THE SHACKLING OF INCARCERATED PREGNANT WOMEN: ANALYSIS OF ALTERNATIVE POLICY

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BIO

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BIO

Angela is a graduating MSW student at Columbia School of Social Work on the Advanced Clinical Practice track. She is a former professional dancer and dance educator and is passionate about the mind-body connection and the role movement plays in supporting mental health. Currently, Angela works as a Research Assistant with the Action Lab for Social Justice and an Orientation Leader with Student Life. She looks forward to serving Black and Brown children, youth, and communities in NYC and beyond.

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BIO

Sofia is a graduating MSW student at Columbia School of Social Work in the Policy Practice track. Throughout her academic and professional experience, she has specialized in international social welfare, immigration, and refugee resettlement. She currently works on the research team at Columbia's Social Intervention Group, contributing to projects focused on strengthening social welfare infrastructure in Uzbekistan. Sofia is passionate about strategic, human-centered humanitarian work, particularly through research, policy development, and program reform. She looks forward to continuing her advocacy in the field following graduation.

INSPIRATION

This paper originated as a broad inquiry into policy reform within carceral systems. When we dug deeper, the overlooked and unethical practice of shackling pregnant incarcerated women emerged as a critical concern. Our policy analysis transitioned from a general examination of systemic inequities in the criminal legal system, to a focused investigation of a practice shaped by racism, misogyny, and reproductive injustice. The evidence underscores the urgency of this issue, given the significant vulnerability and trauma experienced by this population. Employing a policy analysis approach, this paper calls for immediate action to dismantle the practice of shackling pregnant women behind bars.

ABSTRACT

The shackling of pregnant incarcerated individuals, through restraints such as handcuffs, waist chains, and leg irons, is a dehumanizing practice that poses serious physical and mental health risks to both parent and child. This practice is disproportionately imposed on women of color, who are vastly overrepresented in the incarcerated population. Black women are three times more likely than white women to be incarcerated, and women overall represent the fastest-growing segment of the detained population, with an 800% increase over the last 30 years (American Civil Liberties Union [ACLU], 2007; Keyes, 2014). As the number of incarcerated women has grown, so too has the number of pregnancies and births occurring within carceral systems, making the absence of strong anti-shackling protections an urgent public health and civil rights concern. Despite well-documented health risks and widespread recognition of the practice's discriminatory nature, many states maintain weak laws, and some have no laws, prohibiting the shackling of pregnant women (Bandele, 2017). This policy analysis paper exposes the discriminatory practice of shackling, specifically of marginalized pregnant populations in prison, and proposes steps toward ethical policy alternatives. Using the IRAC framework for legal policy analysis (Issue, Rule, Analysis, Conclusion), this paper examines shackling policies from U.S. regulations to global policies, and from the most humane laws to the most restrictive. From this, we developed concrete policy solutions. The proposed *Resilient Mothers Act* addresses the needs of the most marginalized—pregnant Black women experiencing incarceration—as a pathway toward broader equity and justice within prison reform efforts.

Keywords: shackling, mass incarceration, women, pregnancy, discrimination, marginalization, dehumanization, racism

THE SHACKLING OF INCARCERATED PREGNANT WOMEN: ANALYSIS OF ALTERNATIVE POLICY

Pregnancy is a moment of profound vulnerability, requiring care and support. Yet inside carceral systems, pregnant individuals are stripped of both. Women are the fastest-growing population in the prison system; pregnant women are an even more marginalized subgroup (ACLU, 2007). Shackling is a dehumanizing practice designed to impede the movement of incarcerated individuals in prison through the use of physical restraints. For many, especially the most marginalized groups of incarcerated people, shackling can have devastatingly harmful outcomes.

The physical devices used in shackling often consist of handcuffs, waist chains, and leg irons. Various types of steel and metal are forged together to create these devices. Leg irons, similar to handcuffs, can be around nine inches long. They consist of two circular openings for the wrists or ankles connected by either a bar or a chain. The inner workings of the cuffs are such that the "teeth" on the mouth of the cuffs, or "ratchet," interact and can lock with an inside mechanism called a "pawl," which allows the cuff to constrict around the wrist or ankle, preventing full rotation (National Institute of Justice, 1982). Waist chains are used in situations where elevated security is deemed necessary. This involves a chain that can cover up to a 54-inch waist that is placed above the hip bone (ICS Jail Supplies, n.d.). The chain has a special link that loosens once the handcuffs are added, so the chain must be tightened onto the belt to prevent additional movement. Handcuffs are attached to the chain through a piece called a "connector chain" and, in more severe instances, connected to leg irons as well. In some cases, to connect the leg irons, an incarcerated person would have to position themselves on their knees facing away from the corrections officer. The

officer would then tighten the leg irons around the individual's ankles and secure the waist chain with a padlock, which prevents the individual from removing the chain.

Shackling in healthcare environments refers to restraining a patient's body through physical, medical, or mechanical means when there is no medical necessity. While often defended as a safety measure, shackling is a harmful and violent act that negatively impacts both patients and healthcare workers' ability to assess and treat. Shackling is widely considered a violation of human rights, particularly for incarcerated pregnant or perinatal individuals, yet it persists because of ongoing systemic inequities within the criminal legal system. Policy reforms are essential to prevent continued discrimination related to this practice (American Public Health Association [APHA], 2023).

Using the Issue, Rule, Analysis, and Conclusion (IRAC) method for legal policy analysis, we aim to expose the discriminatory practice of shackling pregnant women in prison. We close by proposing the *Resilient Mothers Act*, which would take the necessary first steps toward ethical policy reform.

ISSUE

Mass incarceration serves as the bedrock of modern-day racism in the United States. One of this system's most vulnerable and at-risk populations is pregnant women. Although people of color represent roughly 30% of the population in the U.S., they represent about 60% of the population of incarcerated individuals (Keyes, 2014). Women are the fastest-growing segment within these systems, as the number of women in detention has increased by 800% in the last 30 years and has increased twice as fast as the number of men in detention since 1985 (ACLU, 2007). Women of color are significantly overrepresented in this population,

with Black women being three times more likely than white women to be incarcerated (Keyes, 2014). It is estimated that roughly 55,000 pregnant individuals are admitted to jails each year, many of whom are shackled throughout all stages of pregnancy and postpartum (Dufresne, 2023). Pregnant women are often continuously shackled during labor and delivery, one of the most vulnerable and usually traumatic stages of pregnancy (Bandele, 2017). While it is difficult to gather representative information due to limited transparency, bias, and underreporting, Goshin and colleagues (2019) found that around 83% of perinatal nurses who worked with incarcerated women during pregnancy and postpartum stated that their patients were shackled part of the time to all of the time. Additionally, only 7.4% of nurses correctly identified whether their state had shackling laws.

The U.S. criminal legal system is framed as an effort to maintain public safety and deter crime. But it functions alongside policies and practices that perpetuate racial segregation, disenfranchisement, and systemic inequity to create a modern Jim Crow order. In the U.S., incarceration has become the nation's default response to crime, with 70% of convictions leading to confinement, which is far more than in other countries. Furthermore, carceral systems are driven by racist policies like the "War on Drugs," politically motivated public fear, and capitalism, not actual crime rates (Widra, 2024). Due to intentional discrepancies in how laws are written and upheld, mass incarceration maintains the racial hierarchy established by white supremacy, where whiteness is held as the ideal standard and other races and ethnicities are ordered in subordinate positions based on their proximity to whiteness. This hierarchy aims to enshrine the disempowerment of Black individuals, with other intersecting identities such as gender, sexuality, ability, and class contributing to even further marginalization within

society. This marginalization can be observed in part through limited economic opportunities, decreased social capital, discriminatory policies, adverse health outcomes, and disproportionate representation in systems of incarceration. These unjust outcomes are impacting people of color on a massive scale.

In 2024, nearly 2 million people were detained in this nation's expansive criminal legal system, including state, federal, local, and tribal detention facilities (Sawyer & Wagner, 2024). In early 2025, we observed a notable increase in federal and immigration detention, with an overall systemwide cost of at least $182 billion per year to maintain existing carceral systems (Ghandnoosh & Pearce, 2025; Sawyer & Wagner, 2025). Furthermore, the Justice Policy Institute found that during the 1990s, the New York state prison budget grew by $761 million. In contrast, New York's budget for higher education dropped by $615 million during this decade. Statistics like this show the financial impact of mass incarceration, as the federal government increasingly fails to allocate funding toward social services and education, which would reduce the need for jails (Irwin et al, 1999).

With the population of incarcerated women increasing drastically, the number of pregnancies and births within the criminal justice system has increased as well. According to a 2024 report from the ACLU, about 60% of women in prison were the primary caregivers to a child under 18 years old before their sentencing. Additionally, every year, 80% of women in jail are mothers of children under the age of 18 years old (Kendrick, 2024).

A common justification that state judicial systems use to defend shackling is that it prevents escapes. When incarcerated individuals are taken out of the correctional

facility and transported to nearby hospitals or clinics to give birth, they are often deemed a flight risk. However, according to the American Medical Association (AMA), the overwhelming majority of incarcerated pregnant individuals are unlikely to try to escape, harm others, or harm themselves. Women have been the fastest-growing and least violent population in the prison system since the 1990s (Advocacy Resource Center, 2015; Budd et al., 2025; Kajstura & Sawyer, 2024).

Unequal pain treatment in the U.S. medical system is directly tied to white supremacy culture and racism. Research shows that medical trainees in the U.S. often demonstrate bias against Black patients' pain—for instance, as seen in the false belief that Black people have thicker skin and fewer nerve endings. These biases are directly related to historical narratives used to justify the abuse of enslaved Black Americans (Morais et al., 2022). Additionally, patients with sickle cell disease, which disproportionately affects Black populations, experience 50% longer physician wait times than patients with long bone fractures (Haywood et al., 2013). A 2024 systematic review and meta-analysis found that Black patients were less likely to receive opioid prescriptions than non-Hispanic white patients presenting with the same type of pain (OR = 0.83, 95% CI [0.73–0.94]). These results have stayed consistent for over a decade from the original study (Hirani et al., 2024; Meghani et al., 2012). Racism in the medical system is particularly pronounced for Black women, who face the intersectional effects of both racial and gender bias on how their pain is perceived, reported, and treated.

The practice of shackling incarcerated women during labor not only undermines principles of justice by dehumanizing them and violating their dignity, but also poses serious physical and mental health risks to both the parent and the

baby. Physical risks of shackling include severe bruising, fractures, abrasions, lacerations, infections, scarring, and nerve damage. Pregnant women are especially susceptible to the harms of shackling, as it increases their risk of abdominal trauma, hemorrhage, and preterm birth, as well as risks to the fetus (APHA, 2023). Shackling is also directly linked to limited mobility and forced limb movements that increase the extreme risk of falls, which can lead to heart attacks, strokes, and fetal death (Robinson et al., 2021). Moreover, shackling can hinder the processes of labor and delivery, limit emergency obstetric care, and impede postpartum recovery, including the mother's ability to safely hold and breastfeed her infant (APHA, 2023).

Through qualitative studies that included provider interviews and patient experiences, the American Public Health Association (APHA) found a plethora of emotional harms. They found that witnessing a patient in shackles can exacerbate the existing negative bias toward incarcerated patients. This bias increases inappropriate use of force among healthcare providers and security guards. Incarcerated patients may view their provider as complicit with shackling, which further breaks down trust between patients and providers (APHA, 2023). The presence of shackles heightens feelings of extreme disrespect and a violation of human dignity. According to Goshin et al. (2019), incarcerated women already have disproportionately high rates of depression and posttraumatic stress disorder, which is further intensified by shackling. The inability to adjust their bodies while in pain is degrading and cruel. Immediate separation of infants from parents can lead to extreme behavioral and emotional dysregulation for both the child and the mother. Without maternal–newborn bonding, incarcerated mothers can experience low self-esteem, depression, anxiety, anger, and psychiatric disorders (Ferszt et al., 2018; Franco et al., 2020). Shackling prevents pain-management practices, impedes

time-sensitive lifesaving medical interventions, and can lead to post-birth psychological conditions.

Hessami and colleagues (2022) conducted a systematic review and meta-analysis looking at the inadequate prenatal care and birth outcomes of incarcerated individuals compared to non-incarcerated individuals. They found preliminary results that incarcerated individuals have a higher risk for inadequate prenatal care compared to non-incarcerated individuals. Although their sample comprised 11,534 pregnant women, they suggest that further research is needed. The minimal research in the past decade on pregnant incarcerated demographics does not represent reality, as many reports are unfinished or births are not documented (Bronson & Sufrin, 2019; Sufrin et al., 2019). It is important to note that limited research has been conducted on the full impact of shackling and the quality of healthcare for incarcerated pregnant women, further marginalizing this population through under-documentation.

On a societal level, shackling is inextricably linked to anti-Black racism, as it was used to facilitate the subordination, dehumanization, and control of enslaved individuals. Given the disproportionate incarceration of Black and Brown women, shackling exacerbates the white supremacist racial order (Dufresne, 2023). From forced reproduction during slavery to coercive sterilization practices, Black women's bodies have been objectified, dehumanized, and controlled. Shackling during pregnancy perpetuates this legacy and disproportionately targets Black women, who are overrepresented in prisons due to systemic racism (Weber et al., 2018). Black women are often seen as dangerous or unworthy of compassion, thus making them more likely to experience the degrading practice of shackling (Marsh, 2009). These damaging perspectives lead to harmful

expressions, like the "strong Black woman" trope, which denies Black women the care and attention they need.

From a social work perspective, adopting a liberatory framework in the policy design process would center the voices of Black women, which is vital to this policy (Hacker, 2013). Policymakers would work with currently and formerly incarcerated women and advocacy organizations led by women of color to ensure adequate prenatal care. Social workers and learning coaches would develop provisions for culturally competent, trauma-informed care and staff education on implicit bias, which would affect maternal outcomes and help ensure equitable implementation (Crenshaw, 2014).

RULE

After identifying the issue, we outline the rules and laws governing shackling policies across the U.S. Although many states have individual laws prohibiting restraints, "extraordinary circumstances" loopholes in these laws allow correctional officers' biases to influence the use of shackles. State bans on shackling have been ineffective, as cases have come forward where women were shackled unlawfully despite supposed state protection (Dufresne, 2023). A federal law would better protect the rights, dignity, and health of pregnant women who are incarcerated by creating a widespread shift in attitudes, treatment, and outcomes for people who are incarcerated.

The Eighth Amendment to the U.S. Constitution states that cruel and unusual punishment is prohibited, which most states interpret as a prohibition on shackling pregnant individuals, particularly during childbirth. However, there are many loopholes that correctional facilities use that we believe are human rights violations and violate the Eighth Amendment.

Additionally, the Fourteenth Amendment's Due Process and Equal Protection clauses assert the dignity and worth of every person as a fundamental human right—a principle that shackling infringes on, particularly for vulnerable populations who require additional protection. Take the state of Louisiana as an example, in which Black incarceration rates are one of the highest in the nation, with Black individuals being incarcerated at a rate nearly five times higher than whites. There is a widening public health concern that mass incarceration may be a contributing factor in reproductive health disparities, with a notable 3% risk of preterm births among Black women in Louisiana (Dyer et al., 2019).

In the last 10 years, Louisiana has enacted three state laws to provide better health support for incarcerated women. Act No. 761 (2012) requires staff training and prohibits the shackling of pregnant individuals. Along with this, the Safe Pregnancy for Incarcerated Women Act was established to require all local and state correctional facilities to provide records on the use of restraints, allow incarcerated individuals to request medical staff during body searches after returning from the hospital, and provide written information to pregnant women on their restraint policies. Act No. 392 (2018) requires correctional facilities to provide healthcare products for women. Lastly, Act No. 140 (2020) prohibits the use of solitary confinement for pregnant women.

Despite these laws, the use of restraints, denial of medical professionals' advice, and unclear documentation on incarcerated pregnant women still exist to this day. Only a few facilities complied with providing incarcerated individuals with a written restraint policy. If documentation of shackling is provided under Act 761, it is often left blank or incomplete, leaving out the reason for shackling or the duration of restraint. As for Act 392, many facilities still charge women

for feminine hygiene products unless they have less than $2 in their bank account, and even then, they add this cost as a debt that the incarcerated individuals must pay back (Louisiana Public Health Institute, 2023). This is an inequitable practice, further marginalizing women in prisons.

In 2015, the Rebecca Project for Human Rights and the National Women's Law Center published *Mothers Behind Bars*, a state-by-state report card on shackling policies for pregnant women. They found that 31 states do not require medical staff input when determining whether a pregnant woman should be restrained. 36 states received a failing grade because they do not limit the use of restraints, including the harmful leg irons and waist chains that could injure the mother and the fetus during transportation, labor and delivery, and the postpartum period (Advocacy Resource Center, 2015).

ANALYSIS

For over a decade, the practice of shackling pregnant women in prison in the U.S. has been widely criticized. National correctional and medical associations like the American Congress of Obstetricians and Gynecologists (ACOG), AMA, APHA, and the Federal Bureau of Prisons have all vocally opposed the shackling of pregnant women due to its inhumane, hazardous, and avoidable nature (Advocacy Resource Center, 2015). ACOG released an updated committee opinion concluding that physical restraints impede physicians' ability to effectively care for pregnant people and fetuses, causing serious risk. This includes added bruising and pain, risk of falls, and inability to effectively treat preeclampsia, vaginal bleeding, nausea, and many other medical emergencies during labor, delivery, and postpartum (ACOG, 2021).

Despite these open criticisms citing the understood health risks and the blatant racism and misogyny embedded in this discriminatory practice, most states maintain laws that leave significant room for harm, and some states have no laws prohibiting the shackling of pregnant women. As of August 2024, approximately 40 states had legislation prohibiting the shackling of pregnant women, but reports of prison and hospital staff ignoring these policies are rampant (Rayasam, 2024). Even when the laws are in place, there is limited oversight, confusion about their meaning, and wide loopholes for staff to exploit. These loopholes lead to unsafe childbirth experiences and deliberate discrimination against women of color (Rayasam, 2024).

We began our policy solution search by identifying model policies in states with the most progressive and humane laws. These states include California, New York, Illinois, Vermont, Washington, Connecticut, Colorado, and Minnesota. These states have progressive and protective legislation that emphasizes humane treatment. Some important features of more progressive policies include the prohibition of shackling during labor, delivery, or the postpartum period, except when a clear, documented security risk is present in the most exceptional circumstances. They also make it clear that if restraints must be applied in extraordinary circumstances, they must be removed immediately if they interfere with medical care. There are clear and extensive guidelines for the removal of restraints, and the policies specify that healthcare professionals, not prison staff, make decisions about shackling. These policies also all, in some form, ensure mental health support and trauma-informed prenatal and postpartum care (Kramer et al., 2022). In the U.S., the First Step Act of 2018 could be a beginning step toward a nationwide policy against shackling pregnant women (Federal Bureau of Prisons, n.d.). It prohibits the use of restraints on

pregnant women during all stages of pregnancy, and ensures that medical staff, not corrections officers, are involved in making decisions about the use of restraints. Unfortunately it applies only to federal facilities, and even then is enforced inconsistently (Samant, 2018).

We then looked at other countries for the most humane and restrictive shackling laws in the world. We did this because, despite the progressive policies the aforementioned states enacted, the U.S. continually disregards legal restrictions that promote human rights, medical standards, racial equality, and gender equality. Some of the most humane shackling laws for pregnant women exist in the U.K., Canada, Australia, Norway, Sweden, and New Zealand. These countries have similar laws as the progressive states listed previously, but their restrictions put an extra emphasis on human rights and gender equality. These laws also apply nationwide, rather than leaving jurisdiction to states or territories. Most notably, Norway and Sweden have a more human-rights-based model, prioritizing medical care, dignity, alternatives to incarceration, and gender-sensitive approaches. Within this model, efforts are made to amend legislation to ensure humane practices (United Nations Office on Drugs and Crime, 2014).

Based on this review, we developed a list of proposed policy solutions that constitute our *Resilient Mothers Act*. The *Resilient Mothers Act* will protect women who are pregnant and facing incarceration through all stages of pregnancy, including transportation, labor, delivery, and postpartum recovery. Our justification for this policy draws on research demonstrating that banning the practice is essential to addressing systemic inequities, protecting human rights, closing gaps in state law, countering security myths, and improving health outcomes (Project Nia & Barnard Center for Research on Women, 2020).

First and foremost, we call for a complete prohibition of shackling, including all use of physical restraints. The sole exception would be in cases where the individual poses an immediate threat to themselves or others. This exception, however, would have to be properly documented and justified by medical staff. We would mandate detailed reporting and justification and propose regular audits and reviews by independent bodies. This would ensure that accountability is at the forefront of every decision. If the justification is not sufficient, we propose legal repercussions. Shackling pregnant women in prisons would be a violation of federal law, and therefore, there would be penalties for those who do not comply and legal pathways for individuals to seek civil damages. We hope the detailed paperwork, consistent accountability, and federal repercussions would help mitigate the loopholes that currently lead to rampant racial biases and misogyny.

The Resilient Mothers Act would also require medical oversight and ensure that medical staff, not prison staff, are responsible for any final decisions regarding shackling. Currently, most legislation does not consider medical implications and silences physicians' voices (Dufresne, 2023). A physician's job is to prevent the health complications and harm that shackles cause during birth, but as of now, their requests to remove shackles are often ignored.

In addition to these measures, the law will require staff training, focusing on trauma-informed, antiracist, and gender-sensitive education for all prison staff who oversee pregnant women. This education would include the physical and psychological risks and harms of shackling during pregnancy, such as increased risk of fall, inability to quickly perform medical care (which can lead to complications as drastic as death), increased pain during delivery, fetal distress,

breastfeeding complications, humiliation, triggered PTSD from past trauma, and the inability for parent and child to bond (Hall et al., 2015). Additionally, this training must include diversity training, as the majority of these pregnant individuals are non-white. As the U.S. incarcerates more and more people for nonviolent offenses, minority populations, specifically African Americans and Latinos, unjustly comprise over 70% of new admissions (Irwin et al, 1999).

To ensure the successful implementation of the *Resilient Mothers Act*, we offer a sustainable funding strategy that lays the groundwork for advancing reproductive justice for all incarcerated women. This includes reallocating funds from the prison budget: We propose introducing a dedicated pre-allocation (similar to the pretax system) for the budgets of prison facilities housing women. This funding would be reserved for costs directly associated with compliance, training, implementation, ongoing education for medical and prison staff, feminine care provisions, and enhanced maternal healthcare services. This pre-allocation recognizes facilities' responsibility to address gender-specific needs and ensures that funds are directed toward the initiatives. By reallocating existing resources within the carceral system, we uphold justice and human rights without imposing additional financial burdens on taxpayers.

Approximately two-thirds of incarcerated individuals are employed while in prison. Many earn pennies on the dollar, while states such as Arkansas and Texas do not pay wages at all (Eisen, 2023). We propose that corporations benefiting from incarcerated labor pay a surcharge or fee. This fee would function similarly to employer-paid health benefits (like Uber's driver benefits fee, which customers pay in service charges). It would contribute to the *Resilient Mothers Act* account, which will be dedicated to funding research and

key initiatives to ensure compliance. This fee would serve as a commitment by corporations that profit from the labor of incarcerated individuals, aligning with the growing societal demands for accountability and equitable practices.

This law supports the immediate implementation of bans on shackling and lays the foundation for systemic reforms. By meeting the needs of the most marginalized populations experiencing incarceration, we can create a pathway for more expansive justice within prison reform efforts.

CONCLUSION

We firmly believe a solution that acknowledges the intersectional and systemic oppressions and racism embedded in shackling practices must include a comprehensive federal ban on this cruel and dehumanizing practice. This includes fully dismantling its harmful effects and restoring the dignity and humanity of all pregnant women who are incarcerated. By addressing injustice at its core, we move toward protecting the human rights and health of incarcerated women nationwide.

We envision challenging societal views of incarcerated women by emphasizing their dignity as human beings deserving of equitable treatment and systemic support. *The Resilient Mothers Act* would address the historical and systemic injustices faced by Black and Brown women while creating a foundation for future maternal care reform in carceral systems. This act affirms their humanity, ensures uniform national protection, and eliminates the bias of correctional staff when making decisions about shackling. This approach is not only a matter of justice but also a reaffirmation of the human rights to which all individuals are entitled.

REFERENCES

Advocacy Resource Center. (2015). *An "act to prohibit the shackling of pregnant prisoners" model state legislation.* American Medical Association. https://www.ama-assn.org/media/9791/download

American Civil Liberties Union. (2007). *Facts about the over-incarceration of women in the United States.* https://www.aclu.org/documents/facts-about-over-incarceration-women-united-states

American College of Obstetricians and Gynecologists. (2021). Reproductive health care for incarcerated pregnant, postpartum, and nonpregnant individuals: ACOG committee opinion summary, number 830. *Obstetrics & Gynecology*, *138*(1), 164–165. https://doi.org/10.1097/AOG.0000000000004430

American Public Health Association. (2023). *A call to stop shackling incarcerated patients seeking health care.* https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2024/01/16/shackling-incarcerated-patients

Bandele, M. (2017). *Here's how prison and jail systems brutalize women, especially mothers.* American Civil Liberties Union. https://www.aclu.org/news/womens-rights/heres-how-prison-and-jail-systems-brutalize-women

Bronson, J. & Sufrin, C. (2019). Pregnant women in prison and jail don't count: Data gaps on maternal health and incarceration. *Public Health Reports, 134*(1): 57–62. https://doi.org/10.1177/0033354918812088

Budd, K. M., Napal, D., & Rovner, J. (2025). *Incarcerated women and girls* [Fact sheet]. The Sentencing Project. https://www.sentencingproject.org/fact-sheet/incarcerated-women-and-girls/

Crenshaw, K. (2014). *On intersectionality: Essential writings*. New Press.

Dufresne, L. (2023). Pregnant prisoners in shackles. *Voices in Bioethics*, *9*. https://doi.org/10.52214/vib.v9i.11638

Dyer, L., Hardeman, R., Vilda, D., Theall, K., & Wallace, M. (2019). Mass incarceration and public health: The association between Black jail incarceration and adverse birth outcomes among Black women in Louisiana. *BMC Pregnancy Childbirth*, *19*(525). https://doi.org/10.1186/s12884-019-2690-z

Eisen, L. (2023). *America's dystopian incarceration system: Pay to stay behind bars.* Brennan Center for Justice. https://www.brennancenter.org/our-work/analysis-opinion/americas-dystopian-incarceration-system-pay-stay-behind-bars

Federal Bureau of Prisons. (n.d.). *An overview of the First Step Act.* U.S. Department of Justice. Retrieved April 13, 2026, from https://www.bop.gov/inmates/fsa/overview.jsp

Ferszt, G. G., Palmer, M., & McGrane, C. (2018). Where does your state stand on shackling of pregnant incarcerated women? *Nursing for Women's Health, 22*(1), 17–23. https://doi.org/10.1016/j.nwh.2017.12.005

Franco, C., Mowers, E., & Lewis, D. L. (2020). Equitable care for pregnant incarcerated women: Infant contact after birth—a human right. *Perspectives on Sexual and Reproductive Health, 52*(4), 211–215. https://deepblue.lib.umich.edu/bitstream/handle/2027.42/166238/psrh12166.pdf

Ghandnoosh, N., & Pearce, S. (2025). *America's incarceration crossroads: Reversing progress amid record-low crime rates.* The Sentencing Project. https://www.sentencingproject.org/policy-brief/americas-incarceration-crossroads-reversing-progress-amid-record-low-crime-rates/

Goshin, L. S., Sissoko, D. R., 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, 48*(1), 27–36. https://doi.org/10.1016/j.jogn.2018.11.002

Hacker, K. (2013). *Community-based participatory research.* SAGE Publications.

Hall, R. C. H., Friedman, S. H., & Jain, A. (2015). Pregnant women and the use of corrections, restraints, and substance use commitment. *Journal of the American Academy of Psychiatry and the Law, 43*(3), 359–368. https://jaapl.org/content/43/3/359

Haywood Jr., C., Tanabe, P., Naik, R., Beach, M. C., & Lanzkron, S. (2013). The impact of race and disease on sickle cell patient wait times in the emergency department. *The American Journal of Emergency Medicine, 31*(4), 651–656. https://doi.org/10.1016/j.ajem.2012.11.005

Hessami, K., Hutchinson-Colas, J., Chervenak, F., Shamshirsaz, A., Zargarzadeh, N., Norooznezhad, A., Grünebaum, A., & Bachmann, G. (2022). Prenatal care and pregnancy outcome among incarcerated pregnant individuals in the U.S.: A systematic review and meta-analysis. *Journal of Perinatal Medicine, 51*(5), 600–606. https://doi.org/10.1515/jpm-2022-0412

Hirani, S., Benkli, B., Odonkor, C. A., Hirani, Z. A., Oso, T., Bohacek, S., Wiedrick, J., Hildebrand, A., Osuagwu, U., Orhurhu, V., Hooten, W. M., Abdi, S., & Meghani, S. (2024). Racial disparities in opioid prescribing in the United States from 2011 to 2021: A systematic review and meta-analysis. *Journal of Pain Research, 17*, 3639–3649. https://doi.org/10.2147/JPR.S4771

ICS Jail Supplies. (n.d.). *Peerless waist chain* [Product page]. Retrieved April 13, 2026, from https://www.icswaco.com/PEERLESS-WAIST-CHAIN

Irwin, J., Schiraldi, V., & Ziedenberg, J. (1999). *One million nonviolent prisoners.* Justice Policy Institute. http://www.justicepolicy.org/images/upload/99-03_REP_OneMillionNonviolentPrisoners_AC.pdf

Kajstura, A., & Sawyer, W. (2024). *Women's mass incarceration: The whole pie 2024*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2024women.html

Kendrick, C. (2024). *The painful reality of being an incarcerated mother.* American Civil Liberties Union. https://www.aclu.org/news/prisoners-rights/the-painful-reality-of-being-an-incarcerated- mother

Keyes, O. (2014). *Mass incarceration and people of color.* Southern Coalition for Social Justice. https://southerncoalition.org/mass-incarceration-people-color

Kramer, C., Thomas, K., Patil, A., Hayes, C. M., & Sufrin, C. B. (2022). Shackling and pregnancy care policies in US prisons and jails. *Maternal and Child Health Journal, 27*(1), 186–196. https://doi.org/10.1007/s10995-022-03526-y

Louisiana Public Health Institute. (2023). *Pregnancy and maternal health for incarcerated women in Louisiana*. https://www.incarcerationtransparency.org/wp-content/uploads/2024/02/HCR-85-Report-Final-Corrected.pdf

Marsh, S. (2009). The lens of implicit bias. *Juvenile and Family Justice Today.* https://www.ncjfcj.org/wp-content/uploads/2025/12/The-Lens-of-Implicit-Bias_0.pdf

Meghani, S. H., Byun, E., & Gallagher, R. M. (2012). Time to take stock: A meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. *Pain Medicine, 13*(2), 150–174. https://doi.org/10.1111/j.1526-4637.2011.01310.x

Morais, C. A., Aroke, E. N., Letzen, J. E., Campbell, C. M., Hood, A. M., Janevic, M. R., Mathur, V. A., Merriwether, E. N., Goodin, B. R., Booker, S. Q., & Campbell, L. C. (2022). Confronting racism in pain research: A call to action. *The Journal of Pain, 23*(6), 878–892. https://doi.org/10.1016/j.jpain.2022.01.009

National Institute of Justice. (1982). *Technology assessment program: NIJ standard for metallic handcuffs* (NIJ Standard 0307.01). U.S. Department of Justice. https://www.ojp.gov/pdffiles1/nij/082981.pdf

Project Nia & Barnard Center for Research on Women (2020, October 13). *What is accountability?* [Video]. YouTube. https://www.youtube.com/watch?v=QZuJ55iGI14

Rayasam, R. (2024). *Most states ban shackling pregnant women in custody, yet many report being restrained.* KFF Health News. https://kffhealthnews.org/news/article/pregnant-women-prison-handcuffs-restraints-laws/

Robinson, M., Lavere, K., & Porsa, E. (2021). End the routine shackling of incarcerated inpatients. *Journal of Hospital Medicine*, *16*(19), 376–377. https://doi.org/10.12788/jhm.3581

Samant, A. (2018). *The First Step Act is a small step for incarcerated women.* Human Rights Documents Online. https://doi.org/10.1163/2210-7975_hrd-9970-20180275

Sawyer, W., & Wagner, P. (2024). *Mass incarceration: The whole PIE 2024*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2024.html

Sawyer, W., & Wagner, P. (2025). *Mass incarceration: The whole PIE 2025.* Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2025.html

Sufrin, C., Beal, L., Clarke, J., Jones, R., & Mosher, W. D. (2019). Pregnancy outcomes in US prisons, 2016–2017. *American Journal of Public Health, 109*(5), 799–805. https://doi.org/10.2105/AJPH.2019.305006

United Nations Office on Drugs and Crime (2014). *Handbook on women and imprisonment: 2nd edition, with reference to the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (The Bangkok Rules)*. https://www.unodc.org/documents/justice-and-prison-reform/women_and_imprisonment_-_2nd_edition.pdf

Weber, A., Collins, S.-A., Robinson-Wood, T., Zeko-Underwood, E., & Poindexter, B. (2018). Subtle and severe: Microaggressions among racially diverse sexual minorities. *Journal of Homosexuality, 65*(4), 540–559. https://doi.org/10.1080/00918369.2017.1324679

Widra, E. (2024). *States of incarceration: The global context 2024. Prison Policy Initiative.* https://www.prisonpolicy.org/global/2024.html