Access to Doula and Midwifery Support for Washington State's Incarcerated Population: A Qualitative Policy Assessment

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Abstract

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Background: This thesis assesses perceptions of key stakeholders regarding Washington State RCW 72.09.588 and its impact on the birth support choices and reproductive health of pregnant people incarcerated in the state prison system.

Methods: Semi-structured qualitative interviews were conducted with individuals ($N = 9$) who interface through their work with pregnant incarcerated people to gain insights into the potential impact of RCW 72.09.588 on the birth experience of incarcerated people in Washington State. Data collection and thematic analysis were based on Collins' framework for health policy analysis.

Results: Most participants believed that the passage of RCW 72.09.588 was a positive first step towards providing pregnant, incarcerated people in Washington State with access to doula and midwifery services. No participants believed their work had been substantially affected by the

law. We found no evidence that any pregnant, incarcerated person in Washington State had accessed a midwife or a doula as a result of this law. We identified several key barriers and facilitators impacting the implementation of the law.

Conclusions: While the passage of RCW 72.09.588 is a meaningful first step towards improving incarcerated people's maternal and infant health outcomes and expanding their overall reproductive autonomy, the law has had no reported impact on this population's ability to access doula or midwifery services during the prenatal, perinatal, or postpartum period.

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BACKGROUND & SIGNIFICANCE

Women in Prison

The United States is home to four percent of the world's female population but 30% of its female incarcerated population, the highest rate of female incarceration of any country.[1] These women are incarcerated both in prisons and jails. Prisons are run by state or federal government and hold people who have been convicted of crimes and are serving a sentence of at least one year.[2,3] Jails are typically administered by local law enforcement and hold pre-trial detainees and people serving shorter sentences.[2,3] The U.S. Department of Justice reports that in 2016, more than 200,000 women were being held in prisons and jails.[3] While fewer women are incarcerated than men, they are imprisoned at a higher overall rate.[4] Sufrin et al. found that 15,618 more women were incarcerated in U.S. state and federal prisons in 2016 than in 2004.[4] The United States saw a 742% increase in its number of imprisoned women between 1980 and 2016.[4,5] Notably, compared to the racial and ethnic makeup of the U.S. population, Black, Latinx, and Native people are overrepresented within the prison population.[13] Analysis of the 2010 Census found that while Black people made up only 13% of the general population, they constituted 40% of prisoners; 19% of prisoners were Latinx and 1% of prisoners were Native peoples, compared to 16% and 0.9% of free-world residents, respectively.[13] The same over-representation of Black, Latinx, and Native people is also evident among the incarcerated female population. In 2016, for example, the imprisonment rate for Black females was almost double that of white females.[3]

It is important to recognize that while the carceral system divides its residential population into "male" and "female" subcategories, the gender identity of many incarcerated people exists outside of this binary.[6,7] This paper uses gender-neutral terminology wherever possible; however,

"woman/women" and "she/her" pronouns will be used when necessary to accurately reflect the content of sources cited.

Birthing in Prison

At the time of incarceration, three-quarters of women prison and jail inmates are of childbearing age (15-49 years old).[3] Between four to ten percent of incarcerated women are pregnant at some point during their incarceration.[3-5] Incarcerated people are not eligible to buy private health insurance through the federal Health Insurance Marketplace.[8] Jail and prison inmates are also prohibited from using Medicaid insurance to cover the costs of medical treatment incurred during their incarceration.[8] The carceral system therefore has a significant responsibility to provide prenatal, perinatal, and postpartum care to its residents during their incarceration.

The importance of this care is exacerbated by incarcerated women's elevated probability of experiencing high-risk pregnancies.[9,10] Proximal causes of risk include a lack of access to adequate prenatal care prior to incarceration, overuse or abuse of drugs and alcohol, high rates of sexually transmitted diseases, and poor nutrition due to underlying food insecurity.[9,10] Distal causes of high-risk pregnancies among the incarcerated population are conditions of systematized disadvantage that affect a person's life experiences prior to incarceration and associated with entrenched economic, social, and environmental inequities historically experienced by racially-minoritized groups.[5, 9-12] Given the high percentage of Black, Latinx, and Native people among the population of incarcerated women, these social determinants of health contribute significantly to their elevated risk of adverse maternal health outcomes.[11,12,14,15]

People birthing in a carceral context may also be subject to policies and procedures absent from births in the free world. Examples include the use of shackles or other restraints during labor, compulsory induction of labor at a time predetermined by healthcare providers or administrators, and forced separation of parents and infants during the immediate postpartum period.[16-18] These policies are associated with poor birth outcomes and fall outside of the recommended care standards for pregnancy in prison as defined by the American Civil Liberties Union (ACLU), the American College of Obstetricians and Gynecologists (ACOG), the American College of Nurse-Midwives (ACNM), the American Medical Association (AMA), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).[19,20] While it is known that these conditions contribute to the complex set of emotional, mental, and social support needs of pregnant, incarcerated people, few studies have directly attempted to record or measure the emotional implications of birthing while in prison.[21,22]

Prison Birth Outcomes

There is a dearth of consistent, accessible data on the pregnancy and birth outcomes of people residing in U.S. prisons and jails.[4] However, many of the factors associated with incarceration – such as low socioeconomic status, substance abuse, or belonging to a minoritized and disenfranchised racial/ethnic group – are also associated with increased risk of experiencing serious complications such as gestational diabetes, preterm birth, and having a low birth weight infant.[23,24] Though state and federal prisons are constitutionally obligated under the Eighth Amendment to provide medical care to incarcerated people, the types of medical providers who perform this care varies by institution.[25,26] Notably, several studies reveal protective aspects of incarceration against poor maternal and infant health outcomes, suggesting that the controlled, stable environment and consistent access to healthcare provided by some correctional facilities

may shield incarcerated women from complications experienced by their free-world counterparts.[4,15] However, when stratified by race/ethnicity and level of risk, this protective effect has been shown to benefit white women to a greater degree than Black and Latinx women, a finding consistent with studies among their free world counterparts.[15,27] Importantly, unfavorable health outcomes during incarceration can have far-reaching effects on the life course of both members of the maternal-infant dyad, resulting in a decreased capacity for social and economic participation that spans generations.[28,29]

Doulas and Midwives as Intervention

Multiple studies have found that services for pregnant incarcerated people often do not adequately meet their needs. A 2008 analysis found that in state prisons nationwide, only half of the pregnant inmates accessed any prenatal healthcare.[30] Many institutions do not provide pregnant residents access to appropriate nutrition, rest, and physical accommodations such as access to a lower bunk.[11] Furthermore, a systematic review of perinatal healthcare services for imprisoned pregnant women, a large proportion of prisons were found to make no specific efforts to improve conditions or care for pregnant prisoners.[20]

Increasingly, correctional facilities are using the care of midwives and doulas to fill the persistent gap in care for pregnant, incarcerated people. Midwives are “trained professionals with expertise and skills in supporting women to maintain healthy pregnancies and have optimal births and recoveries during the postpartum period.”[31] Their scope of practice is most comparable to that of an obstetrician-gynecologist. Doulas are “trained professional[s] who provide continuous physical, emotional and informational support to a mother before, during and shortly after

childbirth to help her achieve the healthiest, most satisfying experience possible."[32] Doulas are not medical providers and play a non-clinical role during the birth process.

Midwifery and doula care are demonstrably associated with a decrease in the rate of preterm birth and low birthweight infants, two major risk factors for infant mortality.[33-35] Midwifery and doula care are also linked to lower rates of Cesarean birth and use of pain medication during labor, shorter labor times, higher infant Apgar scores, increased rates of breastfeeding, a decreased incidence of postpartum depression, and a higher overall level of satisfaction with the birth experience.[36-41] Use of doulas and midwives have been associated with cost savings, as their presence reduces the incidence of expensive perinatal procedures and the number of infant who require admission to neonatal intensive care units.[36,42-44] Some evidence exists to support the theory that the continuous, individually-tailored, and empowerment-focused care provided by these attendants could have a "buffering" effect, insulating birthing people from potential trauma experiences and improving the immediate and future health outcomes of both parent and child.[45,47] Support from a midwife or a doula during the perinatal period may also increase incarcerated women's sense of bodily autonomy and satisfaction with their birthing experience and aid in their ability to actively plan for the future.[45-47] Importantly, doulas and midwives are not a panacea for maternal and child health problems that stem from centuries of systematized inequality and medical bias against women and people of color; however, moving towards a person-centered, continuous care model is a promising strategy for addressing persistent maternal and child health concerns experienced in the United States.

State-Level Prison Birth Policies

While it is uncommon for correctional facilities to employ doulas as paid staff members, community-led initiatives offering doula support to incarcerated people have been developed in several states across the U.S. Versions of these programs serve jails, such as the Roots of Labor Birth Initiative in Alameda County (CA) and the Healthy Moms and Babies program in Cook County (IL), and prisons, such as the Minnesota Prison Doula Project in Shakopee, MN, and the Alabama Prison Birth Project in Wetumpka, AL.[47-50] Some jail-focused programs are supported by grants from county government; however, the majority of the doula support and service coordination are provided by community-based nonprofit organizations.[47,48,51] Staffed primarily by volunteers and financially supported by donations, these doula programs are frequently formed in response to media coverage of poor conditions endured by pregnant, incarcerated people and often explicitly locate their work within the larger framework of decarceration and/or prison abolitionist movements.[51,52] No evidence exists of prison doula programs created internally by any state-level Department of Corrections or funded by state or federal monies.

Minnesota was the first state in the U.S. to pass a law explicitly related to the use of doulas by pregnant incarcerated people. Minnesota Statute 241.89 requires access to doula services be granted to incarcerated people while they are pregnant or up to six weeks postpartum if the services come at no cost to the correctional facility. The statute also allows the Commissioner of Corrections and Commissioner of Health to award grants to nonprofit organizations to provide access to doula services.[53] New York's State Senate is currently reviewing Senate Bill 3126, which if signed into law would stipulate the provision of multiple health-related services to pregnant, incarcerated women in New York, including the authorization of a "support person" to accompany an inmate during delivery.[54] Washington State was the only state found to have

adopted legislation that explicitly addresses incarcerated people's access to both midwives and doulas.[55]

Washington State

Nearly three-quarters of imprisoned women in Washington State are incarcerated at the Washington Corrections Center for Women (WCCW) in Gig Harbor, Washington.[56] Although its intended capacity is 764 inmates, WCCW housed an average daily population of 886 individuals as of March 2020.[56] In 2017, the latest year data was reported from the Bureau of Justice Statistics, the total number of women incarcerated in Washington State jails was unavailable.[57]

Washington State has a history of supporting progressive maternal and child health policies for pregnant and parenting incarcerated people. Since 1999, WCCW has operated the Residential Parenting Program, a partnership with the Puget Sound Education Service District Early Head Start that allows some parents to keep their babies with them after giving birth in the prison.[58] Washington also prohibits the use of shackles during labor and delivery and strictly limits the use of restraints on pregnant and postpartum people.[55,58] Despite these policies, advocates have continued to voice concerns about the consistent enforcement of these policies and the general health and safety of people giving birth in Washington prisons.[59] One significant outcome of this advocacy was the 2018 passage of Washington State House Bill 2016, legislation that was codified as RCW 72.09.588 on June 7th, 2018. This law requires the Washington State Department of Corrections, which administers both jails and prisons, to make "reasonable accommodations for the provision of available midwifery and doulas services to inmates who are pregnant or who have given birth in the last six weeks."[55] This law differs from similar policies

in other states due to its inclusion of midwifery services; however, like the policy in Minnesota, it does not directly appropriate any state funding for the provision of these services. RCW 72.09.588 does not apply to federal correctional facilities located in Washington State.[55]

STUDY PURPOSE

Several scholars have attempted to define health issues faced by pregnant, incarcerated women and identified continuous support from a doula or midwife as a promising strategy to improve maternal and child health outcomes within this population.[23,29,34] However, the author is unaware of any publications that address the impact of state-level policies on incarcerated peoples' access to doula and midwifery services or the implementation of programs to supply these services. Furthermore, there is no published research related to birth outcomes in Washington State prisons.

The purpose of this study is to gather input on the perceptions of key stakeholders regarding RCW 72.09.588 and its impact on the health of pregnant people incarcerated in the Washington State prison system. This study employed qualitative semi-structured interviews to gather the professional experiences and expertise of individuals who interface through their work with pregnant incarcerated people to gain insights into the potential impact of RCW 72.09.588 on the birth experience of incarcerated people in Washington State.

RESEARCH QUESTION

How do key stakeholders perceive the impact of RCW 72.09.588 on the use of midwives and doulas by pregnant incarcerated people in Washington State?

Specific aims:

1. Analyze perceived barriers and facilitators to the implementation of the policy.
2. Evaluate the potential outcomes of RCW 72.09.588, including intended and unintended outcomes.

METHODS

Design

The lack of previous research on the impact of state-level policies related to doula and midwifery services for incarcerated people suggested that an exploratory evaluation of RCW 72.09.588 would be most appropriate in this setting.[60,61] This study was a descriptive, qualitative evaluation designed to assess relevant stakeholder's attitudes and beliefs about the importance of RCW 72.09.588 and its estimated impact on pregnant, incarcerated people's access to doula and midwifery services in Washington State. A qualitative approach was chosen for its ability to provide nuanced insight and reflect the complex, multifaceted experience of study participants.[60] At the outset of this project, we intended to interview three groups of people: providers and support people, correctional policymakers and legislators, and community advocates. We ultimately chose to narrow this participant pool down to two groups for the following reasons: firstly, our request to interview prison administrators received no response from the WCCW Public Information Officer. Secondly, many potential interview subjects were unavailable due to the outbreak of COVID-19 in Washington State during the research period. The COVID-19 outbreak also limited the overall sample size of the study. While interviews with currently incarcerated individuals would have been ideal, we chose not to pursue this study design due to the limited scope and timeframe available for completion of a master's thesis.

Sample

Participants were recruited from two groups. The first group comprised healthcare providers and support people whose work connected directly or indirectly to the health of pregnant, incarcerated people in Washington State. The second group was composed of policy experts who specialize in policies related to the reproductive health of pregnant, incarcerated people and had authored at least one peer-reviewed publication related to correctional healthcare and/or reproductive health of incarcerated people. Participants were excluded if they did not meet these criteria or were younger than 18 years of age. We reached participants through purposive sampling to ensure that each person selected would have rich, relevant, and diverse perspectives to contribute to the study.[61,62]

Data Collection

The interview phase of this qualitative evaluation took place between January and April 2020. The Principal Investigator (PI) conducted semi-structured interviews with two stakeholder groups: healthcare providers who work directly or indirectly with pregnant, incarcerated people and academic experts in correctional health policy. This study was deemed exempt by the University of Washington Internal Review Board. Verbal consent to participation in the study, interview procedures, and audio recording was obtained prior to each interview. The consent process included a short description of study background, significance, aims, and protocols and the opportunity for the participant to ask questions of the PI.

To capture the perspectives of participating stakeholders, the iterative process of policy development, and the consequences associated with implementation, Collins' framework for

health policy analysis was chosen to assist in the development of a semi-structured interview guide tailored to fit the needs of each participant group. This framework defines eight steps for analyzing the full scope of a policy's effects and linking policies to health outcomes within a population of interest.[66] Each interview guide included 13 open-ended questions based on the Collins framework (see Table 1 for sample interview questions and their corresponding step of Collins' framework for health policy analysis). Participants were also invited to share anything not covered by the interview guide and provided with another opportunity to ask questions of the PI in order to limit interviewer bias and add further nuance to each individual's testimonial (See Appendix I for full interview guide).

The PI piloted the interview guide with two perinatal healthcare providers and one health policy expert who did not qualify for the study due to the characteristics of their patient population and lack of peer-reviewed publications related to correctional health care, respectively. The interview guide was further reviewed by a workgroup of qualitative research specialists at the Veteran's Administration Puget Sound Health Care System. These pilot interviews resulted in several revisions to the chronology of interview questions, refined word choice, and an increased amount of background information presented to participants.

Four interviews were conducted in-person in the workplaces of the participants. Five interviews were completed over the phone or via a private, password-protected videoconference due to social distancing measures necessitated by the COVID-19 pandemic. The duration of each interview ranged from 20-30 minutes, with the average interview lasting 28 minutes. Interviewees were not compensated for their participation.

Identifying information, such as names and specific job titles, were deleted from interview audio recordings. Interviews were then transcribed using a web-based speech-to-text transcription service with which the PI obtained a nondisclosure agreement. Transcribed interviews were reviewed and edited for accuracy by the PI after they were received from the web-based service. Each participant was assigned a participant number that was used to identify them in recordings, transcriptions, and any materials shared with other members of the research team. All research materials, including recordings, interview transcripts, and communications with participants were stored as encrypted files on a password-protected computer accessible only to the PI.

TABLE 1. Relationship Between Interview Questions and Collins' Framework for Health Policy Analysis

	Step	Step Definition	Corresponding Interview Question
1	Define the Context	Define which contextual factors shape the participant's perception of RCW 72.09.588 and birth support for incarcerated people	*Could you describe how your job relates, directly or indirectly, to pregnant incarcerated people?* Prompts if needed: *a. Please describe the work you do with pregnant incarcerated people* *b. On average, what percentage of your time do you spend with incarcerated people?*
2	State the Problem	Establish participant's knowledge of a situation/condition that has a current or potential effect on people's health.	*I'm interested in learning more about your beliefs regarding a law that passed in Washington State last year that allows pregnant prison inmates to access support from doulas and*

			midwives during their pregnancy and birth. Have you heard of this law?
3	Search for Evidence	Collect meaningful data from participants to identify significant features of RCW 72.09.588	*How does this law affect your work as a [**profession**]?* *a. If it does not affect your work, why not?*
4	Consider Policy Options	Establish participant's understanding of incarcerated persons' birth support options as defined by Washington State law	*Walk me through what a pregnant, incarcerated person should do if they want to access the support of a doula or a midwife?* *a. Does this actually happen?* *b. When does it happen? When does it not happen?* *c. Do people every access these services in other ways?*
5	Project the Outcomes	Participant's perception of the *theoretical* impact of RCW 72.09.588 on incarcerated people's access to birth support services	*How does your work now compare to your work before this law passed?*
6	Apply Evaluative Criteria	Participant's perception of the relevance, progress, efficiency, effectiveness, and impact of RCW 72.09.588	*What barriers do you anticipate an incarcerated person might face when trying to access the support of a midwife or a doula?*
7	Weigh the Outcomes	Participant's perception of the *actual* impact of RCW 72.09.588	*Have you ever had a patient/client who has used a doula or a midwife because of this law?*

8	Make the Decision	Participant's estimation of the overall impact of RCW 72.09.588	*Do you believe this law will impact the reproductive health of incarcerated people in Washington State?* *a. If yes, how so?* *b. If no, why not?*

Data Analysis

Coding

Transcripts were coded and analyzed using Dedoose Version 8.3.17, a web application for managing, analyzing, and presenting qualitative and mixed method research data.[67]

An inductive approach was used to qualitative data analysis to identify emergent themes around participants' attitudes and beliefs regarding the impact of RCW 72.09.588. Thematic analysis was used to develop the codebook, with initial overarching codes based on Rodriguez-Garcia's evaluative criteria indicated by the Collins framework.[66,68] Secondary codes and sub-codes were added iteratively as a result of subsequent examinations of the data and refined in accordance with Lincoln's relational paradigm for interpretive research.[69]

In an effort to limit selective perception and enhance reflexive consideration of how and why study findings were being constructed, the PI and a first-year master's student separately read and coded four transcripts.[61] Initial coding agreement between these individuals ranged from 66% to 89% with an average agreement of 76%. A consensus meeting was held to discuss differences in coding and code definitions, resulting in the refinement of several codes and the addition of three sub-codes. Recurring themes in participant responses were identified through a

further review of codes and sub-codes, resulting in three overarching categories (Table 2 presents categories, codes, and sub-codes used in data analysis).

Table 2. Overarching Categories, Codes and Sub-Codes

Category	Code Number	Code Title	Code Description
Access to Care	1	Doula	Availability/accessibility of doula services to pregnant, incarcerated people
	2	Midwife	Availability/accessibility of midwifery services to pregnant, incarcerated people
	3	International Board-Certified Lactation Consultant (IBCLC)	Availability/accessibility of IBCLC services to pregnant, incarcerated people
Barriers and Facilitators to Care	4	Knowledge of law (incarcerated person)	Incarcerated person's knowledge/awareness of RCW 72.09.588
	5	Knowledge of law (providers)	Providers knowledge/awareness of RCW 72.09.588
	6	Process	System for pregnant people to access care or request access to care
	6a	No process available	Prison has not demonstrably provided a process for inmates to access RCW 72.09.588 services
	7	Continuity of care	Quality and consistency of pregnancy care over time
	8	Patient autonomy	Incarcerated person's ability to make decisions about their medical care during the perinatal period free from the influence of other parties
	9	Provider recognition & response to bias	Provider's sensitivity to potential biases towards an incarcerated patient due to their conviction status

	9a.	Reflexive	Provider acknowledges larger social forces shaping perception of pregnant person
	9b.	Non-reflexive	Provider does not acknowledge larger social forces shaping perception of pregnant person
	10	Lack of Financial Support	No funding provided at the state, health system, or individual level to support access to services included in RCW 72.09.588
Impact of Law	11	Negative Impact	Law has decreased access to services & has had a negative effect on the perinatal health experiences of incarcerated people
	12	No Impact/Unsure	Law has not led to any change in access to services & has had no effect on the perinatal health experiences of incarcerated people OR Participant does not know the impact of the law
	13	Positive Impact	Law has led to expanded access to services & improved perinatal health experiences of incarcerated people
	14	Future Impact	Participant believes RCW 72.09.588 will lead to expanded access to services and improved perinatal health experiences of incarcerated people in the future
	14a.	Perceived need for emotional support	Participant believes that pregnant, incarcerated people will receive an emotional benefit from support people if provided in the future

RESULTS

Participant Characteristics

Nine participants completed the interview. Six participants (66%) were healthcare providers, and three participants (33%) were correctional health policy experts (Table 3 summarizes interviewee characteristics and their role). Healthcare providers included a registered nurse, a

certified nurse midwife, an IBCLC, a social worker, and two birth doulas. Five participants (55%) regularly came into direct contact with incarcerated people as a part of their job. Seven of the nine participants (78%) were familiar with and/or interacted directly with pregnant people incarcerated at WCCW in Gig Harbor, Washington. The assessments of RCW 72.09.588 provided by participants in this study consistently identified three overarching themes related to the development, implementation, and health outcomes related to the law. Multiple sub-themes emerged from the interviews as key factors that contribute to the type of care received by pregnant, incarcerated people, ways in which they are able to access that care, and the ways in which RCW 72.09.588 affects the distribution of that care. Themes and sub-themes are described in detail below.

Table 3. Participant Characteristics by Profession and Stakeholder Category (*N* = 9)

Profession	**n (%)**
Midwife	1 (11)
Doula	2 (22)
IBCLC	1 (11)
Social Worker	1 (11)
Registered Nurse	1 (11)
Policy Expert	3 (33)

Theme One: Pregnant, incarcerated people at WCCW are constrained in their choice of provider and overall ability to access RCW 72.09.588 services

Participants revealed that the actual availability and accessibility of perinatal health care services for pregnant people incarcerated at WCCW differs based on type of provider. Access to certified nurse-midwifery care is guaranteed, while access to care from an obstetrician/gynecologist (OB/GYN) is not. There was no apparent access to doula care among this population. We did not anticipate that incarcerated people would have access to any other forms of perinatal care; however, we discovered that some WCCW inmates are offered access to lactation support from hospital-based IBCLCs. Access to these services may be constrained by factors such as racism, provider bias against incarcerated individuals, and/or a lack of state funding for RCW 72.09.588 services.

Through the interview process, we learned that the primary health care provider for all people incarcerated at WCCW is a certified nurse midwife (CNM) rather than an OB/GYN. This holds true for incarcerated people experiencing higher-risk pregnancies who would likely be referred to a maternal-fetal medicine specialist in a free-world setting. Pregnant, incarcerated people at WCCW are limited in their choice of provider as illustrated in the following quote:

"if [an inmate at WCCW] didn't want to see a midwife, there is an OB/GYN who comes to the facility…once a month." (Participant Two)

Therefore, every pregnant, incarcerated person at WCCW has access to midwifery care by default. However, as this care has been provided on a weekly basis since 2012, WCCW inmates' access to midwifery care is not attributable to the passage of RCW 72.09.588 in 2018. The availability of midwifery services in other correctional institutions in Washington State remains unclear. Additionally, though every pregnant WCCW inmate has access to prenatal and

postpartum midwifery care, they have little control over their primary care provider in labor. This is due to the provider rotation schedule at St. Joseph Medical Center, the hospital in Tacoma, Washington to which WCCW inmates are transferred for labor and delivery.

We found no evidence that any pregnant person incarcerated at WCCW has been supported by a doula since RCW 72.09.588 took effect on June 7th, 2018. Participants unanimously responded "no" when asked whether they knew of any incarcerated person in Washington State who had used a doula because of RCW 72.09.588. The consensus among participants was that there is currently "no clear path" to connect incarcerated people at WCCW with doula support during any stage of their pregnancy, birth, or postpartum journey.

At the outset of this study, we anticipated that care providers would consist only of the provider roles identified by RCW 72.09.588: doula and midwives. However, participant testimonials revealed that people incarcerated at WCCW are offered postpartum lactation support from IBCLCs at St. Joseph Medical Center. A lactation consultant typically provides facilitation and encouragement to new parents seeking to breastfeed their infant. However, one participant noted that they adjust their support when working with an incarcerated person:

"Some of them get to keep their babies, some of them don't. So the support I'm actually providing is either how to stop lactation in a way that's not gonna hurt the body, or basically 'here's all of the lactation education I could possibly give you in the hour window I have with you before you go back [to the prison].'" (Participant Five)

The IBCLCs also provide education around the use of breast pumps and have been instructed to send people back to the prison with breast pumps, indicating a coordinated effort by care

providers and prison administrators to prolong breastfeeding beyond the immediate postpartum period.

There was lack of agreement among participants regarding the equitable application of RCW 72.09.588 to all identity groups incarcerated in Washington State. Some participants believed that every incarcerated person had equal access to the services specified in the law, regardless of their race/ethnicity or conviction status:

"I don't think there are barriers. It's part of the program, part of their care. [Prison administrators] know they have to take care of this pregnancy and they do it." (Participant Three)

This finding suggests that some providers and policy experts may not acknowledge the presence of entrenched structural inequalities within correctional healthcare delivery systems. However, the majority of participants recognized that incarcerated populations are not exempt from the social inequities that exist in the free world, voicing concerns that doula and midwifery services may be less available to nonwhite incarcerated people:

"[the law] is only helping specifically the white population… you're not seeing people of color request those services." (Participant Six)

The stigma associated with being incarcerated was also identified as a potential inhibitor to accessing high-quality, individualized care:

"there's that mentality of, 'oh, you're in [prison], you deserve generic care." (Participant Six)

Participants who espoused the "equity perspective" felt strongly that receiving care from a doula or a midwife might be an incarcerated person's sole opportunity to be recognized as an individual and/or parent rather than an "offender" during their prison term:

"You can see that they just made one dumb choice and now they're living with the consequences. But that doesn't make them bad people. I don't find it difficult to be compassionate when you actually meet the person with the baby. You're like, 'oh, you're just a mom.'" (Participant Five)

Despite the differences in participants' recognition of larger social inequities and their relationship to incarcerated people's access to doula and midwifery services, all participants expressed a belief that adding doula and midwifery services to correctional healthcare would provide much-needed continuity of care and centering of the birthing person's individual experience.

Financial support was consistently identified as a key barrier to the implementation of and sustained access to doula and midwifery services for incarcerated people. RCW 72.09.588 explicitly states that no state monies will be appropriated to pay for doula and midwifery care, a limitation of the law identified by several participants:

"If the bill didn't come with any funding, the patient would have to pay for it themselves like they would any other service that was not ordinarily provided. And given the fact that they're not covered by Medicaid when they're incarcerated, my guess is that most of them couldn't afford it." (Participant Seven)

Participants agreed that while it may be technically possible for an incarcerated person to hire a doula or midwife on a fee-for-service basis, it is unlikely they would have the financial resources to do so:

"Even outside the prison, accessing midwives and doulas is challenging for low income populations. So you can only imagine what it is like when it comes to [incarcerated people] paying for care." (Participant Eight)

Many believed that the responsibility of funding doula, midwifery, or lactation services lay with outside institutions such as a nonprofit organization, St. Joseph's Medical Center, or the Washington State Department of Corrections. Multiple care providers cautioned against relying on volunteers to provide support services long-term, citing a now-defunct doula program that served WCCW inmates until 2015:

"for doulas wanting to help out it, has to be sustainable for us to work with that population." (Participant Five)

Without appropriate compensation for services, participants were pessimistic that midwives, doulas, or IBCLCs could be incentivized to work continuously with incarcerated populations. Several participants noted the willingness of two community-based organizations to fund and implement a doula program at WCCW; however, negotiations between prison administrators and community organizations were postponed indefinitely in March 2020 due to the coronavirus outbreak.

Theme Two: Lack of awareness and understanding of RCW 72.09.588 is a barrier to its implementation

While providers were generally aware of RCW 72.09.588, there was a perceived lack of tailored information about the law to assist with its interpretation and operationalization among incarcerated individuals. Awareness of the law and understanding its content was the potential barrier or facilitator to care most commonly cited by study participants. Seven participants stated that the lack of educational resources regarding the provisions of RCW 72.09.588 that are available to incarcerated people is a primary barrier to accessing doula or midwifery services:

"Information is passed by word of mouth from offender to offender. There aren't a lot of

protocols written down for them or pamphlets available to say, 'this is how you can [work with a doula].'" (Participant Three)

Most participants agreed that the responsibility to inform incarcerated people of their right to doula and midwifery services lay with each individual correctional facility or the Washington State Department of Corrections. Six participants stressed the importance of tailoring this information to increase its relevance to people who are pregnant while incarcerated:

"If you tell a person, 'hey, if you're gonna deliver in custody, you're going to deliver alone, and that's going to be a scary experience and this [doula] is here to support you and make sure you get what you want,' that is very different than saying 'here's a doula.'" (Participant Nine)

Every health care provider included in the study reported that they were aware of the law, though their knowledge of its contents varied. One provider reported that they had printed out the text of the law and posted it in their workplace as a reminder to staff. One provider was involved in advocating for the passage of the law in 2018. Four providers knew of the law but had not changed their behavior at work because of it or felt constrained in their ability to provide the services delineated by the law:

"They talk to me and I really don't have any information about how they're supposed to connect with the doula because I just work in the medical clinic." (Participant Three)

Overall, the providers who were interviewed delivered services to the incarcerated population in the capacity of a contractor or volunteer and felt that they had little influence over the implementation of the services delineated by RCW 72.09.588.

A lack of stated processes and protocols was identified as a key barrier preventing incarcerated people from accessing RCW 72.09.588 services. Participants consistently reported very little knowledge of a specified series of actions an incarcerated person could take in order to access the care of a midwife or doula during their pregnancy, birth, and postpartum period. A distinction was made between the theoretical process for accessing care and the practical implementation of this process in the "real world." When asked what they thought an incarcerated person in Washington State *should* do if they wanted to access the services of a midwife or a doula, most participants stated that interested individuals should simply request the services from their healthcare provider or prison administrators. However, there was a lack of agreement among study participants as to how an incarcerated person could *actually* access services of a doula or midwife other than the current CNM who provides care weekly at WCCW. The majority of participants expressed doubt that a standardized process existed, highlighting the gap between the passage and operationalization of progressive policies:

"[incarcerated people] are in the hands of the prison and their medical system, and…they are dragging their feet to make [services] available." (Participant Eight)

Several participants believed that outside influence from a Department of Correction ombudsman was required to fully implement the policy:

"the best way [for incarcerated people to access services] would be to get denied a doula by the administration and then file an ombuds complaint." (Participant Seven)

Participants theorized that prison officials were loath to authorize birth support workers to enter the prison due to their reputation as social justice advocates:

"they want to protect their image as a 'good facility' – they don't like people witnessing the way they treat [inmates]." (Participant Eight)

Other explanations for the lack of a formal process for accessing services included the relative newness of the law and the difficulty of coordinating the bureaucratic processes of the prison system, the health care system, and community-based organizations.

Without a defined process in place, most participants were skeptical that an incarcerated person would be able to access the services outline by RCW 72.09.588. While the onus of accessing services might be placed on the birthing person in a normal healthcare setting, incarcerated people's diminished autonomy constrains their ability to make informed choices about their prenatal, intrapartum, and postpartum care and subsequently act on those choices:

"They don't even know when their appointments happen until they're loaded into a van and taken. It's a lack of autonomy. Your life is controlled for you and your choices are up to whoever is in charge – if they are aware and if they are compassionate and if they care about you getting access to resources." (Participant Four)

Participants agreed that without a process to access the services outlined by the law, the law functionally does not exist and is unlikely to impact the reproductive health of the incarcerated population.

Theme Three: According to health care providers and policy experts, RCW 72.09.588 has had little impact on the health care and birthing experiences of pregnant, incarcerated individuals

Participants were asked to assess the overall impact of RCW 72.09.588 on the reproductive health of incarcerated people in Washington State. Their responses were placed in one of four categories: negative impact, no impact/unsure, positive impact, and future impact. Eight of the nine study participants reported that the law had no impact or that they were unsure of the law's impact:

"I think the idea of it seems very good, but I don't know that it has really changed anything, at least in this community." (Participant One)

Only one participant believed that the law had a demonstrably positive impact on the reproductive health of incarcerated people in Washington State. Several participants deemed the law's stipulation that correctional institutions must provide "reasonable accommodations" for incarcerated people to access "midwifery *or* doula services" to be too vague and noted that the law explicitly allows correctional institutions to adopt policy guidelines modifying the delivery of services. Participant Four noted that in order to control access to services and the amount of services consumed, individual institutions *"can twist that wording however they want."*

All participants voiced a belief in the law's potential to positively impact the reproductive health of incarcerated people in the future. Amongst the participants, there was agreement that the law would have little impact without continued advocacy for the full implementation and/or expansion of RCW 72.09.588:

"The bill gets passed but it's still the same people doing the same jobs in the same system. It's going to take real organization of motivated individuals to change their minds." (Participant Five)

Despite this, many participants voiced a gratitude for the current iteration of the law and noted that the codification of incarcerated people's rights to these services in state law makes them feel more empowered to pursue implementation:

"It gives you a bit more power…if you're going and talking to leadership, insurance providers or people that control access in the prison, there's this law that you have to help back you up. You're trying to help follow the law – it gives you a backbone." (Participant One)

Overall, there was a sense that the passage of RCW 72.09.588 is an important, if relatively ineffectual, step towards the development of robust reproductive health care options for Washington State's incarcerated population:

"[The law] makes it so that the prison has to at least give the pretense that they're providing services, but it's been like almost three years of them dragging their feet and saying like, no, not yet." (Participant Eight)

Participants, particularly those who work as health care providers, drew on their experience when forecasting the timeline of implementation for this law:

"It's probably going to be years and years before you actually see a change, but that's just how everything in health care works." (Participant Six)

DISCUSSION

The goal of this study was to assess the impact of RCW 72.09.588 on the birth support choices available to pregnant, incarcerated people in Washington State through qualitative interviews with key stakeholders. The application of qualitative methods and centering the perspectives of individuals who regularly interface with pregnant, incarcerated people shed light on the lived experiences of those giving birth in a correctional health care setting and highlighted the gap between the development of state-level policy and its practical implementation. Including both health care providers and correctional health policy experts' perspectives yielded a uniquely holistic contribution to the health policy literature, weaving together clinical, academic, and social justice perspectives to paint a clear picture of carceral birth processes in the Washington State correctional system. Though no analogous studies have been published on this topic, it joins a cohort of qualitative studies related to doulas and/or pregnancy in prison with smaller or equivalent sample sizes.[29,63-65]

Interviews with participants added nuance to our understanding of the types of care readily available at WCCW, the institution where the majority of Washington State's women-identified prison population is held. Our analysis of perceived barriers to the implementation of RCW 72.09.588 found no evidence that the law's passage had resulted in the use of a doula or a midwife by any incarcerated person. Given WCCW's reputation for progressive programming and greater concentration of resources relative to other correctional facilities in Washington, we believe it is unlikely that pregnant, incarcerated people are currently able to access these services while held at other state institutions.

While doula, midwifery, and lactation support services are often conflated, their differences may contribute to the unevenness in incarcerated people's ability to access them. Midwives are clinicians who are certified to deliver the well-woman, prenatal, perinatal, and postpartum care that correctional facilities are already constitutionally required to provide to incarcerated people. In this regard, the presence of a midwife is somewhat interchangeable with that of an OB/GYN and requires little effort on behalf of a prison or jail to facilitate. In contrast, most correctional institutions do not have a preexisting infrastructure for the provision of nonclinical support such as doula services. We theorize that the time, resources, and level of coordination with outside stakeholders necessary to establish such a pathway to care are key barriers to the implementation of the doula and midwifery services delineated in RCW 72.09.588. WCCW is unique in that it formerly worked with a community-based organization to provide doula services. Institutional memory of this program may render WCCW an ideal location for an outside organization to reestablish doula services under the auspices of RCW 72.09.588.

The participants in this study recognized that simply making services available would be ineffectual without concurrently providing incarcerated people with tailored information about the physical, mental, and emotional health benefits with which these services are associated. Education and/or outreach to pregnant, incarcerated people must be considered a crucial component by any individual seeking to establish a process for this population to access birth support services.

Sufficient financial support, and its association with the long-term sustainability of any program aiming to provide birth support to incarcerated people, was another key barrier to care cited by study participants. Even if a community-based organization is committed to sponsoring the provision of doula services, this may only be a short-term solution. Multiple participants voiced support for a state-funded program, viewing doula and midwifery services as belonging to the larger category of correctional health care to which state must provide access. The state may also prove a more reliable source of funding than a donation- and grant-funded nonprofit organization or community-based collective, particularly given the economic instability that resulted from the coronavirus pandemic. At this time, the Washington State Department of Corrections is governed by the Washington State law that guarantees every incarcerated person the right to basic health care, defined as "medically necessary health and mental health care."[71] The likelihood of the state shouldering these costs relies on larger clinical and cultural perceptions of midwifery and doula care as "basic" and "medically necessary." Midwifery is perhaps the oldest and most "basic" form of health care. People who have endured a 72-hour labor with the help of a doula

would likely deem their presence "medically necessary."[72-74] However, these perspectives are often missing in the development of maternal and child health policy.

The lack of comparable policies related to doula and midwifery services for incarcerated people complicates the project of measuring the impact of RCW 72.09.588 against that of programs in other states. Washington State's inclusion of midwifery in addition to doula support renders its law more expansive than Minnesota's comparable policy which only includes access to doulas. However, Minnesota's provision that nonprofit organizations are made eligible for state-funded grants to provide access to doula services may explain the robust programming and long-term sustainability of the Minnesota Prison Doula Project when compared to the now-defunct WCCW doula collective.

Overwhelmingly, participants reported that Washington's law has brought about no change in the birth experiences of incarcerated people in Washington State. However, the passage of the law may represent the beginning of a larger conversation about reproductive autonomy, birthing practices, and emotional experience of pregnant, incarcerated people in the region. To participants in this study, RCW 72.09.588 is an opportunity to engage in continued advocacy and sets a precedent for the treatment of pregnant, incarcerated people in Washington State. The law strengthens the position of those who aim to institute or expand the provision of these services to incarcerated people; however, the mandate is not strong enough to compel institutions to provide services without continued efforts from interested parties. While a meaningful advancement of the policy framework for access to doula and midwifery services in state and local correctional facilitates, the full realization of RCW 72.09.588 will require continued efforts of interested parties to ensure incarcerated people can reliably access those services.

Limitations

This study is affected by multiple limitations. The sample size was small ($N = 9$) and due to the exploratory nature of this study, we cannot claim total data saturation; however, validity is established through their sufficient embodiment of Malterud et al.'s concept of "information power," an alternative model for measuring the completeness of conceptual development in qualitative studies.[70] We are therefore confident that study findings will credibly contribute to current understandings of reproductive health care policies in correctional institutions in Washington State. The use of a purposive sampling technique increases the study's vulnerability to selection bias. Findings may disproportionately represent more extreme views as stakeholders with stronger opinions about the reproductive health choices of incarcerated people may have been more likely to participate in the study. The majority of these stakeholders were only familiar with the experience of people incarcerated at WCCW, limiting the generalizability of study findings to other correctional institutions in Washington State. Researcher bias was mitigated through multiple steps described in the methods section. However, it is possible that some researcher bias affected the outcome of the study. For example, the PI's professional experience as a birth doula may have skewed the development of the interview guide or interpretation of participant responses. The impact of this potential source of bias was likely reduced by piloting of the interview guide with various outside stakeholders and subjecting a portion of the transcripts to dual coding and agreement with a student assistant who had no background in maternal and child health care

The absence of currently incarcerated individuals in the participant pool was a major limitation of this study; though making contact with this population was too time- and resource-intensive for the scope of a Master's thesis research project, the perspectives of incarcerated people are highly valuable and should be prioritized in future research efforts. Including the perspective of prison administrators may have somewhat mitigated this limitation; however, we were unable to gain permission to conduct these interviews from WCCW's public information officer despite attempts to follow up on our request.

An unforeseen but highly influential limitation of this study were the effects of the COVID-19 pandemic on the PI's ability to contact interview subjects. Originally, we intended interview more clinicians, including medical doctors, and the state legislators responsible for the development and passage of RCW 72.09.588. However, these stakeholders were either unable to be reached or unable to participate in an interview due to the demands placed on their time by the outbreak of COVID-19 in Washington State in early March 2020. Overall, this exploratory study has helped generate new knowledge about the birth support options available to people incarcerated in Washington State as a result of RCW 72.09.588, but further research is needed to fully understand the extent to which doula and midwifery services are being accessed by people incarcerated in jails and prisons across the state.

POLICY RECOMMENDATIONS & IMPLICATIONS FOR FUTURE RESEARCH

We found no evidence that WCCW is violating the provisions laid out by RCW 72.09.588. However, this study provides strong evidence of several key barriers standing between institutions' adherence to the letter of the law and their full embodiment of its spirit. These findings have several implications for policy and practice. A clear process for incarcerated

people to access both doula and midwifery services must be established within each correctional institution. Pregnant, incarcerated people must be apprised of this process upon incarceration and provided with unbiased information regarding the benefits of these services. WCCW could be a vanguard among Washington State's correctional facilities in establishing this process due to its proximity to large urban centers, history of working with doulas, and relationship with St. Joseph Medical Center, which hosts a hospital-based doula program. Furthermore, the addition of a doula program is a natural continuation of the existing maternal and child health resources provided by the WCCW administration such as the Residential Parenting Program. Developing and supporting a doula program at WCCW would indicate an institutional commitment to ensuring the health of parents and their children across the life course. Once this process is established, WCCW administrators could mentor other institutions seeking to provide pregnancy support services to their inmate population. Because WCCW already provides midwifery care, we recommend administrators prioritize increasing access to doula services. Maintaining the existing partnership with St. Joseph Medical Center is advised to ensure WCCW inmates can give birth with a midwife should they prefer to do so.

Multiple community-based organizations have voiced an interest in facilitating the provision of doula services to people incarcerated at WCCW, including Open Arms Perinatal Services and Birth Beyond Bars. These organizations could provide a ready-made doula program for WCCW, bypassing the need for prison administrators to build a program from scratch. In the eventuality that these partnerships are formed, we recommend that both prison administrators and doula groups apply lessons from the experience of working with the doulas who formerly served the WCCW population to avoid past mistakes and create optimal conditions for programmatic

success. In the interim, doula programs based at hospitals that serve correctional facilities should be trained to tailor their services to meet the needs of pregnant, incarcerated people. Incarcerated people should be provided with information regarding the availability and benefits of using hospital-based doula services.

To address the barrier created by RCW 72.09.588's lack of financial support, community advocates could focus attention on lobbying Washington State lawmakers to appropriate state funding for doula and midwifery services within the framework established by the 2018 bill. Advocacy efforts should be concentrated on odd-numbered years during which the Washington State biennial budget is enacted. Proposing the reimbursement of doulas and midwives serving the incarcerated population at Medicaid rates could provide a simple platform for such advocacy. In Washington State, Medicaid covers free-world births in all settings and with all licensed providers who have birth attendance in their scope of practice, including midwives.[75] Doulas are not currently eligible for Medicaid reimbursement in Washington State, though this practice is increasingly common in states across the U.S. and may be approved in Washington State in the next biennium.

The topic of birth support for incarcerated individuals is a fruitful area for continued inquiry, particularly for those interested in the intersection of health policy implementation, maternal and child health, and social justice. Future research on this topic should aim to develop a more comprehensive understanding of the birth support preferences of incarcerated people in Washington State through primary data collection within this population. A particular focus on the experiences of people being held in jails would fill an as-yet unexplored gap in the literature

and shed light on the practices of correctional facilities that are smaller and less-resourced than WCCW.

People who give birth while incarcerated are often overlooked, despite recent increases in research efforts attempting to demystify the volume of births that take place in carceral settings and the impact of these experiences on the health and wellbeing of this population. In passing RCW 72.09.588, Washington State positioned itself to become a national leader on the reproductive autonomy of incarcerated people and draw this oft-forgotten population away from the margins of the health care system. This policy stance is supported by providers' strong desire to provide support to this population during pregnancy, birth, and the postpartum period. However, good intentions are not enough to ensure the implementation of robust birth support resources in Washington State's correctional institutions; an equitable process for becoming aware of and accessing care and adequate funding are necessary to ensure that the intent of RCW 72.09.588 translates into meaningful effects on the birth experiences and outcomes of incarcerated people and does not languish in the annals of Washington State law.

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APPENDIX

I. Interview Guide

Interviewer Name	
Participant Name & Job Title	
Date	
Start Time	
End Time	

Interview Mode:

In-Person	
Video Conference	

Opening Statement:
Thank you for taking the time to speak with me today. My name is Ami Hanna, and I am a Master of Public Health Student at the University of Washington, where I study maternal and child health. I would like to learn about your opinions about a law that passed in Washington State in 2017, known as RCW 72.09.588, which requires the Washington State Department of Corrections to allow incarcerated people who are pregnant to access doula and midwifery services while incarcerated. The information you provide will be used for a qualitative research project I am conducting for my master's thesis.

*Through interviews like this one, I am evaluating the impact of RCW 72.09.588on incarcerated people's access to midwives and doulas during pregnancy and birth. I aim to better understand the effects of this law through conversations with individuals whose work is related to pregnancy in prison. The perspective you provide in this interview will provide insight into the potential impact of House Bill 2016 on the birth experience of incarcerated people in Washington State. I am most interested in how you, in your role as a [**insert profession here**], perceive the impact of RCW 72.09.588 on the use of midwives and doulas by pregnant incarcerated people in Washington State.*

Please know that there are no right or wrong answers to any of these questions.

In order to make sure I capture all of the information you give me, I would like to record this interview. Is this okay with you?

Participant Response:

Yes	
No	

If yes, start recording: *Okay, I'm starting the recording and want to confirm again that you are okay with the recording? Do you have any remaining questions?*

Thank you for consenting to participate. It is possible that I might find it helpful to contact you again to follow up on this interview. If this happens, would it be okay for us to contact you again?

Participant Response:

Yes	
No	

If no: *If it's acceptable to you, I'd like to continue the interview and take notes. Is that okay with you?*

Probes: If responses are limited or require clarification, probes may be used to illicit more detailed responses. Probes should use words or phrases presented by the participant using one of the following formats:

1. What do you mean by _____?
2. *Can you tell me more about* _____?
3. *Can you give me an example of* _____?
4. *Can you tell me about a time when* _____?
5. *Can you tell me who*_____?
6. *Can you tell me why*_____?
7. *How does that compare to*_____?

Aim 1: Describe HB 2016, its underlying rational, and its development process as perceived by key stakeholders

2. *Could you tell me about your job and describe your work?*
   Prompts if needed:
   a. *Where do you work?*
   b. *Do you work directly with pregnant people?*
   c. *If so, what services do you most commonly provide to pregnant patients/clients?*
   d. *Are you affiliated with a state agency?*

3. *Could you describe how your job relates, directly or indirectly, to pregnant incarcerated people?*
   Prompts if needed:
   a. Please describe the work you do with pregnant incarcerated people
   b. On average, what percentage of your time do you spend with incarcerated people?

4. *I'm interested in learning more about your beliefs regarding a law that passed in Washington State in 2018 that allows pregnant prison inmates to access support from doulas and midwives during their pregnancy and birth. Have you heard of this law?*

   If yes:

   If no, explain:

In 2018, the Washington State legislature signed RCW 72.09.588 into law. This measure requires the Department of Corrections to make "reasonable accommodations for the provision of available midwifery and doula services to incarcerated people who are pregnant or who have given birth in the last six weeks." This law did not appropriate any funds for the provision of these services.

5. *What do you know about this law?*

6. *How does this law affect your work as a [**insert profession here**]?*
   a. *If no, why not?*

Aim 2: Describe perceived barriers and facilitators to the implementation of RCW 72.09.588

7. *Walk me through what a pregnant, incarcerated person should do if they want to access the support of a doula or a midwife?*
   a. *Does this actually happen?*

   b. *When does it happen? When does it not happen?*

   c. *Do people every access these services in other ways?*

8. *Have you ever had a patient who has used a doula or a midwife because of this law?*
   a. *(For policy experts: have you ever heard of anyone who has used a doula or a midwife because of this law?)*

9. *What do you think most pregnant, incarcerated people in Washington State know about RCW 72.09.588?*

10. *What barriers do you anticipate an incarcerated person might face when trying to access the support of a midwife or a doula?*

11. *Do you think it is important that these services are provided? Why?*

Aim 3. Describe the potential outcomes of RCW 72.09.588, including intended and unintended outcomes

12. *Do you believe this law will impact the reproductive health of incarcerated people in Washington State?*
    a. *If yes, how so?*
    b. *If no, why not?*

13. *How does your work now compare to your work before this law passed?*

Conclusion

14. *Is there anything else you would like to share with me?*
15. *Do you have any questions for me before we conclude our conversation?*

*Thank you for taking the time to speak with me today. If I have any follow-up questions regarding our conversation, would it be okay if I contacted you again at [**confirm contact information**]*

[Share anticipated timeline for analysis & results]

REFERENCES

[1] Fact sheet: incarcerated women and girls. The Sentencing Project. 2015. https://www.sentencingproject.org/wp-content/uploads/2016/02/Incarcerated-Women-and-Girls.pdf

[2] Goshin, L. S., Sissoko, D. R. G., Neumann, G., Sufrin, C., & Byrnes, L. (2019). Perinatal Nurses' Experiences With and Knowledge of the Care of Incarcerated Women During Pregnancy and the Postpartum Period. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN*, *48*(1), 27–36. https://doi.org/10.1016/j.jogn.2018.11.002

[3] Carson EA. Prisoners in 2016. NCJ 251149. Bureau of Justice Statistics. 2018. Available at: https://www.bjs.gov/content/pub/pdf/p16.pdf.

[4] 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. doi:10.2105/AJPH.2019.305006

[5] Sufrin C, Kolbi-Molinas A, Roth R. Reproductive justice, health disparities and Incarcerated women in the United States. *Perspect Sex Reprod Health*. 2015: 47(4):213-219.

[6] White Hughto, J. M., Clark, K. A., Altice, F. L., Reisner, S. L., Kershaw, T. S., & Pachankis, J. E. (2018). Creating, reinforcing, and resisting the gender binary: A qualitative study of transgender women's healthcare experiences in sex-segregated jails and prisons. *International Journal of Prisoner Health, 14*(2), 69–88. https://doi.org/10.1108/IJPH-02-2017-0011

[7] Routh, D., Abess, G., Makin, D., Stohr, M. K., Hemmens, C., & Yoo, J. (2017). Transgender Inmates in Prisons. *International Journal of Offender Therapy and Comparative Criminology, 61*(6), 645–666. https://doi.org/10.1177/0306624X15603745

[8] *Health coverage options for incarcerated people*. (n.d.). HealthCare.Gov. Retrieved April 14, 2020, from https://www.healthcare.gov/incarcerated-people/

[9] Structural racism and health inequities in the USA: evidence and interventions.
Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT
Lancet. 2017 Apr 8; 389(10077):1453-1463.

[10] Clarke, J. G., Hebert, M. R., Rosengard, C., Rose, J. S., & al, e. (2006). Reproductive health care and family planning needs among incarcerated women. *American Journal of Public Health, 96*(5), 834-9. Retrieved from https://search.proquest.com/docview/215085672?accountid=14784

[11] Ferszt, G. G., & Clarke, J. G. (2012). Health care of pregnant women in U.S. state prisons. *Journal of Health Care for the Poor and Underserved, 23*(2), 557–569. https://doi.org/10.1353/hpu.2012.0048

[12] Baker, B. (2019). Perinatal Outcomes of Incarcerated Pregnant Women: An Integrative Review. *Journal of Correctional Health Care: The Official Journal of the National Commission on Correctional Health Care, 25*(2), 92–104. https://doi.org/10.1177/1078345819832366

[13] Initiative, P. P. (n.d.). *Racial and ethnic disparities in correctional facilities*. Retrieved April 15, 2020, from https://www.prisonpolicy.org/graphs/pie2018_race.html

[14] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths - United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3

[15] Howard, D. L., Strobino, D., Sherman, S. G., & Crum, R. M. (2009). Timing of Incarceration During Pregnancy and Birth Outcomes: Exploring Racial Differences. *Maternal and Child Health Journal*, *13*(4), 457–466. https://doi.org/10.1007/s10995-008-0376-7

[16] National Resource Center on Justice Involved Women. (2016). The use of restraints on pregnant women in jails and prisons. Retrieved from http://cjinvolvedwomen.org/the-use-of-restraints-on-pregnant-women-in-jails-and-prisons

[17] Deborah Ahrens, Incarcerated Child Birth and "Broader Birth Control": Autonomy, Regulation, and the State, 80 MO. L. REV. 1 (2015). https://digitalcommons.law.seattleu.edu/faculty/725

[18] Chambers, A. N. (2009). Impact of forced separation policy on incarcerated postpartum mothers. *Policy, Politics & Nursing Practice*, *10*(3), 204–211. https://doi.org/10.1177/1527154409351592

[19] Alirezaei, S., & Roudsari, R. L. (2020). Promoting Health Care for Pregnant Women in Prison: A Review of International Guidelines. *Iranian Journal of Nursing and Midwifery Research*, *25*(2), 91–101. https://doi.org/10.4103/ijnmr.IJNMR_169_19

[20] Bard, E., Knight, M., & Plugge, E. (2016). Perinatal health care services for imprisoned pregnant women and associated outcomes: A systematic review. *BMC Pregnancy and Childbirth*, *16*. https://doi.org/10.1186/s12884-016-1080-z

[21] Grassley, J. S., Ward, M., & Shelton, K. (2019). Partnership Between a Health System and a Correctional Center to Normalize Birth for Incarcerated Women. *Nursing for Women's Health*, *23*(5), 433–439. https://doi.org/10.1016/j.nwh.2019.07.005

[22] Abbott, L. (2016). Becoming a mother in prison. *The Practising Midwife*, *19*(9), 8, 10–12.

[23] Sufrin C. Jailcare: Finding the Safety Net for Women Behind Bars. Oakland, CA: University of California Press: 2017.

[24] Sufrin C. Making mothers in jail: carceral reproduction of normative motherhood. *Reprod Biomed Soc Online*. 2018;7:55-65. doi:10.1016/j.rbms.2018.10.018

[25] Eber, G. B. (2009). USING THE CONSTITUTION TO IMPROVE PRISONER HEALTH. *American Journal of Public Health*, *99*(9), 1541–1542. https://doi.org/10.2105/AJPH.2009.168112

[26] Kelsey, C. M., Medel, N., Mullins, C., Dallaire, D., & Forestell, C. (2017). An Examination of Care Practices of Pregnant Women Incarcerated in Jail Facilities in the United States. *Maternal and Child Health Journal*, *21*(6), 1260–1266. https://doi.org/10.1007/s10995-016-2224-5

[27] Goshin, L. S., & Colbert, A. M. (2019). The Health of Incarcerated Pregnant Women: Some Much Needed Data and Beyond. *American Journal of Public Health*, *109*(5), 657–658. https://doi.org/10.2105/AJPH.2019.305044

[28] Braithwaite, R. L., Treadwell, H. M., & Arriola, K. R. J. (2008). Health Disparities and Incarcerated Women: A Population Ignored. *American Journal of Public Health*, *98*(Supplement_1), S173–S175. https://doi.org/10.2105/AJPH.98.Supplement_1.S173

[29] Shlafer, R. J., Hellerstedt, W. L., Secor-Turner, M., Gerrity, E., & Baker, R. (2015). Doulas' Perspectives about Providing Support to Incarcerated Women: A Feasibility Study. *Public Health Nursing*, *32*(4), 316–326. https://doi.org/10.1111/phn.12137

[30] Maruschak, L. M. (2008). *Medical problems of prisoners: (448112008-001)* [Data set]. American Psychological Association. https://doi.org/10.1037/e448112008-001

[31] *What is a Midwife?* (2010, January 2). Midwives Alliance of North America. https://mana.org/about-midwives/what-is-a-midwife

[32] *What is a Doula*. (n.d.). DONA International. Retrieved April 14, 2020, from https://www.dona.org/what-is-a-doula/

[33] Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. The Cochrane database of systematic reviews. 2017;7:Cd003766.

[34] Butler, M. M., Sheehy, L., Kington, M. M., Walsh, M. C., Brosnan, M. C., Murphy, M., Naughton, C., Drennan, J., & Barry, T. (2015). Evaluating midwife-led antenatal care: Choice, experience, effectiveness, and preparation for pregnancy. *Midwifery*, *31*(4), 418–425. https://doi.org/10.1016/j.midw.2014.12.002

[35] Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer-Peterson C, O'Brien M. Doula care, birth outcomes, and costs among Medicaid beneficiaries. *American Journal of Public Health.* 2013;103(4):e113-121.

[36] Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *The Cochrane Database of Systematic Reviews*, *4*, CD004667. https://doi.org/10.1002/14651858.CD004667.pub5

[37] ten Hoope-Bender, P., de Bernis, L., Campbell, J., Downe, S., Fauveau, V., Fogstad, H., Homer, C. S. E., Kennedy, H. P., Matthews, Z., McFadden, A., Renfrew, M. J., & Van Lerberghe, W. (2014). Improvement of maternal and newborn health through midwifery. *Lancet (London, England)*, *384*(9949), 1226–1235. https://doi.org/10.1016/S0140-6736(14)60930-2

[38] Thomas MP, Ammann G, Brazier E, Noyes P, Maybank A. Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population. *Maternal and Child Health Journal*. 2017;21(Suppl 1):59-64.

[39] Wallenborn, J. T., & Masho, S. W. (2018). Association between Breastfeeding Duration and Type of Birth Attendant. *Journal of Pregnancy*, *2018*, 7198513. https://doi.org/10.1155/2018/7198513

[40] Edwards RC, Thullen MJ, Korfmacher J, Lantos JD, Henson LG, Hans SL. Breastfeeding and complementary food: randomized trial of community doula home visiting. *Pediatrics*. 2013;132 Suppl 2:S160-166.

[41]Kozhimannil KB, Attanasio LB, Hardeman RR, O'Brien M. Doula care supports near-universal breastfeeding initiation among diverse, low-income women. *Journal of Midwifery & Women's Health.* 2013;58(4):378-382.

[42] Chapple W, Gilliland A, Li D, Shier E, Wright E. An economic model of the benefits of professional doula labor support in Wisconsin births. WMJ: official publication of the State Medical Society of Wisconsin. 2013;112(2):58-64.

[43] Strauss N, Giessler K, McAllister E. How Doula Care Can Advance the Goals of the Affordable Care Act: A Snapshot From New York City. *J Perinat Educ* 2015;24(1):8-15.

[44] Walters, D., Gupta, A., Nam, A. E., Lake, J., Martino, F., & Coyte, P. C. (2015). A Cost-Effectiveness Analysis of Low-Risk Deliveries: A Comparison of Midwives, Family Physicians and Obstetricians. *Politiques De Sante*, *11*(1), 61–75.

[45] Hotelling BA. Perinatal Needs of Pregnant, Incarcerated Women. *J Perinat Educ*. 2008;17(2):37-44. doi:10.1624/105812408X298372

[46] Schroeder, C., & Bell, J. (2005). Doula birth support for incarcerated pregnant women. *Public Health Nursing (Boston, Mass.)*, *22*(1), 53–58. https://doi.org/10.1111/j.0737-1209.2005.22108.x

[47] *Alameda County Sheriff's Office*. (n.d.). Retrieved April 19, 2020, from https://www.alamedacountysheriff.org/dc_inmateservices.php

[48] Conway, S. (2019, December 20). *Chicago Is Making the Case for Releasing Pregnant Inmates*. The Atlantic. https://www.theatlantic.com/health/archive/2019/12/doulas-county-jail/603730/

[49] *Home*. (n.d.). The Minnesota Prison Doula Project. Retrieved April 19, 2020, from https://www.mnprisondoulaproject.org/

[50] *Alabama Prison Birth Project*. (n.d.). Apbp. Retrieved April 16, 2020, from https://www.prisonbirth.org

[51] *Ostara Initative—Programs*. (n.d.). Retrieved April 19, 2020, from http://ostarainitiative.org/

[52] *Home*. (n.d.). Black Women Birthing Justice. Retrieved April 19, 2020, from https://www.blackwomenbirthingjustice.org

[53] *Sec. 241.89 MN Statutes*. (n.d.). Retrieved April 16, 2020, from https://www.revisor.mn.gov/statutes/2019/cite/241.89

[54] *NY State Senate Bill S3126*. (2019, February 4). NY State Senate. https://www.nysenate.gov/legislation/bills/2019/s3126

[55] *Chapter 72.09 RCW: DEPARTMENT OF CORRECTIONS*. (n.d.). Retrieved April 16, 2020, from https://app.leg.wa.gov/RCW/default.aspx?cite=72.09&full=true#72.09.588

[56] *Data Analytics | Washington State Department of Corrections*. (n.d.). Retrieved April 19, 2020, from https://www.doc.wa.gov/information/data/analytics.htm

[57] (2019, April 1). *Washington 2017*. National Institute of Corrections. https://nicic.gov/state-statistics/2017/washington

[58] Residential Parenting Program | Justice Involved Women Programs. https://info.nicic.gov/jiwp/node/227. Accessed April 28, 2019.

[59] A Lack of Restraints: Washington's Anti-Shackling Efforts. Rewire.News. https://rewire.news/article/2010/02/02/a-lack-restraints-washington%E2%80%99s-antishackling-efforts/. Accessed April 15, 2019.

[60] Tolley, E. E., Ulin, P. R., Mack, N., Robinson, E. T., & Succop, S.M. (2016). Qualitative methods in public health: A field guide for applied research (2nd ed.). San Francisco, CA: Wiley.

[61] Patton MQ. Qualitative evaluation and research methods. SAGE Publications, inc; 1990.

[62] Marshall MN. Sampling for qualitative research. Family practice. Oxford Univ Press; 1996;13: 522–526.

[63] Pendleton, V., Saunders, J. B., & Shlafer, R. (2020). Corrections officers' knowledge and perspectives of maternal and child health policies and programs for pregnant women in prison. *Health & Justice*, *8*(1), 1. https://doi.org/10.1186/s40352-019-0102-0

[64] Hardeman, R. R., & Kozhimannil, K. B. (2016). Motivations for Entering the Doula Profession: Perspectives From Women of Color. *Journal of Midwifery & Women's Health*, *61*(6), 773–780. https://doi.org/10.1111/jmwh.12497

[65] McLemore, M. R., & Warner Hand, Z. (2017). Making the case for innovative reentry employment programs: Previously incarcerated women as birth doulas - a case study. *International Journal of Prisoner Health*, *13*(3–4), 219–227. https://doi.org/10.1108/ijph-07-2016-0026

[66] Collins, T. (2005). Health policy analysis: A simple tool for policy makers. *Public Health*, *119*(3), 192–196. https://doi.org/10.1016/j.puhe.2004.03.006

[67] Dedoose Version 8.3.17 (2020), Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com.

[68] Rodriguez-Garcia, R. (2000). Health policy analysis in a nutshell. p 16. *Washington, DC: The George Washington University Center for Global Health*.

[69] Lincoln, Y (1995) Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry* 1(3): 275–289.

[70] Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

[71] *Health Services | Washington State Department of Corrections*. (n.d.). Retrieved April 25, 2020, from https://www.doc.wa.gov/corrections/services/health.htm

[72] Brodsky, P. L. (2008). Where Have All the Midwives Gone? *The Journal of Perinatal Education*, *17*(4), 48–51. https://doi.org/10.1624/105812408X324912

[73] Jefferson, E. (2017). How history shaped the modern day midwife. *The Practising Midwife*, *20*(1), 23–25.

[74] Lops, V. R. (1988). Midwifery: Past to present. *Journal of Professional Nursing*, *4*(6), 402–407. https://doi.org/10.1016/S8755-7223(88)80090-5

[76] *Pregnancy services | Washington State Health Care Authority*. (n.d.). Retrieved May 1, 2020, from https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/pregnancy-services