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Impact of Incarceration on Black Maternal Health: Descriptive Analysis of Care for Birthing People in the NYC Jail System

Krupa Harishankar
NYC Health + Hospitals/Elmhurst
Jae Yeun Kim
jkim2@smcgov.org

San Mateo County Health
Sheela Maru
NYC Health + Hospitals/Elmhurst
Rebecca Giusti
NYC Health + Hospitals/Woodhull

Research Article

Keywords:

Posted Date: November 26th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11569014/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

In the U.S., Black women are incarcerated at 1.6 times the rate of white women and experience pregnancy-related morbidity at twice the rate. Black birthing people experiencing incarceration are placed at the intersection of racial inequities, medical complexity, and structural barriers to care. However, information regarding the effect of incarceration on Black maternal health and data describing the health needs of incarcerated birthing people remain limited. This study characterized medical comorbidities and pregnancy outcomes among birthing people incarcerated in New York City and evaluated outcomes before and after a collaborative reproductive health intervention.

Methods

This retrospective observational study included pregnant people incarcerated at Rikers Island who received obstetric care at Elmhurst Hospital and delivered within the NYC public safety net system between July 2019 and July 2023. The intervention linked jail-based prenatal care with hospital obstetric telehealth consultations, specialty visits, and multidisciplinary coordination. Demographic and clinical characteristics and maternal and neonatal outcomes were compared before and after implementation.

Results

Among 44 patients, 45.5% identified as Black and 13.6% as white. Chronic medical conditions affected 77.3%, 86.4% had a documented psychiatric diagnosis, and 86.4% had a history of substance use. During pregnancy, 27.3% experienced hypertensive disorders and 9.1% had a sexually transmitted infection. Cesarean delivery decreased from 36.8% before to 12.0% after intervention implementation ($p = 0.07$). Among patients delivering at Elmhurst Hospital, Cesarean delivery decreased from 75.0% to 14.3% ($p = 0.04$). Maternal complications and neonatal outcomes did not significantly differ. Preterm birth affected 20.5% of the cohort.

Conclusions

This predominantly Black cohort of pregnant people experiencing incarceration had substantial medical and psychiatric comorbidity, as well as elevated rates of preterm birth. The collaborative reproductive health intervention was associated with reduced Cesarean delivery, suggesting that continuity between correctional and community obstetric care may improve maternal outcomes by mitigating care fragmentation. Larger studies in this patient population are needed to further evaluate the impact of incarceration on Black maternal and neonatal health, and to inform integrated models addressing behavioral health, substance use, and racial inequities in pregnancy.

Background

The number of women incarcerated across the United States has grown over 1500% since 1970, [1–3] including an 18% increase since 2022 [4]. Most women are incarcerated in jails, short term facilities designated for pre-trial holding or short sentences, rather than in prisons. The majority of incarcerated women are of reproductive age, [4] and an estimated 3–4% are pregnant upon incarceration [5]. In the U.S., Black women are incarcerated at 1.6x the rate of white women [4]. The disproportionate representation of Black women in the carceral system reflects longstanding patterns of racial inequity, including differential policing, sentencing practices, and the criminalization of poverty and substance use [6, 7]. The impact of structural racism on healthcare outcomes is also evident, as Black women experience severe maternal morbidity at about 2x the rate of white women, with a 2.4x elevated mortality risk. This effect has been described not only via disparities in access to healthcare, transportation, and housing, but also in terms of exposure to chronic stress and experiences of discrimination within healthcare systems [8, 9]. Despite these overlapping structural disadvantages that contribute to both disproportionate incarceration and disparate health outcomes, few studies have examined the impact of incarceration on Black maternal health.

Prior studies regarding pregnant individuals in correctional settings have shown that birthing people in custody often have a high burden of chronic medical conditions and infectious diseases [10]. National data have demonstrated that mental health disorders, now a leading cause of maternal morbidity and mortality in the U.S., are more prevalent in individuals experiencing incarceration, with an estimated 17.7% of pregnant persons in jail holding a mental health diagnosis [11, 12]. Incarceration has also been associated with an increased incidence of low birth weight and preterm birth [13, 14], complications that disproportionally impact Black women and the latter of which is the most prevalent cause of neonatal morbidity in the United States [15], associated with lifelong consequences for neurodevelopment, respiratory health, educational attainment, and chronic disease risk [16]. These findings indicate that incarceration during pregnancy is not simply an issue affecting a small subset of individuals but a significant public health concern reflective of broader racial disparities in maternal health.

The experience of incarceration serves to exacerbate care fragmentation in this high risk patient population. Individuals incarcerated during pregnancy are among those least likely to receive adequate prenatal care [17], with one study demonstrating that 33% of incarcerated patients had late initiation of prenatal care [18]. Patients who have established prenatal care prior to incarceration remain at risk for receiving incomplete care once they enter jail or prison. Restrictions around freedom of movement, lack of autonomy, and limited access to obstetrical providers, are perhaps the most overt barriers faced by pregnant people in custody. Additionally, incarcerated individuals often have limited trust in the care provided in the carceral setting and difficulty accessing sufficient health information due to carceral regulations [19]. The transient nature of jails also presents challenges for healthcare delivery, as frequent admissions, transfers, and releases disrupt continuity of medical care and provision of comprehensive prenatal services. Although organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the National Commission on Correctional Health Care (NCCHC) have issued

clinical guidance on pregnancy care in the setting of incarceration [20], adherence on the part of carceral institutions is voluntary, resulting in considerable variation in policies, staffing, access to obstetric care, use of restraints, nutrition, postpartum support, and continuity of care across facilities [21].

In New York City, about 400 women and gender expansive people are jailed daily on Rikers Island, where 53% of women are Black and only 19% identify as white [22]. Healthcare is provided by Correctional Health Services (CHS), a branch of New York City's public healthcare system, NYC Health + Hospitals. Prenatal care occurs on site through CHS, while acute care and delivery services take place at Elmhurst Hospital Center (EHC), part of the same hospital system and the birthing facility located closest to Rikers Island. To address the complex needs of this population, CHS and EHC initiated a **collaborative reproductive health intervention** to provide joint prenatal care for incarcerated birthing people. This program provided all incarcerated prenatal patients with (a) telehealth consultations with an EHC obstetrician in addition to their primary CHS obstetrician, (b) coordinated in person follow up at EHC for higher levels of care including Level II ultrasound and high risk clinic visits, and (c) multi-disciplinary care coordination for complex medical conditions, social needs, and delivery planning. [23] **This study describes the medical and psychiatric comorbidities of a population of predominantly Black birthing people incarcerated at Rikers Island, discusses racial disparities impacting healthcare in this setting, and reports on maternal and neonatal outcomes before and after the implementation of the collaborative reproductive health intervention.**

Methods

Human Ethics and Consent to Participate

This study was approved by the Elmhurst Obstetrics & Gynecology Quality Improvement Committee, the Icahn School of Medicine at Mount Sinai IRB (STUDY-25-00697) and NYC Health + Hospitals STAR (STUDY00004890). Clinical trial number: not applicable. A waiver of informed consent was granted by the IRB as this study involved retrospective chart review only. Vulnerable populations documentation was completed in accordance with institutional practice given the inclusion of pregnant and incarcerated individuals in the study. All human data was managed in accordance with the Declaration of Helsinki.

Funding Declaration

No funding was provided for or utilized in this work.

Study Design

We conducted a retrospective observational study that describes the demographics, medical and mental health conditions, as well as maternal and neonatal outcomes of pregnant individuals who experienced incarceration in the NYC jail system between July 2019 and July 2023. Patients in the pre-intervention period (July 2019-July 2021) were identified through retrospective chart review of the EHC EMR, by searching keywords "incarceration," "incarcerated," "imprisonment," "Rikers," "custody," "jail," "inmate," and

“DOC.” Patients in the post-intervention period (August 2021-July 2023) were identified via a comprehensive clinical list in the EMR of all incarcerated patients seen by the EHC Obstetrics team during the study period. The method of identifying patients and in the pre- and post- periods was distinct as the clinical list was created as part of the collaborative reproductive health intervention.

Variables

We accessed charts via the EHC EMR to collect data on demographics, medical history, and mental health history. We also collected data specific to pregnancy, including gravidity/parity, gestational conditions, and maternal-fetal outcomes such as mode of delivery, maternal complications, neonatal birth weight, and NICU admission.

Statistical Analysis

Data was analyzed by the study team using descriptive statistics and statistical methods appropriate for small sample sizes, such as Fisher’s Exact Test.

Results

Pre- and post-intervention groups were analyzed for any difference in demographic factors, including race, ethnicity, language, age, parity, medical history, substance use history, psychiatric history, and pregnancy conditions. Findings are listed in Table 1.

Table 1
Demographics

Demographics	Categories	Total N (%) N = 44	Pre n (%) n = 19	Post n (%) n = 25	p-value
Race	African American or Black	20 (45.5%)	7 (36.8%)	13 (52.0%)	.124
	Caucasian or White	6 (13.6%)	*	*	
	Other	18 (40.9%)	7 (36.8%)	11 (44.0%)	
Ethnicity	Hispanic or Latinx	11 (25.0%)	5 (26.3%)	6 (24.0%)	1.00
	Not Hispanic or Latinx	33 (75.0%)	14 (73.7%)	19 (76.0%)	
Language	English	43 (97.7%)	19 (86.4%)	24 (96.0%)	1.00
	Other	*	*	*	
Age	< 35	38 (86.4%)	13 (68.4%)	25 (100.0%)	.004
	≥ 35	6 (13.6%)	6 (31.6%)	0 (0%)	
Parity	Nulliparous	8 (18.2%)	3 (15.8%)	5 (20.0%)	1.00
	Multiparous	36 (81.8%)	16 (84.2%)	20 (80.0%)	

*Individual cell sizes with total n > 1 but < 3 are indicated by * to minimize patient re-identification risk.*

In our cohort of 44 women, 20 identified as Black or African American (45.5%) and 6 identified as Caucasian or White (13.6%), concordant with the population of women incarcerated on Rikers Island. In a comparison of demographic data, advanced maternal age was more prevalent in the pre- (31.6%) vs. post-intervention group (0%). This was the only significant intergroup difference.

Maternal Factors: Medical, Psychiatric, and Gestational Comorbidities

Table 2
Medical, Psychiatric, and Gestational Conditions

Comorbidities or Pregnancy Conditions	Categories	Total N (%) N = 44	Pre n (%) n = 19	Post n (%) n = 25	p-value
Past Medical History	Medical Composite†	34 (77.3%)	17 (89.5%)	17 (68.0%)	.148
	Asthma	21 (47.7%)	13 (68.4%)	13 (52.0%)	.359
	Seizure History	7 (15.9%)	3 (15.8%)	6 (24.0%)	.710
	Hepatitis C	4 (9.1%)	*	*	1.00
Past Psychiatric History	Psychiatric Composite‡	38 (86.4%)	17 (89.5%)	21 (84.0%)	.684
	Psychosis	14 (31.8%)	9 (47.4%)	10 (40.0%)	.761
	Mood Disorder (BPD, MDD, GAD, etc.)	19 (43.2%)	15 (79.0%)	14 (56.0%)	.199
	Trauma/PTSD	13 (29.5%)	7 (36.8%)	8 (32.0%)	.759
	Suicide Attempt	6 (13.6%)	4 (21.1%)	6 (24.0%)	1.00
	Inpatient Psych Hospitalization	13 (29.5%)	9 (47.4%)	12 (48.0%)	1.00
Past Substance Use History	No Substances	6 (13.6%)	*	*	.842
	1 or 2 Substances	17 (38.6%)	7 (36.8%)	10 (40.0%)	
	3 or more Substances	21 (47.7%)	10 (52.6%)	11 (44.0%)	
Pregnancy Conditions	Hypertensive Disorder of Pregnancy	12 (27.3%)	4 (32.1%)	8 (32.0%)	.507
	Gestational Diabetes	0 (0.0%)	0 (0.0%)	0 (0.0%)	1.00
	STI in Pregnancy	4 (9.1%)	0 (0.0%)	4 (16.0%)	1.00

*Individual cell sizes with total n > 1 but < 3 are indicated by * to minimize patient re-identification risk.*

†Medical Composite describes having at least one chronic medical condition from the most common medical diagnoses identified in this population: asthma, history of seizure or seizure disorder, anemia, HIV/AIDs, Hepatitis C, Hypertension, or Type 2 Diabetes.

‡Psychiatric Composite describes having at least one psychiatric condition from the most common psychiatric conditions identified in this population: psychosis or psychotic spectrum disorders, mood disorders, trauma and stressor-related disorders, personality disorder, adjustment disorder, history of suicide attempts, and history of inpatient psychiatric hospitalization.

Table 2 highlights the medical, psychiatric, and pregnancy-related conditions notable in this study's population of incarcerated birthing people. The three most prevalent chronic medical conditions were asthma (47.7%), seizure disorder (15.9%) and hepatitis (9.1%). Common diagnoses such as hypertension and diabetes were found to be less prevalent, at 6.8% and 0% respectively. In this study cohort, 86.4% of individuals were found to have at least one psychiatric diagnosis, including mood disorders (43.2%), traumatic or stress-related disorders (29.5%), and prior suicide attempts (13.6%). The prevalence of serious mental illness (SMI) was approximated by identifying a charted diagnosis of psychosis and/or an inpatient psychiatric hospitalization in the EMR. Through this estimation, about 1 in 3 individuals were found to have SMI with a history of psychosis (30.8%) or inpatient psychiatric hospitalization (29.5%). Additionally, 86.4% of women had a history of at least 1 form of substance use, with 47.7% of the study population evidencing the use of 3 or more substances. The most prevalent substances used were cocaine (38.6%), marijuana (34.1%), and opioids (20.5%). With regards to gestational comorbidities, i.e. conditions developed in the course of pregnancy, hypertensive disorders (27.3%) and STIs (9.1%) were notably prevalent. By contrast, gestational diabetes had a low prevalence of 0%.

Delivery Outcomes: Mode of Delivery, Maternal Complications, and Neonatal Characteristics

Table 3
Mode of Delivery

Mode of Delivery	Pre- Intervention (n = 19)	Post- Intervention (n = 25)	p-value
Cesarean Delivery (Overall)	7 (36.8%)	3 (12.0%)	0.07
Vaginal Delivery (Overall)	12 (63.2%)	22 (88.0%)	0.07
Delivery Location Sub-analysis			
├── Elmhurst Hospital Center deliveries	CS: 3/4 (75.0%) Vaginal: 1/4 (25.0%)	CS: 2/14 (14.3%) Vaginal: 12/14 (85.7%)	**0.04**
├── Other H + H Hospital deliveries	CS: 4/15 (26.7%) Vaginal: 11/15 (73.3%)	CS: 1/11 (9.1%) Vaginal: 10/11 (90.9%)	0.36

Maternal and neonatal complications are not detailed in Table 3 *due to a small n of complications in both pre- and post- groups.*

Mode of Delivery

A comparison of modes of delivery between the pre- and post-intervention groups is summarized in Table 3. The overall rate of CS reduced from 36.8% to 12.0%, with a statistically significant reduction at EHC from 75.0% to 14.3% (p = 0.04). Provider continuity at EHC was also a notable difference between the pre- and post-intervention groups, with no deliveries in the pre-intervention group attended by a provider previously known to the patient, and 92.4% of deliveries in the post-intervention group attended by the same provider who had performed the telehealth visit with the patient.

Maternal Complications

A comparison of delivery complications, which included chorioamnionitis, postpartum hemorrhage, blood transfusion, and maternal ICU admission, demonstrated no significant difference in maternal morbidity. However, a trend towards a greater number of complications was noted in the post-intervention group, with rising rates of chorioamnionitis from 5.4% to 16%, and PPH from 0% to 16%. To examine this trend and to counteract limitations of sample size, a “composite maternal complication” (CMC) score was calculated per delivery by attributing one point for each distinct complication that occurred. The percentage of deliveries with CMC score > = 1 (i.e. more than one complication per delivery) was 5.3% the pre-intervention group and 24.0% in the post-intervention group, but this finding did not rise to statistical significance (p = 0.12).

Neonatal Characteristics

Neonatal characteristics, including mean birth weight, preterm birth, fetal growth restriction, and NICU admission were compared, with no significant differences between the pre- and post-intervention groups. The average birth weight was 2771.8g (2761.4g pre- vs. 2779.7g post-), the preterm birth rate 20.5% (21.1% pre- vs 20.0% post-, p = 0.72) and the prevalence of fetal growth restriction 9% (10.5% pre- and 8.0% post-, p = 1.00). Of note, seven NICU admissions took place in the pre-intervention group, compared to thirteen in the post-intervention group (p = 0.37). However, eleven of these thirteen NICU admissions took place at EHC, where there is no well baby nursery, requiring all babies under observation, including for exposure to substance use, to be admitted to the NICU.

Discussion

This study describes the unique intersection of comorbid medical conditions, serious mental illness (SMI), and substance use disorder (SUD) which interact to complicate pregnancy behind bars. Placing these high risk conditions in the setting of incarceration, where Black women are disproportionately impacted and barriers to care are manifold, may exacerbate racial disparities in maternal and neonatal healthcare that exist in the wider community. In our study, the documented medical comorbidities of incarcerated women were found to be distinct from those of the population of reproductive aged women across the US, with a higher prevalence of asthma, seizure disorder, and hepatitis [24, 25]. Most remarkable was the high prevalence of hypertensive disorders of pregnancy (HDP) at 27.3%, elevated in this study's population compared to 20% of non-Hispanic Black women and 15% of non-Hispanic white women across the US who develop HDP [26–28]. A high prevalence of STIs in pregnancy was also noted in our study population at 9.1%, increased compared to up to 4.2% in non-Hispanic Black women vs. 1.1% in non-Hispanic white women in the U.S. population [29]. Both HDP and STIs represent major risk factors for preterm birth, and require close monitoring in pregnancy [30, 31]. Conversely, a prevalence of 0% for both type 2 diabetes and gestational diabetes suggests an underdiagnosis of certain medical conditions due to a lack of routine screening mechanisms in the carceral setting. Our data highlights the need for programmatic interventions to close screening gaps and respond with treatment modalities specific to this unique profile of medical comorbidities, with consideration that Black pregnant women who are incarcerated may be at significantly higher risk for medical complications of pregnancy.

The most notable psychiatric comorbidity, which affected one third of our cohort, was serious mental illness (SMI). Prior national studies demonstrate 17.7% of pregnant persons in jail have known mental health diagnoses [12], while 7.1% of US women are affected by SMI [32]. Our findings magnify prior studies that demonstrate SMI is generally overrepresented in carceral settings. Outside the setting of incarceration, white women with SMI access mental health services at a higher rate (74.2%) than Black women with SMI (57.7%) [33]. Once incarcerated, individuals living with SMI may face further barriers such as inconsistent access to psychiatric care, interruptions in psychotropic medication management, exposure to chronic stress and trauma, and loss of continuity of care during transitions into and out of custody [34–37]. These factors can exacerbate mental illness and limit engagement in both psychiatric and prenatal care [38, 39]. SMI has been associated with adverse pregnancy outcomes, such as

postpartum hemorrhage and preterm birth [40]. SMI in this patient population can therefore be seen as an additional strong risk factor for adverse maternal and neonatal outcomes.

While active substance use is limited by incarceration, it remains an important healthcare consideration for incarcerated individuals, with prior studies indicating 63% of sentenced individuals in jail meet the DSM-V criteria for drug dependence or abuse, in comparison to 12–13% of reproductive-aged women across the US [41]. The racial disparities in access to substance use treatment are apparent when comparing care utilization among White women (8.2%) and Black women (5.3%) [33]. The high prevalence of SUD (86.4%) in our cohort of pregnant, primarily Black, individuals is especially relevant, as substance use at critical points in pregnancy has long-term effects on both mother and baby. A recent population-based study found that 7.2% of pregnancies affected by SUD were marked by fetal growth restriction (FGR), compared to 3.3% of those without substance involvement [42]. Within this cohort, 9% of pregnancies were notable for FGR. These results suggest this population may benefit from more robust antenatal surveillance (such as growth ultrasounds and non-stress testing), as well as coordinated care between medical and psychiatric services.

Interventions that prioritize partnership between carceral care institutions and community-based medical centers have the potential to strengthen connections to prenatal care, accomplish screening and diagnosis in pregnancy, and improve maternal-fetal outcomes in a vulnerable population already facing stark racial disparities. Our findings suggest that a reproductive health intervention promoting continuity between correctional and hospital-based obstetric care is feasible and may improve maternal-fetal outcomes. Through this collaboration, a medically and psychiatrically high-risk population was able to receive specialized care across distinct settings. The process of collaboration highlighted disparities in diagnoses, such as a lack of screening for gestational diabetes, and subsequent improvements were implemented. In the treatment of complex medical conditions, the carceral care system benefitted from access to tertiary care outside the jail setting as required, and the community hospital benefitted from an early awareness of patients with complex medical and psychiatric conditions, rather than at the time of delivery alone. Importantly, the intervention also provided the patient with care continuity with a provider in the community, allowing the patient to build trust and engage in shared decision-making with the institution where delivery would occur. This relationship proved bi-directional, as the provider's greater knowledge of the patients likely served to counteract potential conservative obstetric management, with a significantly lower rate of C-sections noted in this study's post-intervention group. These findings are consistent with prior literature demonstrating the importance of continuity of obstetric care in improving delivery outcomes, including lowering the rate of Cesarean delivery [43–45].

Notably, the overall rate of preterm birth remained markedly elevated in the study population after implementation of the intervention, with 20.5% of births occurring before 37 weeks gestation. Prior studies have demonstrated a 10% preterm birth rate, or up to 15% for Black birthing people, across the U.S. [46]. The elevated rate of preterm birth in this study population is likely multifactorial and driven by the confluence of medical and psychiatric comorbidities described, which convey risk for preterm birth: hypertensive disorders of pregnancy, infections in pregnancy, as well as maternal SMI and SUD. While

the infrastructure established through this collaboration may have improved pregnancy related care, expanded access to other essential services for this population is likely necessary to mitigate risk factors for preterm birth, beginning with perinatal psychiatric care and addiction treatment, with an emphasis on multidisciplinary care coordination [47].

Strengths

Pregnant individuals who experience incarceration remain substantially underrepresented in public health research, and the impact of incarceration on Black maternal health has not been previously characterized. Accordingly, this study helps address an important gap in the literature by detailing the demographics, medical and psychiatric comorbidities, and maternal and neonatal outcomes of this population. Because the data were derived from routine clinical care, the findings provide insight into the health needs of pregnant incarcerated individuals within a real-world carceral healthcare setting. In addition, because Elmhurst Hospital Center is part of the NYC Health + Hospitals system, which shares an integrated electronic medical record across its 11 acute care hospitals, we were able to capture longitudinal clinical data across the entire system. Restricting the analysis to deliveries occurring within the NYC Health + Hospitals system maximized the completeness of maternal and neonatal outcome data and minimized loss of follow-up across different healthcare systems. Finally, the study's pre-post intervention design allowed for comparison of clinical characteristics and maternal and neonatal outcomes between two cohorts, demonstrating the impact of a reproductive health collaboration between carceral and community-based settings.

Limitations

The primary limitation of this study is the small sample size, which limits statistical power. In addition, the retrospective observational design precludes causal inference regarding the effects of the reproductive health intervention, as temporal changes in clinical practice, healthcare delivery, or broader systemic factors may have influenced outcomes independently of the intervention. The study was also conducted within the relatively well-resourced New York City jail system and a single integrated public hospital network, which may limit the generalizability of these findings across correctional and healthcare settings. Accordingly, this research should be interpreted primarily as a descriptive evaluation of maternal and neonatal outcomes among incarcerated pregnant individuals and as an exploratory assessment of a collaborative care model. Given the lack of available literature regarding pregnancy outcomes among incarcerated birthing people, these data provide valuable descriptive information about the health needs of this population and may help inform future research and care models.

Next Steps

Future research should evaluate the effectiveness of interventions designed to improve pregnancy outcomes, such as integrated psychiatric care, substance use treatment, and doula-supported care, which have demonstrated improvements in racial healthcare disparities and perinatal outcomes among other high-risk populations [48–51]. Future studies among incarcerated pregnant individuals should also

examine patient-centered outcomes, such as the experiences of pregnancy, childbirth, postpartum recovery, and transitions back to the community.

Perhaps most importantly, improving the health of incarcerated pregnant individuals requires attention to the structural conditions that shape both incarceration and health. New York City's public hospital system provides robust, high-quality obstetrical and behavioral healthcare regardless of insurance status. However, access to care among individuals at high risk for incarceration can be inconsistent due to competing priorities and structural inequities. While incarceration frequently interrupts access to these resources, it can also potentially serve as an opportunity for connecting high-risk individuals with care upon release. Future research should examine the role of decarceration strategies and linkage to essential components of reentry support, including community-based prenatal and behavioral health services, as these are vital public health interventions to mitigate disparities for this population.

Declarations

Author Contribution

Krupa Harishankar, MD, and Jae Yeun Kim, MD, share co-first authorship. Krupa Harishankar, MD, Jae Yeun Kim, MD, and Rebecca Giusti, MD, contributed equally to data analysis and manuscript preparation. Sheela Maru, MD, MPH, contributed to manuscript review and editing. All authors reviewed and approved the final manuscript prior to submission.

Acknowledgements

We would like to acknowledge the care provided by Correctional Health Services to incarcerated birthing people at Rikers Island.

Data Availability

All data supporting the findings of this study are available within the paper. Demographics are provided in Table 1; Medical, Psychiatric and Gestational conditions are provided in Table 2; Mode of Delivery in Table 3.

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Figures

Inclusion Criteria	Exclusion Criteria
• All pregnant incarcerated people seen for obstetrical care (televisit, in-person visit, OB triage, ultrasound visit, or inpatient admission) at Elmhurst Hospital Center between July 2019 and July 2023 • Baby delivered at an NYC H+H Hospital	• Patients who experienced an ectopic pregnancy, spontaneous abortion (<20 weeks gestational age), or elective abortion

Figure 1

Inclusion and Exclusion Criteria

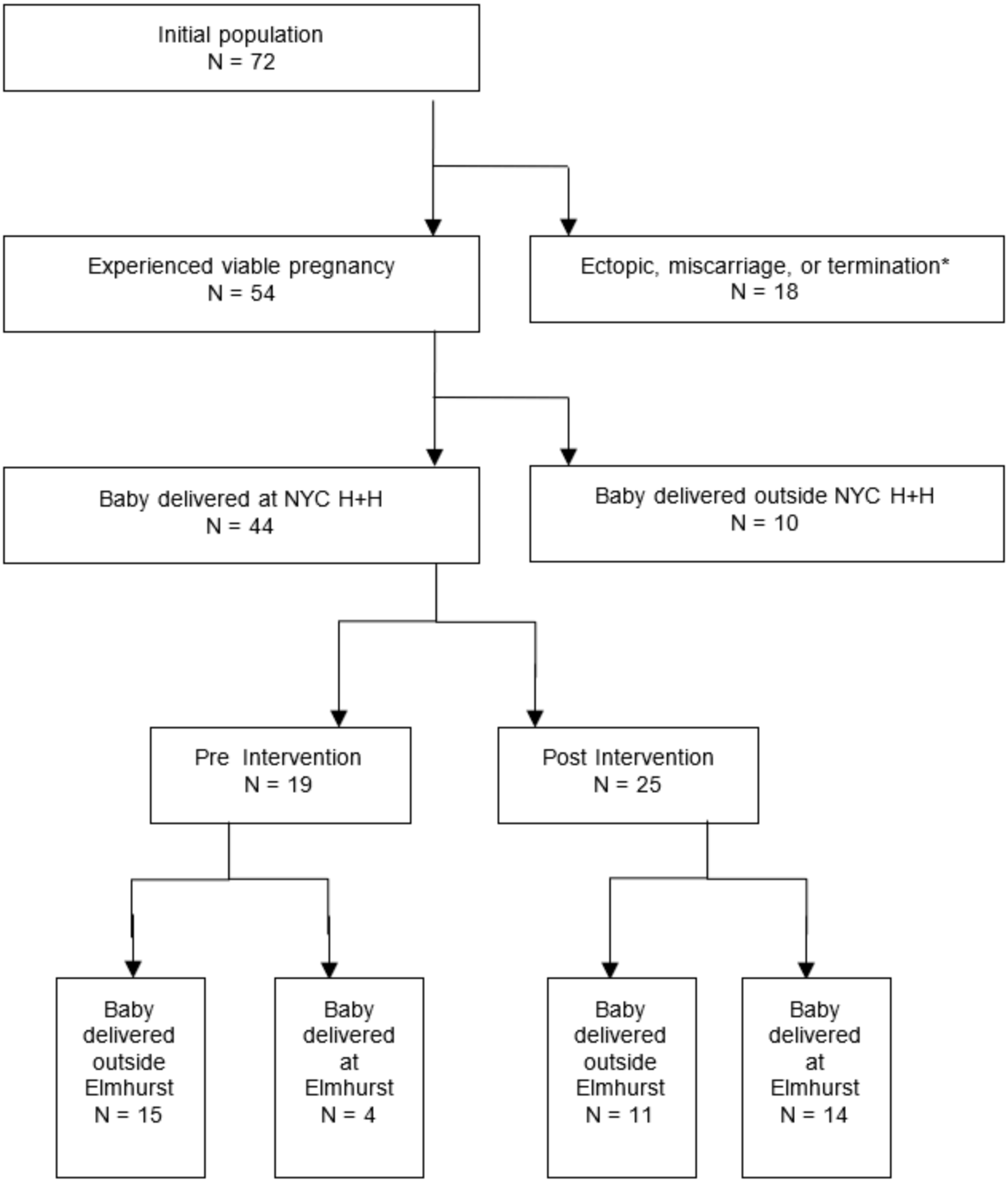

Figure 2

Cohort Selection

*Pre-intervention (9), Post-intervention (9)