Abortion and Access in Prison

Maureen Mansfield, Kirsty Kitchen, Conor Murray, Emma Campbell, Fiona Bloomer

Introduction

Abortion was decriminalised in Northern Ireland in October 2019, following the introduction by the United Kingdom (UK) government of the Northern Ireland Executive Formation Act 2019 (Aiken and Bloomer, 2019). Secondary regulations introduced in March 2020 detailed how abortion services would be provided for (Kirk et al., 2021). Despite the legislative and regulatory framework, the Department of Health (DoH) had refused until October 2022, to commission or fund services, with provision offered on an interim basis by a small group of committed providers (Kirk et al., 2021; NIACT, 2022). The absence of commissioning meant services were only available under 10 weeks' gestation or those with a diagnosis of foetal anomaly. Beyond these criteria, abortion seekers had to travel elsewhere to access services (Kirk et al., 2021). As of 24 October 2022, the Northern Ireland Office (NIO) led commissioning, with full implementation of services beginning in winter 2023. It is of note that neither the legislation nor the regulations considered provision of abortion services in prison and it remains unclear if commissioning will include this provision. Elsewhere in the UK the provision of abortion within prison is under-considered, specific pressure has been placed on prison abortion care via non-government organisations as part of a broader focus on incarcerated reproductive health care.

This policy briefing focuses on reproductive health and abortion specifically for abortion seekers in prisons in England and Wales, and Northern Ireland. It has been informed by experts at a roundtable in 2023, attended by Laura Abbott, University of Hertfordshire; Miranda Davies, the Nuffield Trust; Vicki Dabrowski, Liverpool Hope University; Rachel Foggin, BPAS; Jayne Loughran, Belfast Health and Social Care Trust; Emma Milne, Durham University; Sharon Porter, Northern Health and Social Care Trust; Katherine O'Brien, BPAS; and Rachel Roth, independent researcher.

We first consider research on reproductive healthcare in prisons, with a focus on abortion. This is followed by the international and national policy context, the Northern Ireland prison context, and the report from the expert roundtable. We conclude with an overview of gaps in knowledge and recommendations for policymakers. [1]

[1] The policies and guidelines are often written to only include women, which is the same for the collection of data. Throughout, in order to include the full range of people who can get pregnant in prisons, we will use "women and pregnant people" when specifying abortion needs and women only when referring to the data of another report, guidelines, or policy where it has been specified.

Abortion and reproductive healthcare in prisons

Several studies have examined reproductive healthcare in prisons, focusing on the US context. A systematic review identified limited access to reproductive healthcare as common, with psychological trauma, obstetric violence, and use of shackles during medical procedures (including childbirth), reported (Kirubarajan et al., 2022). Roth (2012) in examining the breadth of evidence within the US, determined that prisons were sites of reproductive injustice, where failure to provide access to reproductive care is part of a widespread pattern of institutional neglect, laden with the racial and class biases present within the criminal justice system.

UK studies identified that the sexual and reproductive healthcare needs of people in prison are not openly talked about, the symptoms of menopause, or conditions such as endometriosis, are also mismanaged or understood poorly (Davies et al., 2022). In a recent study focused on midwifery care in three English prisons, Abbott et al. (2022:1) showed "women's experiences included: disempowerment due to limited choice; fear of birthing alone; and a lack of information about rights, with a sense of not receiving entitlements. Some women reported favourably on the continuity of midwifery care provided."

A systematic review of academic publications by the briefing authors (Murray et al., forthcoming) reveals abortion in prisons to be significantly under-researched. Of the few studies identified, based in the USA, the key findings include the absence of clear policy regarding access to abortion in prisons; varying degrees of assistance with transportation, payment and arranging the appointment; and problematic aftercare or counselling access (Sufrin et al., 2015; 2021; 2023; Liauw, 2021; Kraft-Stolar, 2015). A qualitative study by Sufrin et al., (2023), explored pregnancy decision-making experiences of women in prison or jail, four themes were identified: 'medical providers overt obstruction of desired abortions; participants assuming that incarcerated women had no right to abortion; carceral bureaucracy constraining abortion access and thoughts about pregnancy; and carceral conditions made people to wish they had abortion' (Sufrin et al., 2023:1). Similar findings regarding decision-making about abortion whilst imprisoned were identified by Deboscker et al., (2022) in their study of women in a French Guianan prison.

Women in prison population

The proportion of women in European prisons (as a part of the total prison population) varies, the highest being Portugal with 8.1%, until recently Northern Ireland had the lowest at 2.1% (Council of Europe, 2020). However, recent data indicates that the Northern Ireland women in prison population has increased from 2.1% to 4.4% of the total prison population (Prison Studies, 2022). The average reception rate in the years 2015 - 2019 was 416 (Prison Reform Trust, 2022). Of concern is the high number of women in prison on remand, which made up almost three quarters (74%) of women entering custody in 2021 (Prison Reform Trust, 2022).

Policy and international regulations

Reproductive healthcare provision in prisons is considered through layers of standards, governance, and oversight. The below policies, recognise that healthcare within prisons needs improved so it is equitable to non-prison populations (World Health Organization, 2014; McCann et al., 2020; Davies, et al., 2021). International principles avow parity of provision, meaning incarcerated people require the same standard of medical care as people living in the community. It is a fundamental human right and forms the basis of international commitments to improve health in prison. These include:

- 'The Bangkok Rules,' the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, which states "gender-specific health-care services must be at least equivalent to those available in the community" (UN, 2010).

- The revised European Prison Rules issued by the Council of Europe (2020), require that states develop specific gender-sensitive policies and enact positive measures to meet the distinctive needs of imprisoned women, and access to specialised services must be provided for women in prison.
- The United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) also highlighted disparity in access to services in prison within several states and made specific recommendations regarding access to abortion more broadly in Northern Ireland (UN CEDAW, 2018).

Policy in England and Wales

The policy context in England and Wales falls within the remit of: HM Prisons and Probation Service (HMPPS); the HM Inspectorate of Prisons (HMIP); the Care Quality Commission (CQC) (previously Public Health England); and NHS England. Recognising that previous, individual policy efforts by these bodies had not resulted in consistency or adherence, a joint review by each led to the publication of standards (Public Health England, 2018). These standards centred on improving health services, reducing inequalities, and improving the wellbeing of women in prison. In relation to abortion access the standards are explicit that abortion should be well supported, and care should be comparable to community provision.

The standards were followed by a practitioner's guide (HMPPS, 2018) which reiterated community equity and stressed the importance of timely access. These standards were set by the Ministry of Justice (MOJ) which committed to improve health outcomes for women. Related reviews included operational policy for all pregnant women, women and children in Mother and Baby Units and women experiencing separation from children under two (MOJ, 2020). This latter review followed extensive advocacy on maternal wellbeing in prisons from Birth Companions. During this period, two babies died in prison during/ following birth, with subsequent inspections informing the content of the review. The operational policy and guidance now include pregnancy during a sentence, as well as abortion, unplanned pregnancy, miscarriage, child loss, stillbirth, or abortion. The reproductive justice advocacy of expert organisations means abortion seekers are now included in policy if not yet practice.

Monitoring and oversight mechanisms

Monitoring and oversight mechanisms operating in prisons play an important part in accountability for operation and conditions in prison. The UK government has ratified the UN Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment - known as OPCAT, which requires all parties to maintain, designate or establish one or several independent national mechanisms for the prevention of torture.

His Majesty's Inspectorate of Prisons was implored to develop a greater monitoring on the identification and support of women during pregnancy. It subsequently added health indicators to consider the specific needs of pregnant and postpartum women (HMIP, 2021a). The one indicator related to abortion indicates appropriate access and follow up services. However, there is no guidance on what 'appropriate' might mean. Relevant indicators include screening, referral and appointments, sensitivity to protected characteristics and timely pregnancy testing and contraception where needed (HMIP, 2021a:42). In subsequent inspection reports, no details were provided for how many people considered termination, despite evidence available on those who continued their pregnancy. Additionally, a prisoner survey issued by the Inspectorates does not ask directly about abortion at all.

There have been repeated reproductive injustices in prison, including denial of menstruation products, strip searching, women shackled during appointments and basic care not provided for women miscarrying. Healthcare provision for women in prison, continues with inadequacies and results in the deaths of mothers and their infants, garnering responses from reform groups, raised public interest and attracted the attention of authorities (Bennett and Shuker, 2017). Following secret filming in 1996 by Channel 4 at Whittington Hospital showing a woman known as 'Annette' shackled to prison wardens during her labour, Birth Companions was formed. They established a high-profile campaign to call for mandatory standards of care for women in prison during pregnancy, birth and early motherhood, including an end to the use of restraints. The roundtable participants noted anecdotal evidence that, despite clear policy and guidance, restraints continue to be used for pregnant women during medical treatment.

The mistreatment of pregnant women in prison in England received attention again recently, due to the deaths of two babies in prison in the space of nine months. The first was Baby A in HMP Bronzefield in 2019, followed by a second baby (reported as Baby B) in HMP Styal in 2020. The outrage and concern meant the Prison and Probation Ombudsman (PPO), independently investigated both incidents for the first time, despite the PPO terms of reference at the time not including responsibility for investigating stillbirths. There were 11 separate investigations commissioned into the death in Bronzefield of Baby A (Aisha) born to a teenager, alone in her cell (Taylor, 2021). The PPO's damning report (2021) found multiple failures across prison and healthcare. Following the incidents, calls for pregnant women to be spared prison were made by NGOs, professional bodies and academics and a joint campaign was launched by Level Up, Women in Prison and Birth Companions (Level Up, 2020) which stated:

> Prison will never be a safe place for pregnant women and new mothers. 1 in 10 women give birth inside their cell or on the way to hospital, and in the last two years, two babies born inside prison have died.

Subsequently, a coroner's inquest into the death of 'Baby A', stated that Aisha "arrived into the world in the most harrowing of circumstances" given that her mother, Rianna Cleary – a vulnerable care-leaving black 18-year-old – was left to give birth alone in a prison cell without any care or assistance (INQUEST, 2023). Prior to this renewed interest, Birth Companions published a Birth Charter for prisons (2016), which included abortion:

> During pregnancy, all women should have appropriate support if electing for termination of pregnancy. This means that:
>
> - Women considering termination should be offered abortion counselling to the same standard as that available in the community both while they make the decision and following the termination.
> - Counselling, scans, and other appointments should be provided within a timescale that allows women the choice to terminate their pregnancy.
> - Women should be able to choose a family member or supporter to accompany them for the procedure
> - After termination women should be observed closely for physical and emotional complications
> - Physical complications that may occur post-termination should be assessed promptly by a health care professional. Birth Companions (2016:1)

The Birth Charter was published in May 2016 and subsequent publications issued by HMPPS, MoJ, HMIP and Public Health England cite it in relation to abortion access. The charity followed up the success of the Charter with a detailed, practical guide, 'The Birth Charter Toolkit' (2019), to help prisons translate its principles into practice.

Northern Ireland

There is one facility housing women in prison in Northern Ireland, co-located in a male young offender prison (Hydebank Wood Secure College). Reports from the Independent Monitoring Board (IMB) indicate poor hygiene facilities (CJINI, 2020). Health care is provided by the South-eastern Trust; informal inquiries indicate no abortions have been provided since decriminalisation in 2019. Monitoring reports indicate that one pregnant woman went on to have her baby while in prison during 2021 (IMB, 2021). In a report on developments made since 2015, Campbell (2020) identifies that new programmes, activities and community links were made by prison service staff relating to the awareness of the specific needs of women. Family ties were improved through family information days, and improvements to prison visits for children. However, there is no mention of abortion in the report.

Monitoring data

Within inspection reports no details are available for how many women wanted terminations and no official statistics were released regarding how many people accessed abortion in prison (or following release) in the UK. From the limited data available, prisons in England did not facilitate access to telemedicine abortion services during the pandemic, despite this being the main method of provision for all UK, bar Northern Ireland. As a result of the outcry over the baby deaths in prison and ongoing lobbying, the MOJ began releasing official statistics on pregnancy and how many of these become live births while in custody (HMPPS, 2021). The figures in July 2023 show that 196 were known as pregnant in prison between April 2022 and March 2023, 44 women gave birth while being a prisoner, one birth took place in prison or while in transit to the hospital (HMPPS, 2023). These are the first annual figures published on pregnant women in custody, the result of campaigning efforts by Birth Companions and others.

Expert roundtable

This policy overview was confirmed by roundtable experts, who observed that, despite significant efforts in England and Wales at improvement, there continues to be a disconnect between policy and practice. After providing abortion health care whilst a woman was shackled in England, a doctor stated: "we want pathways to abortion to be more humane for women". The roundtable offered the following for the disconnect between policy and practice:

- There are dedicated 'pregnancy mother and baby liaison officers', however these staff end up being "reworked" back onto wing duty. The focus is also largely on those who are pregnant, and on MBUs – other experiences, like abortion, can slip through the net in pressurised workloads.
- There is stark inconsistency between prison and community services, especially regarding information provision.
- Abortion seekers can be reluctant to approach midwives and/ or prison officers.
- Pregnant women are often reluctant to complain about the quality of care provided in prison (this is a gendered issue, which exacerbates medical and prison power dynamics). There are more women in prison and on remand now (Prison Reform Trust, 2023). Being on remand significantly impacts access to all healthcare services, and planning, given the uncertainty awaiting trial or sentencing.

Gaps in knowledge

There is no clear evidence base related to abortion seekers in prison: the number of abortion seekers in prison, where they access services and what type of abortion is provided is missed. Experiences of those seeking abortions in terms of ease of access, information available, wait times and any barriers faced are invisible. Though the prison environment includes a lack of confidentiality inherent in accessing healthcare (Roth, 2011; Sufrin, et al., 2021; Davies, et al., 2021), attitudes regarding abortion from fellow prisoners is also under researched. Attitudes of staff, prison, healthcare or NGO staff and any impact on ease of access, type of support or quality of care provided is also unknown. It is unclear whether the type and length of sentences have an impact on access or the decisions of abortion seekers. Those on remand or on very short sentences may, on the one hand prefer waiting until they are in the community again and can have more control over the process, or on the other hand for some, their access to healthcare services improves while they are in prison, due to their lives being chaotic and attending appointments a challenge while they are in the community.

Recommendations

The commissioning of abortion services in Northern Ireland presents a need for policy makers and healthcare providers to assess what services are required in prison and to learn from other jurisdictions. This knowledge can inform service development based on best practice. In addition, the focus could be broadened to include reproductive healthcare. This moment also allows for consideration of the context elsewhere in the UK, where severe problems in maternity care following infant deaths have led to improvements in policy and guidance. There is evidence to suggest that there have been some positive changes made in terms of care pathways in England regarding maternity care, but how this translates to the experience of abortion seekers is unknown. Based on the gaps identified in this briefing we make the following recommendations:

1. Data must be collected on access to abortion services in prisons.
2. Research is needed on the views and experiences of abortion seekers, prison staff and healthcare providers.
3. Research should be conducted acknowledging the range of factors impacting on the reproductive lives of those incarcerated.

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About the authors:

Maureen Mansfield is Family Engagement Coordinator at INQUEST Charitable Trust.

Kirsty Kitchen is Head of Policy and Communications at Birth Companions.

Conor Murray is Lecturer in Criminology at the School of Applied Social and Policy Sciences, Ulster University.

Emma Campbell is a Research Associate at the School of Applied Social and Policy Sciences, Ulster University.

Fiona Bloomer is Senior Lecturer in Social Policy at the School of Applied Social and Policy Sciences, Ulster University.

QUEEN'S UNIVERSITY BELFAST

T. 028 9097 3034 E. info@ark.ac.uk

T. 028 9036 6339 E. info@ark.ac.uk