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**PREGNANT WOMEN IN CALIFORNIA
PRISONS AND JAILS:**
A Guide for Prisoners and Legal Advocates
Third Edition, 2006

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This manual is intended for use by prisoners, attorneys, and legal workers. This edition is an updated and expanded version of the second edition that was published in 1993. Contributors and co-authors of the earlier edition include: Ellen M. Barry, Vicki Cormack, Harriette Davis, Monica Freeman-Brennan, Carrie Kojomoto, Kirby Randolph, Keriena Yee, and Linda Yu.

This edition contains some general information on pregnancy that may not be specifically relevant to an incarcerated woman's experience. However, we decided to include it so that women would have access to information not readily available in prison or jail.

Our sincere appreciation goes out to the following people who assisted with this third edition:

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DISCLAIMER

The information in this manual is not intended to be, and should not be used as, a substitute for the advice of an attorney or a medical professional.

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INTRODUCTION

Recent estimates indicate that eight to ten percent of women who enter prison are pregnant. Not until the past 10 years has much attention been given to the specific needs of pregnant women in prison. Prisons are still far from providing adequate health care to pregnant prisoners. The major problems are access to health care, the completeness of care and the care providers' sensitivity to the emotional needs of the prisoners. Other problems include lack of childbirth preparation classes and an increased rate of cesarean delivery. One of the major problems that is specific to prisons is a lack of adequate dental care. Studies have shown that gum disease may lead to pre-term delivery and low birth rate. The California Department of Corrections and Rehabilitation (CDCR) as a result of a lawsuit, *Plata v. Schwarzenegger*, recently adopted policies specifically relating to the care of pregnant prisoners and although the dental care of prisoners was not included in the *Plata* lawsuit, legislation in 2005, did address the issue of dental care and pregnant prisoners in adult and juvenile facilities.

If you are an expectant mother in prison or jail, you may be anxious and concerned about having a healthy and comfortable pregnancy. You may also find it difficult to make plans for your baby's future while you are incarcerated. If you are an advocate for pregnant women in jails and prisons, you may also have many questions about how to obtain the best quality medical care for your pregnant clients.

This booklet is intended to address some of these legal and practical concerns and to help you become better prepared and informed about your pregnancy. You must be all the more vigilant and assertive about taking care of yourself when you are pregnant and incarcerated. This manual is not intended to take the place of your doctor or lawyer. It is important that you contact your physician for medical advice and your lawyer for legal advice. We hope that you will find this booklet useful, and that it will enable you to have a healthy baby in spite of your incarceration.

GENERAL INFORMATION ON BEING PREGNANT AND INCARCERATED

(All information in this section can be found in Chapter 24, Vol. 4, "Inmate Medical Services Policies and Procedures," California Department of Corrections, June 2003).

Due to a major lawsuit settled in 2001, *Plata v. Schwarzenegger*, the California Department of Corrections and Rehabilitation (CDCR) has been forced to adopt policies concerning pregnant women prisoners. In addition, recent legislation (AB 478) addressed the issues of shackling and dental care as they apply to pregnant prisoners. AB 478 was signed into law by the governor and is now codified under Penal Code sections 3419, 3423, 3424, 6030, and Welfare and Institutions Code section 222. It is important to know and exercise your rights for the health of you and your baby.

What are my rights as a pregnant woman at reception?

After an initial health screening by a Registered Nurse (RN) and a Medical Technical Assistant (MTA) the medical staff must notify the Obstetrical Coordinator (pregnancy doctor) of your pregnancy. If you have any possible medical conditions that might place your pregnancy at a high-risk status then the Supervising Obstetrician (OB) must be notified. You must also be provided with a priority ducat to be seen by an OB Physician or an OB Nurse Practitioner within seven business days. You will also be ducated to the Reception Center for laboratory work to verify your pregnancy within three working days.

Do pregnant women get special housing considerations?

You must be issued a chrono for a lower bunk and housing on the first floor unless the OB places you in the Outpatient Housing Unit (OHU) or Correctional Treatment Center (CTC).

What if I am pregnant and on the methadone program?

The CDCR is required to provide methadone treatment to all pregnant prisoners who have been on heroin or who are currently receiving methadone treatment. If you are pregnant and on methadone maintenance you will be recommended for immediate transfer to the California Institution for Women (CIW) in Corona. While awaiting transfer the OB Physician or the Physician on Call (POC) after hours will admit you to the OHU or CTC, where you will stay until the transfer process is complete.

What are my medical rights as a pregnant prisoner while I am in prison?

You must be seen for a thorough medical examination within seven business days by an OB. The doctor should go over your medical history, your family medical history as well as the father's medical history. The doctor may then order certain tests to determine your health and the health of the baby. You should also be issued a chrono for any medical clearances or restrictions.

After the first visit the OB (unless otherwise indicated by the Supervising OB) must schedule you for visits:

- Every 4 weeks in the first trimester and up to 24-26 weeks into your pregnancy.
- Every 3 weeks up to the 30th week into your pregnancy
- Every 2 weeks between the 30th and 36th weeks.
- Every week after the 36th week and up to delivery.

You are also entitled to see a dentist on a priority basis. Seeing a dentist is very important because certain studies have shown that gum disease can lead to lower birth weight for your baby or premature delivery. You should have your teeth cleaned at least once during your pregnancy.

If you go for treatment to an outside facility the prison must ensure that copies of all your health records including prenatal forms are sent with you.

Does the prison have to provide me with a special diet?

You are entitled to receive prenatal vitamins, iron and folic acid. If the institution for any reason does not provide three meals a day then you are entitled to an extra carton of milk and an extra snack each day.

What if a pregnant prisoner must be disciplined/physically restrained?

Health care staff must only use physical restraint if you pose a threat to the physical safety of yourself or others (including the fetus), threat of substantial damage to state property, or attempted escape. When the state does physically restrain a pregnant prisoner special efforts must be taken to avoid harm to the fetus. Handcuffs must only be applied with your hands in front of your body. When you are being transported for medical care the only restraint that can be used are handcuffs to the front of your body.

Can a pregnant prisoner be put in Administrative Segregation?

Pregnant prisoners who commit a serious disciplinary offense will be placed in Administrative Segregation (Ad-Seg) pending medical evaluation and Administrative Review. When escorting you to Ad Seg the only restraint that may be used is handcuffs to the front of your body. The Physician or RN will perform a medical evaluation within 24 hours to see if you are suitable for Ad Seg. Even when you are in Ad Seg you should still be housed on the first floor on a lower bunk. The case will be referred to the Institutional Classification Committee (ICC) if you are to be held in Ad Seg beyond ten (10) days. You must still receive the same medical and prenatal care in Ad Seg as you would if you were living in a regular housing unit.

What other services must the prison provide?

You will be required to undergo HIV counseling. The prison will also provide you with pregnancy information pamphlets. In addition, the CDCR is required to provide you with information on terminating your pregnancy but you must ask for it (see section on Abortion, page 22).

You will also be referred to a medical Social Worker for Case Management to discuss the options available for placement and care of your child after delivery. The social worker must provide you with access to a phone to contact your relatives regarding the placement of your newborn.

What will happen when I go into labor?

When you go into labor it will be treated as an emergency and you will be transported to a local hospital in an ambulance. The Supervising Obstetrician, Physician or RN should immediately be notified so they can provide you with the appropriate assistance.

Custody staff will accompany you in the ambulance to the hospital. It is the responsibility of the RN to ensure that all copies of your prenatal forms accompany you to the hospital. Emergency medical transports should be allowed to depart institutional grounds before, during, or after any institution count.

You should not be shackled when being transported to the hospital, during labor, during delivery, or during recovery at the hospital. This means that you should not be handcuffed or restrained in any manner—in front of your body or to the bed at the wrist or ankle. (This applies to pregnant prisoners in state prison, county jails and juvenile detention; see Appendices 1 and 2).

May I have visitors while I'm at the outside hospital?

Appointed guardians of your baby and others who wish to visit you at the hospital, must comply with Title 15 visiting regulations. They must also notify and obtain the approval of the Watch Commander. Because it may take weeks for a person to be approved to visit you while you are incarcerated, you should begin the visitor's application process as soon as possible after arriving at the prison, jail or juvenile facility.

What rights do I have for special medical care after I give birth?

If you delivered the baby via C-section you must be admitted to OHU or CTC. Any prisoner who delivered vaginally will be assessed in the Emergency Treatment Area (ETA) to determine housing and to initiate post-partum (after-birth) care. The Supervising Obstetrician or the RNNP (OB nurse practitioner) will determine when you are ready for housing in the yard. A ducat will be issued for your 6-week post-partum checkup. At your 6-week checkup the OB or the RN will decide whether you can be cleared for full duty or further medical restrictions are warranted.

If your release date or parole date falls within six to eight weeks after you deliver your baby, you are to be given family planning services.

CONDITIONS AND DISEASES THAT CAN AFFECT YOUR PREGNANCY

(General information in this section was taken from the March of Dimes web site www.MarchofDimes.com)

The Postpartum Blues

After the baby is born, many new mothers have the "postpartum blues" or the "baby blues." You may feel more irritable, you may cry more easily, or you may feel sad or confused.

The postpartum blues peak three to five days after delivery. They usually end by the tenth day after the baby's birth. Although the postpartum blues are not pleasant, you can function normally. The feeling of the "blues" usually lessens and goes away over time.

Medical experts believe that changes in the woman's hormones after delivery cause the postpartum blues. The fact that you are incarcerated and separated from your baby may also add to your feelings of sadness.

There are things you can do to help relieve the "postpartum blues": Talk to a friend or someone you trust about how you feel. Try to get as much rest as possible.

If your symptoms last for longer than two weeks or worsen, you may have postpartum depression, which is a serious medical condition.

Postpartum Depression

About one out of every eight women has postpartum depression after delivery. It is the most common complication among women who have just had a baby.

Postpartum depression is a serious medical condition. It is not something you can control. It is not a sign of being a bad mother. It may pose a risk for the woman and her baby. The most important things to do are:

- Recognize the signs of postpartum depression (see below)

- Reach out and get help because a range of treatments is available

Medical experts believe that changes in the woman's hormones after delivery cause postpartum depression. Postpartum depression is not the same as the "postpartum blues." (See above)

What Is Postpartum Depression?

A woman who has postpartum depression feels sad, "down" or depressed. She also has five or more of the following symptoms lasting two weeks or longer:

- Trouble sleeping

- Lack of interest

- Feelings of guilt
- Loss of energy
- Difficulty concentrating
- Changes in appetite
- Restlessness or slowed movement
- Thoughts or ideas about suicide

Postpartum depression can begin at any time within the first three months after delivery. If you have any of the symptoms listed above, talk to your doctor. If necessary, your doctor can refer you to a mental health professional.

Treatments

Postpartum depression can be treated in several ways. Support groups may help. Some women go to therapy or counseling with a mental health professional. Your doctor may prescribe antidepressant medication.

The most commonly used antidepressants for postpartum depression come from a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Here are the names of some of those drugs:

- Zoloft (sertraline)
- Paxil (paroxetine)
- Celexa (citalopram)
- Prozac (fluoxetine)

Like many drugs, antidepressants can have side effects. Women differ in the type and seriousness of the side effects that they have. Because no drug is proven to be entirely safe, a woman and her health care team must look at her case and weigh the risks and benefits of various drugs.

Sickle Cell Anemia and Pregnancy

Sickle cell anemia is a genetic, chronic (persists over a long period of time) form of anemia. Due to an abnormal type of hemoglobin, the red blood cells are sickle or crescent-shaped. Hemoglobin is the protein in the red blood cells. Its function is to carry oxygen from the lungs to the tissues. When the blood cells are deformed, they do not flow normally and may clog the blood vessels. The sickle shaped cells also break down more easily, causing anemia.

Sickle cell anemia occurs most commonly among people of African descent and people from the Mediterranean. About one out of every 500 African Americans has sickle-cell anemia.

What are the symptoms?

If you have sickle-cell anemia you will feel very weak and tired, and may experience fainting or breathlessness. You may also have sickle cell crises, which are marked by acute pain in the abdomen and bones. If you or your partner has sickle cell anemia make sure that the medical staff at the prison or jail knows your medical history. The doctor will probably analyze a sample of your blood to confirm that you have sickle-cell anemia.

Can a woman with sickle cell disease have a safe pregnancy?

Yes. However, women with sickle cell disease are at increased risk of complications that can affect their health and that of their babies. During pregnancy, the disease may become more severe and pain episodes may occur more frequently. A pregnant woman with sickle cell disease is at increased risk of preterm (early) labor and of having a low birth weight baby. However, with early prenatal care and careful monitoring throughout the pregnancy, women with sickle cell disease can have a healthy pregnancy and deliver a healthy baby.

What are the risks that my child will get sickle cell anemia?

There is a 50 percent chance that a child born to parents who both carry a sickle cell gene will have the trait. There is a 25 percent chance that the child will have sickle cell disease if only one of the parents carries the trait. There also is a 25 percent chance that the child will have neither the trait nor the disease. These chances are the same in each pregnancy.

Is there a test for sickle cell disease or trait?

Yes. You can have a blood test to find out if you have either the sickle cell trait or a form of the disease. There also are prenatal tests to find out if the baby will have the disease or carry the trait.

Is there a cure for sickle cell disease?

A small number of children with severe sickle cell disease have been cured through a blood stem cell transplant. The stem cells (immature cells that develop into blood cells) come from bone marrow, or less frequently from umbilical cord blood, usually donated by siblings who are a good genetic match. Most children with sickle cell disease, however, do not have siblings who are good genetic matches. For this reason, researchers have recently begun performing stem cell transplants using umbilical cord blood from unrelated donors with apparent success.¹

¹ Vichinsky, E. New Therapies in Sickle Cell Disease. The Lancet, volume 360, number 9333, August 24, 2002, pages 629-631.

About 150 children worldwide with sickle cell disease have had blood stem cell transplants, and about 85 percent of them appear to be cured of the disease.² However, this approach carries a high risk: about 5 percent of children who underwent bone marrow transplants died. The transplant did not cure the disease in another 10 percent.³ Gene therapy may someday offer a cure with less risk.

Diabetes in Pregnancy

Diabetes is a disorder in which the levels of sugar in the blood are too high. This occurs because the body doesn't produce enough insulin or can't use insulin properly. Insulin is a hormone made by the pancreas that lets the body turn blood sugar into energy or store it as fat. In untreated diabetes, high blood sugar levels can damage organs, including blood vessels, nerves, eyes and kidneys. Some people with diabetes need daily insulin injections to prevent these complications. About 1 woman in 200 of childbearing age has diabetes before pregnancy (**preexisting diabetes**). Another 2 to 5 percent develop diabetes during pregnancy (**gestational diabetes**). Today, most of these women can look forward to having a healthy baby. While diabetes poses some risks in pregnancy, advances in care have greatly improved the outlook for these pregnancies.

What risks does diabetes pose to the baby?

Women with poorly controlled preexisting diabetes in the early weeks of pregnancy are three to four times more likely than non-diabetic women to have a baby with a serious birth defect, such as a heart defect or neural tube defect (NTD; a birth defect of the brain or spinal cord). They also are at increased risk of miscarriage and stillbirth.

Women with gestational diabetes, which generally develops later in pregnancy, usually do not have an increased risk of having a baby with a birth defect. However, some of these women may have had unrecognized diabetes that began prior to pregnancy. They may have had high blood sugar in the early weeks of pregnancy, which increases the risk of birth defects. Poorly controlled gestational diabetes also increases the risk of stillbirth. However, with improvements in medical care, stillbirth is rare.

² National Institutes of Health. Hematopoietic Cell Transplantation, in Management of Sickle Cell Disease. NIH Publication Number 022117, revised May 28, 2002, accessed 04/19/04.

³ Id.

Women with poorly controlled diabetes (gestational or preexisting) are at increased risk of having a very large baby (10 pounds or more). Macrosomia is the medical term for this. These babies grow so large because some of the extra sugar in the mother's blood crosses the placenta and goes to the fetus. The fetus then produces extra insulin, which helps it process the sugar and store it as fat. The fat tends to accumulate around the shoulders and trunk, sometimes making these babies difficult to deliver vaginally and putting them at risk for injuries during delivery. During the newborn period, babies of women with poorly controlled diabetes are at increased risk of breathing difficulties, low blood sugar levels and jaundice. These problems can be treated, but it's better to prevent them by controlling blood sugar levels during pregnancy. Babies of women with poorly controlled diabetes also may be at increased risk of developing obesity and diabetes as young adults.

Does diabetes cause other pregnancy complications?

With advances in medical care, women with diabetes are almost as likely as women without diabetes to have an uncomplicated pregnancy and a healthy baby, as long as blood sugar levels are well controlled beginning before pregnancy. However, women with poorly controlled diabetes, especially preexisting diabetes, are at increased risk of certain pregnancy complications. These include miscarriage, pregnancy-related high blood pressure, polyhydramnios (an excess of amniotic fluid, which can contribute to preterm labor), preterm delivery, and stillbirth.

What tests are recommended to detect complications?

The doctor will carefully track the size and well being of the fetus, especially during the third trimester of pregnancy. He or she may recommend one or more ultrasound examinations to assure that the fetus is growing at a normal rate. If the baby reaches a weight of 9 pounds, 14 ounces or more, the doctor will likely recommend a cesarean delivery at term. The doctor also may recommend a nonstress test (which may be repeated weekly or more frequently), a procedure that monitors the baby's heart rate. In most cases, these tests will show that the pregnancy is progressing normally. Although women with diabetes are at increased risk of cesarean delivery, most have normal vaginal deliveries.

Why is pre-pregnancy care crucial for women with diabetes?

Women with diabetes should consult their doctors before pregnancy to ensure that their blood sugar levels are well controlled. This is important because the most serious birth defects associated with diabetes originate in the early weeks of pregnancy, before a woman may realize she is pregnant.

Studies have shown that blood sugar control begun before pregnancy largely eliminates the extra risk of birth defects for women with diabetes requiring insulin. Studies also show that excellent blood sugar control before and during pregnancy reduces the risk of miscarriage, stillbirth, macrosomia and complications in the newborn period.

When a woman with diabetes plans to conceive, doctors often recommend a blood test that measures glycosylated hemoglobin (a substance formed when glucose in the blood attaches to the hemoglobin protein in red blood cells) every one to two months. This test shows how well blood sugar has been controlled during the past two to three months. It can help determine when it is safest to try to conceive. The test also may be used to monitor blood sugar control during pregnancy.

All women should take a multivitamin containing 400 micrograms of the B vitamin folic acid, as part of a healthy diet, starting at least one month before pregnancy, to help prevent neural tube defects (NTDs). Women with preexisting diabetes are at increased risk of having a baby with an NTD, so taking folic acid may be especially important for them. A recent study found that taking a daily multivitamin supplement before and during early pregnancy appeared to reduce the risk of birth defects in babies of women with preexisting diabetes. At a preconception visit, women with diabetes should ask their doctors whether they should take a daily dose of folic acid greater than 400 micrograms. While there are no studies on the use of larger doses of folic acid to prevent NTDs in women with preexisting diabetes, daily doses of 4,000 micrograms have proven successful in reducing the risk of having another baby with an NTD in women who already have had an affected baby.

Women with preexisting diabetes who take medications to control their blood sugar levels will probably need to switch to insulin before conceiving and during pregnancy because it is not known whether medications are safe during pregnancy, especially during the early weeks.

What are the symptoms of gestational diabetes and how is it detected?

Gestational diabetes is one of the most common pregnancy complications. It usually develops during the second half of pregnancy, when hormones or other factors interfere with the body's ability to use its insulin. Most women with gestational diabetes have no symptoms. Blood sugar levels generally return to normal after delivery. Women at increased risk of gestational diabetes include those who are over age 30, are obese, have a family history of diabetes, or have had a very large (over 9½ pounds) baby or a stillborn baby. According to the Centers for Disease Control and Prevention (CDC), gestational diabetes occurs more frequently in African-Americans, Hispanic/Latina Americans, Pacific Islanders, South or East Asians and Native Americans.

Most pregnant women are screened for gestational diabetes between the 24th and 28th week of pregnancy. Women who are considered at high risk (including women who have had gestational diabetes in a previous pregnancy) often are screened at an early prenatal visit and, if test results are normal, screened again at 24 to 28 weeks. According to the American Diabetes Association (ADA), women under 25 years of age who have no other risk factors for diabetes do not require screening because they have a very low risk of having the disorder. The test involves taking a blood sample one hour after consuming a drink of 50 grams of glucose (a form of sugar). Women with high blood levels of glucose will take the similar, though longer, glucose tolerance test, which involves

drawing blood samples while fasting and at one, two and three hours after drinking 100 grams of glucose. Once gestational diabetes is diagnosed, most women can control their blood sugar levels with diet and exercise, but some women may need to take insulin to control their blood-sugar level (BSL).

What diet is recommended for pregnant women with diabetes?

The number of calories a pregnant woman with diabetes should eat and the proportion of foods from the various food groups (i.e., fat, carbohydrates, proteins, dairy, fruits and vegetables) depends upon many factors, including weight, stage of pregnancy and baby's rate of growth. Ask the prison OB/GYN to recommend a special diet if you have diabetes.

As a general rule, a pregnant woman with diabetes (gestational or preexisting) who is of average weight should consume about 2,000 to 2,200 calories a day. This should help her gain the recommended 25 to 35 pounds during pregnancy. Daily calories are usually divided among three meals and about three snacks, including one at bedtime. The doctor will most likely recommend a diet that includes: 10 to 20 percent of calories from protein (meat, poultry, fish, legumes); about 30 percent from fats (with less than 10 percent from saturated fats); and the remainder from mainly complex carbohydrates (whole-grain bread, cereal, pasta, rice, fruits and vegetables). Sweets should be avoided. (For more information see Nutrition section, page 24)

Should a pregnant woman with diabetes exercise?

Exercise can help control diabetes by prompting the body to use insulin more efficiently and is recommended for most women with gestational diabetes and some women with preexisting diabetes. However, pregnant women with diabetes always should talk to their doctors about exercising. Pregnant women with poorly controlled diabetes or certain complications, such as high blood pressure or blood vessel damage (caused by preexisting diabetes), should exercise only upon the advice of their health care provider.

Many women with preexisting diabetes require insulin injections to keep blood sugar levels under control. Insulin requirements increase during pregnancy, generally rising most rapidly between about 28 and 32 weeks of pregnancy. Some women with preexisting insulin-dependent diabetes find that an insulin pump—a beeper-sized device that delivers insulin via a tiny plastic tube inserted through the skin—helps improve blood sugar control.

Up to 40 percent of women with gestational diabetes require insulin treatment. Insulin is recommended for the remainder of the pregnancy if blood sugar levels do not stabilize after two weeks on a special diet. Soon, however, women may have the option of taking a pill instead of injections. A recent study found that women with gestational diabetes could be treated successfully with an oral diabetes medication called glyburide. This drug does not cross the placenta. Women treated with the oral medication did not have more pregnancy complications than women in the insulin-treated group. While additional studies to confirm these results are needed, some doctors have begun to offer glyburide

to women with gestational diabetes that can't be controlled with diet. (Because the women in the study received the drug after the first trimester, the study does not demonstrate whether or not treatment is safe to use earlier in pregnancy.)

How can a pregnant woman monitor her diabetes?

Pregnant women with preexisting diabetes should monitor their blood sugar levels several times a day. This is also advised for women with gestational diabetes controlled by diet. They use a spring-loaded finger-stick device to obtain a small blood sample, which is placed on a strip and inserted in a meter. This makes it easy to check blood sugar levels and adjust insulin dosage between prenatal visits.

The doctor may suggest a urine test to measure levels of ketones, weak acids produced when the pregnant woman is not consuming enough calories and her body burns fat instead of blood sugar for energy. Moderate to large amounts of ketones in the urine can also be a sign of poorly controlled diabetes and of ketoacidosis, a complication that, unless promptly treated, can lead to death of the fetus.

Do women with diabetes require special care after delivery?

Some women with preexisting diabetes find that their blood sugar levels may be more difficult to predict in the weeks after delivery. This is especially true if a woman is breast-feeding. Women with preexisting diabetes should monitor their blood sugar levels frequently, so that they and their doctors can adjust their insulin dose.

After delivery, blood sugar levels return to normal for most women with gestational diabetes. The ADA recommends that women who had gestational diabetes have their blood sugar level checked six to eight weeks after delivery to make sure sugar levels are normal. Women who have had gestational diabetes have about a 40 to 50 percent chance of developing diabetes in the future, so the ADA recommends a blood sugar check every three years. These women can help reduce their risk by starting a weight loss and exercise program after delivery. They also face about a 35 to 50 percent risk of gestational diabetes in another pregnancy. Studies suggest that achieving a healthy weight between pregnancies and after pregnancy also may reduce this risk.

Chickenpox (Varicella)

Chickenpox (varicella) is a viral illness that mainly affects children. Its symptoms include an itchy rash and fever. Between 85 and 95 percent of pregnant women are immune to chickenpox, meaning that they cannot catch it. About 1 woman in 2,000 will develop chickenpox during pregnancy, however.

If a woman does catch chickenpox during pregnancy, there can be serious consequences to the baby, depending on when in pregnancy the infection occurs. If infection occurs in the first 20 weeks of pregnancy, there is a very small risk (less than 1

percent) that the baby will be born with congenital varicella syndrome, a group of serious birth defects.

If infection occurs around the time of delivery, the baby may be born with chickenpox infection. If this infection is treated, most babies have only a mild illness. Without treatment, up to 30 percent of infants die.

What you can do:

There is a blood test that can determine whether you are immune to chickenpox. If you are not sure if you have had the disease, you can get this blood test before pregnancy or early in pregnancy. Women who are not immune, and not yet pregnant, can get vaccinated. (See the Frequently Asked Questions section, page 30).

Pregnant women who are not immune should avoid anyone with chickenpox and anyone who has had contact with someone with the disease. An infected person is contagious (can give the virus to someone else) before he or she develops the disease.

Contact the doctor right away if you are pregnant and have been exposed to chickenpox.

Flu and Pregnancy

Influenza (commonly called “the flu”) is a contagious respiratory illness caused by viruses. It can result in severe illness and life-threatening complications. Symptoms of flu include fever (usually high), headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches. Some people, especially children, also have nausea, vomiting and diarrhea.

Influenza viruses are spread when a person who has the flu coughs, sneezes, or speaks. The viruses spread into the air, and other people inhale them. Flu can also be spread when a person touches a surface that has viruses on it (such as a door handle) and then touches his or her nose or mouth.

Pregnancy can increase the risk for complications from the flu, such as pneumonia. Pregnant women are more likely to be hospitalized from complications of the flu than non-pregnant women of the same age. Pregnancy can change the immune system in the mother, as well as affect her heart and lungs. These changes may place pregnant women at increased risk for complications from the flu.

Preventing the Flu

The following steps may help prevent the spread of respiratory illnesses like flu:

- ❖ If possible, avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick too.
- ❖ Clean your hands. Washing your hands often will help protect you from germs.

- ❖ Avoid touching your eyes, nose or mouth. Germs are often spread when a person touches something that has germs on it and then touches his or her eyes, nose, or mouth.
- ❖ Cover your mouth and nose with a tissue when coughing or sneezing. This may prevent those around you from getting sick.

If You Get the Flu

Tell the doctor if you think you have the flu. Get plenty of rest, and drink a lot of liquids.

Group B streptococcus

Group B streptococcus (GBS) infection is a common bacterial infection that is generally not serious in adults but can be life-threatening to newborns. GBS affects about 1 in every 2,000 babies born in the United States. Anyone can carry GBS, and between 10 and 30 percent of pregnant women carry it.

If a pregnant woman carries the GBS bacterium in her vagina or rectum at the time of labor, there is a 1 in 100 (1 percent) chance that her baby will become infected. Babies infected with GBS can get pneumonia, sepsis (blood infection) or meningitis (infection of the membranes surrounding the brain). Infected babies can be treated with antibiotics. Most have no long-lasting damage, but about 5 percent die, and some babies who develop meningitis suffer lasting neurological damage.

What you can do:

You can be screened for GBS infection during the last few weeks of pregnancy. If you carry GBS, or the doctor determines you are at risk for GBS infection, you may be treated with intravenous antibiotics during labor and delivery.

If you have any questions about GBS, ask the doctor near the end of your pregnancy.

Listeriosis/ Salmonellosis

Listeriosis is a form of food poisoning caused by bacteria called *Listeria monocytogenes*. If a pregnant woman has listeriosis, she may have a miscarriage or stillbirth, or her baby may become very ill.

Foods that may be contaminated with *Listeria* include unpasteurized milk, foods made from unpasteurized milk, poultry, fish and ready-to-eat meats (such as cold cuts or deli meats). Symptoms of listeriosis can include a flu-like illness with fever, muscle aches and chills and sometimes nausea and diarrhea. It can progress to meningitis (an infection of the membranes surrounding the brain) and blood infection. A blood test can determine if a person has listeriosis.

Salmonellosis is a food-borne infection caused by the bacteria Salmonella. Symptoms include diarrhea, fever and abdominal cramps, which can be severe in pregnant women. Occasionally a pregnant woman passes the infection to her baby, who can develop diarrhea, fever and, rarely, meningitis.

Foods that can become contaminated with Salmonella include raw or undercooked meats, unpasteurized milk and foods made from it, raw or undercooked eggs and alfalfa sprouts

What you can do:

The U.S. Centers for Disease Control and Prevention (CDC) recommends that all pregnant women take steps to protect themselves and their babies from listeriosis. You should:

- ❖ Eat only meats, poultry and seafood that have been cooked thoroughly.
- ❖ Avoid cold cuts or deli meats or undercooked hot dogs.
- ❖ Avoid unpasteurized milk and foods made from it.
- ❖ Avoid soft cheeses such as Brie, feta, Camembert, blue-veined and Mexican-style. (Hard cheeses, processed cheeses, cream cheese and cottage cheese are safe.)
- ❖ Avoid alfalfa sprouts.

Rubella (German Measles)

Rubella (German measles) is a mild childhood illness that can cause serious birth defects in an unborn baby. About 25 percent of babies whose mothers get rubella in the first trimester of pregnancy are born with one or more birth defects (congenital rubella syndrome) including eye defects, hearing loss, heart defects, mental retardation and, less frequently, movement disorders.

With the widespread use of the rubella vaccine, major outbreaks of rubella no longer occur in the United States. Still, small outbreaks do occur. As many as 20 percent of childbearing women are susceptible to rubella infection.

What you can do:

There is a simple blood test that can determine if you are immune to rubella. Pregnant women are routinely tested for rubella immunity at an early prenatal visit. Be sure to ask the nurse or doctor at the prison/jail if this blood test is part of your initial examination. If you find out you are not immune, you should not be vaccinated during your pregnancy. All you can do is try to avoid exposure to anyone with the illness. You can get vaccinated soon after delivery so you are immune during any future pregnancies.

Toxoplasmosis

Toxoplasmosis is a common infection that, when contracted by a pregnant woman, can pose serious risks to her fetus. An estimated 400-1,000 babies in the United States are born with toxoplasmosis each year. Babies born with toxoplasmosis often develop eye infections that can cause blindness. Some develop hearing loss and/or learning disabilities. Some babies are so severely infected at birth that they die or have serious long-term physical and mental disabilities. Toxoplasmosis in pregnancy can also cause miscarriage and stillbirth.

The major carriers of toxoplasmosis are cats. Pregnant women should avoid having any contact with cat feces and should not change a cat's litter box.

What you can do:

Try to wash all raw fruits and vegetables before eating them. Avoid raw or undercooked meat.

HIV and Pregnancy

The virus that causes AIDS can be transmitted from an infected mother to her newborn child. Without treatment, about 20% of babies of infected mothers get HIV. Mothers with higher viral loads (the amount of HIV in your blood, this can be tested) are more likely to infect their babies. However, no viral load is low enough to be "safe." Infection can occur any time during pregnancy, but usually happens just before or during delivery. The baby is more likely to be infected if the delivery takes a long time. During delivery, the newborn is exposed to the mother's blood. Drinking breast milk from an infected woman can also infect babies. Mothers who are HIV-infected should not breast-feed their babies. The risk of transmitting HIV is extremely low if antiviral medications are used. Transmission rates are only 1% to 2% if the mother takes combination antiviral therapy.

The rate is about 4% when the mother takes AZT during the last six months of her pregnancy, and the newborn takes AZT for six weeks after birth.

Perinatal transmission rates of less than 2% have been achieved with the combination antiviral drug ZDVE (Zidovicedine) and cesarean section. A cesarean section prior to the rupture of the membranes has been shown to decrease HIV transmission. The American College of Obstetricians and Gynecology (ACOG) recommends that women who are HIV-infected and pregnant be offered a scheduled cesarean delivery at 38 weeks gestation to reduce the risk of vertical transmission.

Remember: Mothers can reduce the risk of infecting their babies if they:

- ❖ Use antiviral medications;
- ❖ Deliver the baby by cesarean section (this keeps the delivery time short); and
- ❖ Don't breast-feed the baby.

How do we know if a newborn is infected?

Most babies born to HIV-infected mothers test positive for HIV. Testing positive means the baby has HIV antibodies in his/her blood. Babies get HIV antibodies from the mother even if they aren't infected.

If babies are infected with HIV, their own immune systems will start to make antibodies. They will continue to test positive. If they are not infected, the mother's antibodies will disappear and the babies will test negative after about 6 to 12 months.

Another test, similar to the HIV viral load test can be used to find out if the baby is infected with HIV. Instead of antibodies, these tests detect the HIV virus in the blood.

What about the mother's health?

Recent studies show that HIV-positive women who get pregnant do not get any sicker than those who are not pregnant. Becoming pregnant is not dangerous to the health of an HIV-infected woman.

However, "short-course" treatments to prevent infection of a newborn are not the best choice for the mother's health. Combination therapies are the standard treatment. If a pregnant woman takes medications only during labor and delivery, she might develop resistance to them

A pregnant woman should consider all of the possible problems with antiviral medications.

- Pregnant women should not use both ddI and d4T in their antiviral treatment due to a high rate of a dangerous side effect called lactic acidosis.
- Do not use efavirenz (Sustiva) or indinavir (Crixivan) during pregnancy.
- If you have more than 250 T-cells, do not start using nevirapine (Viramune).

Some doctors suggest that women interrupt their treatment during the first 3 months of pregnancy for two reasons:

- The risk of missing doses due to nausea and vomiting during early pregnancy, giving HIV a chance to develop resistance.
- The risk of birth defects, which is highest during the first 3 months. There is almost no evidence of these birth defects, except with efavirenz.

Sexually Transmitted Infections/Diseases (STD's) During Pregnancy

(The following two charts are from the American Pregnancy Association;

www.americanpregnancy.org)

Bacterial STD'S - Infections that are curable			
Infection	Risks (M=Mom; B=Baby)	Method of Transfer	Treatment
Gonorrhea	M - Can result in ectopic pregnancies and leads to Pelvic Inflammatory Disease (PID), which can cause infertility B - Premature birth, stillbirth, eye infections	Can transfer in the birth canal during delivery	M - Antibiotics approved by OB/GYN B - Antibiotics are given in the eyes to prevent infection
Chlamydia	M - Can result in ectopic pregnancies and leads to Pelvic Inflammatory Disease (PID), which can cause infertility B - Pneumonia, eye infections, blindness	Can transfer in the birth canal during delivery	M & B - Antibiotics approved by OB/GYN
Trichomonis Vaginalis	M - Can cause fallopian tube damage B - Premature birth, low birth weight	Can transfer in the birth canal during delivery	M & B - Antibiotics approved by OB/GYN
Bacterial Vaginosis	B - Premature birth, low birth weight	Can transfer in the birth canal during delivery	M & B - Antibiotics approved by OB/GYN
Syphilis	M - Miscarriage B - Stillbirth, congenital syphilis which can result in mental & physical problems	Can cross the placenta during pregnancy and can transfer in the birth canal during delivery	M & B - Antibiotics approved by OB/GYN can be given to prevent damage to the fetus

Viral STD'S - Infections that are not curable

Infection	Risks (M=Mom; B=Baby)	Method of Transfer	Treatment
Human Papilloma Virus (HPV) also known as "Genital Warts"	M - Can lead to genital cancer B - Warts can develop in the baby's throat which will require surgery M & B - Warts in birth canal can cause complications during delivery.	Can transfer in the birth canal during delivery, but very rare	M & B - Wart treatment can occur during pregnancy but has to be approved by OB/GYN
Hepatitis B	M - Can cause significant damage to the liver B - Unless treated within an hour of birth 90% of babies will be a carrier for life	Can transfer in the birth canal during delivery	B - No cure, but can be prevented with vaccinations
Herpes	M - Severe outbreak in the first trimester can result in miscarriage B - Fetus is at higher risk if herpes is contracted during pregnancy, and can lead to neonatal herpes.	Can transfer in the birth canal during delivery and rarely can cross the placenta during pregnancy	M - No cure, but outbreaks can be treated with drugs. B - Treatment immediately following birth improves chances of a healthy baby
Human Immuno-deficiency Virus (HIV)	M & B - HIV can develop into AIDS, which can be fatal without treatment.	Can cross the placenta during pregnancy and can transfer in the birth canal during delivery. Also possible to transfer through breast-feeding	M - Antiviral medication is given to reduce symptoms during pregnancy B - Treatment during pregnancy greatly reduces the chance of transmission to the baby

(The following definitions are from Web MD; www.webmd.com)

Bacterial vaginosis (BV)- A change in the balance of bacteria that are normally present in the vagina, which can cause bothersome symptoms. BV is the most common cause of vaginal symptoms in women of childbearing age. The most noticeable symptom is an excessive grayish-white discharge (fluid) coming out of the vagina. A “fishy” smell after sex is also a telltale sign. However, about half of women with BV have no symptoms.

Chlamydia - A bacterial infection of the cervix, urethra or upper reproductive organs, or sometimes all three. Chlamydia can also infect the rectum and the lining of the eyelids. Between 50% and 75% of babies born to mothers with chlamydia get the infection. The symptoms for women are: Painful urination, cloudy urine, abnormal vaginal discharge, abnormal vaginal bleeding with sex or between periods, genital itching, irregular bleeding during your period, pain in the lower abdomen, fever and feeling tired, swollen and painful glands at the opening of the vagina and conjunctivitis (pinkeye). Most severe symptoms appear as the disease progresses. There may be **no** apparent symptoms in the early stages of infection.

Hepatitis - Hepatitis B is a liver disease caused by infection with the hepatitis B virus (HBV). Symptoms include jaundice (a yellowing of the eyes and the skin), extreme tiredness, mild fever, headache, loss of appetite, nausea, vomiting, discomfort in the liver area (below the rib cage on the right side), diarrhea or constipation, muscle aches, skin rash, and, joint pain.

Herpes - A viral infection caused by the Herpes Simplex Virus (HSV). Symptoms may include: Flu-like symptoms such as fever, headache, and muscle aches; Tingling, itching, redness and burning where the outbreak is about to occur; Painful itchy blisters on the vulva or the vagina; Blisters may also occur on the anus, buttocks, thighs or scrotum, either alone or in clusters (blisters that break become slow, painful, oozing sores; Painful urination and abnormal vaginal discharge. Some or all of these symptoms may be present, from mild to severe.

Human Papillomavirus (HPV) - HPV is the virus that causes genital warts. The primary symptom is warts on the genitalia. Warts look like tiny bunches of cauliflower or like flat white areas that are difficult to see. Irritation, itching or bleeding may occur with the warts. A person may appear symptomless in early stages of infection. (Note: HPV has been shown to lead to cervical cancer).

Gonorrhea - A bacterial infection of the cervix. About half of men and women who are infected do not have symptoms. Symptoms usually occur within 2 to 5 days of infection. The symptoms for women are: Painful or frequent urination; anal itching, pain, bleeding, or discharge; abnormal vaginal discharge; abnormal vaginal bleeding with intercourse or between periods; genital itching; irregular menstrual bleeding; lower abdominal pain; fever and general tiredness; swollen and painful glands at the opening of the vagina. A

woman may not have apparent symptoms until the infection has progressed to the fallopian tubes.

Syphilis - A bacterial infection that can cause serious medical problems if left untreated. Usually sexually transmitted, but can be transmitted orally or by contact with someone else's genitalia or rectum. The first symptom is a painless chancre (sore) that develops where the bacteria entered the body. This commonly occurs within 3 weeks of diagnosis. In women, chancres can develop on the outer genitals or on the inner part of the vagina. A chancre may go unnoticed if it occurs inside the vagina or at the opening to the uterus (cervix) because the sores are usually painless and are not easily visible. The chancre lasts for 28 to 42 days, heals without treatment, and may leave a thin scar. However, just because the chancre has healed does not mean the syphilis is cured or that a person cannot pass the infection to others.

Trichomoniasis - Sometimes called Trichomonis vaginalis infection or trich (pronounced "trick"). Trich should be treated to prevent transmitting it to others and to prevent complications if you are pregnant. Trich is the second most common STD in the United States. Both men and women can get a trich infection. However, Trich is more common in women. About 50% of women and 90% of men infected with Trich do not have symptoms. Symptoms may be worse during pregnancy or right before or after a menstrual period. If symptoms develop, they may include: Large amounts of pale yellow or gray-green, sometimes foamy discharge from the vagina, vaginal itching or irritation, large amounts of pale yellow or gray-green, sometimes foamy discharge from the vagina, itching or irritation in the vagina, abnormal musty odor of the vagina, pain with sexual intercourse, patchy red areas on the genitals or in the cervix, painful urination or frequent urination.

What can I do to prevent STD's (sexually transmitted diseases)?

The best way to avoid becoming infected with a sexually transmitted disease is to be sure to *never have unprotected sex*. Use a condom or dental dam every time you have intercourse or oral sex. While it is true that you will probably not have access to condoms or dental dams while you are incarcerated, it is important to remember that to avoid STDs you should not engage in unprotected sex.

Remember: using birth control methods may keep you from becoming pregnant but they will not protect you from STDs. To avoid STDs, always use protection.

ABORTION

Can I legally obtain an abortion while I am incarcerated?

Yes. Abortion is legal in the state of California. If you are in a California state prison or jail, California Youth Authority facility or local juvenile facility, you have the legal right to have an abortion should you decide to terminate your pregnancy. Cal. Penal Code §§ 3405, 4028; Cal. Welfare and Institutions Code §§ 220, 1773.

If you are in federal prison in California, the Bureau of Prisons may pay for an abortion only where the life of the mother would be endangered if the fetus were carried to term (such as an ectopic pregnancy) or if the pregnancy is the result of rape. 42 C.F.R § 50.304 50.306 (2005). If you want to end your pregnancy under other circumstances, you have to pay for the abortion with your own funds. The Bureau may, regardless of whether they pay for the abortion or not, pay for transportation to an outside facility to receive an abortion. (A Birth Control, Pregnancy, Child Placement and Abortion Program Statement 6070.5, August 9, 1996).

The choice to continue or terminate your pregnancy is yours alone to make. No one has the legal right to force you to have or not to have an abortion. Each woman makes her decision based on her personal beliefs and individual circumstance. As an incarcerated woman, other factors you may consider are the quality of the medical care you will receive during your pregnancy and potential separation from your infant at birth. Be aware of your options and talk with someone you trust to help you make the decision that is best for you.

If I am a juvenile can I obtain an abortion?

Yes, even if you are under the age of 18, you may obtain an abortion. You do not need the consent of your parents, your legal guardian, or a judge. It is your decision to make.

How do I arrange for an abortion?

If you think you are pregnant, you should ask to be tested as soon as possible. You have the legal right to receive the services of a physician to determine if you are pregnant. (Cal. Penal Code §§ 4023.6 and 3406; Cal. Welfare and Institutions Code §220). The medical officer must tell you the results of the pregnancy test as soon as it becomes available.

The regulations for receiving an abortion may vary among the different institutions. If you are at CIW or VSPW it is your choice to have an abortion up to 16-18 weeks. You must fill out a "Request for Services" with the prison doctor. Currently the CDCR will pay for your non-therapeutic abortion. Between the 18th and 24th week (2nd trimester) the clinic that the prison contracts with will decide whether it is safe for you to have an abortion. After the 24th week you may not receive an abortion unless your life is in danger.

Ask a health worker at your facility for specific information about obtaining an abortion. The prison, jail, CYA, or juvenile detention medical staff may have to locate an outside medical facility that performs abortions. Consequently, you should promptly notify the medical staff to request an abortion, so they can schedule the procedure and arrange for transportation and security. If you wait too long, you will be too far along in your pregnancy for an abortion to be performed unless your life is in danger.

What are the different types of abortions?

Generally, the simplest type of abortion, a ***vacuum aspiration***, can be performed until the twelfth week of pregnancy. You will be given local anesthesia around your cervix (you will be awake during this procedure). With this method, the cervix is first expanded with slender rods. Then a flexible tube is inserted into the cervix from the vagina. One end of the tube is connected to a suction machine, which removes the fetal tissue. The procedure usually lasts 10-15 minutes, but you may have to stay at the clinic for a few hours. Common side effects of this procedure include cramping, nausea, sweating and feeling faint. Less common side effects include heavy or prolonged bleeding and damage to the cervix. You should ask to see a doctor if these symptoms don't go away.

More complicated procedures must be performed if you want an abortion after the twelfth week of pregnancy. A ***dilation and curettage*** abortion is performed between the 12th and 15th week of pregnancy. Dilation and curettage is similar to vacuum aspiration except it uses a curette. A curette is a long, looped shaped knife that scrapes the lining, placenta and fetus away from the uterus. A cannula may be inserted for a final suctioning. This procedure usually lasts 10 minutes with a possible stay of 5 hours. A dilation and curettage has the same side effects as a vacuum aspiration.

A ***dilation and evacuation*** procedure is performed between the 15th and 21st week of gestation. 24 hours before the procedure your doctor will insert Laminaria (a plant) or a synthetic dilator into your cervix which will dilate (expand) your cervix. The next day your physician will place a clamp-like device on your cervix to keep it from moving and then will insert a cannula (a long silver tube) to begin removing tissue from the lining of the uterus. Forceps may be used to remove the larger parts. The last step is a final suctioning to make sure the contents are completely removed. This procedure is usually performed in hospitals, as there is a greater risk of complications.

A ***dilation and extraction*** procedure is used after the 21st week of gestation. Two days before the procedure Laminaria is inserted vaginally to dilate the cervix. Your water should break on the third day and you should return to the clinic. The fetus is then grasped with forceps by the legs and pulled through the birth canal. A small cut is made at the base of the skull and a catheter is inserted to remove any cerebral matter. The fetus is then completely removed.

Nutrition and Pregnancy

(The information in this section is from the U.S. Department of Health and Human Services web site: www.hhs.gov)

Nutrition is a very important part of prenatal care. A healthy diet can contribute to a successful pregnancy by reducing complications and promoting adequate fetal growth and development. The purpose of this section is to provide you with general guidelines for maintaining good nutrition during pregnancy.

It may be hard for you while incarcerated to get some of the most nutritious foods, but try to choose comparable substitutes. Use the example foods listed below as a guide of what and how much you should consume in your daily diet.

According to the American Dietetic Association, pregnant women should increase their usual servings of a variety of foods from the four basic food groups (up to a total of 2,500 to 2,700 calories daily) to include the following:

Fruits and Vegetables –

Seven or more servings of fruits and vegetables combined (three servings of fruit and four of vegetables) daily for vitamins and minerals. Fruits and vegetables with vitamin C help you and your baby to have healthy gums and other tissues, and help your body to heal wounds and to absorb iron. Examples of fruits and vegetables with vitamin C include strawberries, melons, oranges, papaya, tomatoes, peppers, greens, cabbage, and broccoli. Fruits and vegetables also add fiber and other minerals to your diet and give you energy. Plus, dark green vegetables have vitamin A, iron, and folate, which are important nutrients during pregnancy.

One Serving Size Fruit = 1 medium apple, 1 medium banana, ½ cup of chopped fruit, ¾ cup of fruit juice
One Serving Size Vegetable = 1 cup raw leafy vegetables, ½ cup of other vegetables (raw or cooked), ¾ cup vegetable juice

Whole-grains or Enriched Breads/Cereals Aim for nine or more servings. Whole grain products and enriched products like bread, rice, pasta, and breakfast cereals contain iron, B vitamins, some protein, minerals, and fiber that your body needs. Some breakfast cereals have been enriched with 100% of the folic acid your body needs each day. Folic acid has been shown to help prevent some serious birth defects. Choosing a breakfast cereal or other enriched grain products that contain folic acid is important before and during pregnancy.

One Serving Size = 1 slice bread, ½ cup of cooked cereal, rice, or pasta, 1 cup ready-to-eat cereal

Dairy Products –

Aim for four or more servings of low-fat or non-fat milk, yogurt, or other dairy products like cheese for calcium. You and your baby need calcium for strong bones and teeth. Dairy products also have vitamin A and D, protein, and B vitamins. Vitamin A helps growth, resistance to infection, and vision. Pregnant women need 1,000 milligrams (mg) of calcium each day. If you are 18 or younger, you need 1,300 mg of calcium each day. Try to have low-fat or non-fat milk and milk products to lower your fat intake. Other sources of calcium include dark green leafy vegetables, dried beans and peas, nuts and seeds, and tofu. If you are lactose intolerant or can't digest dairy products, you can still get this extra calcium. There are several low-lactose or reduced-lactose products available. In some cases, your doctor might advise you to take a calcium supplement.

One Serving Size = 1 cup of milk or yogurt, 1 ½ oz. natural cheese, 2 oz. processed cheese

Proteins –

Pregnant women need about 60 grams of protein per day. This is about the same as two or more 2-3 oz. servings of cooked lean meat, poultry without the skin or fish, or two or more 1 oz. servings of cooked meat. **Don't eat uncooked or undercooked meats or fish. These can make you sick.** Pregnant women should avoid deli luncheon meats, too (bologna for example). Eggs, nuts, dried beans, and peas also are good forms of protein. Protein builds muscle, tissue, enzymes, hormones, and antibodies for you and your baby. These foods also have B vitamins and iron, which is important for your red blood cells. Your need for protein in the first trimester is small, but grows in your second and third trimesters when your baby is growing the fastest, and your body is working to meet the needs of your growing baby.

One Serving Size = 2-3oz. of cooked lean meat, poultry, or fish, 1 oz. meat also = ½ cup cooked dried beans, 1 egg, ½ cup tofu, 1/3 cup nuts, 2 T. peanut butter

Should I limit how much fish I eat when I'm pregnant?

Some fish have mercury, which, in high doses, can hurt your baby's growing brain and nervous system. There are some fish you should NOT eat if you are pregnant.

Here are some guidelines:

Do not eat any shark, swordfish, king mackerel, or tilefish (also called golden or white snapper) because these fish have high levels of mercury.

Do not eat more than six ounces of "white" or "albacore" tuna or tuna steak each week. Limit your fish to no more than 2 servings (12 ounces total) per week. When you eat fish, choose shrimp, salmon, pollock, catfish, or "light" tuna as they are usually low in mercury.

What other nutrients do I need for a healthy pregnancy?

Folic acid: Folic acid is an important vitamin for any woman who could possibly become pregnant. Folic acid is a B vitamin that helps prevent serious birth defects of a baby's brain or spine (called neural tube defects) and other birth defects like cleft lip and congenital heart disease. Folic acid is needed very early in pregnancy, usually before a woman knows she is pregnant. That is why it's so important that every woman who could possibly become pregnant gets enough folic acid every single day, starting at least one month before pregnancy. One easy way to ensure getting enough folic acid every day is to take a daily multivitamin. Most multivitamins sold in the U.S. contain enough folic acid for the day. Your vitamin should contain 400 micrograms (400 mcg) or 100% of the Daily Value (DV) for folic acid. The prison should provide you with a vitamin that contains your daily folic acid needs.

Iron: You need iron to keep your blood healthy for you and your baby. Bones and teeth also need iron to develop properly. Too little iron can cause a condition called anemia. If you have anemia, you might look pale and feel very tired. Pregnant women should take a low-dose iron supplement, beginning at the first prenatal visit, or even before, when you are planning to get pregnant. If your doctor finds that you have anemia, he or she will give you a higher dose of iron supplements to take once or twice a day. You can help prevent anemia by eating more iron-rich foods like lean red meat, fish, poultry, dried fruits, whole-grain breads, and iron-fortified cereals.

Water: Water plays a key role in your diet during pregnancy. It carries the nutrients from the foods you eat to your baby and helps prevent you from getting constipation, hemorrhoids, excessive swelling, and urinary tract or bladder infections. Drinking enough water, especially in your last trimester, prevents you from becoming dehydrated. Not getting enough water can then lead you to have contractions and premature or early labor. Pregnant women should drink at least six eight-ounce glasses of water per day and another glass for each hour of activity. You can drink juices for fluid, but they also have a lot of calories and can cause you to gain extra weight. Coffee, soft drinks, and teas that have caffeine actually reduce the amount of fluid in your body, so they cannot count towards the total amount of fluid you need. Women exposed to heat and humidity may need more than ten cups of fluid each day. Enough fluid should be consumed to replace that lost in sweat. That may mean drinking water or other fluids regularly whether you feel thirsty or not.

Drugs and Pregnancy

Cocaine, Crack, Speed & Methamphetamine

Cocaine (including crack) and Methamphetamine (speed, or ice) are powerful stimulants of the central nervous system. They suppress the mother's appetite and exert other drastic forces on her body, causing the blood vessels to constrict, the heart to beat faster, and the blood pressure to soar. The growth of the fetus may be hindered, and there are higher risks of miscarriage, premature labor, and a condition called *abruptio placentae* (the partial separation of the placenta from the uterus wall, causing bleeding).

According to the American College of Obstetricians and Gynecology (ACOG), women who use cocaine during their pregnancy have a 25 % increased chance of premature labor. Babies born to mothers who use cocaine throughout their pregnancy may also have a smaller head and their growth hindered. There may also be deformation of the kidneys, brain and genitals. (Source: American Pregnancy Association)

If these drugs are taken late in pregnancy, the baby may be born drug dependent and suffer withdrawal symptoms, such as tremors, sleeplessness, muscle spasms, and sucking difficulties. Some experts believe learning difficulties may later develop. (Source: American Council for Drug Education)

Heroin & Other Narcotics

Heavy narcotics use increases the danger of premature birth with such accompanying problems for the infant as low birth weight, breathing difficulties, low blood sugar (hypoglycemia), and bleeding within the head (intra cranial hemorrhage).

The babies of narcotics-dependent mothers are often born dependent themselves and suffer withdrawal symptoms, such as irritability, vomiting and diarrhea, and joint stiffness. Women who inject narcotics may become infected with the HIV virus from dirty needles and may subsequently develop AIDS. HIV-infected women run a high risk of passing the virus on to their babies.

If you are pregnant and addicted to heroin, trying to go "cold turkey" can be very harmful to the fetus. Becoming slowly detoxified in a methadone maintenance program, where the mother and fetus's health are carefully monitored, appears to be a safer option. (Source: American Council for Drug Education). According to the CDCR, women who are addicted to heroin and found to be pregnant must be given methadone maintenance treatment. (See General Information section, page 2).

Inhalants

At least one inhaled substance has been clearly connected with birth defects. The organic solvent toluene, widely used in paints and glues, appears to cause malformations like those produced by alcohol (which is itself an organic solvent). It is possible that all organic solvents may cause birth defects.

PCP

PCP (phencyclidine, or angel dust) taken late in pregnancy can cause newborns to have withdrawal symptoms, such as lethargy alternating with tremors. PCP use can also lead to low birth weight, poor muscle control, brain damage, and withdrawal syndrome if used frequently. Withdrawal symptoms include lethargy, alternating with tremors. LSD can lead to birth defects if used frequently. (Source: American Pregnancy Association and American Council for Drug Education)

Marijuana

THC (the active ingredient in Marijuana) crosses the placenta to your baby. Studies of marijuana in pregnancy are inconclusive since many women who smoke marijuana also use tobacco and alcohol. Smoking marijuana increases the levels of carbon monoxide and carbon dioxide in the blood, which reduces the oxygen supply to the baby. Smoking marijuana during pregnancy can increase the chance of miscarriage, low birth-weight, premature births, developmental delays, and behavioral and learning problems.

What will happen if I tell my doctor about my drug use during my pregnancy?

If you are on the streets, inform your doctor if you cannot quit, so that your pregnancy can be closely monitored and any specialized treatment given to minimize injury. There are also many agencies you can call for help. We have listed some organizations in a resource list included with this manual.

Be aware that you might have problems with the department of social services if you notify your doctor of your drug use. You should weigh this risk against the risk to your baby if she/he goes untreated. Many hospitals routinely test newborns for drug exposure.

Can I face legal penalties for using illegal drugs during my pregnancy?

Recently some jurisdictions have tried to impose legal penalties on pregnant substance-dependent women, supposedly to discourage them from using substances. Women who used cocaine or heroin during pregnancy have been charged with violating criminal and civil child abuse or neglect laws. See *Whitner v. South Carolina*, 328 S.C. 1 (1997). In 2005, two women in Maryland were convicted of child endangerment as a result of using drugs while pregnant and sentenced to prison. However, the Maryland Court of Appeals overturned those convictions in August 2006, holding that the state's reckless endangerment statute was not intended to apply to women in relationship to their own pregnancies. The Court reasoned that if the statute applied to women who ingested cocaine during their pregnancy, it would also have to apply to women who failed to wear a seat belt while pregnant or to women who engaged in any injury-prone activity while pregnant.

So far California courts have declined to prosecute women who have given birth to an addicted child. See *Reyes v. Superior Court*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977).

Under Penal Code §11165.13, if an infant tests positive at the time of delivery, that factor alone is not enough to report the mother for child abuse or neglect. However, it is enough to require that an assessment of the mother's and child's needs be made under Health & Safety Code section 123605. A report on this assessment will be made and given to county welfare or the probation department. According to California Penal Code § 11165.13, the report is not to be given to law enforcement.⁴

Even though you may not be facing charges of abuse or neglect because your baby tested positive for drugs, your baby could be made a dependent of the court due to other circumstances. In one 1989 case, the court held that the fact that Troy D. was diagnosed as being born under the influence of drugs was enough to give the juvenile court jurisdiction. Furthermore, the court held that the toxicology report, the testimony of a physician regarding the effects of prenatal drug use, and the fact that the parents had lost custody of an older child was sufficient to declare Troy D. a dependent child. (*In re Troy D.*, 215 Cal.App.3d 889, 263 Cal.Rptr. 869)

What happens if my baby is made a dependent of the court?

If your baby is made a dependent of the court, it means that you will have to work very hard to have the baby returned to your custody. If you will be incarcerated for only a short amount of time, you may be given a reunification plan. Reunification plans might require that you take parenting classes, substance-abuse classes, anger management classes and/or attend NA or AA. You will have a social worker who will make reports to the court about your progress with the reunification plan.

If you will be incarcerated for more than two years, you may not be given a reunification plan because you won't be able to complete the plan within the time limits under California law. For example, if your child is under the age of three years at the time she is made a dependent of the court, you would only have six months (might be extended to 12 months) to comply with the court-ordered services (reunification plan). For children who are older than three years old at the time they are removed from the parents' custody, the time to reunify is limited to 12 months (might be extended to 18 months). However, in cases where there are two or more children (a sibling group) removed from the home, if any one of the children is under the age of three years, the time to reunify is limited to six months for all of the children. In some circumstances it is possible to have the time extended to 18 months. However, the court will only extend the time of reunification to 18 months if it finds that there is a "substantial probability" that the child will be returned to the parent's custody within that extended time.

⁴ A report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to county welfare or probation department and not to a law enforcement agency. (Cal. Penal Code § 11165.13)

FREQUENTLY ASKED PREGNANCY QUESTIONS

(All the following information is from WebMD and/or <http://www.emedicine.com/med/topic3238.htm>)

What are the first symptoms of pregnancy?

Missing a period is usually the first sign of a new pregnancy, although women with irregular periods may not at first recognize a missed period as pregnancy. During this time, many women experience a need to urinate frequently, extreme fatigue, nausea and/or vomiting, and increased breast tenderness. All or some of these symptoms are normal.

How is the baby's due date calculated?

Pregnancy lasts 281-282 days, according to most studies of normal pregnancies. Determine the first day of the last menstrual period, add 7 days, and then subtract 3 months. This is the expected month and date the baby will be due.

How does a woman know if she has an ectopic or tubal pregnancy?

Normally, at the beginning of a pregnancy, the fertilized egg travels from the fallopian tube to the uterus, where it implants and grows. In nearly 2% of pregnancies, however, the fertilized egg attaches to an area outside of the uterus, resulting in an ectopic pregnancy (also known as tubal pregnancy or extrauterine pregnancy).

Nearly all ectopic pregnancies develop in a fallopian tube; the remainders occur in an ovary, the cervix, or the abdomen. Generally none of these areas are capable of holding or sustaining a growing fetus.

The most common symptom of an ectopic pregnancy is cramping or tenderness on one side of the lower abdomen. If the tube ruptures pain becomes very sharp and steady before spreading throughout the entire pelvic region. Other symptoms include brown vaginal spotting, light bleeding, or heavier bleeding if the tube ruptures. If rupture leads to bleeding severe enough to cause anemia, a patient may experience dizziness or weakness.

If you are diagnosed with an ectopic pregnancy your pregnancy must be ended right away, as this condition can become life threatening.

Factors that increase your risk for ectopic pregnancy include previous ectopic pregnancies, Pelvic Inflammation Disease (PID) (often caused by gonorrhea or chlamydia) and smoking cigarettes.

When should a woman have her first prenatal visit? After the first visit, how often should a woman see her doctor?

Ideally, patients should see their physician before becoming pregnant for preconception counseling. If this is not possible, patients should see their physician as soon as pregnancy is suspected to maximize prenatal health care and to minimize risk for birth defects and complications. Seeing a health care provider to begin prenatal care by the 10th week of pregnancy is recommended. Screening blood tests, starting prenatal vitamins, and early detection of problems are better accomplished sooner rather than later. A physical examination and screening for sexually transmitted diseases are part of the first prenatal visit. An ultrasound is recommended for women who are uncertain of their menstrual cycle. A woman who experiences bleeding, unusual pain, or unrelenting vomiting should seek care immediately.

When should a woman have her first ultrasound?

Each obstetrician has his/her own guidelines. The earliest a pregnancy can be visualized on transvaginal sonography is at 4-5 weeks' gestation; if the patient has bleeding, a suspected ectopic pregnancy, or a suspected error in the dating of the pregnancy, a first trimester ultrasound is indicated. If the pregnancy is proceeding normally, most women will have their first ultrasound early in the second trimester. A scan at 18-20 weeks' gestation is a common and acceptable time for accurate detection of most major fetal anomalies. This timing allows a woman to make a decision regarding termination; however, diagnosing problems is easier with a slightly later scan at 22-24 weeks' gestation.

Later in pregnancy, at 23-28 weeks' gestation, growth and development can be better evaluated, and second ultrasounds usually are performed at that time.

Central nervous system abnormalities are most likely to be detected and cardiac and skeletal anomalies are more likely to be missed, when routine ultrasounds are performed early in pregnancy rather than after 23 weeks' gestation.

What are the signs of a miscarriage?

The medical term for a miscarriage is a spontaneous abortion. Abortions that are in the process of occurring are called inevitable abortions. Pregnancies that have actually passed tissue (but not all tissue) are called incomplete abortions; those in which all tissue is passed are referred to as complete abortions.

Bleeding, passing tissue, rupturing membranes (passing clear fluid), and clotting are all typical signs of a miscarriage. However, not all women who bleed during pregnancy miscarry. If all the tissue is passed, the bleeding has slowed, and the cervix has closed, the pregnancy is termed a complete abortion. Almost one fourth of women experience implantation bleeding (bleeding in early pregnancy). Fewer than half of women with first trimester bleeding have a miscarriage. Typically, women who have miscarriages report a loss of the usual side effects of pregnancy, such as resolution of nausea or loss of breast tenderness.

Spontaneous abortion (miscarriage) is usually caused by the death of the embryo, which then becomes detached from the placenta and is expelled. Researchers estimate that the embryo in at least sixty percent of these cases does not survive because they are anatomically or genetically abnormal. *In other words, most of these early miscarriages are not due to anything that the mother could have prevented.* The less frequent spontaneous abortions that occur later in the pregnancy are more likely to be caused by a severe illness or trauma. **Remember:** Bleeding should always be reported to the medical staff at the prison or jail. In some circumstances there may be some treatment that will prevent you from losing the pregnancy. Even if you are in the process of having a miscarriage or if there is nothing that can be done to prevent the loss of pregnancy, it is extremely important that you receive appropriate medical care during this time.

Is cramping during pregnancy normal?

Early in pregnancy, uterine cramping can indicate normal changes of pregnancy brought on by hormonal changes; later in pregnancy, it is a sign of a growing uterus. Cramping that is different from previous pregnancies, worsening cramping, or cramping that happens with any vaginal bleeding may be a sign of ectopic pregnancy (see above), threatened abortion, or missed abortion. A missed abortion refers to when there is a fetal death before the 24th week of pregnancy, but the fetus is still in the uterus.

Why do I feel more tired than usual?

Feeling tired in early pregnancy is very normal. Many changes are occurring as your pregnancy develops, and many women experience this as fatigue and an increased need for sleep. Lower blood pressure, lower blood sugars, hormonal changes, changes in metabolism, and the physiologic anemia (not enough iron in your blood) of pregnancy all contribute to fatigue.

Other physical effects that are normal during pregnancy, and not necessarily signs of disease, include nausea, vomiting, increase in stomach size, changes in bowel habits, increased need to urinate, palpitations or more rapid heart beat, up-heaving of the chest (particularly with breathing), heart murmurs, swelling of the ankles, and shortness of breath.

Should all women have a test for Tay-Sachs disease?

Tay-Sachs is a rare disease that causes a build up of substances called gangliosides in the central nervous system. The eventual result is a severe, progressive illness in the brain with death at a very young age. Jewish individuals of Eastern European descent (Ashkenazi) have a 1 in 30 chance of carrying the gene. Parents of Cajun descent also have an increased incidence of carrying the gene for Tay-Sachs. In others, the risk is about 1 in 300. If 2 individuals who are carriers have a baby, there is a 25% risk that their baby will have the disease.

The carrier status of a woman can be determined by a blood test prior to pregnancy. However, even if one parent does not appear to be from a group at high risk for carrying

the mutant Tay-Sachs gene, the parents still should be offered testing. American College of Obstetricians and Gynecologists (ACOG) also recommends testing for Canavan disease in women at risk for Tay-Sachs.

What are the safest treatments for nausea and vomiting in early pregnancy?

Nausea and vomiting occur frequently in pregnant women, especially during the first trimester. As in the nonpregnant state, causes of nausea and vomiting include stomach problems (infection, gastritis, cholecystitis, peptic ulcer, hepatitis, pancreatitis), urinary tract infection (UTI), ear/nose/throat disease (motion sickness, labyrinthitis), drugs (digoxin, morphine), metabolic disorders (hypercalcemia, hyperparathyroidism), and psychological problems. Nausea and vomiting often are difficult to treat, especially because they generally occur in the first trimester. Because this is the most critical time for the fetus' organ development, drug usage is not recommended.

Watching your diet is usually the best treatment. It may be difficult to be picky in prison, but try to eat foods you know you will tolerate well. Dry crackers, lemonade, and ginger products (for example, ginger ale) may be helpful. Vitamin B-6 also can decrease nausea and may be administered orally, straight to the muscle, or intravenously.

How much alcohol is safe to consume during pregnancy?

No amount of alcohol is considered safe. Fetal alcohol syndrome (FAS) has been reported with very low levels of drinking. Pregnant women who drink even minimal amounts of alcohol may be affecting fetal development. Heavy drinking (3.5 drinks per day) during pregnancy remains an established risk factor for FAS and other negative outcomes. FAS is completely preventable, but it is not curable once alcohol has damaged the fetus. Consequences of FAS include mental retardation or borderline mental deficiencies and a decrease in the length, weight and head circumference of the fetus.

Further consequences include abnormal brain development and/or behavioral difficulties. Physical abnormalities of FAS are a smooth groove in the upper lip; narrow, small, and unusual eye shape; a small skull; an upturned nose; and a small or malformed upper jaw. Abnormalities of the heart have been reported but remain relatively rare, as are other limb abnormalities, such as hand and feet deformities. In the United States today, doctors diagnose about 1 in 750 newborns with FAS.

Research has shown that even minimal consumption can have detrimental effects on fetal development. Children exposed to moderate levels of alcohol during pregnancy show growth deficits and intellectual deficits along with behavioral problems similar to, although less severe than, those found in children with FAS. Drinking during the seventh month increases the odds of preterm delivery, even for light or moderate drinking.

Additionally, moderate consumption of alcohol by pregnant women can have significant consequences on the developing nervous system of the fetus. Research has begun to examine the extent to which these problems affect the child's ability to function on a day-to-day basis at school and with peers. A number of factors, including gestational period,

how often the mother drinks, and genetic factors, play important roles in determining the effects of drinking alcohol on the fetus.

What should I do if I cannot stop drinking alcohol?

If you can't stop drinking alcohol, try to cut down as much as possible. There are many agencies that can help you deal with this problem. Use their services. We have listed many organizations in the resources packet included with this manual.

How much caffeine is safe in pregnancy?

For most women, drinking 2 cups of coffee a day is safe, but a large amount of caffeine should be avoided in pregnancy. It is a natural stimulant that is found in many plants and is present in many foods. A typical brewed cup of coffee might contain about 150 mg of caffeine. One can of soda (for example, Coke®, Pepsi®, Mountain Dew®) can contain anywhere from 35 to 70 mg of caffeine. Caffeine levels of over 500 mg (4 cups per day) are too high. Caffeine affects the central nervous system 15 minutes after intake. It slightly increases blood pressure and heart rate and stimulates urination, which lowers the amount of fluids in your body. This may potentially cause harm in pregnancy because good hydration is thought to be essential to good pregnancy health. The amount of caffeine found in chocolate is very low.

What are the effects of smoking on pregnancy?

Low birth weight (LBW) is the most common problem with babies born from mothers who smoke. Babies born to mothers who smoke weigh about 170-200 grams (6-7 ounces) less than those whose mothers do not smoke. An increased risk of miscarriage also is a factor. In some studies, an increase of mental retardation and cleft lip/palate has been associated with smoking. This may be a smoke-related effect, and, although not specifically approved for use during pregnancy, nicotine patches probably are safer than smoking cigarettes. You should also try to avoid second hand smoke as much as possible.

Can women safely dye their hair during pregnancy?

Women absorb chemicals through their skin, and chemicals applied to the scalp can be a source of toxic chemical exposure. Because hair dyeing was not established as safe in the past, obstetricians have been advising women against exposure to both hair dyes and perm chemicals. However, hair dyes are thought to be safe to use during pregnancy because actually very little is absorbed through the skin. The hormonal changes of pregnancy and the speed of hair growth (usually improved during pregnancy because of better nutrition and more vitamin use) will make the color of the hair vary in response to dyeing and the roots growing out faster.

Can pregnant women safely take medications during pregnancy?

Each medication has specific considerations, and when in doubt, you should check with the RN or the Supervising Obstetrician. However, some generalities do apply.

The FDA requires a system of ranking drugs that appears on the labels and in the package inserts and is reprinted in the Physician Desk Reference (PDR) as follows:

Category A: These medications have been available for many years, have been tested for safety during pregnancy, and have been found to be safe. Remember the medication may not remain in this category (i.e. be considered safe) if the recommended dose is changed. This would include folic acid, vitamin B-6, and thyroid medicine.

Category B: These include drugs that have been used a lot during pregnancy and, through reporting by physicians and patients and uncontrolled studies, do not appear to cause major birth defects or other fetal problems, including drugs such as many antibiotics, acetaminophen (Tylenol), aspartame (artificial sweetener), famotidine (Pepcid), prednisone (cortisone), insulin (for diabetes mellitus), and ibuprofen (Advil, Motrin) before the third trimester. Pregnant women should not take ibuprofen during the last 3 months of pregnancy.

Category C: These drugs may still be used if the benefits of use outweigh the risks, but they are more likely to cause problems for the mother or fetus. This category also includes drugs for which safety studies have not been finished. The majority of these drugs do not have safety studies in progress. These drugs include prochlorperazine (Compazine), fluconazole (Diflucan), and ciprofloxacin (Cipro) and some antidepressants.

Category D: This category includes drugs that have clear health risks for the fetus and include alcohol, lithium (treats bi-polar disease), phenytoin (Dilantin), and most chemotherapy drugs to treat cancer. Most physicians recommend finding a different drug to treat the condition with before planning a pregnancy.

Category X: This category includes drugs that have been shown to cause birth defects and should never be taken during pregnancy. These include drugs to treat skin conditions such as cystic acne (Accutane) and psoriasis (Tegison or Soriatane), a sedative (thalidomide), and a drug to prevent miscarriage used until 1971 in the United States and until 1983 in Europe (diethylstilbestrol [DES]). Proper birth control should always be used when taking any of these drugs.

Most physicians recommend avoiding aspirin use in pregnancy.

Why does a woman's posture change during pregnancy?

Women experience a progressive increase in the curvature of the spine during pregnancy. This change, termed lordosis, helps keep the center of gravity stable as the uterus gets bigger. Late in pregnancy, aching, weakness, and numbness of the arms may occur because of posture changes due to lordosis. A shifting center of gravity can contribute to an increase in unsteadiness while walking. These changes are most exaggerated in later pregnancy. Over 50% of women complain of back pain during pregnancy. About 4-6 women per 1000 will have scoliosis. Spinal changes usually are not severe enough to affect the pregnancy or the lung's functional capacity.

Treatment for back pain includes heat and ice, acetaminophen, massage, proper posturing, good support shoes, and a good exercise program for strength and conditioning. Pregnant women also may relieve back pain by placing one foot on a stool when standing for long periods of time and placing a pillow between the legs when lying down.

When is fetal movement usually felt?

Most women feel the beginnings of fetal movement before 20 weeks' gestation. In a first pregnancy, this can occur around 18 weeks' gestation and, in following pregnancies, as early as 15-16 weeks' gestation. Early fetal movement is felt most commonly when the woman is sitting or lying quietly and concentrating on her body. It usually is described as a tickle or feathery feeling below the umbilical area. As the fetus grows in size, these feelings become stronger, regular, and easier to feel. The medical term for the point at which a woman feels the baby move is quickening. Babies should move at least 4 times an hour as they get larger, and some obstetricians advise patients to count fetal movement to follow the baby's well being.

What tests can be performed to detect preterm (early) labor?

Many tests have been proposed, but few are considered universally reliable. First, a pelvic examination or ultrasound can detect thinning or opening of the cervix. A swab test can detect ruptured membranes. A recently proposed test, called fetal fibronectin (fFN), also has been used to detect a preterm labor. In addition, fetal monitoring can detect uterine contractions. Finally, some hormone tests can be used to detect abnormalities (e.g., salivary estrogen testing). Most cases of preterm labor cannot be predicted.

At what stage of pregnancy are fetuses considered viable (able to survive)?

This is a complex topic. No definite age or stage exists, and even experts may disagree. The survival rate of infants born after 23-25 weeks' gestation increases with each additional week of pregnancy. The survival rate of infants born before 23 weeks' gestation is very low. Babies born during these early weeks may require prolonged and intensive medical care, including care with a variety of life-support measures.

What special risks are associated with a multiple pregnancy?

Twin pregnancies have a higher rate of complications than single pregnancies.

Complications for the mother include anemia, polyhydramnios (too much amniotic fluid), hypertension (high blood pressure), premature labor, postpartum hemorrhage (excessive bleeding), diabetes, preeclampsia, and cesarean delivery.

Fetal complications include incorrect positioning of fetus at birth, placenta previa (when the placenta is unusually low in the uterus), abruptio placentae (separation of placenta from the uterus wall after the 20th week but before birth), premature rupture of the membranes, prematurity, umbilical cord prolapse (Umbilical cord prolapse occurs when the cord slips into the vagina after the membranes have ruptured, before the baby

descends into the birth canal. This complication affects about 1 in 300 births), congenital anomalies, and increased perinatal morbidity and mortality (death during childbirth).

Although single pregnancies are considered term at 37 weeks' gestation, half of all twin pregnancies deliver at 36 weeks' gestation. The average age of triplets is 33.5 weeks' gestation, and, in a small series of quadruplet pregnancies, the average gestational age at delivery was 31 weeks' gestation (Spellacy, 1999).

Why do women undergo skin pigmentation changes during pregnancy?

Increased levels of hormones cause your skin to darken in certain areas of your body. There may be a darkening of the nipple area and the area down the middle of your stomach from the navel to pubic region. The facial pigment may also darken. The darkening of the skin usually disappears after birth. Do not try to bleach your skin because the solutions may be harmful to your baby.

Why is acne increased during pregnancy?

Progesterone, is increased during pregnancy, resulting in more secretions from the skin glands. Drinking a lot of water should help. Most acne medications including tetracycline are not recommended during pregnancy

Will changes in headache patterns occur during pregnancy?

For most women, headaches remain unchanged during pregnancy. Some women improve, but some may worsen. Because migraines have a hormonal component, many women's migraines improve with increasing hormone levels, such as those that occur during pregnancy. For women whose conditions remain unchanged or worsen, treatment options are limited, especially in the first trimester. Some physicians suggest acetaminophen, narcotics, and antiemetics (drugs used to control nausea or vomiting). Other treatments include relaxation strategies, eliminating stressors, and a good exercise program. These should be tried before taking drugs.

Is feeling the heart racing a common occurrence during pregnancy?

A significant number of changes occur to your heart and blood vessels during pregnancy, which may be accompanied by dyspnea (difficulty breathing) and a reduced tolerance for endurance exercise. Women expand their blood volume by approximately 30-50%. The heart rate may also increase by 10-20 beats per minute. The changes peak during weeks 20-24 and usually end within 6 weeks of childbirth.

What are the common respiratory system changes during pregnancy?

Pregnant women experience a stuffy nose due to the increase in hormones. Nosebleeds are also common. The safest treatment of these symptoms is a saline nasal spray.

Is gallbladder disease more common during pregnancy?

For some, gallbladder disease is more common during pregnancy. Estrogen (a hormone) increases the concentration of cholesterol in the bile leading to an increased risk of forming gallstones.

What hair changes are common during pregnancy?

Hair grows in the anagen phase and rests in the telogen phase. About 15-20% of all hairs are in the telogen phase at any given time. During this resting phase, it is normal for hair to fall out so a new hair can regrow. During late pregnancy, fewer hairs are in telogen; immediately after birth, more hairs are in telogen phase. This often results in loss of hair immediately after giving birth. This may be very disturbing, but it is normal.

What is Rh disease? Why is a pregnant woman's blood type important?

Knowing the blood type of a pregnant woman is an important part of preventing a potentially deadly disease for the newborn. About 15% of the US population has blood that is Rh negative. If the mother's blood type is Rh negative and the baby's blood type is Rh positive (inheriting this type from the father) the mother may make antibodies that can cross over the placenta into the baby's blood stream and attack the baby's red blood cells. Sensitization (Immunity) can occur at any time, including after spontaneous abortion.

The first pregnancy usually poses no problems because sensitization typically occurs at delivery. Subsequent pregnancies are at risk if the mother was not protected with an injection of RhoGAM, which prevents the mother from forming antibodies. This condition eventually leads to fetal anemia and heart failure. Administering RhoGAM (RH immunoglobulin) to a pregnant woman early in the third trimester (before the baby's blood type is known) or after miscarriage or abortion can prevent formation of these attack immunoglobulins. After birth, the newborn's blood type is checked; if the baby is Rh negative like the mother, no further treatment is necessary. Other antibodies and incompatibilities can produce similar problems, but they are rare and less likely to cause severe disease.

How much does the uterus grow during pregnancy?

The uterus grows from an organ that weighs .2 lbs with a cavity space of about .0003 gallons to an organ that weighs more than 2.2 lbs that can accumulate a fluid area of over 5 gallons. The shape also evolves during pregnancy from the original pearlike shape to a more round form, and it is almost a sphere by the early third trimester. By full term, the uterus becomes oval shaped. After 20 weeks' gestation, most women begin to appear pregnant upon visual examination.

Why do women get varicose veins during pregnancy?

Varicose veins, abnormally dilated or swollen veins, are more common as women age and/or gain weight. Also, the pressure on major veins in the legs, and family history increase the risk of developing varicose veins during pregnancy. These can occur in the

vulvar area and be fairly painful. Rest, leg elevation, acetaminophen, topical heat, and support stockings typically are all that is necessary.

Why are my breasts larger and more tender than usual?

Your breasts are larger and more tender because of the increased amounts of hormones that your body is producing. Although the tenderness should decrease after the first trimester, your breasts will continue to grow in preparation for nursing your baby. Wear a supportive bra. You might want to have one of your family members buy you a bra that is one or two sizes larger than your normal size and send it in to you if the prison or jail permits this.

Is it normal to secrete milk from the breast prior to delivery?

Yes. Each woman is different, and some women notice secretions beginning before the fifth month of pregnancy. Many women find they spontaneously leak or express some fluid by the ninth month. The initial milk, may be watery and pale. Bumps that appear to enlarge around the areola normally appear during mid-pregnancy. Early secretion does not mean that a woman will produce less milk after delivery.

Can I breast-feed my baby while I am incarcerated?

Breast-feeding is almost impossible to do while you are incarcerated. However, you should check with the prison or jail OB-GYN about this. There is only one published court decision in which a woman was permitted to breast-feed her infant. In *Berrios-Berrios v. Thornburg*, 716 F.Supp.987 (E.D. Ky. 1989), a federal prisoner was allowed to breast-feed her child during regular visitation periods. Indeed, the courts have stated that breast-feeding is a constitutionally protected right and the most elemental form of parental care. *Dike v. School Board*, 650 F.2d 783, 787 (5th Cir. 1981). However, the court in *Thornburg* decided that storing breast milk in the prison refrigerator and making arrangements for delivery of the milk to the baby's caretaker was outweighed by the government's interest in preserving the security of the prison.

In the only other published decision about a prisoner's right to breast-feed her newborn, the court ruled that the state's penal interest outweighed the interest of the prisoner's infant receiving his mother's breast milk, even though the baby had special medical considerations that made breast-feeding even more important than usual. *Southerland v. Thigpen*, 784 F. 2d 713 (D. Miss. 1986).

Why is a baby born in the breech position? Can this pose a problem?

Most babies settle into a head down position before labor. At 28 weeks of pregnancy, about one third of babies remain breech (buttocks down); by term, only 3% are still breech. The head is the largest part of the baby, and, because it comes down first in the birth canal, the body usually follows without difficulty. When the baby is in a breech position, the head is the last to come out, which may pose a risk to successful vaginal birth. The specific risks of a breech birth include minor stretching of the shoulder area of the arm or fetal head entrapment (which is fatal in rare cases).

Many ways exist to detect breech position before birth (sonography and manual examination). Women should check with their doctors to determine how this delivery will be handled (vaginal or elective cesarean delivery) and if the doctor would consider trying to turn the baby before birth. Some physicians perform cesarean deliveries on breech pregnancies.

How often is a woman put on the fetal monitor in labor?

Once active labor is diagnosed, the baby's heart rate needs to be checked every 15 minutes; during the second stage of labor, the heart rate should be checked every 5 minutes. Continuous fetal monitoring is necessary for all cases in which questions of fetal health or previous abnormal heart rates exist. Unfortunately, once strapped to the fetal monitor, walking around in labor is not possible. Many physicians choose to monitor on a schedule of 15 minutes before and after the hour to allow time for the woman to move around. This is an individual choice made between a woman and her doctor.

Why do I have to urinate so often?

During the early stage of pregnancy, the blood supply to your pelvis increases, which makes you need to empty your bladder more frequently. As your uterus grows to accommodate the baby, it presses more heavily on your bladder causing you to have to urinate more often. If you Limit your fluid intake in the evening, you will not have to urinate as much during the night.

Are urinary tract infections (UTIs) more common during pregnancy?

Normal pregnancy-related changes contribute to UTIs. Urinary Tract Infections in pregnant women usually do not present with typical symptoms and may have no symptoms at all. Pyelonephritis (inflammation of the kidney or pelvic area) is a serious complication of UTIs.

Typical symptoms include: Pain or burning when urinating, abdominal pain in the area over the bladder, a need to urinate immediately as soon as any urine collects in the bladder, need to urinate extremely frequently, passage of small amounts of urine at a time, need to get up from sleep to urinate, low back pain, cloudy or bloody urine, bad-smelling urine.

Are yeast infections more common during pregnancy?

Yes, yeast infections are more common during pregnancy. Symptoms include: Vaginal itching that is often severe; Vaginal discharge that is usually white, curdlike, and odorless; Red, irritated skin around the opening to the vagina (labia); Pain while urinating when urine touches irritated skin. Symptoms of a vaginal yeast infection are more likely to occur during the week before a menstrual period.

Is heartburn more common during pregnancy?

Heartburn is a burning sensation and discomfort in your digestive system. Heartburn is more common in pregnancy because as the baby grows there is more pressure on the

stomach. Small, frequent meals (if possible) may be better than large meals. Try to avoid:

Bending, lifting or lying down after meals

Excessive consumption of tea, coffee or alcohol, chocolate, peppermint and spicy or greasy foods.

You may also like to try sleeping with the head of your bed raised a few inches. You can do this by putting a folded blanket or pillow under your mattress.

Constipation has recently become a problem. What can I do about it?

Eat more fiber, if you can, by increasing your intake of fruits, vegetables and whole grains. Try including more peas and dried beans in your diet. Also it is very important to drink more water, at least eight glasses per day. Warm or hot fluids are especially helpful in the mornings. If you are not physically active, some exercise may also help.

How can stretch marks be prevented?

Unfortunately, *striae* (stretch marks) cannot be prevented. The degree to which a woman experiences stretch marks is genetic. Stretch marks usually occur when weight is lost or gained quickly. Using creams and gels rarely help. Fortunately, stretch marks fade with time, and the marks become silvery white, but they do not tan. Striae may be considered the "stripes of motherhood."

Should newborn boys be circumcised?

Circumcision of male newborns has evolved from a religious and cultural ceremony. Many women choose circumcision for hygienic reasons. Circumcision has become commonplace among many American cultural and social groups. Most fathers are circumcised and want their sons to be the same. The procedure usually is performed in the hospital 24-48 hours after birth by a pediatrician or obstetrician. Religious circumcisions in the Jewish faith occur a week after birth. The procedure is not painless, and anesthesia may or may not be used. Circumcised infants may be at lower risk for rare penile cancer and some infections. The choice of circumcision is a private and personal decision and is yours to make.

When will the uterus return to normal size?

The uterus returns to pre-pregnancy size after about 6 weeks. During this process, the uterus has contractions that women may be able to feel.

What is the purpose of folic acid supplementation during pregnancy?

According to the Cochrane Data Base, folate supplementation, generally recommended as 400 mg/d, may reduce the incidence of neural problems by 72%. The National Institutes of Health recommends that this supplementation begin at least 3 months before conception and continue for the first 3 months of pregnancy. Folic acid has also

shown to possibly prevent events such as miscarriage, ectopic pregnancy or stillbirth. (Also see Nutrition section, page 24)

What vaccinations are necessary prior to pregnancy?

Women who are planning to get pregnant should make sure that they have been properly vaccinated and are immune to certain diseases, such as rubella (also called German measles), which can be determined by blood testing. Rubella infection during pregnancy is a serious disease, with the developing fetus at increased risk for a condition called congenital rubella, which can include deafness, heart problems, eye problems, and mental retardation. ACOG reports that the fetus has a 50% chance of being affected if the infection is acquired during the first month of pregnancy but only a 10% chance if the mother is affected in the third month. After vaccination, ACOG recommends avoiding pregnancy for 1 month. If pregnancy occurs before vaccination or in a woman without immunity, the vaccine should be administered immediately postpartum before leaving the hospital.

Chicken pox is caused by the varicella zoster virus, and it can also cause severe fetal infections. In the recent report on vaccinations, the Advisory Committee on Immunization Practices (ACIP), part of the Centers for Disease Control and Prevention (CDC), recommended nonpregnant women of childbearing age be vaccinated against varicella if they are not yet immune, and the American Academy of Pediatrics and the ACIP also recommend that women wait at least 1 month after getting vaccinated before trying to get pregnant.

See pages 12 and 15 for more information about chickenpox and rubella.

What vaccinations are safe during pregnancy?

Getting tetanus and influenza vaccinations during pregnancy is safe. For women with risks, getting a pneumococcal vaccine during pregnancy is safe. If exposed, women may safely get specific treatments for measles, hepatitis A or B, tetanus, chickenpox, or rabies.

ALTERNATIVES TO INCARCERATION

Women make up one of the fastest growing groups of prisoners in the United States and California. Nationwide, the number of incarcerated women has tripled since 1980. In California the number of women in state prison has risen from about 1,000 in 1980, to more than 11,000 in 2006. This rise is due in part to the so-called 'war on drugs' that has had a devastating impact on communities of color and poor communities.

Because more women are finding themselves in prisons, jails and juvenile detention centers, the number of children affected by the absence of their mothers has also increased. It is estimated that at least 85% of women prisoners are mothers and more than half of them have a child who is under the age of eighteen. In addition, at any given time there are about 200 women who are pregnant and in state prison in California.

Women who are pregnant or have children under the age of six may be eligible for one of the programs below where they can serve out their sentences in community settings and have their children with them. Both programs are administered by the Women's and Children's Services Unit of the CDCR's Office of Community Resources. The programs are highly structured residential treatment facilities.

California Prisoner Mother Program

The Community Prisoner Mother Program (CPMP) was established in 1980 as a result of 1978 legislation. It is a community treatment program that allows eligible women prisoners to transfer from state prison to a CPMP facility and serve their sentences at halfway houses where they can live with and care for their young children. A woman prisoner qualifies for the CPMP program if:

- ❖ She has a child or children under the age of six years or she is pregnant;
- ❖ She was the primary caretaker of her child before she entered prison;
- ❖ She is within six years of her release date (calculated after deduction of any possible good time credit);
- ❖ The person who is now taking care of her child agrees to the child's participation in the program;
- ❖ She has not been found to be an unfit parent in any court proceeding;
- ❖ She has more than 60 days until she is released or paroled from prison;
- ❖ There are no holds or detainers against her;
- ❖ She has not been convicted of a violent crime. [However, it is important to note that women whose crime involved the death of the victim may still be eligible for CPMP provided that: (1) They were convicted of manslaughter in response to a physically abusive partner, (2) They

have no prior felony convictions, **and**, (3) They have no prior history of violence whether convicted or not.

Because of a lawsuit settled in 1985 (*Rios v. Rowland*), the CDCR must notify women about the CPMP program within one week of their being taken into custody and allow pregnant women to submit applications prior to delivery. The CDCR must also inform recently transferred women by including a copy of the settlement agreement in their orientation materials, and by posting the agreement in the areas housing potentially eligible women. The CDCR must keep regional waiting lists of eligible applicants to the program and must train the staff in processing the applications.

Family Foundations Program

In 1994, the California Legislature created the Family Foundations Program (FFP) as an alternative to sending mothers and pregnant women to State prison. Eligible mothers go from the courtroom directly to a residential correctional facility similar to those in the CPMP; the difference is that no time is spent in prison. Since it is an alternative sentencing program, the probation department must recommend placement in the FFP, with agreement by the district attorney, sentencing judge, and the CDCR.

Women applying for this program must meet many of the same criteria as prisoners seeking to enter CPMP. For example, their children must be no more than six years old, or the woman must be pregnant at the time of sentencing, and the woman must have been a fit parent and primary caretaker of her children. If eligible for FFP mothers and pregnant women will spend a minimum of 12 months in residential treatment followed by a 12-month intensive aftercare and transition period to assure successful completion of parole, and to help the mother reenter society.

CPMP and FFP Programs

Current as of August 2006

Community Prisoner Mother Program (CPMP) & Family Foundations Program (FFP)

501 J Street, Suite 350, P.O. Box 942883
 Sacramento, CA 95814
 Office Phone: (916) 323-0125 Office FAX: (916) 445-6029

CPMP FACILITIES- NORTH	BED CAPACITY
EAST BAY COMMUNITY RECOVERY PROJECT - PROJECT PRIDE 2551 San Pablo Avenue Oakland, CA 94612 PHONE: (510) 446-7160;	24
CPMP FACILITIES- SOUTH	BED CAPACITY
PROTOTYPES 845 East Arrow Highway Pomona, CA 91767 Los Angeles County PHONE: (951) 624-1233	24
CPMP FACILITIES- SOUTH	BED CAPACITY
TURNING POINT 4941 David Road Bakersfield, CA 93307 PHONE: (661) 858-2975	23
FAMILY FOUNDATIONS PROGRAM- SAN DIEGO	BED CAPACITY
FAMILY FOUNDATIONS PROGRAM – SAN DIEGO (Center Point) 3050 Armstrong Street San Diego, CA 92111 PHONE: (858) 874-6599	35
FAMILY FOUNDATIONS PROGRAM- SANTA FE SPRINGS	BED CAPACITY
FAMILY FOUNDATIONS PROGRAM – SANTA FE SPRINGS (LACADA) 11121 Bloomfield Avenue Santa Fe Springs, CA 90670 PHONE: (562) 946-7675	35

Appendix 1

Penal Code sections 3419, 3423, 3424, and 6030

Sections 3419, 3423, 3424

West's
**ANNOTATED
CALIFORNIA CODES**



PENAL CODE
Sections 1543 to 4399

Volume 51B

**2006
Cumulative Pocket Part**

Replacing 2005 Pocket Part supplementing 2000 main volume.
Pocket Part will be supplemented by Interim Annotation Service Pamphlets
No. 1 and No. 2 in 2006.

**Includes all laws through the 2005 portion of the 2005-2006 Regular Session,
Governor's Reorganization Plans No. 1 and No. 2,
and propositions from the November 8, 2005 election**

THOMSON

WEST

§ 3419. Birth after receipt of inmate; notice and application to inmate; care required by program

(a) In the case of any inmate who gives birth after her receipt by the Department of Corrections and Rehabilitation, the department shall, subject to reasonable rules and regulations promulgated pursuant to Section 3414, provide notice of, and a written application for, the program described in this chapter, and upon her request, declare the inmate eligible to participate in a program pursuant to this chapter if all of the requirements of Section 3417 are met.

(b) The notice provided by the department shall contain, but need not be limited to, guidelines for qualification for, and the timeframe for application to, the program and the process for appealing a denial of admittance.

(c) Any community treatment program, in which an inmate who gives birth after her receipt by the Department of Corrections and Rehabilitation participates, shall include, but is not limited to, the following:

- (1) Prenatal care.
- (2) Access to prenatal vitamins.

Additions or changes are indicated by underline; deletions by asterisks * * *

§ 3419

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(3) Childbirth education.

(4) Infant care.

(Added by Stats.1978, c. 1054, p. 3255, § 4. Amended by Stats.1982, c. 42, § 9, eff. Feb. 17, 1982; Stats.2004, c. 297 (A.B.1530), § 4; Stats.2005, c. 608 (A.B.478), § 1.)

Historical and Statutory Notes

2004 Legislation

Stats.2004, c. 297 (A.B.1530), rewrote this section, which had read:

"In the case of any inmate who gives birth after her receipt by the Department of Corrections, the department shall, subject to reasonable rules and regulations promulgated pursuant to Section 3414, upon her request, declare the inmate eligible to participate in a program pursuant to this chapter if all of the requirements of Section 3417 are met."

2005 Legislation

Stats.2005, c. 608 (A.B.478), in subd. (a), inserted "and Rehabilitation"; and added subd. (c).

Section 8 of Stats.2005, c. 608 (A.B.478), provides:

"SEC. 8. If the Commission on State Mandates determines that this act contains costs mandated by the State, reimbursement to local agencies and school districts for these costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code."

Cross References

Corrections Standards Authority, pregnant inmates, see Penal Code § 6030.

Juvenile Court, right of pregnant female in custody of local juvenile facility to choice and services of physician or surgeon, see Welfare and Institutions Code § 222.

Transfer of pregnant inmate to hospital, shackles, see Penal Code § 5007.7.

Youth Authority, right of pregnant female committed to Youth Authority to choice and services of physician and surgeon, see Welfare and Institutions Code § 1774.

Research References

Encyclopedias

CA Jur. 3d Penal and Correctional Institutions § 35, Community Treatment Programs for Incarcerated Women With Children.

§ 3423. Transfer to hospital for childbirth; charges; care

Any woman inmate who would give birth to a child during her term of imprisonment may be temporarily taken to a hospital outside the prison for the purposes of childbirth, and the charge for hospital and medical care shall be charged against the funds allocated to the institution. The inmate shall not be shackled by the wrists, ankles, or both during labor, including during transport to a hospital, during delivery, and while in recovery after giving birth, except as provided in Section 5007.7. The board shall provide for the care of any children so born and shall pay for their care until suitably placed, including, but not limited to, placement in a community treatment program.

(Added by Stats.1978, c. 1054, p. 3255, § 4. Amended by Stats.2005, c. 608 (A.B.478), § 2.)

Historical and Statutory Notes

2005 Legislation

Stats.2005, c. 608 (A.B.478), added the second sentence, relating to shackles.

Reimbursement provisions relating to Stats.2005, c. 608

(A.B.478), see Penal Code § 3419.

Cross References

Corrections Standards Authority, pregnant inmates, see Penal Code § 6030.

Juvenile Court, right of pregnant female in custody of local juvenile facility to choice and services of physician or surgeon, see Welfare and Institutions Code § 222.

Transfer of pregnant inmate to hospital, shackles, see Penal Code § 5007.7.

Youth Authority, right of pregnant female committed to Youth Authority to choice and services of physician and surgeon, see Welfare and Institutions Code § 1774.

§ 3424. Prenatal health care

A woman who is pregnant during her incarceration and who is not eligible for the program described in this chapter shall have access to complete prenatal health care. The department shall establish minimum standards for pregnant inmates in its custody who are not placed in a community treatment program including all of the following:

- (a) A balanced, nutritious diet approved by a doctor.

~~Additions or changes are indicated by underline; deletions by asterisks~~

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- (b) Prenatal and postpartum information and health care, including, but not limited to, access to necessary vitamins as recommended by a doctor.

- (c) Information pertaining to childbirth education and infant care.

- (d) A dental cleaning while in a state facility.

(Added by Stats.2005, c. 608 (A.B.478), § 3.)

Historical and Statutory Notes

2004 Legislation

Former § 3424, added by Stats.1978, c. 1054, § 4, amended by Stats.1982, c. 42, § 13, relating to a report to the Legislature that was to be completed in 1983, was repealed by Stats.2004, c. 193 (S.B.111), § 146.

Subordination of legislation by Stats.2004, c. 193 (S.B. 111), to other 2004 legislation, see Historical and Statutory Notes under Business and Professions Code § 29.

2005 Legislation

Reimbursement provisions relating to Stats.2005, c. 608 (A.B.478), see Penal Code § 3419.

Cross References

Corrections Standards Authority, pregnant inmates, see Penal Code § 6030.

Juvenile Court, right of pregnant female in custody of local juvenile facility to choice and services of physician or surgeon, see Welfare and Institutions Code § 222.

Transfer of pregnant inmate to hospital, shackles, see Penal Code § 5007.7.

Youth Authority, right of pregnant female committed to Youth Authority to choice and services of physician and surgeon, see Welfare and Institutions Code § 1774.

Section 6030

West's
**ANNOTATED
CALIFORNIA CODES**



PENAL CODE
Sections 4400 to 11999

Volume 51C

**2006
Cumulative Pocket Part**

Replacing 2005 Pocket Part supplementing 2000 main volume.
Pocket Part will be supplemented by Interim Annotation Service Pamphlets
No. 1 and No. 2 in 2006.

**Includes all laws through the 2005 portion of the 2005-2006 Regular Session,
Governor's Reorganization Plans No. 1 and No. 2,
and propositions from the November 8, 2005 election**

THOMSON

WEST

§ 6030. State and local correctional facilities; establishment of standards

(a) The * * * Corrections Standards Authority shall establish minimum standards for state and local correctional facilities * * *. The standards for state correctional facilities shall be established by January 1, 2007. The * * * authority shall review those standards biennially and make any appropriate revisions.

(b) The standards shall include, but not be limited to, the following: health and sanitary conditions, fire and life safety, security, rehabilitation programs, recreation, treatment of persons confined in state and local correctional facilities, and personnel training.

(c) The standards shall require that at least one person on duty at the facility is knowledgeable in the area of fire and life safety procedures.

(d) The standards shall also include requirements relating to the acquisition, storage, labeling, packaging, and dispensing of drugs.

(e) The standards shall require that inmates who are received by the facility while they are pregnant are provided all of the following:

(1) A balanced, nutritious diet approved by a doctor.

(2) Prenatal and postpartum information and health care, including, but not limited to, access to necessary vitamins as recommended by a doctor.

Additions or changes indicated by underline; deletions by asterisks * * *

(3) Information pertaining to childbirth education and infant care.

(4) A dental cleaning while in a state facility.

(f) The standards shall provide that at no time shall a woman who is in labor be shackled by the wrists, ankles, or both including during transport to a hospital, during delivery, and while in recovery after giving birth, except as provided in Section 5007.7.

(g) In establishing minimum standards, the * * * authority shall seek the advice of the following:

(1) For health and sanitary conditions:

The State Department of Health Services, physicians, psychiatrists, local public health officials, and other interested persons.

(2) For fire and life safety:

The State Fire Marshal, local fire officials, and other interested persons.

(3) For security, rehabilitation programs, recreation, and treatment of persons confined in * * * correctional facilities:

The Department of Corrections * * * and Rehabilitation, state and local juvenile justice commissions, state and local correctional officials, experts in criminology and penology, and other interested persons.

(4) For personnel training:

The Commission on Peace Officer Standards and Training, psychiatrists, experts in criminology and penology, the Department of Corrections * * * and Rehabilitation, state and local correctional officials, and other interested persons.

(5) For female inmates and pregnant inmates in local adult and juvenile facilities:

The California State Sheriffs' Association and Chief Probation Officers' Association of California, and other interested persons.

(Added by Stats.1957, c. 2025, p. 3596, § 1. Amended by Stats.1971, c. 1789, p. 3854, § 1; Stats.1973, c. 142, p. 408, § 55, eff. June 30, 1973, operative July 1, 1973; Stats.1978, c. 1018, p. 3141, § 2; Stats.1986, c. 376, § 1; Gov.Reorg.Plan No. 1 of 2005, § 59, eff. May 5, 2005, operative July 1, 2005; Stats.2005, c. 10 (S.B.737), § 59, eff. May 10, 2005, operative July 1, 2005; Stats.2005, c. 608 (A.B.478), § 5.)

Historical and Statutory Notes

2005 Legislation

For Legislative Counsel Digest regarding Governor's Reorganization Plan No. 1 of 2005, as well as the operative date for this plan, see Historical and Statutory Notes under Government Code § 11552 and see, generally, Government Code § 12080.5.

Stats.2005, c. 10 (S.B.737), rewrote this section, which had read:

"(a) The Board of Corrections shall establish minimum standards for local detention facilities by July 1, 1972. The Board of Corrections shall review such standards biennially and make any appropriate revisions.

"(b) The standards shall include, but not be limited to, the following: health and sanitary conditions, fire and life safety, security, rehabilitation programs, recreation, treatment of persons confined in local detention facilities, and personnel training.

"(c) Such standards shall require that at least one person on duty at the facility is knowledgeable in the area of fire and life safety procedures.

"(d) The standards shall also include requirements relating to the acquisition, storage, labeling, packaging, and dispensing of drugs.

"(e) In establishing minimum standards, the Board of Corrections shall seek the advice of the following:

"(1) For health and sanitary conditions:

The State Department of Health Services, physicians, psychiatrists, local public health officials, and other interested persons.

"(2) For fire and life safety:

The State Fire Marshal, local fire officials, and other interested persons.

"(3) For security, rehabilitation programs, recreation, and treatment of persons confined in local detention facilities:

The Department of Corrections, the Department of the Youth Authority, local juvenile justice commissions, local correctional officials, experts in criminology and penology, and other interested persons.

"(4) For personnel training:

The Commission on Peace Officer Standards and Training, psychiatrists, experts in criminology and penology, the Department of Corrections, the Department of the Youth Authority, local correctional officials, and other interested persons."

For operative and urgency effective provisions, legislative intent and budget considerations relating to Stats. 2005, c. 10 (S.B.737), see Historical and Statutory Notes under Government Code § 11552.

Stats.2005, c. 608 (A.B.478), rewrote the section, which had read:

"(a) The Corrections Standards Authority shall establish minimum standards for state and local correctional facilities. The standards for state correctional facilities shall be established by January 1, 2007. The authority shall review those standards biennially and make any appropriate revisions.

"(b) The standards shall include, but not be limited to, the following: health and sanitary conditions, fire and life safety, security, rehabilitation programs, recreation, treatment of persons confined in state and local correctional facilities, and personnel training.

Additions or changes indicated by underline; deletions by asterisks * * *

"(c) The standards shall require that at least one person on duty at the facility is knowledgeable in the area of fire and life safety procedures.

"(d) The standards shall also include requirements relating to the acquisition, storage, labeling, packaging, and dispensing of drugs.

"(e) In establishing minimum standards, the authority shall seek the advice of the following:

"(1) For health and sanitary conditions:

"The State Department of Health Services, physicians, psychiatrists, local public health officials, and other interested persons.

"(2) For fire and life safety:

"The State Fire Marshal, local fire officials, and other interested persons.

"(3) For security, rehabilitation programs, recreation, and treatment of persons confined in correctional facilities:

"The Department of Corrections and Rehabilitation, state and local juvenile justice commissions, state and local correctional officials, experts in criminology and penology, and other interested persons.

"(4) For personnel training:

"The Commission on Peace Officer Standards and Training, psychiatrists, experts in criminology and penology, the Department of Corrections and Rehabilitation, state and local correctional officials, and other interested persons."

Section affected by two or more acts at the same session of the legislature, see Government Code § 9605.

Reimbursement provisions relating to Stats.2005, c. 608 (A.B.478), see Penal Code § 3419.

Cross References

Community treatment programs, notice and written application forms to pregnant inmate, see Penal Code § 3419.

Community treatment programs, prenatal health care, pregnant inmates, see Penal Code § 3424.

Department of Corrections and Rehabilitation, see Government Code § 12838 et seq.

Juvenile Court, right of pregnant female in custody of local juvenile facility to choice and services of physician or surgeon, see Welfare and Institutions Code § 222.

Transfer of pregnant inmate to hospital, charges for care, see Penal Code § 3423.

Transfer of pregnant inmate to hospital, shackles, see Penal Code § 5007.7.

Youth Authority, right of pregnant female committed to Youth Authority to choice and services of physician and surgeon, see Welfare and Institutions Code § 1774.

Code of Regulations References

Appeal for adult facilities holding minors, see 15 Cal. Code of Regs. § 1018.

Jail management training, see 15 Cal. Code of Regs. § 1023.

Jail supervisory training, see 15 Cal. Code of Regs. § 1021.

Minors in court holding facilities,

Classification, see 15 Cal. Code of Regs. § 1163.

Conditions of detention, see 15 Cal. Code of Regs. § 1161.

Supervision of minors, see 15 Cal. Code of Regs. § 1162.

Minors in jails,

Classification, see 15 Cal. Code of Regs. § 1102.

Disciplinary procedures, see 15 Cal. Code of Regs. § 1106.

Education program for minors in jails, see 15 Cal. Code of Regs. § 1120.

Health appraisals/medical examinations, see 15 Cal. Code of Regs. § 1123.

Health education, see 15 Cal. Code of Regs. § 1121.

Prostheses and orthopedic devices, see 15 Cal. Code of Regs. § 1124.

Psychotropic medications, see 15 Cal. Code of Regs. § 1125.

Recreation programs, see 15 Cal. Code of Regs. § 1105.

Release procedures, see 15 Cal. Code of Regs. § 1103.

Reproductive information and services, see 15 Cal. Code of Regs. § 1122.

Restrictions on contact with adult prisoners, see 15 Cal. Code of Regs. § 1101.

Supervision of minors, see 15 Cal. Code of Regs. § 1104.

Minors in temporary custody,

Care of minors, see 15 Cal. Code of Regs. § 1143.

Conditions of secure detention, see 15 Cal. Code of Regs. § 1146.

Contact between minors and adult prisoners, see 15 Cal. Code of Regs. § 1144.

Criteria for non-secure custody, see 15 Cal. Code of Regs. § 1149.

Decision on secure detention, see 15 Cal. Code of Regs. § 1145.

Intoxicated and substance abusing minors in a lockup, see 15 Cal. Code of Regs. § 1151.

Minors arrested for law violations, see 15 Cal. Code of Regs. § 1141.

Supervision of minors held inside a locked enclosure, see 15 Cal. Code of Regs. § 1147.

Supervision of minors in non-secure custody, see 15 Cal. Code of Regs. § 1150.

Supervision of minors in secure detention outside of a locked enclosure, see 15 Cal. Code of Regs. § 1148.

Written policies and procedures, see 15 Cal. Code of Regs. § 1142.

Public information,

Death of a minor in an adult detention facility, see 15 Cal. Code of Regs. § 1046.

Serious illness or injury of a minor in an adult detention facility, see 15 Cal. Code of Regs. § 1047.

Research References

Treatises and Practice Aids

³ Witkin Cal. Crim. L. 3d Punishment § 9, Board of Corrections.

Additions or changes indicated by underline; deletions by asterisks * * *

Appendix 2

Welfare and Institutions Code section 222

Section 222

West's
**ANNOTATED
CALIFORNIA CODES**

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**WELFARE AND INSTITUTIONS  
CODE**

**Sections 1 to 599**

Volume 73

**2006  
Cumulative Pocket Part**

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**Includes all laws through the 2005 portion of the 2005-2006 Regular Session,  
Governor's Reorganization Plans No. 1 and No. 2,  
and propositions from the November 8, 2005 election**

**THOMSON**  
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**WEST**

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§ 222. Pregnancy; determination; right of choice and services of any physician or surgeon

(a) Any female in the custody of a local juvenile facility shall have the right to summon and receive the services of any physician and surgeon of her choice in order to determine whether she is pregnant. If

Additions or changes indicated by underline; deletions by asterisks \*\*\*

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WELFARE AND INSTITUTIONS CODE

§ 223

she is found to be pregnant, she is entitled to a determination of the extent of the medical services needed by her and to the receipt of those services from the physician and surgeon of her choice. Any expenses occasioned by the services of a physician and surgeon whose services are not provided by the facility shall be borne by the female.

(b) A ward shall not be shackled by the wrists, ankles, or both during labor, including during transport to a hospital, during delivery, and while in recovery after giving birth, subject to the security needs described in this section. Pregnant wards temporarily taken to a hospital outside the facility for the purposes of childbirth shall be transported in the least restrictive way possible, consistent with the legitimate security needs of each ward. Upon arrival at the hospital, once the ward has been declared by the attending physician to be in active labor, the ward shall not be shackled by the wrists, ankles, or both, unless deemed necessary for the safety and security of the ward, the staff, and the public.

(c) For purposes of this section, "local juvenile facility" means any city, county, or regional facility used for the confinement of juveniles for more than 24 hours.

(d) The rights provided to females by this section shall be posted in at least one conspicuous place to which all female wards have access.

(Added by Stats.1976, c. 1068, p. 4741, § 1.5. Amended by Stats.2005, c. 608 (A.B.478), § 6.)

Historical and Statutory Notes

2005 Legislation

Stats.2005, c. 608 (A.B.478), inserted subdivision designators "(a)", "(c)", and "(d)"; in the second sentence of subd. (a), substituted "those services" for "such services";

in the third sentence of subd. (a), substituted "the female" for "such female"; and inserted subd. (b).

Reimbursement provisions relating to Stats.2005, c. 608 (A.B.478), see Penal Code § 3419.

Cross References

Community treatment programs, notice and written application forms to pregnant inmate, see Penal Code § 3419.

Community treatment programs, prenatal health care, pregnant inmates, see Penal Code § 3424.

Corrections Standards Authority, pregnant inmates, see Penal Code § 6030.

Transfer of pregnant inmate to hospital, charges for care, see Penal Code § 3423.

Transfer of pregnant inmate to hospital, shackles, see Penal Code § 5007.7.

Youth Authority, right of pregnant female committed to Youth Authority to choice and services of physician and surgeon, see Welfare and Institutions Code § 1774.

Research References

Encyclopedias

CA Jur. 3d Penal and Correctional Institutions § 102, Female Prisoner's Right to Services Respecting Pregnancy.

Treatises and Practice Aids

3 Witkin Cal. Crim. L. 3d Punishment § 74, Special Requirements for Women Prisoners.

10 Witkin Cal. Summ. 9th Parent and Child § 513, Rights of Minor.

## **Appendix 3**

### **The Pregnant Patient's Bill of Rights**

#### **Summary of the Pregnant Patient's Bill of Rights**

The following bill of rights for pregnant women was found on the web site for Lourdes Hospital (Binghamton, NY; [www.lourdes.com](http://www.lourdes.com)). A summary of these rights was found on another web site, [www.allina.com](http://www.allina.com), and is included in this appendix. The pregnant patient's bill of rights was prepared by the International Childbirth Education Association.

### **The Pregnant Patient's Bill of Rights**

The pregnant patient has the right to participate in decisions involving her well-being and that of her unborn child, unless there is a clear-cut medical emergency that prevents her participation. In addition to the right set forth in the American Hospital Association's "Patient's Bill Of Rights", the pregnant patient, because she presents two patients rather than one, should be recognized as having the additional rights listed below:

The Pregnant Patient Has The Right:

1. Prior to the administration of any drug or procedure, to be informed by health professionals caring for her, of any potential direct or indirect effects, risks or hazards to herself or her unborn or newborn infant which may result from the use of a drug or procedure prescribed for, or administered to her, during pregnancy, labor, birth or lactation.
2. Prior to the proposed therapy, to be informed, not only of the benefits, risks and hazards of the proposed therapy, but also of known alternative therapy, such as available childbirth education classes which could help to prepare the pregnant patient physically and mentally to cope with the discomfort or stress of pregnancy and the experience of childbirth, thereby reducing or eliminating her need for drugs and obstetric intervention. She should be offered such information early in her pregnancy, in order that she may make a reasoned decision.
3. Prior to the administration of any drug, to be informed by the health professional who is prescribing or administering the drug to her, that any drug which she receives during pregnancy, labor and birth, no matter how or when the drug is taken or administered, may adversely affect her unborn baby, directly or indirectly, and that there is no drug or IV chemical which has been proven safe for the unborn child.
4. If cesarean birth is anticipated, to be informed prior to the administration of any drug, and preferably prior to her hospitalization, that minimizes the intake for her and her baby of non-essential preoperative medicine, which will benefit her baby.
5. Prior to the administration of a drug or procedure, to be informed of the areas of uncertainty if there is NO properly controlled follow-up research which has established the safety of the drug or procedure with regard to its direct and/or indirect effects on the physiological, mental and neurological development of the child exposed, via the mother, to the drug or procedure during pregnancy, labor, birth or lactation (this would apply to virtually all drugs and the vast majority of obstetric procedures).
6. Prior to the administration of any drug, to be informed of the brand name and generic name of the drug, in order that she may advise the health professional of any past adverse reaction to the drug.

7. To determine for herself, without pressure from her attendant, whether she will accept the risks inherent in the proposed therapy, or refuse a drug or procedure.
8. To know the name and qualifications of the individual administering a medication or procedure to her during labor or birth.
9. To be informed, prior to the administration of any procedure, whether the procedure is being administered to her or for her baby's benefit (medically indicated) or as an elective procedure (for convenience, teaching purposes or research).
10. To be accompanied during the stress of labor and birth by someone she cares for, and to whom she looks for emotional comfort and encouragement.
11. After appropriate medical consultation to choose a position for labor and birth which is least stressful to her baby and herself.
12. To have her baby cared for at her bedside, if her baby is normal, and to feed her baby according to her baby's needs, rather than according to hospital regimen.
13. To be informed, in writing, of the name of the person who actually delivered her baby, and the professional qualifications of that person. This information should also be on the birth certificate.
14. To be informed if there is any known or indicated aspect of her baby's care or condition which may cause her or her baby later difficulty or problems.
15. To have her and her baby's hospital medical records complete, accurate and legible and to have their records, including Nurses' Notes, retained by the hospital until the child reaches at least the age of majority, or, alternatively, to have the records offered to her before they are destroyed.
16. Both during and after her hospital stay, has the right to have access to her complete hospital medical records, including Nurses' Notes, and to receive a copy, upon payment of a reasonable fee and without incurring the expense of retaining an attorney.

It is the obstetric patient and her baby, not the health professional, who must sustain any trauma or injury resulting from the use of a drug or obstetric procedure. The observation of the rights listed above will not only permit the obstetric patient to participate in the decisions involving her and her baby's health care, but will help to protect the health professional and the hospital against litigation arising from the resentment or misunderstanding on the part of the mother.

*Source: Lourdes Hospital. Binghamton, NY. Retrieved: September 10, 2006.*  
[www.lourdes.com/Centers\\_and\\_Services/womens\\_and\\_childrens/bill\\_of\\_rights.aspx](http://www.lourdes.com/Centers_and_Services/womens_and_childrens/bill_of_rights.aspx)



## **Summary of the Pregnant Patient's Bill of Rights**

Each pregnant patient has the right:

- To be informed of the effects and risks of drugs and procedures on her and her baby
- To be told of all possible alternatives and options in treatment and procedures
- To choose for herself, without pressure from any health care provider, whether or not she and her baby will accept drugs, treatments, and procedures
- To know the names and qualifications of anyone who treats her
- To be accompanied through labor and birth by a friend, partner, or family member
- To labor and birth in the position most comfortable to her, if it's medically sound
- If she does not care for or get along with a nurse or staff member, to ask that a different one be assigned to her
- To care for her baby at her bedside, if the baby is healthy

*Source: Allina Health System Press, "Beginnings: Pregnancy, Birth and Beyond," fourth edition, American College of Obstetricians and Gynecologists. Retrieved: September 11, 2006. [www.allina.com](http://www.allina.com)*