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Abortion and contraception within prison health care: a qualitative study

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Abstract

Background Although abortion was completely decriminalized in Canada 36 years ago, barriers to pregnancy prevention and termination persist across the country, such as travel and information gaps. Research demonstrates incarcerated people face barriers to family planning care, yet there is no systematic data collection of sexual and reproductive health experiences and outcomes among incarcerated people in Canada. The aim of this study was to explore family planning care experiences among women and gender diverse people who have experienced incarceration in Canada.

Methods We conducted a qualitative community-based research study using focus groups for data collection and reflexive thematic analysis to generate key themes. Our study team included members with lived experience of incarceration. We conducted recruitment in partnership with community organizations. We asked about accessing abortion and contraception while incarcerated and on release.

Results We conducted six focus groups with 35 recently incarcerated participants. Five themes emerged: (1) Competing health needs; (2) Institutional barriers to care; (3) Mistreatment and unethical care; (4) Health knowledge gaps; and (5) Challenges to care-seeking in community.

Conclusion People in prison experience concurrent unmet health needs that crowd out sexual and reproductive health. Prison procedures and perceived unethical professional behaviours impinge care-seeking. Information about abortion and contraception is not readily available in prison. Barriers to care persist upon release. Family planning professionals may improve care for people who experience incarceration by recognizing concurrent mental health needs; anticipating impact of prior negative experiences on care-seeking; challenging limitations to health education in prison; and addressing post-release challenges for patients.

Keywords Prisoner health, Abortion, Contraception

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Introduction

Incarceration presents known barriers to reproductive health and justice including separation from children, vulnerability to permanent loss of custody, disruption in fertility, delayed and denied access to services, and carceral harms such as segregation, use of restraints, and personal (strip) searches [1]. Women are the fastest growing population in prisons in Canada [2] and most incarcerated women are of reproductive age [3]. Our 2021 scoping review of sexual and reproductive health research among prisoners in Canada found most studies addressed sexually transmitted and blood-borne infections [4]. Our international scoping review synthesizing studies of abortion and contraception and people experiencing incarceration found just two Canadian studies [5]. In one, a survey at an Ontario provincial jail designated for women, Liauw et al. [6] found respondents to have higher rates of unintended pregnancy, abortion and unmet contraceptive need than is found in the general population. In a qualitative follow-up study, Liauw et al. [7] found participants commonly encountered discrimination and stigma when seeking reproductive healthcare in jail.

Background

Women in prisons have complex health histories and needs that intersect with sexual and reproductive health. They experience high rates of chronic physical illness [8], sexually transmitted and blood-borne infections (STBBIs) [9, 10], histories of childhood abuse [11], post-traumatic stress disorder (PTSD) [12], mental illness and substance use [13, 14]. Approximately 4% of people in prisons designated for women are pregnant on admission [15]. Further, healthcare is the most frequent topic of complaints expressed by people in prison [2]. Federal and provincial laws affirm the rights of people in prison to health services at professional standards [16], and United Nations international minimal standards for the treatment of prisoners, known as the Mandela Rules [17], and for women prisoners, known as the Bangkok Rules [18], require attention be paid to the distinctive needs of women, including access to sexual and reproductive health care [19]. Yet, there is no systematic data collection of sexual and reproductive health experiences and outcomes among incarcerated people in Canada [9], and this area of health experience is generally under-researched in Canada.

Abortion was completely decriminalized in Canada 36 years ago, and both procedural and medication abortion are publicly funded; prescription contraception is universally funded in one province. However, barriers to pregnancy prevention and termination persist across the country, such as travel and information gaps. Internationally, research demonstrates incarcerated people face barriers to family planning care including restrictive security practices, institutional processes, staff shortages, stigma, coercion and privacy violations from both health care providers and corrections staff [5, 20]. Our recent study of distance to procedural abortion found institutions of incarceration designated for women may be over 700 km from the nearest procedural abortion facility [21]. Prison health is not routinely taught in health professional curricula, and family planning professionals may be unfamiliar with the specific needs and rights of incarcerated people. Access to abortion for incarcerated people is critical to address structural, gender-, and race-based reproductive health inequities in Canada. The aim of this study was to understand the family planning experiences and needs of women and gender diverse people who have experienced incarceration in Canada and to identify key issues family planning professionals must consider in their provision of care to this underserved population.

Methods

Aim

The aim of this study was to understand the experiences of seeking contraception and abortion among women and gender diverse people who have experienced incarceration in Canada. Our objective was to explore how family planning professionals can improve knowledge and delivery of sexual and reproductive health care for women and gender diverse people in prisons, and after release.

Design

This qualitative study was designed and conducted within a framework of community-based research [22]. We partnered with six community organizations designated for women and gender diverse people involved in the criminal legal system at project outset and throughout each step of the research process. Together, we developed research questions, organized recruitment, collected data, conducted analysis, validated key themes and engaged in knowledge mobilization [23]. Our team includes academic researchers, family planning professionals, and expert advisors with lived experience of incarceration. The experts were suggested by the community organizational partners and invited to join the team via email. They received support from other team members in research methods and were financially reimbursed for their time. All research team members identified as ciswomen. We worked collaboratively and iteratively through regular meetings and consultation in person and online. We chose focus groups for data collection because it was logistically easier for the partner community groups, however all participants had the option to talk to a researcher one-on-one instead.

Theoretical framework

We used a theoretical framework of reproductive justice to underpin the study design and implementation with several key assumptions. Reproductive justice theory was conceptualized in 1994 by twelve Black women working within the human rights movement [24]. The key tenets of reproductive justice include the right to bodily autonomy, to not have children, to choose to have children and to parent those children in safe and sustainable communities. This study was designed and implemented with the theoretical assumption that incarceration is a violation of these rights, as being in prison prevents reproduction, separates parents from their children and families, and elevates risks to the health and survival of women and gender diverse individuals [1].

Study setting and recruitment

We recruited focus group participants in partnership with six community organizations providing housing, legal and/or practical support to people with experience of criminalization across Canada. Contact with these organizations is not a requirement for release, and all potential participants were assured participation would have no bearing on their receipt of organizational services. Spanning four provinces, two of the six organizations were located in major urban centres, three in medium size cities, and one in a small city. We provided organizational staff with study materials to distribute through their offices and client-base. We held the focus groups on site at the organizations.

Inclusion/Exclusion criteria

Eligible participants included English-speaking adult women and gender diverse people who have experienced incarceration in provincial and/or federal institutions designated for women.

Data collection

We used a semi-structured interview guide, developed for this study. The interview guide was co-developed with expert advisors with lived experience of incarceration (see supplementary file 1: interview guide). The interview guide asked about experiences accessing abortion and contraception during incarceration, barriers to accessing abortion and contraception in the prison environment, what would make doing so safer and easier for people experiencing incarceration, and what they think health professionals should know about supporting people experiencing incarceration. Focus groups were facilitated by team members MP or CH. We stopped data collection once we had conducted focus groups with all partnering organizations. All potentially identifying information, including names and places, were removed during the transcription process.

MP and CH conducted three focus groups each (six in total) between August to December 2023. Locations included Saint John, New Brunswick; Halifax, Dartmouth, and Sydney, Nova Scotia; Vancouver, British Columbia and Toronto, Ontario. Focus group size ranged from three to nine participants, with a total of 35 participants. Given the narrowness of the study aim, and relative specificity of the target participant group, this sample size was determined to provide adequate information power [25]. Focus groups were one to two hours long. To build trust with participants and ensure their anonymity within the study, demographic information was not collected. While we did not require participants to identify their gender, race or other factors, nor did we collect and tabulate this data, we did encourage sharing of pronouns during introductions, and we asked participants to reflect on and share what aspects of their identity might be particularly relevant to the issues. From what was shared, our research team determined deductively that participants had varying experiences in length of time in custody, time since release, as well as diversity in age, racial and cultural backgrounds as well as sexual orientation and gender identity.

Data analysis

We used reflexive thematic analysis to analyze the transcripts [26]. Reflexive thematic analysis is both methodologically and theoretically flexible, allowing for the use of different theoretical frameworks to guide the analytic process. We used reflexive thematic analysis informed by reproductive justice theory. Data analysis was conducted with the underlying theoretical assumption that the rights to bodily autonomy, to not have children, to choose to have children and to parent those children in safe and sustainable communities are essential human rights. Reflexive thematic analysis also "emphasises the importance of the researcher's subjectivity as analytic resources", allowing for the lived experience expertise of the team to inform the development of themes. The team included two lived experience experts, an early career health professional researcher with 10 years of experience in prisoner health and reproductive justice, a senior health professional in reproductive health, and two graduate students in health research. All team members identified as white and several as queer. Reflexivity on how team member identities may have influenced data analysis was practiced through regular check-ins among team members throughout the data analysis process. During team check-ins, team member decisions about coding were reviewed and discussed. Reflexivity practices ensured that team members personal experiences either providing or accessing abortion or contraception did not influence the interpretation of participant experiences. For example, team members without lived experience of

Table 1 Key themes

Theme	Subtheme
Competing health needs	
Institutional barriers to care	*Requesting care* *Online and brief appointments* *External care*
Mistreatment and unethical care	*Disrespect and neglect* *Mistreatment generates mistrust* *Contraceptive coercion*
Health knowledge gaps	*Abortion and stigma* *Misinformation*
Challenges to care-seeking in community	

incarceration may have misinterpreted institutional barrier related codes due to the lack of first-hand experience of the institutional processes to request care, and due to personal experiences providing or accessing care in non-correctional clinical settings. Check-ins with lived experience experts allowed for a more fulsome understanding of how the institutional request process can facilitate or impede access to care.

We used shared google sheets and google docs to manually code, allowing all team members access to transcripts and coding spreadsheets. First, research team members reviewed the raw data to gain familiarity with emerging themes. Two research team members double coded all focus group transcriptions and iteratively developed an initial coding scheme in consultation with the entire team, including lived experience experts. Then, the entire team reviewed initial codes to develop and synthesize shared themes and subthemes. Generated themes were then reviewed in comparison to the initial coding scheme and with lived experience experts. Following review, themes were re-named and collapsed as needed to develop final key themes. Lived experience experts participated in regular coding meetings, sharing their perceptions of meanings, and validated or disputed other team member's interpretations to come to consensus agreement on themes.

Ethical considerations

Participants reviewed a consent form and provided informed consent prior to participation. All participants received a gift card of $50 as an honorarium for their involvement. A professional transcriptionist de-identified and transcribed the audio-recordings. This study was approved by the University of New Brunswick Ethics Review Board on June 14, 2023 under the file number 2023-074, in accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2018).

Rigor and reflexivity

Expert advisor participation in data analysis ensures reliability of the community-based approach and credibility of findings.

Results

Five key themes emerged from our analysis (see Table 1: *Key themes*): (1) Competing health needs; (2) Institutional barriers to care; (3) Mistreatment and unethical care; (4) Health knowledge gaps; and (5) Challenges to care-seeking in community.

Theme 1: competing health needs

Most participants described how, with scarce access to health services in prison, they felt forced to prioritize their most emergent needs. As one participant described, it was difficult enough to access over-the-counter medications for a headache or menstrual cramps:

> *"Like you can barely get a Tylenol in there let alone birth control or abortion." -FG2.*

Participants concluded that given the difficulty they experienced accessing basic health care needs, they expected sexual and reproductive health needs would not be addressed.

> *"They don't care about anything, so even pregnancy is far off the radar there. Like you're lucky if you get just your basic care." -FG1.*

Sexual and reproductive health was perceived as less serious, given emergencies are commonplace in prison and must take priority.

> *"There was a bunch of emergency situations people have all the time, like crazy shit and nothing happens. -FG3.*

Rather than health-promoting care like family planning, participants felt care was focused on "sedation".

> *"[Birth control is] not something that's brought up, if anything they're coming in to do psych evaluations to see what medications they can put you on to slow you down, not to help your problems or whatever, they want you to, I don't know sedate you as much as possible." -FG6.*

Focus group conversations frequently turned to unmet mental health and substance use needs. Participants repeatedly expressed the importance of these concerns, stating that in prison, people have *"actual things"* (FG3)

and can't get care, therefore they believed nobody would get reproductive healthcare:

> *"Because the doctor is also the methadone doctor too so when she comes on Wednesdays, she also has to see the 25 people on methadone or suboxone." -FG4.*

Further, the urgency of mental health and substance use concerns were exacerbated by the prison environment:

> *"After a while the stress on you of just being there, being stuck in that room, imagine being in there day in and day out, […] You'd eventually fucking snap, we all would for sure, you would be losing it." -FG3.*

Just as sexual and reproductive care concerns were crowded out by mental health and substance use concerns in prison, sexual and reproductive care concerns in the community were crowded out by basic material needs. One participant explained:

> *"So if you're in active addiction or you're off doing whatever, […] all you're thinking every day is about how you're going to get your drugs and what you're going to do to get them, every day. They're not thinking about the doctor, they're not thinking about getting a prescription for birth control, they're not thinking about taking it, so unless they have something like the Mirena already or they've had their tubes tied, like that's the least of their worries." -FG1.*

Participants needed to secure housing, food, and income support before they started to seek healthcare:

> *"Once you have your basic needs met you can focus on other things." -FG2.*

Theme 2: institutional barriers to care

Requesting care

Like assumptions about the need for contraception in facilities designated for women, participants described how institutional norms and procedures presented barriers to family planning care, and care generally. For example, to request health services, they were first required to submit a written request to a correctional officer.

> *"So basically the guards are assessing our medical needs, which should not happen." -FG6.*

Participants explained their paper requests were frequently lost, ignored, or inappropriately triaged:

> *"Their [correctional officer] negligence becomes our problem 100% of the time." -FG5.*

Participants recounted prolonged delays between submission of a request and being seen by a health care professional:

> *"The doctor would come weekly, but then they have like 10-minute time slots to see you and they're like, 'No you're fine, you're fine.' Like it's like a running joke in that jail where they're, for stuff like that, cause you could literally be bleeding to death and they're like, 'Put in a request in and we'll see you in a seven days.'" -FG4.*

Participants described how elevated security classification further exacerbated delays.

> *"Yeah in max you put a request in, it can take like up to four or five days before they answer you back, if they answer you back." -FG4.*

Participants characterized the non-response as stressful:

> *"And it's stressful cause you have to write like a bunch of requests to get anything and a lot of them they don't answer." -FG3.*

Several participants recounted trying themselves to support peers while waiting extensively for staff to respond:

> *"Do you know how many times I've called the guards to say, 'She needs this, she needs that,' and they're like, 'Oh well.' She was having a seizure in the bathroom, it took them 10 minutes to get there, I'm sitting there trying to get her out of it" -FG6.*

One participant described the multi-step process for seeking emergent care:

> *"O.k. so if anything happens you pick up the house phone, the house phone calls main control, main control then sends the guards over, they assess the situation then go based off of there, so it's like 15–20 minutes after the fact of the situation before an ambulance actually gets called." -FG6.*

Expecting disbelief, delays, and non-response, participants described feeling they had to escalate or exaggerate their health complaints in order to be taken seriously. One participant advised:

> *"So always lie. Always lie and tell them it's an emergency." -FG4.*

Some participants feared that submitting multiple requests for health care may lead to being labeled as

"difficult", or punishment like segregation or solitary confinement. As one participant described:

"You're getting punished for trying to get help, trying to get your healthcare." -FG2.

Participants explained navigating the challenge of communicating a health need was serious and needed attention, without appearing frenetic or causing aggravation:

> *"I was pretty much saying I'm thinking about killing myself, I was pretty much saying that without saying it, […] Without pissing them off enough that they put you in seg with a fucking smock right. They will." -FG2.*

Online and brief health appointments

Participants felt prison health services were inappropriately organized to support patients with complex, competing needs. The transition to virtual care as a COVID-19 protection in prisons had, in many places, not shifted back, and all appointments were very short.

> *"Most times when you get in to see a doctor you've got like ten things you need to talk to her about, chances are you make it through three, if that." -FG4.*

When asked what would improve health care in prison, participants expressed the importance of time with providers:

> *"Schedule more time for each inmate, seriously you've got to have, because like if you're only seeing inmates once every three months, like I feel like there should be more cause ten minutes isn't enough." -FG4.*

External care

During external appointments or hospital stays, participants explained the impact of institutional procedures such as shackling (ankle restraints) and observation by correctional officers.

> *"I had to undress while they were standing outside watching me and stand there half naked getting these x-rays done while there's another officer just behind the partition, expecting me to run. Where am I going to go?" - FG5.*

One participant described giving birth while in restraints and under surveillance:

> *"But even then you get taken to hospital, you're shackled, you're cuffed, you're uncomfortable, you're irritated, you're going through labour pains and you have these two people that are like attached to you already while you're trying to push a watermelon out." -FG5.*

Theme 3: mistreatment and unethical care

Disrespect and neglect

Participants described experiencing mistreatment and unethical practices while seeking care in prison, such as routine breaches of confidentiality from health services to correctional officers. This felt especially uncomfortable in the context of family planning services:

> *"The guards just chit-chat among themselves, like the whole fucking place knows what your information. It's like a big gossip factory." -FG1.*

For participants, healthcare is the "*biggest thing going wron*g" (FG2) inside prisons, when it should be a site of respect.

> *"It's such a disrespectful and imbalanced power dynamic inside of prison anyway, that if there's one area where we should be treated with respect is indeed our healthcare, if they just chose one area." -FG5.*
>
> *For some, the disrespect amounted to a tool of punishment:*
>
> *"There's a lot of disrespect for inmates in the system anyways and so when you throw in healthcare it's just another way to disrespect you."-FG5.*

Participants recounted how stigma and stereotypes affected care.

> *"And it's [health services] already potential for violence, or violations, power dynamics, so it's already ripe for that even in the community. But when you're in prison they already just have this inherent stigma and disrespect for you, and they have this, 'Well it's your own fault you're here so you just put up with this.'" -FG5.*

One participant described how staff perceptions of STBBIs impacted the treatment of a peer, who was vomiting blood and denied care:

> *"They kept her like that for two weeks, they're just like, 'No, you're fine, you're fine.' Because she had AIDS they didn't want to touch her right" -FG2.*

Mistreatment generates mistrust

Bearing witness to peer mistreatment or neglect, including the death of a peer, generated severe mistrust of prison health services:

"There was a girl when I was in jail who died in there of pneumonia cause they wouldn't help her, it's all fucked up." -FG3.

Participants shared how the experience of mistreatment caused some to become reactive or even violent:

"But even in [X facility] that psychiatrist there has gotten popped so many times in the face he's just, even the staff are like, "I don't know why he hasn't learned". Like he doesn't know how to correspond with us, he just provokes." -FG4.

Participants felt health professionals in the institutions lacked experience in trauma and violence-informed care and failed to recognize how their actions while providing care could cause emotional anguish.

"None of the nurses there can do my bloodwork because from being human-trafficked, I have really bad veins. I've had, they can only try three times each. I've had four nurses go at me and be pricked fourteen times and if you don't think that that's not triggering…" -FG4.

Participants felt health care providers working in the prison context should have training to work with populations with unique and complex health needs.

"A lot of people who are coming into the system already have trauma, not saying all but a good number and the healthcare you get in there is the opposite of trauma-informed, they do not understand, like you know, so it makes it even harder, more of a barrier." -FG6.

Shaken by the extent of ethical violations, one participant shared her mistrust was so deep, she did not believe the prison nurses were actually licensed to practice:

"Prison nurses, I'm convinced they're not even real nurses." -FG1.

Contraceptive coercion [26]

Some participants believed health care providers in the institutions would be unwilling to provide family planning services (downward contraceptive coercion), because the context restricts and/or prohibits sexual activity:

"I don't think they would administer birth control to you while you were there, even if you asked, I don't think they would, cause you're not really sexually active while you're there and I don't think they really care if you're trying to do your own type of thing." -FG3.

Some participants reported experiences of upward contraception coercion, both inside the prison and in community healthcare settings, where they felt pressured or forced to use birth control. One participant recounted how even when she felt her contraception was making her unwell, her request for its removal was denied:

"I was in jail for a while, and I couldn't get it [IUD] taken out so it [messed] up my stomach and it really hurt so I had to go to the hospital when I was in jail so that kind of sucked. […] I kept telling them I was like, 'Hey, I need to get this out!' and they were basically like, 'Well, we're not going to do anything.'" -FG2.

Upward coercion contributed to participants feeling apprehensive and distrusting family planning care providers.

"They push it on you. […] In general birth control. […] The nurses bring it up." -FG4.

While some felt family planning to be an afterthought, others describe contraceptive coercion from prison health professionals:

"The healthcare is harder in jail than it is on the street. It can be hard, but they push birth control anyway, the doctors" -FG3.

Theme 4: health knowledge gaps

Abortion and stigma

People in prison described limitations to accessing health information due to restrictions against Internet use, expense of phone communications, and limited access to health professionals; this was particularly true for sexual and reproductive health (SRH) needs.

Person 1: "I kind of think it's a little funny that anywhere you go, in the houses, in the jail, healthcare, wherever, you can always find condoms and lube but don't know how to get a hold of any kind of contraception or to get an abortion, and there's no pamphlets on any of this stuff. There's nothing that we can educate ourselves with, except for the books in the library."
Person 2: "That are twenty years outdated.."
Person 1: "And there's nothing about abortion.."
Person 2: "Nothing about birth control, any contraception, nothing." -FG5.

Although abortion is completely decriminalized in Canada, participants felt uncertainty about access to it while

incarcerated. Describing a peer with an unintended pregnancy, several focus group participants shared their uncertainty about what was legally possible while incarcerated:

> *Person 1: "I didn't know when she got picked up that [abortion] was even an option to get one when she was in there…."*
> *Person 2: "I had no idea.."*
> *Person 3: "I didn't know that.."*
> *Person 4: "I didn't know that either." -FG1.*

Participants explained that although a common experience for most at some point in their lives, abortion was stigmatized among prisoners and not discussed openly.

> *"Pretty much everybody gets one, we just don't talk about it." -FG1.*

This elevated stigma was attributed to the grief and loss of women and gender diverse people separated (temporarily or permanently) from their existing children. One participant expressed:

> *"You bring up their child, they will melt. So, if you start talking about, 'Oh I'm pregnant but I want to have an abortion,' you're putting yourself in a bad position, really bad." -FG1.*

One participant feared disclosing abortion would result in mistreatment from peers. Offences against children were not tolerated.

> *"My fear, if I say I'm going to get an abortion, I'm killing a child in their eyes." -FG1.*

As a result of shame and fear, participants believed little information about abortion circulated in prisons:

> *"It's terrible and I think that's why maybe the access to the information is hard for women to get it, is because of the stigmatization." -FG1.*

Further, participants believed access to abortion depended on the beliefs of the correctional officers or health professionals who were gatekeepers to services:

> *"If they're pro-life, like guards and healthcare could withhold information to access. So, you could be a pregnant inmate just thinking well there's no recourse, there's no pills, or other inmates could tell you oh no you can't get those in prison and you would just stop looking for the truth. So, if you come across that misinformation that's deliberate, because they don't believe in abortion." -FG5.*

One participant considered how a prisoner may have wanted an abortion to avoid losing a future child to the child protection system, but did not have the information needed to get the care:

> *"I know of two girls where they came in pregnant, knew they were pregnant and didn't want the baby but ended up having the baby and then it was taken away, you know, and I think that's what they didn't want." -FG5.*

Participants who used substances said they were particularly afraid to seek help in pregnancy, because they were concerned about the consequences of their perinatal substance use:

> *"Well yeah, if someone gets pregnant, if they're using, they get scared and they don't know what to do and they don't know the resources out there that's provided." -FG6.*

Misinformation

In several of the focus groups, participants discussed how in the absence of information about family planning resources, misinformation circulated in its place. For example, several shared a belief that "a lot of people" get pregnant with an IUD:

> *"That's what stressed me out because I was like, how would I know if I got pregnant? I had a friend who got pregnant with an IUD, and she had a tubal pregnancy and she came real close to, you know, so I was always so scared of that." -FG2.*

Or, that the contraception "causes infertility":

> *"So, my first stint was in [X institution] there was a girl that got put on Depo-Provera so this is like thirteen years ago, the shot, and she was on it for like three years and she can't have any kids anymore because of it." -FG4.*

Available, or lack of available, information impacted participants' contraceptive decision making.

> *"I didn't know IUD was like contraception, I just think about like condoms. I'm like well I wasn't using any of those." -FG2.*

Many expressed a desire to know more about their family planning and reproductive options both while in prison and in transitional housing in community.

Theme 5: challenges to care-seeking in community

A final theme emerged that we determined was outside of the scope of this paper, as it pertained to the complex logistics and stigma experienced when accessing health care, period, once released. These barriers include lack of discharge planning, feeling punished by health professionals for not having appropriate paperwork, being stereotyped or stigmatized for a history of criminalization, and the impact of bail or parole conditions that restrict where a person can live, with whom they can have sexual or personal relationships, and what medications they can take or substances they use. Despite the difficulty of accessing healthcare in community, participants consistently reported that accessing care in community was much easier than accessing care in prison:

> *"It's definitely a lot easier to access stuff now that we're out [...] It's not like begging a corrections officer." -FG2.*

Discussion

The intention of this qualitative study was to explore family planning care experiences among women and gender diverse people who have experienced incarceration. To our knowledge, this is the first study among formerly incarcerated women in community to focus on abortion and contraception experiences and needs. We found barriers to care-seeking included competing health needs, institutional procedures, mistreatment by health professionals, health knowledge gaps, and persistent challenges on release.

Women and gender diverse people who have experienced incarceration have complex health histories, and describe prioritizing mental health and substance use treatment over family planning. Yet mental illness and substance use have significant physiological and social impacts on pregnancy and parenting [27–30]. Further, despite high lifetime rates of pregnancy, unintended pregnancy, unmet contraceptive need and abortion among incarcerated women and gender diverse people [6], family planning may not be prioritized by staff in prisons designated for women because of the domination of other health needs and institutional restrictions on sexual activity. We were surprised that the subordination of family planning care continued upon release, associated with protracted disruptions to income, housing, and health services.

We expected institutional procedures to present barriers, as has been described in earlier studies and internationally [7, 31]. While some participants brought up the violations they felt in restraints and under observation by correctional officers in the context of reproductive services, they placed greater emphasis on the harm presented by ineffective systems to request care. Submitting requests on paper through correctional officers resulted in lost requests, lack of or delayed response, violations of confidentiality, and a described need to exaggerate symptoms to prompt action. Perceiving emergent needs would go unmet, and having experienced deaths of peers in custody, participants were unconvinced any appeals for family planning would be heard.

Further, and most disturbingly, mistreatment when seeking other services caused participants to fear health professionals in the institutions. While dual loyalty and institutionalization of prison-based health professionals are described extensively in the literature [32], these participants also experienced discrimination and stigma from health professionals in community settings after release. Stereotypes about criminalization, substance use, and drug-seeking persist among health professionals [33–36]. Research has found even health professionals working in prisons lack preparatory education about circumstances and needs prisoners experience [37], suggesting a deep need to augment the inclusion of prison health in health training programs. Women and gender diverse people in prison lack confidential and trusted sources of information about their rights to care and pathways to service both inside the institutions and on release.

Despite decriminalization, abortion remains stigmatized and mythologized in the broader Canadian society, allowing for information gaps and for misinformation to circulate [38]. Our research suggests the restrictive environment of the prison not only further bars factual dialogue and information sharing, but grief and loss from separation from existing children, and intolerance of violent offences against children, may deepen the silence about abortion. In a routinely restrictive and punitive environment, prisoners may expect restrictions and/or punishment for seeking abortion services, even if access to such services is not specifically restricted and is actually affirmed by provincial, federal and international law. Finally, the impact of bail and parole conditions [39, 40] on seeking family planning care are underappreciated. Relationships, housing, work activities and even medication use may all be restricted, and thus monitored by transitional housing staff and/or parole officers and police. Family planning professionals may not be aware of how these restrictions mediate reproductive decision-making.

Strengths and limitations of the work

The strengths of this study include the contributions of lived experience experts to the research process, the

partnerships with frontline organizations for recruitment, the national scope of inclusion, and participant ability to freely express themselves in a post-incarceration context. Conducted with formerly incarcerated women and gender diverse people, our focus groups were able to not only shed light on experiences while in prison, but those afterwards.

This study had several limitations. This study collected data from people with recent histories of incarceration now living in community. People who are currently incarcerated may have varying experiences. We did not formally collect participants' information about their gender identity, age, race, or other factors, although many did volunteer this information. People who volunteered and were willing to participate in focus groups may not be representative of all people with recent histories of incarceration who are now living in the community, and the experiences they chose to relate may not be representative of all relevant experiences. Some participants may have felt uncomfortable sharing their experiences of abortion in the company of peers in the focus group context. All focus groups were conducted in English, limiting the participation of people for whom English is not their first language.

Recommendations for future research

The family planning care experienced while incarcerated is a highly under researched area. Future studies should examine health professionals' knowledge and understanding of the needs of people who have experienced criminalization and examine clinician biases and behaviours towards incarcerated and formerly incarcerated people.

Implications for policy and practice

Family planning professionals may support improvements to sexual and reproductive health experiences and outcomes among people who have or are experiencing incarceration by recognizing the disproportionate burdens of mental illness and substance use; anticipating the impact of prior negative experiences of care on care-seeking; accepting the limitations to health education and information in the prison context; and appreciating post-release challenges such as displacement and housing precarity. By routinely including care for people in prison in health professional curricula, future care providers may better address these needs as well as challenges to care provision, such as institutional policies and procedures like restraint use and presence of officers. Health facilities and professional organizations should develop policies and position statements to support ethical and comprehensive service delivery for people experiencing incarceration. Family planning is foundational to health and social equity, and service provision should affirm humanity and dignity, including for people in prisons. Future research should address health care provider attitudes and practices and health institutional policies with respect to patients who are or have been incarcerated.

Conclusions

Women and gender diverse people who have experienced incarceration in Canada described multiple barriers to accessing family planning services. Health needs considered more urgent, such as mental health and substance use, may crowd out care-seeking for sexual and reproductive health care. Institutional policies and procedures impinge care-seeking, such as the requirement to request care via correctional officers, and the use of restraints and surveillance while receiving reproductive care. Mistreatment by health professionals, such as violations of privacy and confidentiality, denial of service and coercion, stimulates mistrust and avoidance of care. Although a common experience among incarcerated women and gender diverse people, abortion is stigmatized and information about abortion and contraception is not readily available in Canadian prison contexts.

Supplementary Information

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Supplementary Material 1

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Author contributions

MP conceptualized the analysis. MP and CH conducted focus groups and analyzed data. MP, CH and AM organized the data. MP, CH, AM and WVN and contributed to writing the manuscript. All authors read and approved the final manuscript.

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Data availability

The data generated and analysed during the current study are not publicly available due to privacy/ethical restrictions but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Approved by the University of New Brunswick Research Ethics Board, file number 2023-074. Informed consent to participate in the study was obtained from participants.

Consent for publication

Written informed consent for publication was obtained from all participants (de-identified for privacy).

Competing interests

The authors declare no competing interests.

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