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The experiences of family planning health professionals providing care to incarcerated patients: a qualitative study

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Abstract

Background Although Canada completely decriminalized abortion in 1988, barriers persist, and people experiencing incarceration may face additional challenges. Family planning health professionals (FPHP) in the community may provide care to incarcerated people. This study is the first to examine their experiences and needs.

Methods We used a community-based approach to this qualitative study and conducted interviews and focus groups with FPHP across Canada from multiple disciplines. Experts on the research team with lived experience of incarceration enhanced relevance of research questions and approaches.

Results We spoke with thirty participants from eight provinces, including nurses, nurse practitioners, family medicine and obstetrics-gynecology physicians, and social workers. Analysis generated three themes: *Managing Multiple Systems; The Prison in the Clinic;* and *Future Recommendations*, and six subthemes, *A Firewall of Secrecy*, *Logistical Hoop-Jumping*, *Surveillance by Correctional Officers*, *Health Professional Strategies*, *A Policy for Legitimacy* and *We Need This in Our Training.* FPHP described commitment to providing incarcerated patients equivalent care to that provided to people in community, but faced challenges with communication, preserving patient dignity, privacy, confidentiality, and safety.

Conclusion Findings indicate FPHP feel ethics and safety in jeopardy when caring for incarcerated patients. FPHP express needs for improved education about roles, and for supportive professional position statements or clinical workplace policies to buttress efforts at patient advocacy. No FPHP organization in Canada has a position on care of incarcerated pregnant people. Professional position statements and workplace policies could support confident care. FPHP training should include information about incarcerated peoples' needs.

Keywords Family planning, Incarceration, Prison health, Reproductive health

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Introduction

People experiencing incarceration may face threats to reproductive autonomy and barriers to health care, including lack of access to reproductive and sexual health services and health information, separation from children and partners, isolation from support people, and physical harms such as restraints, strip searches, and use of force [1–4]. In Canada, most people incarcerated in prisons for women are of 'reproductive age' [5]. Yet, there is a lack of both Canadian and international data on the rate of abortion or contraception use among incarcerated people. Our recent cross-sectional survey of 90 people in all four provincial prisons for women in Atlantic Canada identified that 81% of participants had a lifetime prevalence of at least one unplanned pregnancy [6], which compares to estimates that among the entire Canadian population, 40% of pregnancies are unintended [7]. Fifty percent of participants who had ever been pregnant had had an abortion, which compares to national estimate that one in three women will have an abortion in her lifetime [8]. The most used forms of contraception were the least effective, consistent with contraception use among the general population in Canada [9]. A survey of 85 people in one provincial prison for women in Ontario identified that among participants who had ever been pregnant, 57% had had an abortion, 77% reported having experienced at least one unintended pregnancy, and that among participants who were at risk of an unintended pregnancy, 80% had an unmet need for contraception [10].

Although abortion was completely decriminalized in Canada in 1988, barriers to access persist, including travel requirements for people in rural or remote areas, limited availability of second and third trimester abortion, and private costs for migrants and newcomers without documented public insurance [11–15]. International research has identified specific barriers to abortion access for incarcerated people include private costs, staff shortages, confidentiality and privacy violations, contraceptive coercion, restrictive security practices, and institutional policies and procedures [3, 16]. Our 2023 review of policies governing access to abortion and contraception in prisons in Canada identified only one outdated policy pertaining to abortion access, and no policies governing hormonal contraception [17]. Only two provinces among Canada's 13 provinces and territories universally cover contraception within publicly funded health insurance.

Geospatial research conducted in Canada, Australia and the United States has identified the potentially insurmountably large distances incarcerated people would need to travel to access procedural abortion, with travel reliant on prison institutional capacity for medical transport [18–20]. While medication abortion could be administered on-site, it may not be an ideal option for incarcerated people due to a lack of privacy, lack of access to menstrual hygiene products, and limited emergency health services [21].

Qualitative research with formerly incarcerated and incarcerated women and gender diverse people in Canada identified they experience discrimination and stigma when seeking reproductive health care in prison, describe reproductive health as crowded out by urgent mental health and substance use concerns, and face significant gaps in access to health information and institutional barriers to care [22–24]. Barriers to care persist on release, when seeking care in community with study participants describing experiences of stigma and coercion from community-based health professionals in clinics and hospitals [24]. The responsibility for in-prison health services depends on the jurisdiction and in many places it has changed in recent years, for example, responsibility for health services shifting from the Department of Justice to the Ministry of Health [25]. Likewise, the types of health care providers working in or for prisons depends on the institution, some small institutions might have very limited access to a prescriber or someone able to for example, insert a long-acting reversible contraceptive (LARC). In some prison settings it would be very uncomfortable and potentially dangerous for a patient to experience medication abortion. So, the extent to which people in prison may leave prison for family planning services varies greatly across jurisdictions. FPHP in community are independent from the prison system and professional responsibility to provide equitable treatment to all patients including privacy and confidentiality.

With appropriate training and resources, family planning health professionals (FPHP) working outside of prison settings (e.g. family doctors, OBGYNs, nurses, social workers, working in clinics or hospitals that provide family planning care) could mitigate some of the identified systemic barriers to accessing abortion and contraception among incarcerated populations, however there is a lack of research examining the experiences of FPHP caring for this population. Our 2023 international scoping review of studies on abortion and contraception for people experiencing incarceration identified one study where the population of focus was health professionals [3]. Sufrin, Creinen and Chang [26] conducted a cross-sectional survey of 286 correctional health professionals about the availability of contraception services and found that 70% reported providing some form of contraception counselling for women at their facilities, and 38% prescribed some contraceptive method at their facilities. Cheedalla and Sufrin [27] surveyed prison or jail administrators at 31 US facilities and found 65% had policies regarding contraception; their details varied significantly with respect to the types of contraception patients could continue or initiate while incarcerated. No

studies, to our knowledge, have focused on community-based FPHP caring for this population. Further, FPHP may be unfamiliar with the needs and rights of incarcerated people, as these may not be routinely taught in health professional curricula [28, 29].

Our prior research has found there are no up-to-date policies on abortion or contraception among prisons in Canada [17] and to date, there have been no position statements about care for incarcerated pregnant patients from Canadian organizations representing reproductive health professionals [30–33]. No studies exist measuring the extent of the use of restraints with this population in Canada [2]. The US Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) [34] and the American College of Obstetricians and Gynecologists [35] both have position statements with respect to care of pregnant people in prison. The AWHONN statement allows restraints only in exceptional circumstances. US-based health and legal professionals and organizations have spoken out against the practice of shackling hospitalized patients in pregnancy [36–39]. Although most states have bans in place against shackling in pregnancy [40], compliance is patchy. A 2017 survey of thirty state prisons and county jails designated to detain women in the US found that only 43% of surveyed facilities prohibited the use of shackling during pregnancy, although all facilities prohibited the use of shackling during labour [41]. A 2017 survey of 932 perinatal nurses in the US found that 83% reported the use of shackling of their incarcerated patients and only 17% reported awareness of the AWHONN position statement [42].

The aim of this study was to identify the experiences and needs of community-based FPHP working in hospitals, family practice, and reproductive health clinics in Canada, to improve care for people experiencing incarceration when seeking sexual and reproductive health care.

To ensure rigor in the project, we followed Tracy's [43] recommendations to aim for richness with respect to theoretical constructs, data and time in the field, the sample and context. As described below, reproductive justice formed a theoretical foundation for our approach, which recognizes intersecting oppression and infringement upon reproductive freedom in the context of incarceration. We conducted the data collection over the course of four months, however, this study fits within a longstanding larger research program in the area of family planning for people in prison. Our sample size of 30 people is ample for a qualitative study, particularly in a small sphere of clinical practice such as abortion, and includes the diverse contexts of primary care, community and hospital clinics. We approached the study with sincerity and reflexivity about our positions, which are critical of prison systems. The contributions of lived experience experts enhanced the credibility of the findings. Finally, the study makes a meaningful contribution by identifying concrete gaps in knowledge and policy infrastructure to support practice that upholds human dignity and professional ethics.

Methods

Theoretical framework

This study is informed by reproductive justice theory, which recognizes that reproductive autonomy and freedom to plan families is dependent not only on legal access to abortion and contraception, but conditions of social, economic, and political justice that allow for genuine choices [1]. The theory, developed by Black feminists in the United States, calls for attention to the threats to reproductive freedom resulting from systemic racism and intersecting sources of oppression including sexism, ableism, and homo/transphobia. Reproductive justice is an appropriate theoretical framework for this study as it emphasizes the connection between reproductive oppression and imprisonment [1]. Isolation from family, service gaps during pregnancy, interference in parenting, and various trauma are all products of incarceration [44]. Further, reproductive justice theory recognizes that these injustices disproportionately impact Black, Indigenous, people of colour as well as members of lesbian, gay, bisexual, trans, queer, and Two-Spirit communities (LGBTQ2S+) [45, 46].

Study design

We used a community-based approach to this qualitative study which engages community members at each step of the research process to validate and to provide additional insight into the interpretation of emergent themes [47]. The research team collaborates closely with community organizations including Wellness Within: An Organization for Health and Justice and Elizabeth Fry Societies. The research team members identified as white, LGBTQ+, academic researchers, FPHPs, and experts with lived experience of incarceration in prisons for women in Canada and lived experience of abortion. Experts with lived experience provided consultation on the interview/focus group guide and made suggestions to the coding scheme.

Sample/participants

Health professionals based in community and providing family planning care in non-carceral settings were eligible to participate. We did not require participants to have experience providing care to incarcerated patients. We used purposive sampling to gather participants with expertise in family planning care, with diversity in their roles (i.e. family doctors, OBGYN, nurse practitioner, RN, social worker) and to obtain a sample with representation

from across Canada. We did not collect demographic identity information due to the small size of this community and potential identifiability. The Research Coordinator or Research Assistant sent a recruitment email to relevant professional organizations (e.g., regional networks of abortion care providers), reproductive healthcare clinics, and to specific contacts identified through our networks who were eligible to participate. If interested, potential participants could respond by scheduling a virtual interview conducted via Zoom. We offered the option of a focus group (virtual or in-person) if multiple staff members at the same hospital or clinic were interested in participating. Multiple data collection methods (interviews and focus groups) were used for the purpose of ease of participants; given the demand placed on frontline healthcare providers it was important that participation was flexible. All participants could participate in either English or French. We used snowball sampling by encouraging participants to share study information with peers. Participants received a $25 electronic gift card as a thank you.

Data collection

From June to September 2024, two team members (MP and CH) conducted interviews and focus groups using a semi-structured interview/focus group guide (Table 1). Interviews and focus groups occurred both in-person and online, depending on the preference of the participant and geographic proximity to the research team. We audio-recorded all interviews and focus groups. Audio-recordings were transcribed by a professional transcriptionist. We collected information about participants' clinical setting and professional designation. We asked questions about the participant's work, prior learning about care for prisoners, the correctional facilities in their jurisdictions, their experiences caring for an incarcerated patient (if any), workplace policies regarding care for incarcerated people, charting practices with regards to currently or formerly incarcerated patients, and participant perceptions of information needs.

Table 1 Interview and focus group guide

Interview and focus group guide
Please describe the focus of your work as a reproductive health care provider (i.e. your role), and the environment you work in (i.e. your place of work)
Did you learn about care for prisoners in your training? Please tell me about that.
Are you aware of any correctional facilities in your jurisdiction?
Please describe your experience, if any, caring for incarcerated patients. (Prompts: when was this, how did you feel about the experience, did you have any support to navigate the experience, etc.)
If you have never cared for an incarcerated patient, what questions would you have about how the care experience might be different for the patient and for you?
Are you aware of any policies or procedures at your workplace regarding care for incarcerated people?
If you had an incarcerated or formerly incarcerated patient, how would you chart that information?
What would you like to know more about, with respect to incarcerated patients?
Is there anything we did not ask you about that you would like to share?

Data analysis

We analyzed de-identified transcripts using a collaborative process of thematic analysis [48, 49]. First, three research team members reviewed all transcripts to gain familiarity with emergent themes. Two team members then conducted an initial double coding of transcripts and developed a coding scheme based on initial codes through a lens of reproductive justice, considering prison as a form of reproductive oppression insofar as it exerts control over bodies, limits reproductive decision-making, and separates parents from their children [1, 44, 45]. The scheme was adapted through discussion with the full research team. Data was then re-coded by one team member against the refined coding scheme. At this stage, context experts with lived experience of incarceration reviewed and revised theme organization both individually and through collaborative team meetings. Following this review, we finalized themes and sub-themes and synthesized the data.

Ethical considerations

This study was approved by the University of New Brunswick Research Ethics Board in accordance with the Declaration of Helsinki, (file number 2024-080). All participants received an informed consent form in advance of agreeing to participate.

Results

Overview of findings

We conducted 12 individual interviews and 3 focus groups both online and in-person and spoke with a total of 30 participants between July and September 2024. The participants lived in eight provinces: Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Ontario, Quebec, and Prince Edward Island. Participants included 17 registered nurses, three family physicians, two obstetrician-gynecologists, three registered social workers, two nurse practitioners, one licensed practical nurse, and two medical secretaries. Participants worked in a range of clinical settings, including hospital-based clinics, community-based sexual health centres, and primary care practices (Table 2). The composition of the sample is reflective of the dominance of nurses in the health care workforce generally, and in family planning clinics.

Table 2 Participant table

Participant ID/ Focus Group ID	Role	Clinical Setting
1	RN	Hospital-based abortion clinic
2	RN	Hospital-based abortion clinic
3	Forensic RN	Hospital
4	Forensic RN	Hospital
5	NP	Women's health clinic
6	OBGYN	Hospital
7	OB	Hospital
8	RN	Hospital
9	RSW & Executive Director	Sexual Health Centre
10	Family MD	Community family practice; Hospital-based abortion clinic
11	Family MD	Community family practice; Reproductive clinic
12	Family MD	Hospital-based abortion clinic
FG1 (4 participants)	RN	Centre for sexual and reproductive health (hospital-based)
FG2 (2 participants)	RSW & RN	Abortion clinic
FG3 (12 participants)	RSW (1), RN (7), NP (1), LPN (1), medical secretary (2)	Hospital-based sexual and reproductive health clinic

Table 3 Themes

Theme	Subtheme
Managing Multiple Systems	Firewall of Secrecy
	Logistical Hoop-Jumping
The Prison in The Clinic	Surveillance by Correctional Officers
	Strategic Communication
Recommendations for the Future	A Policy for Legitimacy
	We Need This in Our Training

Participants were not required to have experience providing care to incarcerated patients, however only two of the 12 interview participants did not have experience providing care to incarcerated patients, and all three of the focus groups had participants with experience providing care to incarcerated patients.

We identified three key themes and six sub-themes (Table 3).

Theme 1: managing multiple systems

While there is wide recognition silos cause communication and practical challenges in health services, participants found these to be amplified and unsurmountable with respect to divisions between corrections and health services.

Firewall of secrecy

Participants described not knowing about the type and amounts of health care available to patients while incarcerated, including contraceptive counselling, what medications prison pharmacies stocked, and how often patients could see health professionals. One participant perceived an intentional "firewall" between the clinical setting and the facility:

> *It's not like we don't interact with these places on a regular basis, so it just seems like there's a firewall or like you know, it's like what happens in the institution stays in the institution. It feels very paternalistic in that sense. (P3)*

Lack of information left participants worried about their patients' autonomy seeking family planning care. They perceived the information vacuum as part of the punitive, coercive context of the prison setting.

> *I would wonder about their access to informal support. Some of our other patients access informal support before and after their abortion. So, I would wonder what they would have access to. Like peer support, online support? (FG3)*

Participants worried pregnancy termination may be driven by gaps in support for pregnant incarcerated people and ineligibility for, or absence of, prison nursery programs, which did not seem like a "choice" at all.

> *…what is the typical timeframe that people are discovering that they are pregnant while in care? And how much is an option, like really an option? Because we know how few facilities support people birthing and staying with baby in care. Are people making a decision to have an abortion because the decision to continue a pregnancy means being separated from their child? (P9)*

Others worried about outright pressure from correctional staff to terminate:

> *What are their options, if they are pregnant and they're incarcerated do they have the option of continuing the pregnancy, what does that look like for them, like what choices are they given? What is their support option being within that facility? Is each facility different or have they just been told you're pregnant, you need to have an abortion because you are incarcerated? We don't know how any of that goes. (FG2)*

Participants expressed concern about follow-up care, and frustration they were prohibited from providing patients with details like future appointment dates. One participant gave an example of a IUD "string check", typically booked 6 weeks after insertion:

They were like, "You can book her for it but we don't know, we can't tell you that we're going to bring her, because if we tell her that she has an appointment in six weeks, that's a safety issue, right?" It's like okay but are you guys going to do it then when she needs it? Well, we don't know. So, then she's just getting an IUD and walking away and hope that it's in the right place, which it probably is but we would routinely provide community members with the option to check it in six to eight weeks. (P1)

A participant worried about how medication abortion would be experienced:

That person who is having their medication abortion is going to have their medication abortion while incarcerated and whether they have the products that they need for the bleeding that they're going to experience, the discomfort that they're going to experience, a private place to be able to use the medication, whether or not they're going to be granted the time to be able to take that medication and comfortably use it also all depends on the systems in place in the facility where they are and unfortunately we often aren't privy to feedback after people use the medication. (P9)

One participant remembered an incarcerated patient who was terminating a pregnancy resulting from sexual assault by a correctional officer. They did not even know if emergency contraception would have been available for the patient:

I had somebody when I was working at the outpatient abortion clinic who was incarcerated and had become pregnant by, after an assault from a male guard, and was able to actually come to our clinic and receive an abortion. And I just remember having a lot of questions from that. Like you know, she had reported it to at least to the institution, and I just remember wondering if you reported it to your institution and they knew about this, it sounds like maybe they didn't believe you because if they had believed you they probably, maybe would have gotten you medical care to prevent that pregnancy from happening. I just had a lot of questions and of course when you're in that situation with somebody, I'm not going to start peppering that individual with questions like, "How did we end up here?", because I'm sure she's thinking along those lines as well, like, how did we get here? (P3)

Logistical hoop-jumping

Participants described navigating complex coordination across multiple systems as "hoop-jumping". For example, as incarcerated patients do not have independent access to phone or any access to Internet, simply booking the initial and/or subsequent appointments often proved difficult. The time-limited nature of pregnancy and the severe implications of services delayed or denied made this particularly frustrating:

While the patient is accessing urgent, time-sensitive medical care it's at the whim of the carceral facility and their schedule and when they can get them to appointments, so the coordination piece is a bit challenging there and obviously we can have no direct communication with the patients themselves. (P2)

Participants expressed how logistical organization and prison personnel availability impeded follow up services:

In terms of like any sort of follow-up care that we can offer, that feels very disjointed because typically they don't want to bring them back here because it's an extra trip to [city], it's two guards off-site, it's you know all of the things that they organize, and again that's not necessarily fair to this person. (FG1)

Participants also encountered barriers to communicating confidential test results:

We'll do extra testing while they're here like syphilis, HIV, that kind of stuff and it's really hard getting it to them, we can't even talk to them in regards to their Pap results or STI testing…so the patient never gets her information, it all goes back through the guards. (FG2)

One participant explained how their clinic's use of telemedicine, intended to reduce barriers for patients, actually created more delays for incarcerated patients:

The inmate would need access to a telecommunication device like a laptop or a telephone as well as a private space in order for them to be able to have their appointment. What we often find gets in the way is needing to go through several hurdles of coordinating…(P8).

Participants recounted how patients may be released before an appointment, and the prison does not inform them or provide a way to reach the patient.

There are very high no-show rates for those patients and again you're not allowed to give the patient the appointment, so how do I know that they gave the patient the appointment when that person left? Or if the person said, "Hey I don't really want this appointment, you were forcing me into it, I don't want it", and they could maybe contact us and let us know. I'd like a little bit more kind of communication. (P6)

Participants felt not interacting directly with the patient was ethically problematic.

I had an interaction with the police last week just about a patient who was assaulted and essentially they were like, "Can you take a verbal directive from us to do x, y,z,?" and I'm like, "No, that needs to come from the person who we're providing care to and I can't and I won't." And so I would have questions in terms of people's access to being able to book their own procedures and appointments. (P11)

Theme 3: the prison in the clinic

Participants described how they felt the prison culture and norms took hold in their clinical spaces when patients arrived with correctional officers and in restraints. The uniforms, shackles and handcuffs were overt instruments of the prison, and the tone, language and power struggles of correctional contexts infiltrated the health care space and impacted everyone. Participants sought to provide what they characterized as "equivalent care" to incarcerated patients and were prevented from doing so by these carceral norms.

Surveillance by correctional officers

Participants characterized the presence of correctional officers (CO) as threatening patient dignity.

I find it really uncomfortable because they're a looming presence throughout the entire procedure, after the procedure the patient has been sedated, they're in recovery resting, like the COs last time didn't want to let her check her pad with the door closed, like the door had to be ajar or at least open and they stand right outside the door. I said, "There's no windows, the door can't lock, there's nothing she could do in there, like could we just give her some privacy?" And then they kind of made a joke about it like, "Yeah she can't run anywhere," and it's like, "Yeah, actually, you can stand outside of the recovery room, thanks." (P2).

Many participants discussed how surveillance abutted with their professional duties to provide confidential care:

In a typical scenario if there was somebody else in the room we would ask them to leave. In this scenario if the guard is in the room, is that appropriate, is it not appropriate, are they there for a reason, are they there because they feel they need to be there? (P7)

Participants felt it was difficult to develop a trusting therapeutic relationship with the patient:

…doing a session like that where you have to have guards present because that's the rule, it doesn't lend itself to being able to develop a great relationship with your patient. And it's hard to build trust with someone who likely is in an environment where there's not a lot of trust and that's already been broken and maybe the whole reason that they're incarcerated is because someone broke trust at some point. (FG1)

Another participant questioned whether their incarcerated patients would be able to talk freely, and felt this had implications for patient safety:

I do find and feel there's a lack of confidentiality with the patients because you are asking them personal questions and then there are these two guards there listening to everything. So like I don't know if sometimes they're always telling the truth or really saying what they want to say because there's someone there listening right? It complicates things because you're also wanting to provide safe care and the reality is that we don't know that we're getting a clear history from someone because it's possible that they're not going to disclose everything. (P13)

The presence of correctional officers in the clinic impacted the entire atmosphere:

It throws off the vibe completely. It impacts the energy in that space so dramatically, for anyone walking into the unit. A housekeeping person, a physician who's just checking in about something, you see officers in their bullet-proof vests and their chests puffed out because they're uncomfortable probably standing in a birthing unit, they kind of don't want to see anything, but of course insecurity can never be portrayed, so if they're feeling uncomfortable at all, I think the automatic reaction is to puff out their chest more and stand taller and become more gruff. (P8)

Participants described how correctional officers made other patients feel afraid:

> *The last time I was brought a patient that was incarcerated she arrived with two escorts, a man and a woman, in full uniform and shebang and guns and you know this is [city], this is not Texas, we're not used to that kind of apparatus. Obviously terrifying everybody in the place, most of my other patients are migrant women who have walked across three fucking countries avoiding the military guard so I'm like wow that's fantastic for my other patients that have to be subjected to this. (P13)*

In one example, a correctional officer was vocally anti-choice, creating an unsafe situation for the patient, staff, and other patients seeking care:

> *We've had guards that are not pro-choice that have to accompany the patient which makes it a very awkward situation throughout the clinic because they are not supportive of what type of work is actually happening here. Yes everyone has their individual rights and thoughts but I think that they should be selecting someone to accompany the patient that believes in the choice. (FG2)*

Participants explained they felt that an incarcerated patient posed no greater risk than a non-incarcerated patient, because abortion is a field in which providers are acquainted with a long history of violence and threats. Another expressed that while there were legitimate risks to providing reproductive care to any patient, correctional officers did not increase safety:

> *I don't want to sound naïve, there are absolutely times when we do need security back-up, like I've been struck, I've been hit by patients. Violence against nurses is a real thing, I don't mean to suggest that it's this utopian place where security is never needed, but like armed, bullet-proof vests, police officers? I haven't seen good come from the presence of police officers. (P8)*

Strategic communication

Participants described strategies to negotiate with correctional officers for privacy with the patient or to have restraints removed, recognizing the need to strike a balance between advocating for the patient and providing patient-centred care. Some found correctional officers more apt to respect requests if their clinic had an established relationship and good rapport with their nearby prison. Others found it depended on the individual:

> *I've had experiences where the guard that would come in with them was very respectful and quiet, and then other ones that have interjected and started trying to talk to them about what I'm here to do, like contraception and things, and I'm like, "Yeah, no, you need to be quiet. This is about the patient, the person accessing care, not you and you're not the professional in this. I don't tell you how to do your job so please don't tell me how to do mine." It's quite an extreme, it's either they're quite lovely or they're not, I've found. (FG2)*

To participants, the use of restraints in gynecological care was not only a violation of dignity and consent, but impractical. Some felt correctional officers recognized these conflicts:

> *I personally haven't had any problem because it's obvious to do the gynecology procedure they can't be in shackles right, so it's just a no-brainer. (P10)*

Several participants decided against asking correctional officers to leave or for shackles to be removed, mindful of how advocacy efforts may have harmful repercussions for the patient:

> *Another reason why we don't want to be in conflict with the guards around shackles and location of the guards and all that stuff, because if we make problems maybe that patient will pay the price later that day when they're in the facility and away from our eyes. So again being very mindful of that too, like making the experience smooth will be of benefit to the patient. (P10)*

Another recounted a harrowing experience where a correctional officer threatened the patient would be forced to remain pregnant if there was an expectation from clinic staff that restraints be removed:

> *For safety purposes we do often ask that they be, like if their hands are cuffed we ask that their hands be un-cuffed and they will un-cuff their hands from being together but then they hook them to the bed so in the event of an emergency you're still tied up, which we've asked many times, "That it's not safe, we don't feel comfortable doing this," and then it's, "O.k. well we have to follow our rules so if you can't then she's going to remain pregnant." (FG2).*

Given the stakes, the participants felt they had to subsume their ethical and professional standards to ensure the patient received the service.

Theme 4: future recommendations

Participants' recommendations for how to improve care in the future centred the creation of policies or positions statements and for more education.

A policy for legitimacy

While many participants were aware of their role to advocate for the rights of incarcerated patients, they expressed that a policy could facilitate legitimacy and increase their confidence in doing so. They suggested creating a workplace policy or a professional position statement as a lever to improve services.

> *Statements by the colleges themselves would be great if the hospital doesn't enact a policy. If the College of Nursing for example said, "under your license"…I know it's harder to move those big organizations but a statement by the college would be helpful to know where we kind of stand or where they stand and what they'll back us up on and what they won't. (P2)*

In one case, a participant and their colleagues had, in fact, developed such policy after caring for an incarcerated patient:

> *We just made up a policy based on what we thought was, what things that didn't go wrong and we can improve on. It was just based on our debrief of how things went and how things could be improved with the group of nurses and the physician that was there and then our manager and we like collectively came up with the policy. (P5)*

The policy included procedures like having the patient enter through a back entrance to not be on display and securing a private room to wait in and for recovery. One participant explained that while their hospital had a general policy for care for incarcerated people under review, they doubted it would be for their specific area of practice.

> *I'm sure that they have them on the newborn, labour and delivery side, I've never looked because they have a lot of policies that just aren't applicable. They haven't thought of us so then we're often not included in these policies. (P12)*

Most participants stated their clinical setting had no policy, but they felt one would be helpful for guidance, to have something official they could present to COs, to support the training of new hires, and to promote the institutional memory, reducing confusion when people who had strong relationships with the correctional facility changed positions.

> *It might be helpful to codify the relationship between [clinic] and [prison]. Wondering if all the knowledge is held with [individual staff member], what happens if she changes jobs? (FG3)*

A few participants worried a hospital policy would be focused on risk and liability, and centre the provider or the health institution, rather than promote the dignity and safety of the patient.

We need this in our training

All participants stated that they received little to no education on care for incarcerated people in their training:

> *I can't recall anyone ever checking in to be 'oh you're taking care of a patient who is incarcerated, how is that, do you need anything, here are some resources,' […] it was just kind of like 'this is who you're assigned today.' (P12).*

Participants felt that it was important to understand their rights to best advocate for patients:

> *We just want to know the really basic stuff, like do they remain shackled, is that necessary, can we ask them to remove the shackles, just those sort of things, does the patient want them off, of course they want them off, are they allowed? I don't know those sort of nuances. (P5)*

Lacking instructions caused participants to feel uncertain:

> *It's a little unnerving because you're not really sure what you can do and what you can't do. So like normally, if I'm going in to see a patient I want to provide privacy and dignity and when you have an inmate it's very, it feels different because you want to still treat them as a human, as a person, cause they still are, but then on the flip side there's usually two corrections officers and I don't really know if I can ask them to step out of the room, are they allowed to? (P4)*

When considering the need for education on caring for people in prison, one participant believed first-person accounts were optimal to learn from. Participants also wanted to better understand the criminal legal system, such as the difference between provincial and federal incarceration, and legislation governing health care.

Discussion

Our aim with this qualitative study was to understand the experiences and needs of FPHPs to improve care for people who experience incarceration. We are not aware of any prior study in Canada on this topic. Through the theme of "Managing Multiple Systems", participants spoke about information vacuums and logistical barriers impacting their interactions with correctional institutions. This theme suggests generating proactive connections and intentional effort to create information sharing pathways may expedite and improve care. Reproductive justice requires looking beyond the sphere of reproductive health services and legal rights "on paper," to recognize the lived realities of people experiencing oppression. The lived reality for prisoners is bureaucratic and punitive; FPHPs need to foresee the likely challenges in access posed by system barriers.

As the theme "the Prison in the Clinic" illustrates, the lack of clinical policy leadership governing care for the incarcerated population allows carcerality to infiltrate the clinical space. Participants described the impact of surveillance and restraint use on their ability to provide ethical and effective reproductive care, and struggled to navigate power differences with correctional officers. This is, to our knowledge, the first time a study in Canada has captured the fraught experience of trying to uphold reproductive freedom through family planning services while simultaneously confronting the threats to bodily autonomy posed by correctional procedures. Reproductive justice is grounded in a commitment to fostering conditions - not just law - that empowers bodily autonomy; FPHPs must reckon with and overcome the threats to autonomy that come with care under carceral conditions, regardless of the ends of the care affording greater control over one's reproductive future.

Under the theme "Recommendations for the Future", participants acknowledged their lack of training and poor understanding of their rights as health professionals in these contexts. They express a strong desire for policy infrastructure to support providing equitable care to people in prison, as well as training opportunities to better understand this patient population and to navigate the challenges to providing care. Canadian health professional organizations can look to international examples such as the AWHONN [34] and ACOG [35] statements to develop Canadian statements that reflect our context, including attention to disproportionate incarceration of Indigenous people. Further, community organizations in Canada that support people in prison have a role to play in crafting standards and expectations for acceptable care. For example, in the United Kingdom, the Royal College of Obstetricians and Gynecologists endorses the Birth Charter developed by Birth Companions, a doula and advocacy group [50]. The Birth Charter stipulates that pregnant people in prison should have equivalent standard of care as pregnant people in the community, be able to attend prenatal classes, have adequate housing and food, have support for abortion, have access to a birth support person of their choice, be accompanied by officers who have had appropriate training, be provided with essential items for labour and postpartum, and receive appropriate care during transfer between prison and hospital. The Royal College of Midwives also endorses the Birth Charter, and in their position statement explain, "Midwives can play an important role in ensuring that women's care is not compromised, for example, by requesting that officers remove restraints that are being applied inappropriately and that officers are not present for examinations while women are giving birth or while confidential medical information is being discussed" [51]. Several studies commissioned by the UK government have evaluated and found improvements to prison maternity care in recent years [52–54].

All study participants described correctional officer surveillance as threatening patient dignity, privacy, confidentiality, and safety, and undermining professional and ethical standards in care. Most women in prison have experienced sexual violence, and the presence of a correctional officer introduces potentially threatening perceptions of voyeurism into the clinic and undermines a person-centered relationship between the patient and health care provider. In our studies with formerly incarcerated people, participants described violations stemming from institutional requirements to submit health care requests through correctional officers and the presence of correctional officers during care [24]. To our knowledge, there are no studies in Canada examining correctional officer experience, roles, and resource needs with respect to reproductive health services for incarcerated people. One US study found that correctional officers opposed the use of restraints on pregnant people and felt that maternal child health policies helped them in their role [55]. A study of correctional officers and prisoner health more generally identified that they perceive high unmet health needs for incarcerated people and would like further training to support mental health [56]. Future research should investigate the training and resource needs of correctional officers with respect to both reproductive health and health care in general.

We were not surprised to find participants lacked training about care of incarcerated patients and felt uncertainty about their professional rights vis-a-vis security measures, processes to ensure adequate follow-up care, and wanting more confidence to advocate for their patients. These are consistent with findings from other areas [28, 57–59]. Our study is novel in its focus on family planning, which is subject to increased stigma and sensitivity. Incarcerated people have high rates of

lifetime sexual victimization [60], and the presence of correctional officers during gynecological care may be particularly triggering. The threat of forced pregnancy if the patient does not comply with security protocols is harrowing. Further, participants emphasized the harmful implications of correctional officer presence on the safety and confidentiality of other patients and staff in their clinics. These findings suggest correctional officers and FPHPs need resources and education specific to reproductive health care for incarcerated people.

Strengths and limitations

This study has many strengths. Following a community-based methodology, team members with lived experience of incarceration and abortion contributed to the development of interview/focus group guide and provided input on coding that resulted in the themes presented. It is the first study to explore community-based FPHP experiences caring for people in prison. FPHP have the potential to mitigate stigma and discrimination that people in prison report facing when seeking sexual and reproductive health care, as they work outside of the prison setting and have professional responsibility to provide confidential and equitable care.

This qualitative study also has limitations. We used purposive sampling to recruit participants among our existing FPHP networks and thus participants who have experience with, or an interest in, providing care to incarcerated patients may have self-selected for an interview. We are missing the perspective of FPHP with little or no knowledge of or experience with providing care to this population, and these providers could have unique insight into knowledge and resource needs. To protect the anonymity of our participants we did not collect demographic information, and did not match role and/or clinical setting with participant ID, however, we appreciate that this may be considered a limitation. Finally, we did not interview correctional health care providers, as the aim of the study was to understand the knowledge and resource needs of community FPHPs, however, a small amount of reproductive health care is available on-site. Future studies should explore the knowledge and resource needs of these providers, as well as the needs of correctional staff who organize appointments or officers accompanying patients.

Recommendations

The experiences and needs of FPHP caring for people in prison gathered in this qualitative study point to an urgent need for Canadian reproductive health professional organizations such as the Society of Obstetricians and Gynecologists of Canada, the Canadian Midwifery Association, and the Canadian Association of Perinatal and Women's Health Nurses to define and share positions on the care of incarcerated people in pregnancy. They may choose, as the RCOG and RMA have, to make calls for changes or improvements to the justice system, such as urging non-custodial sentences for pregnant people, collection of data regarding pregnancy prevalence and outcomes, and prison procedures in the care and movement of pregnant people. However, more appropriately and urgently, these position statements must provide guidance about the roles and responsibilities of health professionals. The research team has created the following list of suggested recommendations to health professional organizations:

1. Proactively contact and develop relationships with nearby prisons designated for women.
2. Delegate one appropriate person to act as a key liaison between prison institutions and clinic or hospital leadership.
3. Proactively discuss among clinic or hospital staff the potential threats to ethical and practice standards associated with care for incarcerated people, such as the presence of correctional officers and use of restraints and develop a shared goal for response.
4. Assert the obligation to provide equivalent care to incarcerated people as is available to people in community, including respect for dignity, privacy, and confidentiality.
5. Commit to ask correctional officers to leave the room and to remove restraints and suggest strategies to follow through with this commitment.
6. Develop documentation practices and data collection protocols for services provided to and experiences with incarcerated people.
7. Strategize to reduce clinic-wide alarm, such as the use of back exits and private rooms to use during waiting time.
8. Strategize to enhance follow-up and information sharing.

These position statements could serve as a foundation for the development of workplace policies.

Conclusions

This is the first study in Canada to investigate community family planning health professionals' experiences and needs with respect to care of incarcerated people. In practice, FPHPs navigate great uncertainty with respect to what care and information patients receive in prison settings, and how they should advocate for patients facing common threats to dignity, privacy, confidentiality, and safety such as correctional officer surveillance and use of restraints. To improve FPHP confidence and competence in caring for incarcerated people, clear guidance through clinical institutional policies and

health professional organization position statements are direly needed. FPHPs are looking for continuing professional educational tools and opportunities and indicate the desire for this content in training curricula. By clarifying roles and responsibilities and nurturing FPHP understanding of strategies to respectfully but ethically interact with correctional authorities, it may be possible to improve the potential that care for this population is equivalent to that provided to patients in community.

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Authors' contributions
MP contributed to research study design. MP, CH, and AM collected data by conducting participant interviews. MP, CH, and AM analysed and interpreted data. CH and MP were major contributors in 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 reasons of sensitivity but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
This study was approved by the University of New Brunswick Research Ethics Board in accordance with the Declaration of Helsinki, (file number 2024-080). All participants received an informed consent form in advance of agreeing to participate.

Consent for publication
Not Applicable.

Competing interests
The authors declare no competing interests.

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References

1. Hayes CM, Sufrin C, Perritt JB. Reproductive Justice Disrupted: Mass Incarceration as a Driver of Reproductive Oppression. Am J Public Health (1971). 1971;110(S1):S21-4.
2. Paynter M, Heggie C, McKibbon S, Martin-Misener R, Iftene A, Murphy GT. Sexual and reproductive health outcomes among incarcerated women in Canada: a scoping review. Can J Nurs Res. 2022;54(1):72–86.
3. Paynter M, Pinzón Hernández P, Heggie C, McKibbon S, Munro S. Abortion and contraception for incarcerated people: a scoping review. PLoS One. 2023;18(3):e0281481-0281481.
4. Sufrin CB, Devon-Williamston A, Beal L, Hayes CM, Kramer C. I mean, I didn't really have a choice of anything: how incarceration influences abortion decision-making and precludes access in the united States. Perspect Sex Reprod Health. 2023;55(3):165–77.
5. Malakieh J. Adult and youth correctional statistics. Statistics Canada; 2019. Available from: www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54972-eng.htm.
6. Paynter M, Heggie C, Kouyoumdjian F, Edwards R, McLeod A, Liauw J. A cross-sectional survey of reproductive, gynecological, and breast health outcomes among people in provincial prisons for women in Atlantic Canada. JOGC.102950. 5 Jun 2025. https://www
7. Government of Canada. Abortion in Canada. Ottawa: Public Health Agency of Canada. Available at https://www.canada.ca/en/public-health/services/sexual-health/abortion-canada.html.11 Oct 2024.
8. Dunn S, Xiong AQ, Nuernberger K. Non-use of contraception by Canadian youth aged 15 to 24: findings from the 2009–2010 Canadian community health survey. J Obstet Gynaecol Can. 2019;41:29–37.
9. Canadian Contraception Consensus Chap. 1 contraception in Canada. J Obstet Gynecol Can. 2015;37:S5–12.
10. Liauw J, Foran J, Dineley B, Costescu D, Kouyoumdjian FG. The unmet contraceptive need of incarcerated women in Ontario. J Obstet Gynecol Can. 2016;38(9):820–6.
11. Chabot F. Access to abortion for undocumented persons during the COVID-19 pandemic. Statelessness & Citizenship Review. 2021;1:142–7 https://statelessnessandcitizenshipreview.com/index.php/journal/article/view/305.
12. Lavoie-Lebel E, Ennis M, Renner R, Munro S, Leung R, Chisholm J, Dineley B, Knutzen L, Robertson J, Liauw J. Clinical care pathways for second and third trimester termination of pregnancy for medical reasons in Canada. J Obstet Gynaecol Can. 2025;(3): 102770. https://doi.org/10.1016/j.jogc.2025.102770.
13. Norman WV, Munro S, Brooks M, Devane C, Guilbert E, Renner R, et al. Could implementation of mifepristone address Canada's urban–rural abortion access disparity: a mixed-methods implementation study protocol. BMJ Open. 2019;9(4):e028443.
14. Renner R, Ennis M, Guilbert E, Roy G, Barrett J. Second- and Third-Trimester medical abortion providers and services in 2019: results from the Canadian abortion provider survey. J Obstet Gynecol Can. 2022;44(6):690–9.
15. Sethna C, Doull M. Spatial disparities and travel to freestanding abortion clinics in Canada. Womens Stud Int Forum. 2013;38:52–62.
16. Murray C, Campbell E, Burns D, Roth R, Newbury-Birch D, Bloomer F. Women's experiences of needing abortion care whilst incarcerated: a systematic review of the international literature. Cult Health Sex. 2024;27(5):535–53.
17. Paynter MJ, Heggie C. Abortion and contraception policy in prisons in Canada. Prison J (Philadelphia Pa). 2025;105(1):44–61.
18. Paynter M, Heggie C. Distance between institutions of incarceration and procedural abortion facilities in Canada. Contraception. 2023;124:110079–110079.
19. Heggie C, Noonan A, Paynter M. Travel distances from institutions designated to detain women and girls to procedural (surgical) abortion facilities in australia: A Geospatial analysis. Women's Stud Int Forum. 2024;107:103019.
20. Gips J, Psoter KJ, Sufrin C. Does distance decrease healthcare options for pregnant, incarcerated people? Mapping the distance between abortion providers and prisons. Contracept (Stoneham). 2020;101(4):266–72.
21. Law S, CBC News. National groups, municipality back push to get proper menstrual products to Kenora District Jail inmates. 23 Jul 2024. Available from: https://www
22. Jones R, Lemberg-Pelly S, Dineley B, Jurgutis J, Kouyoumdjian FG, Liauw J. We wish we had the option: a qualitative study of women's perspectives and experiences with contraception in a provincial prison in Ontario, Canada. Health Justice. 2024;12(1):15–15.
23. Liauw J, Jurgutis J, Nouvet E, Dineley B, Kearney H, Reaka N, et al. Reproductive healthcare in prison: a qualitative study of women's experiences and perspectives in Ontario, Canada. PLoS One. 2021;16(5): e0251853–0251853.
24. Paynter MJ, Heggie C, Mcleod A, Norman WV. Abortion and contraception within prison health care: a qualitative study. BMC Womens Health. 2025;25(1):34–11.
25. CBC News. John Haggie says changes coming to correctional care, in wake of latest inmate death, CBC News. 2018 Jul 4. Available from: https://www.cbc.ca/news/canada/newfoundland-labrador/more-mental-health-support-in-nl-prisons-1.4732705#:~:text=NL-,John%20Haggie%20says%20changes%20coming%20to%20correctional%20care%2C%20in%20wake,completed%20within%20the%20next%20year
26. Sufrin CB, Creinin MD, Chang JC. Contraception services for incarcerated women: a national survey of correctional health providers. Contraception. 2009;80(6):561–5.

27. Cheedalla A, Sufrin CB. Contraception policies in U.S. Jails, prisons, and juvenile detention systems: A National survey. J Correct Health Care. 2021;27(4):226–31.
28. Jeker B, Shaw D, Lagnaux N, Wangmo T, Elger BS. Motivation and training needs of prison healthcare professionals: findings from a qualitative study. BMC Psychol. 2023;11(1):167–167.
29. Min I, Schonberg D, Anderson M. A review of primary care training programs in correctional health for physicians. Teach Learn Med. 2012;24(1):81–9.
30. Canadian Nurses Association. Position statements [Internet]. Ottawa: Canadian Nurses Association. Available from: https://www.cna-aiic.ca/en/policy-advocacy/policy-support-tools/position-statements
31. Society of Obstetricians and Gynaecologists of Canada. Current position statements [Internet]. Ottawa: Society of Obstetricians and Gynaecologists of Canada. Available from: https://sogc.org/en/en/content/guidelines-jogc/Current-Position-Statements.aspx
32. Canadian Association of Midwives. Position statements [Internet]. Ottawa: Canadian Association of Midwives. Available from: https://canadianmidwives.org/about-cam/#position-statements
33. College of Family Physicians of Canada. CFPC policy papers & position statements [Internet]. Mississauga: College of Family Physicians of Canada. Available from: https://www.cfpc.ca/en/policy-innovation/health-policy-government-relations/cfpc-policy-papers-position-statements
34. Association of Women's Health, Obstetric and Neonatal Nurses. Shackling incarcerated pregnant women. Nurs Womens Health. 2011;15(6):549– 50. https://doi.org/10.1111/j.1751-486X.2011.01691.x. PMID: 22900699.
35. American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women. Reproductive health care for incarcerated pregnant, postpartum, and nonpregnant individuals: ACOG committee opinion, number 830. Obstet Gynecol. 2021;138(1):e24–34.
36. American Public Health Association. Shackling incarcerated patients. Am Public Health Assoc. 2023 Nov 13. Available from: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2024/01/16/shackling-incarcerated-patients
37. Brawley V, Kurnat-Thoma E. Use of shackles on incarcerated pregnant women. J Obstet Gynecol Neonatal Nurs. 2024;53(1):79–91.
38. Grundy SJ, Peterson M, Brinkley-Rubinstein L. Comprehensive reform urgently needed in hospital shackling policy for incarcerated patients in the United States. J Correct Health Care. 2022;28(6):384–90.
39. Haber LA, Pratt LA, Erickson HP, Williams BA. Shackling in the hospital. J Gen Intern Med. 2022;37(5):1258–60.
40. Advocacy and Research on Reproductive Wellness of Incarcerated People. States with laws addressing shackling of pregnant people in custody. ARRWIP. 2024. Available from: https://arrwip.org/anti-shackling-laws/
41. Kramer C, Thomas K, Patil A, Hayes CM, Sufrin CB. Shackling and pregnancy care policies in US prisons and jails. Matern Child Health J. 2023;27(1):186–96.
42. Goshin LS, Sissoko DRG, Neumann G, Sufrin C, Byrnes L. Perinatal nurses' experiences with and knowledge of the care of incarcerated women during pregnancy and the postpartum period. J Obstet Gynecol Neonatal Nurs. 2019;48(1):27–36.
43. Tracy SJ. Qualitative quality: eight big-tent criteria for excellent qualitative research. Qual Inq. 2010;16(10):837–51. https://doi.org/10.1177/1077800410383121.
44. Shlafer R, Hardeman R, Carlson E. Reproductive justice for incarcerated mothers and advocacy for their infants and young children. Infant Mental Health J. 2019;40(5):725–41.
45. Ross L, Solinger R. Reproductive justice: an introduction. 1st ed. Berkeley, CA: University of California Press; 2017.
46. Paynter M, Jefferies K, Carrier L, Goshin L. Feminist abolitionist nursing. ANS adv Nurs sci. 2022; 45(1):53–68.
47. Israel BA, Schulz AJ, Parker EA, Becker AB. Community-based participatory research: policy recommendations for promoting a partnership approach in health research. Educ Health. 2001;14(2):182–97.
48. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
49. Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qual Res Psychol. 2020;18(3):328–52.
50. Royal College of Obstetricians & Gynaecologists. RCOG position statement: Maternity care for women in prison in England and Wales. RCOG. 2021. Available from: https://www.rcog.org.uk/media/wwhogsk5/rcog-maternity-care-and-the-prison-system-position-statement-sept-2021.pdf
51. Royal College of Midwives. Position statement: Perinatal women in the criminal justice system. RCM. 2024 Mar. Available from: https://rcm.org.uk/wp-content/uploads/2024/03/rcm-position-statement-perinatal-women-in-the-criminal-justice-system.pdf
52. Cahalin K, Knight L, Binley J, Callender M. Evaluation of Healthcare Services Provided to Women at HMP Peterborough 2021. Institute of Public Safety, Crime and Justice. 2022;1–66.
53. Cahalin K, Clews C, Pendleton J, Callender M. Complexities of midwifery care delivered to perinatal women in prison: a qualitative study. Midwifery. 2024;136:104099.
54. Callender M, Cahalin K, Lugli V, Armstrong S. Evaluation of Women's Health Services for Perinatal Female Offenders in HMP Peterborough. NHS England. 2019;1–66.
55. Pendleton V, Saunders JB, Shlafer R. Corrections officers' knowledge and perspectives of maternal and child health policies and programs for pregnant women in prison. Health Justice. 2020;8(1):1–12.
56. Ricciardelli R, Johnston MS, Jones M. Correctional Officer Reflections on How to Address Incarcerated People's Unmet Needs in Canadian Prisons. Corrections: policy, practice and research. 2024;10(2):59–80.
57. Brooks KC, Makam AN, Haber LA. Caring for hospitalized incarcerated patients: physician and nurse experience. J Gen Intern Medicine: JGIM. 2022;37(2):485–7.
58. Douglas AD, Zaidi MY, Maatman TK, Choi JN, Meagher AD. Caring for incarcerated patients: can it ever be equal?? J Surg Educ. 2021;78(6):e154–60.
59. Patil A, Hutchins GJ, Dabbara H, Handunge VL, Lewis-O'Connor A, Vanjani R, et al. Talking About Incarceration History: Engaging Patients and Healthcare Providers in Communication. J Gen Intern medicine: JGIM. 2025;40(3):603–10.
60. Karlsson ME, Zielinski MJ. Sexual victimization and mental illness prevalence rates among incarcerated women: a literature review. Trauma Violence Abuse. 2020;21(2):326–49.

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