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Winter January 22, 2020

Reproductive Justice Disrupted- Mass Incarceration as a Driver of Reproductive Oppression

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Reproductive Justice Disrupted: Mass Incarceration as a Driver of Reproductive Oppression

We describe how mass incarceration directly undermines the core values of reproductive justice and how this affects incarcerated and nonincarcerated women.

Mass incarceration, by its very nature, compromises and undermines bodily autonomy and the capacity for incarcerated people to make decisions about their reproductive well-being and bodies; this is done through institutionalized racism and is disproportionately done to the bodies of women of color. This violates the most basic tenets of reproductive justice—the right to have a child, not to have a child, and to parent the children you have with dignity and in safety.

By undermining motherhood and safe pregnancy care, denying access to abortion and contraception, and preventing people from parenting their children at all and by doing so in overpoliced, unsafe environments, mass incarceration has become a driver of forms of reproductive oppression for people in prison and jails and in the community. (*Am J Public Health.* 2020;110:S21–S24. doi:10.2105/AJPH.2019.305407)

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Kima gave birth to baby Koia on a bright fall day. It was an uneventful birth, except for the looming presence of a sheriff's deputy stationed outside the delivery room. Kima—a pseudonym of an actual incarcerated mother whose full narrative is documented in the book *Jailcare: Finding the Safety Net for Women Behind Bars*¹—was incarcerated at the local jail, charged with shoplifting and violating probation, and could not afford her bail. Kima was allowed to bond with and breastfeed her baby in her postpartum room—until 12 hours after birth, when a nurse abruptly removed the baby from Kima's arms and nervously explained that the baby had to go to the nursery. Child protective services had put a police hold on baby Koia—which meant that Kima could only spend time with the baby there, one arm chained to a wheelchair and a deputy lurking nearby—because Kima's sister, who agreed to care for the baby until Kima's release, had a child protective services record. Although a supervisor later indicated that the police hold was unnecessary, it was too late for Kima, who had already returned to jail.¹ While the child protective services worker's actions may have been legal, they were not ethical or just.

Kima's experience illuminates the ways that mass incarceration in the United States disrupts the core principles of reproductive justice: the right to have children,

the right not to have children, and the right to raise children in safety and with dignity.² Reproductive justice addresses reproductive oppression—the regulation and exploitation of individuals' bodies, sexuality, labor, and procreative capacities as a strategy to control individuals and entire communities.² Examining the broader context of Kima's reproductive life—as a Black woman whose life was shaped by racism, sexual trauma, addiction, poverty, chronic recidivism, and homelessness—makes clear that structural inequities made her vulnerable both to being targeted by carceral institutions and to reproductive oppression, so much so that a child protective services worker had the ability to inappropriately deny her the right to be with her baby. This recognition requires us to consider how mass incarceration and its violation of reproductive justice are intimately entwined.

“Mass incarceration” is a term that refers to the exponential, unprecedented, and disparate rise in the number of people behind bars in the United States since the

early 1980s. It is a phenomenon with intersecting political, social, and economic dimensions that are rooted in White supremacy and whose policies have led to the disproportionate imprisonment of people of color.³ This includes the proliferation of private prisons and prison health care companies that profit from imprisoning people.³

We argue that the disproportionate hyperincarceration of Black individuals and other historically marginalized groups violates the principles of reproductive justice, and that the entire phenomenon of mass incarceration must be understood through the lens of reproductive justice to more fully grasp its ubiquitous reach into society. In this light, it becomes clear that mass incarceration perpetuates the conditions that sustain reproductive inequities throughout US society.

WHAT IS REPRODUCTIVE JUSTICE?

“Reproductive justice” is a term, framework, and movement

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This article was accepted September 29, 2019.

doi: 10.2105/AJPH.2019.305407

that integrates reproductive rights, human rights, and social justice. This concept was developed in 1994 by 12 Black women, who, while attending a pro-choice conference in Chicago, sought to create a more expansive framework to understand and address reproductive health and rights.² Although they did important work, the reproductive rights and reproductive health movements often neglected the impact of structural conditions that shape reproductive experiences. These conditions manifest as systems of oppression based on race, ability, class, gender, sexuality, age, and immigration status. They intersect and affect the ability of individuals to control their reproductive life course. Reproductive justice recognizes that control over one's fertility is complex and cannot be fully understood outside the social conditions that affect it—including the racialized phenomenon of mass incarceration and its historical relationship to slavery and Jim Crow.^{2,4} The pioneers of reproductive justice built on Black feminist thought and saw a need for a broader framework for achieving justice for women and girls, their communities, and others who had been historically marginalized and disenfranchised.⁵

The reproductive justice framework holds three tenets at its core. Every woman has the human right to

- Decide if and when she will have a baby and the conditions under which she will give birth,
- Decide if she will not have a baby and her options for preventing or ending a pregnancy, and
- Parent the children she already has with the necessary social supports in safe environments

and healthy communities and without fear of violence from individuals or the government.

In the linking of the human rights framework with Black feminist theory, we recognize that people may require differing supports to achieve these rights based on intersecting oppressions that are unique to an individual's life. Reproductive justice connects reproductive oppression to struggles for social justice and human rights by focusing on the roles that social institutions—such as prisons and jails—the environment, economics, and culture play in each woman's reproductive life.²

Women behind bars have been largely eclipsed in broader discussions on health care for incarcerated people, criminal legal system reform, and critiques of the negative impact of incarceration on health status and outcomes. This is evident in common descriptions of incarceration rates. Recent attention to the declining prison population ignores that the number of incarcerated women continues to rise, with more than 225 000 women in jails and prisons in 2017, representing more than a 700% increase since 1980.^{6,7} Women, especially women of color like Kim, have been disproportionately affected by the criminalization of poverty—incarcerating people for poverty that results from neoliberal market inequalities⁸—and the policies of the “war on drugs.”⁹ Statistically reflecting this racialized phenomenon, 53% of sentenced female prisoners were women of color in 2017.⁶ Black women are twice as likely to be incarcerated as White women, and 1 in 18 Black women will be imprisoned in her life, compared with 1 in 111 White women.^{6,10} Seventy five percent

of incarcerated women are of reproductive age, and two thirds are mothers and the primary caregivers to young children.^{6,11} Incarceration of these mothers leaves a large population of children functionally orphaned without caregiver stability.¹¹

Up to 80% of women report being sexually active with men in the months before incarceration, with less than 30% reporting consistent use of contraception at the time of incarceration.¹² Some women will, therefore, be pregnant at the time of incarceration, and the care they receive—or do not receive—can significantly influence their health and the outcome of their pregnancies.^{13,14} Until 2019, there were no national statistics about pregnancy outcomes in incarceration settings. Such a data omission calls attention to the ways that incarcerated pregnant people have been overlooked. A 2019 study of state and federal prisons reported nearly 1400 admissions of pregnant people, more than 750 live births, almost 50 miscarriages, and only 11 abortions in one year.¹⁵ The nature of the carceral system's role in separation, punishment, and domination means that these pregnancies are inherently marked by infringements on reproductive justice. The forces leading to rising and racially disproportionate rates of incarceration overlap with reproductive oppression through persistent devaluation and control of people's reproductive well-being. We explore those overlaps further.

THE RIGHT TO HAVE CHILDREN

At its most basic level, incarceration interferes with people's

abilities to decide if and when to have children. Although jail stays may be short, current sentencing laws can keep women behind bars for a long time. Because a woman's fertility in general declines with age, this means that a woman who is released from prison after a lengthy sentence will have less fecundity than when she entered. Given that most incarcerated women are confined during their childbearing years, and given that imprisonment generally precludes procreation, incarceration violates this first tenet of reproductive justice; because men's fertility is not time dependent, this is a reproductive oppression that is unique to incarcerated women.

The right to have children also includes the right to determine the conditions in which one gives birth. Medical standards and best practices for obstetrical health care apply to all pregnant, birthing, and postpartum people regardless of incarceration status. Yet available evidence shows that many jails and prisons provide substandard, minimal, or even dangerous prenatal care.^{13,14} And although some individuals may access care in prisons and jails that they would otherwise not receive, this reality reflects the broader deficiencies of a social safety net that fails to adequately address the needs of people on the margins of society.¹

This variability in prenatal care stems, in part, from the lack of mandatory standards or oversight in incarceration health care. Despite the Supreme Court's declaration that incarcerated people have a constitutional right to health care,¹⁶ there is no agency that oversees health care in prisons or jails or requires that they provide a certain basic set of health care services, including pregnancy care. When

incarcerated pregnant people are denied the care that they need, it is in direct violation of this constitutionally protected right. Moreover, despite national health care organization guidelines, incarcerated pregnant people are shackled to beds and kept in solitary confinement, in direct violation of United Nations Rules for the Treatment of Women Prisoners.¹⁷ As of December 2019, only 29 states, the District of Columbia, and the federal government had anti-shackling laws in place. Even in states with antishackling laws, the practice still routinely happens, owing in part to a lack of oversight and accountability of custody officers, hospitals' lack of awareness of the laws, and punitive attitudes toward pregnant incarcerated people.¹⁸

It is common for incarcerated mothers to be separated from their newborns within less than 24 hours of birth. This practice disrupts important bonding time and denies both the mother and the infant the benefits that come from breastfeeding. Such was the case for Kima, the woman described earlier. Black women and other women of color carry the heaviest burden, as they are disproportionately incarcerated and more likely to die in childbirth than White women, as a result of many factors, including embedded racism in health care systems.¹⁹

Incarceration also violates the rights of women to have children through coercive contraceptive and sterilization practices. For instance, women in California prisons were unlawfully sterilized without consent as recently as 2010.²⁰ These practices share legacies of forced sterilization of other historically devalued and oppressed groups—such as immigrants and people with disabilities, including psychiatric

disabilities.⁵ Recognizing the potential for coercion in incarcerated settings, the American College of Obstetricians and Gynecologists advises that incarcerated women generally not undergo tubal sterilization while in custody.²¹

THE RIGHT NOT TO HAVE CHILDREN

The reproductive rights movement has historically focused on protecting the legal rights to choose and access contraception and abortion. However, the ability to secure these rights is constrained when access to care is limited, bodily autonomy is controlled, and physical movement is restricted, as is the case with incarceration. In other words, the notion of reproductive “choice” is irrelevant.

The courts have affirmed that women's constitutional right to abortion exists even during incarceration.²² However, realizing this right in a system designed to control and dominate all aspects of an individual's life can be nearly impossible. Barriers created by institutions of incarceration may include absent or prohibitive written abortion policies, requiring women to pay for the abortion or transportation to the facility where she is to obtain an abortion, or mandating a court order for what is labeled an “elective procedure.”²² Such policies are undue burdens for incarcerated people. For instance, many incarcerated women cannot afford the procedure or custody transportation cost requirements; were they not incarcerated, they might have insurance or be in a state where Medicaid covers their abortion—but Medicaid is suspended upon incarceration.²³ Getting a court

order to be allowed to have an abortion adds complicated logistics and time to the process, notable for a medical procedure that is time sensitive. These carceral impediments can all result in delays or an outright inability to have an abortion, effectively forcing women to continue pregnancies against their will as part of their punishment.²² Such incarceration-specific barriers play out in a broader context in the United States, where restrictive laws have already limited abortion access for all women.

Accessing contraception during incarceration can prove equally problematic. Although most incarcerated women plan to resume sexual activity with heterosexual partners within six months of their release and the majority want to start contraception before release, few prisons and jails provide access to contraception.^{12,24} Most do not even permit women to continue preincarceration methods; temporarily discontinuing birth control puts women, particularly those in short stay jails with unpredictable release dates, at especially high risk of unplanned pregnancy upon reentry. Incarceration thus interferes with women's efforts to avoid unwanted pregnancies.

THE RIGHT TO RAISE A FAMILY WITH DIGNITY

Mothers who are incarcerated are immediately prevented from raising their families with dignity and in safety because they are confined. They are also more likely to lose their children to the foster care system and are more likely to lose their parental rights than incarcerated fathers and those who neglect, abuse, and

sexually molest their children.¹¹ Reinstating parental rights after release can be challenging, especially if children have been placed in state custody. Incarcerated mothers are released into circumstances in which they often have difficulty accessing housing, employment (especially because many employers will not hire those with a criminal record), and other resources; these factors impair their ability to raise their children in safety and with dignity after incarceration. Furthermore, the intergenerational impact of incarceration also signals the limitations on their abilities to raise flourishing families. In addition to being more likely to be incarcerated than those without an incarcerated parent, children of incarcerated parents experience social stigma, isolation, and poor self-image.¹¹ These issues make it difficult for children of incarcerated parents to develop into confident adults.

CONCLUSIONS

Mass incarceration has had a disproportionate and negative impact on Black families, including on economic stability, children's academic achievement, the involvement of child welfare and the juvenile justice system, and the overall ways it strips families of crucial bonds over time.²⁵ Framing mass incarceration as solely a male problem, either explicitly or by the subtle omission of women, leaves out critical pieces of this debate. Focusing on Black women provides a unique opportunity to fully show the intersecting relationships between reproductive oppression, structural racism, and mass incarceration, as Black women sit at the intersection of race and gender. Black women's

positionality in US society offers inroads into understanding how mass incarceration disrupts reproductive justice, as their racial and gender identity makes them targets for incarceration and violations of their reproductive rights, unlike White women.⁵

Central to reproductive justice is the ability to make decisions about your own fertility without fear, coercion, or violence. It is a human right that includes the ability to choose if, when, and how to have children and under what circumstances you will be a parent. In this sense, reproductive justice exposes the ways that mass incarceration is tied to the systemic violations of human rights. These violations have contributed to the acceptance and normalization of removing children from incarcerated parents and the denial of reproductive rights and health and, thus, has made it impossible for all incarcerated people and communities of color to enjoy what it means to be fully human. Indeed, it then becomes a heuristic for recognizing reproductive oppressions throughout society. This lens is an apt way of understanding the reproductive experiences of Kima, the mother we described who gave birth in custody.

Confronting the many ways that mass incarceration and our criminal legal system routinely disrupt reproductive justice and therefore drive reproductive inequities requires significant attention in these four areas: (1) ensuring that incarcerated women have access to comprehensive, quality reproductive health care; (2) dismantling structural and institutional racism, including our own internalized racism and sexist thinking and practices; (3) promoting reproductive justice and women's health as core parts of any political agenda; and (4) developing a

commitment to imagining a world without prisons. If we are going to live in a society that is equitable and that does not violate the basic principles of reproductive justice, particularly for people like Kima who are most susceptible to reproductive oppression, we need a set of new tools and analysis for addressing our criminal legal system and mass incarceration. Most importantly, we need imagination. We also need to always ask ourselves, does this criminal legal policy, practice, or procedure violate any of the core tenets of reproductive justice? And if we find that it does, we must commit to holding ourselves and our institutions accountable for rectifying this, to ensure we are not violating anyone's reproductive rights—no matter their status as an incarcerated or free person. **AJPH**

CONTRIBUTORS

C. M. Hayes led the writing and revision of the article. C. Sufirin and J. B. Perritt contributed to writing and revising the article. The authors contributed equally to the concept and outline for the article and compiling references.

ACKNOWLEDGMENTS

C. Sufirin is supported by the National Institute on Drug Abuse, National Institutes of Health (grant 5K23DA045934-02) and the Society of Family Planning Research Fund (grant SFPRF11-09). C. M. Hayes is supported by the Council on Social Work Doctoral Minority Fellowship and the Vivian Michealson Fellowship, University of Connecticut School of Social Work.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

REFERENCES

1. Sufirin C. *Jailcare: Finding the Safety Net for Women Behind Bars*. Oakland, CA: University of California Press; 2017.
2. Strickler R, Simpson M. A brief history of SisterSong. In: *Radical Reproductive Justice: Foundation, Theory, Practice, Critique*. New York, NY: Feminist Press; 2017:9.
3. Davis A. *Race and Criminalization: Black Americans and the Punishment Industry*. New York, NY: Pantheon Books; 1997.

4. Alexander M. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York, NY: New Press; 2010.
5. Roberts D. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York, NY: Pantheon Books; 1997.
6. Bronson J, Carson EA. *Prisoners in 2017*. Washington, DC: Bureau of Justice Statistics; 2019. NCJ 252156.
7. Zeng Z. *Jail Inmates in 2017*. Washington, DC: Bureau of Justice Statistics; 2019. NCJ 251774.
8. Wacquant LJD. *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Durham, NC: Duke University Press; 2009.
9. Paltrow LM, Flavin J. Arrests of and forced interventions on pregnant women in the United States, 1973–2005: implications for women's legal status and public health. *J Health Polit Policy Law*. 2013; 38(2):299–343.
10. Sentencing Project. Criminal justice facts. Available at: <https://www.sentencingproject.org/criminal-justice-facts>. Accessed July 20, 2019.
11. Smyth J. Dual punishment: incarcerated mothers and their children. *Columbia Social Work Review*. 2012;10(1):33–45.
12. Clarke JG, Hebert MR, Rosengard C, Rose JS, DaSilva KM, Stein MD. Reproductive health care and family planning needs among incarcerated women. *Am J Public Health*. 2006;96(5): 834–839.
13. Ferszt GG, Clarke JG. Health care of pregnant women in US state prisons. *J Health Care Poor Underserved*. 2012; 23(2):557–569.
14. Kelsey CM, Medel N, Mullins C, Dallaire D, Forestell C. An examination of care practices of pregnant women incarcerated in jail facilities in the United States. *Matern Child Health J*. 2017;21(6): 1260–1266.
15. Sufirin 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.
16. *Estelle, Corrections Director, et al. v. J. W. Gamble*, 429 U.S. 97 (1976).
17. United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules). In: Kleinig J, ed. *Prisoners' Rights*. Abingdon, UK: Routledge; 2017:435–457.
18. Goshin LS, Sissoko DRG, Neumann G, Sufirin C, Byrnes L. Perinatal nurses' experiences with and knowledge of the care of incarcerated women during pregnancy and the postpartum period. *J Obstet Gynecol Neonatal Nurs*. 2019;48(1): 27–36.
19. McLemore MR. To prevent women from dying in childbirth, first stop blaming them. *Scientific American*. May 2019.

Available at: <https://www.scientific-american.com/article/to-prevent-women-from-dying-in-childbirth-first-stop-blaming-them>. Accessed July 20, 2019.

20. Roth R, Ainsworth S. "If they hand you a paper, you sign it": a call to end the sterilization of women in prison. *Hastings Womens Law J*. 2015;26(1):7–49.
21. American College of Obstetricians and Gynecologists Committee on Ethics. Committee opinion no. 695: sterilization of women: ethical issues and considerations. *Obstet Gynecol*. 2017;129(4):775–776.
22. Kasdan D. Abortion access for incarcerated women: are correctional health practices in conflict with constitutional standards. *Perspect Sex Reprod Health*. 2009;41(1):59–62.
23. Gates A, Artiga S, Rudowitz R. Coverage and care for the adult criminal justice-involved population. 2014. Available at: <https://www.kff.org/wp-content/uploads/2014/09/8622-health-coverage-and-care-for-the-adult-criminal-justice-involved-population1.pdf>. Accessed September 27, 2019.
24. Sufirin CB, Creinin MD, Chang JC. Contraception services for incarcerated women: a national survey of correctional health providers. *Contraception*. 2009; 80(6):561–565.
25. Ta-Nehisi Coates. 50 Years after the Moynihan Report, examining the Black family in the age of mass incarceration. *The Atlantic*. October 2015. Available at: <https://www.theatlantic.com/magazine/archive/2015/10/the-black-family-in-the-age-of-mass-incarceration/403246>. Accessed July 20, 2019.