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ORIGINAL ARTICLE

BIRTH ISSUES IN PERINATAL CARE WILEY

Experiences of midwifery care in English prisons

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Abstract

Background: In the United Kingdom (UK), all prisoners must receive healthcare equivalent to that available in the community. However, evidence suggests that equality in healthcare provision for perinatal women in UK prisons is not always achieved. The aim of this research was to examine pregnant women prisoners' and custody staffs' experiences and perceptions of midwifery care in English prisons.

Methods: A qualitative approach based on institutional ethnography was used to research women's experiences in three English prisons over a period of 10 months. In total, 28 women participated in audio-recorded, semi-structured interviews. Ten staff members were interviewed, including six prison service staff and four health care personnel. Ten months of prison fieldwork enabled observations of everyday prison life. NVivo was used for data organization with an inductive thematic analysis method.

Results: 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 favorably on the continuity of midwifery care provided. There was confusion around the statutory role of UK midwifery.

Discussion: Experiences of perinatal prisoners contrast starkly with best midwifery practice—women are unable to choose their care provider, their birth companions, or their place of birth. In addition, a reliance upon "good behavior" in return for appropriate treatment may be detrimental to the health, safety, and well-being of the pregnant woman and her unborn baby.

Conclusion: Prison is an adverse environment for a pregnant woman. This study provides key insights into imprisoned women's experiences of midwifery care in England and shows that midwives play an essential role in ensuring that perinatal prisoners receive safe, high-quality, respectful care.

KEYWORDS

institutions, midwifery, pregnancy, prison, women's health

1 | INTRODUCTION

The United Nations (UN) states that all women in prison should receive gender-specific care and that pregnant prisoners should be provided with all entitlements, including appropriate health advice and adequate nutrition.[1] The Council of Europe[2] decreed that prisoners should receive the same healthcare as that provided in the community. In the UK, all prisoners must receive equivalence of healthcare[3,4]; however, evidence suggests this is not always achieved for perinatal women.[5]

There is an estimated global prison population of 10.35 million, of whom 7% ($n = 714\,000$) are women and girls.[6] The United States (US) has the highest number of imprisoned women at 12 per 100 000 of the national population, with 3% of the prison population being pregnant.[7] In the UK, women make up 5% of the prison population. Denmark has the lowest at 2.6 per 100 000.[8] In Australia, one in 50 women entering prison are pregnant.[9] The Norwegian Criminal Code indicates that a pregnant woman's sentence can be postponed. If a Norwegian woman chooses to serve her prison sentence, she will usually be freed in the sixth month of her pregnancy, to complete her sentence later.[10]

1.1 | Midwifery care provision in English prisons

The number of women being held in UK prisons in May 2022 was 3260[11] with approximately 600 pregnancies and 100 births occurring annually.[12] England has 12 prisons for women, six of which have a Mother and Baby Unit (MBU) located within the prison but separate from the main population. Following birth, women who have been allocated a place in a prison MBU return to the MBU with their babies. Those who have not been allocated a place in an MBU return to the general prison population without their babies.[13]

Midwives, based in community teams, are the lead care providers for all perinatal women in the UK. Scans and specialist referrals are typically facilitated in the hospital closest to the prison, and women are usually accompanied to appointments by two prison officers. When a birthing person's active labor begins in prison, she will be transferred to hospital, usually accompanied by prison officers.[14] When this research was undertaken, policy and guidance for the care of perinatal prisoners were limited.[14] More recently, pregnant women and new mothers in prison have received positive attention from policy makers with the mandating of new and more equitable operational policy.[15]

1.2 | Health outcomes for pregnant prisoners

There is widespread evidence of poorer health outcomes for pregnant prisoners and their babies than for non-incarcerated mothers and babies. A systematic review of UK evidence found that the babies of women in prison were more likely to be premature.[16] Subsequent analysis identified several missed opportunities to improve the health of pregnant women during incarceration.[17] A retrospective cohort study exploring perinatal outcomes for incarcerated women in Australia found an increased likelihood of poor health outcomes, including low birthweight and increased neonatal intensive care admissions.[18]

Evidence from a scoping review indicated inconsistency in care provision with the voices of women underrepresented.[19] A further systematic review that included qualitative studies found similar inconsistencies.[20] Interviews in one US prison found that a deep relationship (connectedness) formed between an incarcerated woman and her unborn baby.[21] Elevated levels of satisfaction were recorded among incarcerated pregnant women offered doula care, though having a doula did not lead to improvements in clinical outcomes.[22,23] The scarcity of qualitative evidence documenting women's experiences precipitated the development of a qualitative research proposal to examine perinatal women's experiences in prison.

The objectives of this paper are to examine pregnant women prisoners' and custody staffs' experiences and perceptions of midwifery care in English prisons. Elsewhere, we have discussed the stigma faced by pregnant women in prison[13] and the experience of loss of those separated from their babies at birth.[14] In response to our research findings, we offer practice recommendations designed to improve care and outcomes for incarcerated pregnant women and their babies.

2 | METHODS

2.1 | Design

Institutional Ethnography (IE) informed the methodological approach; specifically, we draw upon methods employed by Dorothy Smith.[24] In alignment with IE principles, the prison settings were described and interpreted by the primary researcher[25]—an experienced Registered Midwife (RM) with no previous experience of working in prison. All fieldwork was undertaken by [Senior Author] in three English prisons: Prison A: a closed (maximum security) prison with no Mother and Baby Unit (MBU); Prison B: a closed prison with an MBU; and Prison C: an open prison

(minimum security) with an MBU. Post-release, interviews were undertaken in the community. Semi-structured interviews with imprisoned pregnant women, with women post-release who were part of the pilot project, and with prison staff were undertaken over a 10-month period. Participant-observation in the prisons also enabled the recording of descriptions of everyday prison life in written reflections in fieldnotes; these were included in the analysis (eg, prison schedules, encounters with prisoners, and descriptions of the prison milieu). The lead author was responsible for the analysis, with interviews transcribed verbatim and then read and re-read to identify recurrent themes and emic codes. NVivo software was used for data organization and an inductive thematic analysis method was employed. The latter entailed an authentic coverage of the women's experiences, analyzing inductively from within the data to avoid speculation and contamination through researcher bias.[26]

Ethics approval was granted by the National Offender Management Services (NOMS) through the Health Research Authority Integrated Research Application System (IRAS).

2.2 | Sample

Because the lead researcher spent time navigating the prison system prior to commencing fieldwork and during the pilot phase, women and staff were familiar with the lead researcher and potential participants were comfortable being approached. Each prison maintained a "pregnancy list" of women; staff helped to locate prisoners on the different prison wings to facilitate recruitment. Post-release, women were recruited via a charity as part of the pilot phase. Of 29 invitations to take part in audio-recorded interviews, 28 women consented to participate—22 while incarcerated and six following release from prison. A convenience sampling approach was undertaken to recruit 10 members of staff.

Participants were aged between 18 and 41. Of the 28 participants, 21 were in prison for the first time. Most of the women ($n = 21$) had been sentenced for a non-violent crime and were usually serving a sentence of 6 months or less. Twelve women were at various stages of pregnancy at the time of interview; the remainder were interviewed post-birth. Five of the women who were still incarcerated agreed to follow-up interviews. Ten staff members consented to audio-recorded interviews, including six prison service staff and four health care personnel.

3 | RESULTS

Among the women interviewed, there were no major differences in the core themes of recalled experiences among the women who had been released versus those that remained incarcerated. For the purposes of this paper, only experiences of pregnancy are described. The following key themes are discussed: midwifery care provision; antenatal education and birth choices; relationship with midwife; and staff perceptions of midwifery care. To protect the identity of women and staff, pseudonyms are used throughout; staff are denoted as Prison Officers (POs) or Health Care Workers (HCWs). In addition, fieldnotes give the unique perspective of an RM researching in a prison setting.

3.1 | Midwifery care provision

In each prison, maternity care was provided by one midwife from the local community. The midwife entered the prison from her community location to provide antenatal and postnatal care but did not provide care in labor. The midwife had limited specialist prison training and liaised with several geographical areas, organizing care for women whose sentences varied in length. Reliance on one midwife meant that women received limited care when the midwife was away. At the time this research was undertaken, English maternity policy regarding pregnant prisoners was inconsistent.[27] Susan described how she simply accepted the limited influence the midwife had as her maternity care provider in prison:

> "There is not much they can do...it's not like being pregnant on the outside." (Susan).

Inconsistencies in the system were further highlighted by Caroline as she described how her midwife's lack of authority, as an outsider to the institution, meant that she was unable to resolve common maternity challenges:

> "Because the midwife isn't based here, she doesn't have a lot of jurisdiction about what happens...she can tell me what the process is, but she can't implement it." (Caroline).

Some women built a positive relationship with their midwife:

> "She makes sure the prison pulls out all the stops...out of everybody she seems to be the one that's most upfront and tells me what's going to happen." (Lola).

Women had mixed experiences of their midwifery care in prison, often describing how they felt *"rushed"* or like they were "just a number". Karis described it as:

> "It's not like being pregnant on the outside where you talk about daily things... 'Are you getting enough fresh veg and exercise?' ...it's more of a quick 'How you doing?' appointment...there's not much they can do to help the situation...they can't' say 'Oh excuse me she needs to have more fresh air'." (Karis).

Reliance on one midwife meant that no preparation was made for an alternate when the midwife was absent (eg, when she went on holiday). The complexity of prison security, training, and protocol requirements precluded plans being made for an alternative. This troubled pregnant women who were unable to contact a midwife during her time away:

> "She (the midwife) wasn't here last week, or the week before. I've got an appointment for this week, but they said she's not in so by the time I see her, it would have been three weeks." (Sinead).

The midwife who was assigned to Prison A left her position toward the end of the research and no replacement had been identified, leaving the women without antenatal care.

3.2 | Antenatal education and birth choices in prison

In the UK, women in the community can choose to access antenatal courses. There were no midwifery-run classes reported in this research. Therefore, women may not have been in receipt of accurate information about labor, infant feeding, and birth choices. In Prison A, there were no antenatal groups and women commonly received information about labor and birth from other prisoners. In Prison B, antenatal classes were facilitated by the MBU staff and health visitors, and in Prison C, women could access classes in the community. These findings, elicited from both women and staff, demonstrate inconsistencies for pregnant women between the three prisons. Post-release, women who had the opportunity to attend volunteer-run antenatal classes, reflected on their value during their pregnancy:

> "It's not until you look back and see, the little groups were so important, just being able to talk to someone, just something little, like, how will I know I am in labor? Just to be able to ask someone that question." (Frances).

Several participants reported that they were given no choice of a labor and birth partner, further diminishing the autonomy they had in prison. This highlighted further inconsistencies across the prison system. Caroline said:

> "I've been told I cannot have a birth companion from like, a family member or a friend. I can't even have the officer of my choice. It could just be any random person." (Caroline).

Birthing alone in a prison cell and having no chosen birth partner were commonly expressed anxieties. The reliance upon nursing staff rather than RMs, especially at nighttime, caused worry among participants:

> "I just hope I don't go into labor at night... there's no midwife...you've just got nurses." (Trixie).

The fear of having an unsupported labor and birth was a source of underlying stress for many. Women described how they coped with these and other fears by trying to be optimistic:

> "I try and think about the best of things and try not to get stressed." (Ellie).

3.3 | Relationship with midwives in prison

The relationships women experienced with their midwives varied. Some women enjoyed the continuity of care of having the same midwife visiting the prison, whereas others found the relationship challenging. Women were often resigned to the limitations of their midwives' abilities to ensure their entitlements; yet some, like Trixie, suggested that the midwife did not go far enough in her role:

> "I should be entitled to antenatal classes; the midwife hasn't gone through my birthing plan. She hasn't said that this is going to happen, that's going to happen." (Trixie).

At times, the researcher's position as a qualified midwife presented a professional dilemma, as fieldnotes demonstrate:

> When I'm introducing myself and my background, ie, as a midwife, I'm usually met with, "Can I ask you a question?"'. My dilemma is not as simple as undertaking research with a woman who can easily be referred to a midwife or other health care

professional. I cannot ask them to call their midwife. Although I made my position clear, there have been times when I've given simple advice, especially when a woman has talked to me about the fear of a quick labor with no support. There have been times where I have needed to switch hats, especially with listening and offering a therapeutic, compassionate ear. (Researcher fieldnotes).

3.4 | Prison officers' perceptions of midwifery care

Prison officers demonstrated limited understanding of the role of the RM, mistakenly presuming that Registered Nurses held statutory responsibility and were qualified to make autonomous decisions in relation to the pregnant woman:

> "If you've got any concerns (about a pregnant woman) you get healthcare straight away, which is usually one of the nurses." (PO).

Healthcare staff also seemed unsure about the role of the midwife in the prison and made assumptions about what antenatal care involved, based on their own experience:

> "And that's just the bloods and a BP, and a urine dip, isn't it? Not the stuff you get in the community, where you go to your groups. The doctor prescribes them the folic acid and I think, to be honest, that's it." (HCW).

Staff views also revealed moral evaluations of prisoner behavior. When the lead researcher expressed compassion toward the plight of a woman who was suffering from severe nausea, an HCW suggested: "If you (the researcher) had greater knowledge of her crime you, too, would be less sympathetic." Another HCW suggested that women may be provided with additional "privileges, the nicer they are to us." These privileges included items such as extra pillows and mattresses. Although only one midwife was interviewed, valuable insight into midwifery care in prison was offered. The midwife could implement minor changes; however, she was detached from the prison health care team:

> "Since I've been here, I've introduced that they all have a multivitamin tablet, because nutrition's not the best...while they're here and in my care, at least they're getting the multivitamin..." (HCW).

The general perception was that pregnant women should not be treated differently from other prisoners. Staff were sometimes more sympathetic toward a woman when she was pregnant, reporting concern regarding women laboring without qualified midwives available.[27]

Ensuring access to maternity services equivalent to the community was a challenge with layers of complexity, including inconsistent provision and a lack of planning for alternative care provision. Imprisoned pregnant women appreciated compassion, yet this sometimes depended on the midwife/woman relationship. The lack of choice afforded to women in prison demonstrated an absence of care equivalence where women are free to choose, for example, their birthing partner.

4 | DISCUSSION

Women's experiences of prison midwifery care and their opinions about their midwives varied, mirroring the diverse experiences women may have with midwives in the community.[28] The sense of being controlled starkly contrasts with best midwifery practice, where current evidence indicates that empowerment, continuity of care, and choice of birth location should be the guiding principles.[29–31] Significant differences for pregnant women in prison included: the lack of a replacement midwife when the usual one was absent; the midwife being an outsider to the prison, thereby making advocacy difficult; and the lack of differentiation between the role of a nurse and a midwife in caring for the pregnant woman in prison. In the community, it is recommended that a woman choose her midwife and where she gives birth.[14,19,31] In prison, there was no choice of midwifery care provider or place of birth. Of positive note was the continuity of care offered to women in prison, who often saw the same midwife every week. Interviews with staff uncovered some confusion around the protected role of the midwife, sometimes with incorrect advice being given.[27] Both women and staff displayed a lack of awareness of what entitlements a pregnant woman should receive.

Ross argues that prison health care frequently blends into prison culture, with health care staff often adopting the prison climate.[4] This potentially impacts negatively upon pregnancy care, due to the perception that a patient is part of a homogenous group (prisoners), rather than a person with unique maternity care needs. Conversely, healthcare and prison officer staff viewed the environment and the care pregnant women received as positive, as is in line with previous research.[19,32,33] In this study, staff held varying views on the pregnant prisoners. Relationships were often dependent on the perceived extent of the women's compliance with rules and standards of behavior, as well

as to the nature of their crime. Such moral judgments conflict with the midwifery philosophy of unbiased, person-centered care. Women who were perceived to misbehave in prison or who were convicted of more serious crimes were at a disadvantage relative to those who demonstrated "good behavior" and/or had been convicted of non-violent crimes; some were described as undeserving.

Findings in this research confirm contradictory experiences that contrast with the generally optimistic view staff held of the treatment of pregnant women in prison. Research has shown that prison officers are in favor of programs supporting pregnant women in prison (such as doula programs) and against the shackling of pregnant women.[34] However, evidence also suggests that women's experiences often deviate from custody staffs' perception.[18,19,32] Elsewhere we have discussed how embodiment in prison diverges from mainstream societal perceptions.[14] Experiences of stigma for pregnant prisoners has been recently defined as "institutional ignominy": an expression of the institutional response to pregnancy due, in part, to pregnant women's feelings of shame in being caught "between two institutions – prison and hospital" (14, p671).

The centralization of maternity services in the UK[35] could explain why prisoners have been overlooked until recently. An example of neglecting the needs of pregnant prisoners includes having to give birth in one's cell, recorded in the current research.[14] Further cell births are reported in Davies et al.[5] and in the media.[36,37] Illustrations of inconsistencies (such as consistent access to midwifery care and antenatal classes) demonstrated in this research are similar to experiences of women who are excluded from society in other ways, such as those seeking asylum or living with a disability.[35] Oakley suggests that research should empower and amplify the voices and experiences of women who may be oppressed.[38] Yet, as this research[27] and our findings reveal, until recent policy changes, pregnant prisoners remained as voiceless outsiders with little autonomy over their midwifery care. Furthermore, ignoring the voices of those already marginalized and enduring complex issues—as is the case with pregnant prisoners—exacerbates the risks for these individuals who are already experiencing multiple disadvantages.[37] The tragic consequences of this culminate in examples of alleged omissions in care such as those that occurred between 2019 and 2020, wherein two newborn babies in English prisons died.[36]

4.1 | Strengths of this study

This study is unique as it is the first ethnographic study of perinatal experiences in prison globally, amplifying the voices of a group of women who are often overlooked in research. Since the publication of first author's (2018) thesis,[27] questions have been raised publicly in UK Parliament[39] with evidence given to The Joint Committee for Human Rights. Through working in partnership with advocacy organizations and with women who have experienced imprisonment while pregnant, recommendations for best practice made by multi-disciplinary academics and the Royal College of Midwives (RCM) have been delivered and actioned.[40,41]

TABLE 1 Key recommendations from the current research

- 1. Ensuring high-quality midwifery care
- Development of the role of specialist prison midwife with experience in prison maternal health to include a small team involved to ensure appropriate coverage and team support for perinatal women in prison.
- 2. Auditing outcomes for pregnant women in prison
- Appropriately specialized midwife representative on health inspectorate teams with regular inspections across the prison estate until benchmarks have been set, training given, and guidance is firmly in place to ensure consistency.

Key recommendations from the current research are summarized in Table 1:

5 | LIMITATIONS

Only one midwife was interviewed as part of the staff interviews. Future research should include more midwives who work in prisons. The challenge of researching sensitive populations has been well documented: In prison research, reflexivity and taking an auto-ethnographic stance is critical in order to maintain a stable state of mind and to increase objectivity.[42,43] Predictably, the complexity of unraveling the researcher's own feelings to ensure interpretations of the women's voices were as accurate as possible required rigorous self-critique and reflection.

5.1 | Conclusion

In this paper, we describe ethnographic research findings, providing significant new understanding of pregnant prisoners' experiences of midwifery care in UK prisons and shows that midwives play an essential role in ensuring that perinatal prisoners receive safe, high-quality, respectful care. Findings from this study have contributed to key reforms aimed at improving the support birthing people receive perinatally in prison in the UK.[15]

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CONFLICTS OF INTEREST

We confirm that there are no conflicts of interest involved in this research and the writing of this paper.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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