Incarcerated Women and Abortion Provision: A Survey of Correctional Health Providers

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CONTEXT: *Many women entering jail or prison are pregnant, and correctional facilities are therefore an important venue for providing a range of pregnancy-related care, including access to abortion services. However, the availability of abortion services to inmates in the United States is unknown.*

METHODS: *Between October 2006 and March 2007, surveys about abortion provision were mailed to 951 health professionals who provided clinical care in correctional facilities. Descriptive statistics were tabulated, and measures of association were calculated using chi-square analysis.*

RESULTS: *Of the 286 respondents who returned analyzable surveys, 68% indicated that inmates at their facility can obtain "elective" abortions. Eighty-eight percent of this group indicated that their facility provides transportation, but only 54% said that they help arrange appointments. Responses did not differ by providers' individual or institutional characteristics. However, providers from states with a Republican-dominated legislature or with a Medicaid policy that severely restricted coverage for abortion were more likely to indicate that availability of abortion services was limited than were those whose state had a predominantly Democratic legislature or a Medicaid program that covered all or most medically necessary abortions.*

CONCLUSIONS: *Although incarceration does not preclude women's need for access to abortion, full access to services is not available in all settings. Improving women's overall health care in correctional settings should include increasing the accessibility of abortion services.*

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On October 20, 2005, a woman incarcerated at a Missouri state prison in Vandalia, 80 miles south of St. Louis, was transported to a St. Louis abortion provider for a second-trimester abortion. While her procedure was medically uncomplicated, it was legally quite complicated. She had requested a pregnancy termination at approximately nine weeks' gestation, but because the policy of the Missouri Department of Corrections prohibited the transport of prisoners to obtain "elective" abortion care, her request had been denied. By the time she had been informed of the policy, reached legal counsel, sought an emergency court order and defeated two attempts by the state to appeal the emergency order, nearly two months had elapsed. Thus, when the corrections department finally complied with the court's order and prisoner Jane Roe obtained an abortion, she was already into her 18th week of pregnancy.[1]

Jane's case, *Roe v. Crawford,* proceeded as a class action on behalf of all women in the custody of the Missouri Department of Corrections desiring abortions. Two years later, on September 24, 2007, the Eighth U.S. Circuit Court of Appeals heard arguments surrounding the constitutionality of banning transport of prisoners to abortion facilities. In his opening statement, a counselor representing the state argued that "the decision of the Department of Corrections to stop sending prisoners out of prison to obtain nontherapeutic, that is, non–medically necessary, abortions is a reasonable, appropriate and constitutional measure. . . . A woman's right to an abortion is fundamentally inconsistent with incarceration."[2] The court disagreed: On January 22, 2008, the 35th anniversary of *Roe v. Wade,* the court held that the Missouri policy was unconstitutional.[2] This case and the controversies it has engendered demonstrate the need to consider and understand the reproductive health services that are accessible to incarcerated women.

Each year, millions of U.S. women are brought through the doors of a correctional facility.[3] At the end of 2005, more than 1.2 million were in custody—in jails or prisons, or on parole or probation.[4] These women disproportionately represent marginalized sectors of our society; they are predominantly women of color, poor, unemployed and undereducated,[3,5,6] and thus may not have adequate access to health care in general, and reproductive health services in particular.[7,8] Although many of them may spend only a short period of time in custody, their involvement with the correctional health system may represent one of their few opportunities to access medical care.[9–11]

Some 6–10% of women in custody at any given time are pregnant, and about 1,400 women per year give birth while incarcerated.[12] The number of incarcerated women who obtain abortions each year and the wantedness of their pregnancies are not known. However, among nonincarcerated American women, about half of all pregnancies are

unintended, and 24% of pregnancies are terminated with an abortion.[13] Accordingly, it seems likely that a significant proportion of pregnant incarcerated women did not intend their pregnancies. In the only study to date of the reproductive health needs of incarcerated women, 84% of such women of reproductive age surveyed in Rhode Island reported having had an unplanned pregnancy, and 35% had a history of at least one abortion.[7]

Political scientist Rachel Roth systematically investigated correctional facilities' abortion policies[14] and discovered vast inconsistencies and lack of standardization. However, her study did not explore how health care providers who work under these policies translate them into practice.

Because published information addressing the availability of abortion services to incarcerated women is limited, we sought to obtain this information by surveying correctional health care providers. Our objectives were to describe abortion access at correctional facilities and to identify potential barriers to incarcerated women's obtaining pregnancy termination.

METHODS

We mailed questionnaires to 951 correctional health professionals across the United States. Potential respondents were drawn from the membership of the Academy of Correctional Health Professionals, a national organization for health care providers and administrators at correctional facilities. At the time of the study, the organization had approximately 1,600 members. Because the focus of our investigation was providers of direct clinical care to incarcerated women, we excluded attorneys, wardens, dentists, pharmacists, administrators and others whose professional degrees and titles indicated that they do not provide such care. We also excluded persons who did not have a mailing address listed in the database. The study was approved by the institutional review board of the University of Pittsburgh.

The survey consisted of 26 multiple-choice and three open-ended questions. In addition to measures about providers' and their facilities' characteristics, it included questions about abortion services, contraceptive counseling and provision, and general medical and reproductive health care for incarcerated women. Respondents were asked "Are women at your facility allowed to obtain an elective abortion if they request one?" If they answered yes, they were asked which, if any, of the following they did: refer women to an options counselor, help to arrange an appointment, give women the phone number of a provider or provide transportation to an abortion facility. In addition, to evaluate respondents' perception of institutional-level restrictions, the survey asked "Are you aware of any county, state or federal guidelines that prohibit you from providing women with information on abortion?"

To assess contraceptive services, the questionnaire asked whether providers counsel women on birth control. If they answered yes, they were asked which methods and whether they prescribe or dispense them while women are incarcerated or prior to release In addition, they were asked whether women are permitted to continue using contraceptives while incarcerated.

General medical practices were assessed by asking whether women routinely undergo an intake and release examination and whether they receive health care maintenance—vaccine updates, cholesterol and blood sugar screening, and mammography—when appropriate. The survey also assessed screening for specific STDs, tuberculosis and cervical dysplasia. Providers were asked whether they perform tests for each of these conditions routinely, on request or not at all.

The open-ended questions asked respondents to describe challenges or solutions to providing reproductive health care in the correctional setting, as well as to offer any additional comments. Some of the multiple-choice questions about contraception and abortion had space for respondents to provide comments if they desired. We took clinicians' responses to be a reflection of their understanding of their facilities' policies, but not a representation of official policies.

Before the survey was mailed, we pretested it with 10 physicians and five nurses and nursing professors, all of whom had expertise in either correctional medicine or women's health care delivery. Adjustments in content and format were made on the basis of their feedback. These experts were not included in the mailing of the final survey.

The first mailing occurred in October 2006; all survey packets included a self-addressed, stamped envelope. If a survey came back marked "returned to sender" with a forwarding address, it was resent to that address. In March 2007, a second mailing was sent to all nonrespondents.

Because both the legislative and the executive branches of state governments play a role in correctional policy and personnel appointments, we also evaluated abortion service trends by party affiliation of the legislature and the governor of respondents' home state after the November 2006 elections.[15] We did not ask respondents about their own political beliefs, because of concern that this line of inquiry would discourage them from participating.

In addition, under Medicaid, states pay for women's abortions in certain circumstances, although the extent of coverage differs across states.[16] Currently, 26 states' Medicaid programs have "very restrictive" policies—that is, they pay for abortions only if the woman's life is endangered or she is the victim of rape or incest. Six states have "semi-restrictive" programs, in which Medicaid covers abortions in cases of life endangerment, rape or incest, as well as fetal anomalies or other maternal health concerns. Eighteen states have "least restrictive" programs, which pay for all "medically necessary" abortions.[16] We analyzed abortion services by these coverage schemes of a respondent's state.

Data were analyzed using Stata version 9.0. Descriptive statistics were tabulated, and measures of association were calculated using chi-square analysis. Respondents who did not provide information for a particular question were

TABLE 1. Percentage distribution of correctional health providers participating in a survey on abortion provision, by selected characteristics, 2006–2007

Characteristic	% (N=286)
Facility type	
Jail	63
State prison	22
Federal prison	1
Juvenile center	9
Other	5
Gender	
Female	73
Male	27
Race	
Black	8
White	85
Asian	3
Native American	1
Other	4
Ethnicity	
Hispanic	5
Non-Hispanic	95
Profession	
Physician	22
Nurse practitioner	11
Registered nurse	57
Social worker	<1
Physician assistant	1
Other	8
Specialty	
Internal medicine	13
Family medicine	20
Obstetrics-gynecology	14
Pediatrics	6
Emergency medicine	19
No response	28
Years practicing correctional health care	
<5	17
5–10	19
>10	64
Certified in correctional health	
Yes	68
No	32
Region	
Northeast	7
South	30
Midwest	29
West	34
Total	100

Note: Percentages may not add to 100 because of rounding.

excluded from the tabulation of frequencies or proportions. Text responses were examined and then manually coded for key themes.

RESULTS

In total, 405 (43%) of the surveys were returned: 231 from the first mailing and 174 from the second. Of these, 119 were ineligible—15 because the respondent indicated no clinical interaction with incarcerated women, 15 because they came from a state that required prior approval for its workers to complete a survey and 89 because respondents indicated that they worked at male-only facilities. In addition, 64 were marked "returned to sender" and had no valid forwarding address. Our analyses therefore were based on 286 surveys, or 30% of those mailed.

Respondents were, on average, 45 years old (range, 29–75); the majority were female and white, and worked in jails (Table 1). In general, this sample comprises a group of practitioners committed to correctional health: Approximately two-thirds of respondents were certified in correctional health, and two-thirds had been caring for incarcerated persons for more than 10 years. Fifty-seven percent were nurses, and 22% were doctors.

Ninety-seven percent of respondents indicated no awareness of any county, state or federal guidelines that prohibited them from providing inmates with information on abortion. Asked whether women at their facility are allowed to obtain an elective abortion if they request one, 68% of respondents (95% confidence interval, 62–73%) answered yes. Of these, 44% refer pregnant women to an options counselor. Fifty-four percent of respondents who said yes reported that they assist women in arranging an appointment for an abortion, and the remainder indicated that women must schedule the appointment without help from correctional health providers; 88% replied that their facility arranges transportation for women seeking an elective abortion.

We found no statistically significant correlations between a response that abortion was permitted and type of facility, gender of provider, years in practice, type of provider, medical specialty or certification in correctional health. These variables also did not correlate to the likelihood of providers' saying that they facilitated abortion by arranging transportation or other means.

Our examination of contraceptive service provision revealed that overall, 71% of clinicians counseled women on birth control at some point in their incarceration. Providers who did so were more likely than those who did not to answer that women at their facility could obtain an abortion (72% vs. 59%, p=.04). Eighty-four percent of clinicians who provided women with birth control, either by dispensing a method or by writing a prescription upon women's release, reported that abortion was allowed, compared with 58% of providers who did not dispense or prescribe contraceptives (p<.001). Although not statistically significant, there appeared to be a trend suggesting that facilities that allowed women to continue their pre-incarceration method of contraception were more likely to permit abortion than were facilities that did not allow contraceptive continuation (74% vs. 65%, p=.12).

By all of the measures we assessed, abortion appears to be more accessible to incarcerated women in states with predominantly Democratic or bipartisan legislatures than in states with Republican-controlled legislatures (Table 2). Seventy-eight percent of respondents from states with Democratic-controlled legislatures and 72% of those from states with

TABLE 2. Percentage of correctional health providers reporting selected abortion services, by majority party of legislature in provider's home state

Service	Republican (N=91)	Democratic (N=119)	Bipartisan (N=72)
Abortion is allowed***	50	78	72
Provider arranges appointments*	40	62	50
Provider arranges transportation**	77	95	87

*p<.05. **p=.01. ***p<.001. *Notes:* Sixteen states have predominantly Republican legislatures, 22 states predominantly Democratic legislatures and 11 states bipartisan legislatures; in Nebraska, legislators do not identify themselves or run as members of a particular party. This analysis excludes four respondents—three who did not indicate their state of origin and one who was from Nebraska. *Source:* Majority party of legislature—reference 15.

bipartisan legislatures indicated that women could obtain an abortion, compared with 50% of those from states with predominantly Republican legislatures. Patterns of association were similar with regard to arranging an appointment at an abortion clinic and providing transportation. The party affiliation of state governors, however, was not associated with increased abortion access responses.

State funding for abortion also was associated with all of our accessibility measures (Table 3). Correctional health providers from states with very restrictive Medicaid abortion coverage were significantly less likely than those from states with the least restrictive Medicaid programs to say that abortion was allowed (60% vs. 80%), that they helped women arrange an appointment for an abortion (41% vs. 62%) and that transportation was provided (81% vs. 86%). No distinct trend was noted for the six states with semirestrictive coverage, possibly because the number of respondents in this category was small (37).

The main theme that emerged from respondents' open-ended comments is that provision of abortion services to incarcerated women is heterogeneous. Some providers reported that their facility arranged every aspect of abortion care while a woman was in custody: counseling, scheduling, transportation and funding. Others noted that women must get a court order to obtain an abortion while incarcerated; such an order would then stipulate the details of her abortion-related care. Several respondents indicated that prisoners must make financial arrangements themselves. In justifying this funding requirement, one provider underscored that the "procedure is considered elective." Some answers reflected that abortion requests are met with a sense of uncertainty and are dealt with on an individual basis. For example, one respondent wrote, "[I've] only had one patient request [an abortion]; family took her to the appointment. Not sure if we would provide transportation if this came up again." One respondent offered another solution to the dilemma posed when a prisoner requests an abortion: "[We] facilitate early release if abortion [is] requested." In this scenario, the burden is lifted from the correctional facility to address the woman's access to abortion; a woman is freed from incarceration so that she can exercise her reproductive freedom. As this represents only one provider's response, we cannot speculate on the frequency of early release for this purpose.

TABLE 3. Percentage of correctional health providers reporting selected abortion services, by restrictiveness of Medicaid abortion coverage in provider's home state

Service	Very restrictive (N=128)	Semi-restrictive (N=37)	Least restrictive (N=117)
Abortion is allowed**	60	53	80
Provider arranges appointments**	41	65	62
Provider arranges transportation**	81	82	86

**p<.01. *Notes:* "Very restrictive" coverage pays for abortions only in cases of life endangerment, rape and incest; "semirestrictive," abortions that are necessary because of maternal physical health problems or fetal anomalies; "least restrictive," all or most medically necessary abortions. Twenty-six states have very restrictive coverage, six semirestrictive and 17 least restrictive. In South Dakota, Medicaid covers abortions only in cases of life endangerment; South Dakota is excluded from this analysis. This analysis excludes four respondents—three who did not indicate their state of origin and one who was from South Dakota. *Source:* Restrictiveness of Medicaid coverage—reference 16.

DISCUSSION

The Eighth Amendment, which prohibits cruel and unusual punishment, guarantees all prisoners the right to health care; the Fourteenth Amendment, which prohibits states from depriving a person privacy without due process of the law, protects women's right to choose abortion regardless of incarceration. Nevertheless, the Missouri case[1,2] illustrates how the thicket of abortion politics can limit prisoners' access to health services. Similarly, our study sheds light on their constrained access to care. The impact of withholding care remains salient for this traditionally marginalized population not only because abortion is an important component of reproductive health services for women overall, but also because the discretion afforded to officials in the correctional setting allows for varied, and sometimes unconstitutional, interpretations of laws and medical standards pertaining to the provision of abortion services.

Our findings reveal wide variations in the degree of abortion access for women in correctional facilities. Many correctional health providers asserted that incarcerated women are allowed to obtain an abortion. Yet when they were questioned about the details of facilitating the procedure for women, inconsistencies emerged surrounding transportation, help arranging appointments and other logistical assistance. This finding is consistent with those of Roth's analysis, which was based on a comprehensive search of documents and policies pertaining to abortion services for incarcerated women.[14] Of the 44 states that provided Roth with information, 14 had no official written policy on prisoners who requested abortions. Furthermore, among those that had a policy or followed legal precedent, provisions regarding transportation, funding and facilitating varied. Besides

heterogeneity, the dominant theme that emerged in Roth's analysis was the distinction that facilities made between elective and "medically necessary" abortions when describing their policies. We cannot make similar conclusions from our study, as it did not specifically explore a differentiation between medically necessary and elective abortions.

Our results also suggest that provision of contraceptive services in correctional facilities is associated with an incarcerated woman's being allowed to obtain an abortion. One possible explanation for this finding is that providers who have a greater awareness of women's reproductive health needs in general, or who work at facilities with such an awareness, may be more attuned than others to women's need to access abortion services. Alternatively, it could signify a concordance between facilities' contraception and abortion policies, which providers then follow.

We did not identify other provider- or institution-specific variables that predicted an incarcerated woman's having access to abortion, but we did find state-level differences. Consistent with the state-by-state investigation by Roth,[14] our analyses demonstrated that abortion services for incarcerated women follow trends in state politics. According to our results, providers from states with Republican-dominated legislatures were significantly less likely to help incarcerated women obtain an abortion than were those from states whose legislatures were under bipartisan or Democratic control. Similarly, least restrictive Medicaid abortion coverage in a respondent's state was associated with reporting greater access to abortion care.

Our data should be framed not only in a political context, however, but also in a medical one. The correctional health system, which is widely recognized as an important venue for caring for persons who were medically marginalized prior to incarceration,[5,7,17–18] operates under a set of guidelines and policies enumerated in most cases by the National Commission on Correctional Health Care. In collaboration with the American Public Health Association, the commission has published standards for health services that an institution must provide to be an accredited correctional health facility. One standard specifies that pregnant women receive "comprehensive counseling and assistance . . . in keeping with their express desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child."[19] Although the commission recommends that facilities draft a written policy on abortion, it provides no further instructions for abortion services. This lack of accountability for pregnancy termination provision, combined with variable correctional policies, allows for multiple interpretations and applications of a medical service; our data support this contention.

Limitations

While highlighting issues not previously explored in the literature, this study has several limitations. The Academy of Correctional Health Professionals is the largest national professional community of correctional health providers, and thus its membership database was the most comprehensive pool of such providers available. Our response rate was consistent with those of other postal survey studies of health care providers.[20] However, because detailed characteristics of nonrespondents are not known, we cannot ensure that our convenience sample is representative of all clinicians belonging to the organization. Furthermore, because we did not directly sample facilities, we were unable to correlate responses with actual practices. Also, these respondents may have little to do with institutional-level policy decisions. Nonetheless, since providers are usually the gatekeepers to medical referrals, their answers to these survey questions reflect how they interpret—and, likely, how they put into practice—institution policies.

Finally, this was a descriptive study on a topic not previously explored in the literature; our results suggest trends but were not powered to demonstrate statistically significant differences. Though anecdotes appear in the media, further research is needed to document the experiences of women requesting abortions in correctional settings, so that interventions can be designed to ensure their access to pregnancy termination services. Further directions of this work also include formalizing policy requirements through the National Commission on Correctional Health Care.

Conclusions

Incarcerated women's access to abortion services is highly variable, and we suspect that the inconsistencies are related to complex, facility-specific social and political issues. Abortion in the context of the highly regulated and often coercive setting of prisons and jails raises a myriad of intricate and interconnected issues: legal, constitutional, moral, political, financial and medical, among others. Institutional control of individuals as the backdrop for medical care creates a unique set of challenges for providing reproductive health services. The correctional health system should strive to provide quality, comprehensive medical care to inmates. To help achieve this goal, gaps in the range of pregnancy services offered to incarcerated women must be further explored, and interventions to address them must be developed.

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