregnancy?
    a. If the pregnancy is high-risk, what / if any precautions are taken?

8. What is your role when an inmate goes into labor?
    a. Have you ever seen someone shackled during labor?

9. Does the jail have a policy to monitor women for postpartum depression after they give birth?
    a. If so, what signs do you look for?
    b. What kind of care for postpartum depression is available?
    c. Do you think that postpartum depression is a serious issue for inmates?

10. What other postpartum care is available for incarcerated women?

11. Have you ever had a dispute with administrators regarding policies for incarcerated pregnant or postpartum women?

12. Do women have access to contraception through the jail after they give birth, or upon release?

13. How are your experiences here different from places you have worked in the past?

14. Is there adequate funding to administer all the care you feel is appropriate?

15. Thank you so much for your time. Is there anything you would like to add before we wrap up the interview?

Appendix 4: Questionnaire for Incarcerated Pregnant and Postpartum Women

1. How far along are you in your pregnancy, or, how many weeks ago did you give birth?

2. How would you rate the quality of your care here in the jail on a scale of 1-5, 1 being very bad and 5 being very good?
    a. What did you like?
    b. What did you dislike?
    c. What would you change?

3. Have you ever received care for pregnancy besides now?
    a. If so, where?
    b. How did it compare to the healthcare you're getting here?

4. At this jail, did they…

Upon Intake

- Assess for pregnancy risk by inquiring about menstrual history, heterosexual activity, and contraceptive use and test for pregnancy as appropriate?
- Screen for depression or mental stress and treat as needed?

During Pregnancy

- Provide pregnancy counseling and abortion services?
- Provide perinatal care?
- Assess for substance abuse and initiate treatment; prompt initiation of opioid-assisted therapy with methadone or buprenorphine is critical for pregnant women who are opioid-dependent?
- Test for and treat human immunodeficiency virus (HIV) to prevent perinatal HIV transmission?
- Provide dietary supplements?
- Deliver services in a licensed hospital that has facilities for high-risk pregnancies when available? Shackling?

Postpartum

- Provide postpartum contraceptive methods during incarceration?
- Perform a mental health screening and provide care if necessary?

1. Thank you so much for your time. Is there anything you would like to add before we wrap up the interview?

Appendix 5: Recruitment Email for Jails

"Dear [recipient],

Hello, my name is Kathleen Wright. I am a second year Master of Public Health student at the University of Washington School of Public Health in Seattle. My concentration is Health Services and Maternal & Child Health. I am currently working on my thesis entitled "Pregnancy Care in Washington Jails: A Policy Analysis" and I would be honored if [jail] chose to participate. I received approval from the University of Washington Institutional Review Board to conduct this research on June 14, 2019.

For this research project, I am interested in learning about how jails across the state choose and implement policies regarding the healthcare that women receive in jail when they are pregnant or have given birth recently. I want to understand more about this intersection of health concerns and how jails address it.

I am requesting an interview with you or another administrator, a jail healthcare provider, and, if possible, any pregnant or postpartum women in custody. The interviews would be semi-structured; the interview with you and the healthcare provider would be under 60 minutes, and the interviews with the incarcerated women would be under 30 minutes.

I understand that the number of women in custody changes every day, and there are no guarantees that any eligible women would be present on the day of my visit. If that is the case, I am happy to limit the interviews to you and a healthcare provider.

Thank you so much for reading this proposal. There is very little research on this topic, and you are an important source of information. I will of course guard participant confidentiality—no names will be included in the research, and jails will not be identified. Additionally, I will acquire informed consent from all participants.

Please do not hesitate to reach out with any questions. Thank you for your time, and I look forward to hearing from you. Please find my contact information and the contact information for my thesis advisors below. Thanks again.

Sincerely,"