

**Experiences of Pregnancy in Prison: Understanding access to prenatal care in Canadian
Federal Prisons**

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Abstract

Criminalized women represent an acutely marginalized portion of the population with specific healthcare needs that have been overlooked within the Canadian carceral landscape. This thesis aims to focus on the unique experiences and needs of pregnant and incarcerated women in Canadian Federal Prisons with a focus on the prenatal and post-natal care that they receive while incarcerated. This thesis presents an analysis of three qualitative interviews with individuals involved in healthcare and advocacy for pregnant women in prison, by interpreting them in light of the current academic and grey literature. The dominant themes that emerged throughout this thesis include an emphasis on standard of care, community-based programming and supporting mothers and babies as a unit, in order to have the best possible outcome. This project draws on insights from medical anthropology, Foucauldian theory and feminist criminology to frame the discussion of the needs of incarcerated women in Canada. Specifically, it argues that women in Canadian federal prisons should: 1) have access to the same level of care as non-incarcerated women; 2) be empowered to be mothers (should they so desire); and 3) be supported in their return to the community. Through analyzing the interviews, literature, and publicly available grey literature, the thesis focuses heavily on the complex challenges faced by marginalized and incarcerated women, the extent of institutional power to make a difference, and the challenges of early motherhood.

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Introduction

In the current state of mass incarceration of marginalized and racialized women, and the increasing imprisonment of women in the Canadian criminal justice system, vulnerable pregnant women, mothers and children are coming directly under the control of a carceral state (Belknap & Holsinger, 2006). I use the term ‘carceral’ when referring to the ideologies and systems that support and make possible regimes of criminalization and incarceration. This term is adopted from the Foucauldian ‘carceral state’ which Foucault uses when referring to the correctional system as one mechanism through which state power operates (Foucault, 1979). As more families are affected by incarceration it becomes necessary to understand the needs of the people within these institutions—particularly mothers—and whether those needs are being effectively met by current standards of care (Kouyoumdjian et al., 2015). Criminalized women represent an acutely marginalized segment of the prison population in Canada and their needs have been overlooked by a clear gender divide, according to which prisons are organized according to male norms (Belknap & Holsinger, 2006). This study seeks to better understand the experiences of pregnant incarcerated women in Canadian Federal Prisons and their access to pre- and post-natal care. The project draws on qualitative interviews and publicly available documents to synthesize an argument framing the experience of women in prison and the care they receive.

In approaching this project, I asked the following research questions: 1. What is the current state of prenatal care for pregnant incarcerated women in Canadian Federal prisons? Can it be enhanced to meet women’s right to the highest attainable standard of health (the global standard as articulated by the United Nations)?¹ If so, how? 2. How can pregnant women in Canadian

¹ The right to healthcare is outlined by the United Nations as an inclusive right. The Committee on the Elimination of Discrimination against Women further requires States parties to ensure women have appropriate services in connection with pregnancy, childbirth and the post-natal period, including family planning and emergency obstetric

prisons be better supported by healthcare policy? I argue, based on scholarly and grey literature review, along with three qualitative interviews with individuals involved in prison-based care, that women in Canadian federal prisons should: 1) have access to the same level of care as non-incarcerated women; 2) be empowered to be mothers (should they so desire); and 3) be supported in their return to the community. The findings are situated within a broader frame of socioeconomic trends, women's healthcare and the confines of the criminal justice system. In this first section, I will provide context to the current state of prenatal care and the available experiences of women who have navigated the criminal justice system. Through the work of medical anthropologists, Foucauldian theory and feminist criminology, I situate the research within these critical perspectives in order to glean the information present throughout the data I have collected.

The first chapter will lay the theoretical framework for the central argument of the thesis. In doing so chapter one will explore medical anthropology, Foucault and feminist criminology as its theoretical markers. Supported by the theoretical foundation, chapter two will include a literature review and a review of grey literature and documents pertaining to the overarching theme of healthcare for incarcerated women. Lastly, chapter three will analyze and explore the themes relevant from three semi structured interviews.

The World Health Organization acknowledges that incarcerated mothers are marginalized and vulnerable group with specific health needs (WHO, 2009). This is supported by literature stating that "women in prison generally have more, and more specific, health problems than male prisoners" (Van den Bergh et al, 2011, p. 690). Criminalized Women are at a far higher risk for

care. The requirement for States to ensure safe motherhood and reduce maternal mortality and morbidity is implicit here (Office of the United Nations High Commissioner et al., 2008, p. 3)

developing medical complications during pregnancy and researchers cite that all prison pregnancies should be considered high-risk (Kyei-Aboagye et al., 2000). To situate the research's importance and relevance, I begin with the infamous story of Julie Bilotta and her experience as a woman navigating the criminal justice system in Canada (CBC News, 2013). The stories and experiences of women who are incarcerated in the Canadian prison system offer a glimpse into the realities of navigating prison through pregnancy and as a mother. In 2013, Julie Bilotta was incarcerated in an Ottawa jail² for minor charges. While incarcerated, she gave birth to her baby—who was in a breech (bottom-down) position—in a cell, alone. One year after his birth her child, Gionni, died due to respiratory complications from his traumatic birth (CBC News, 2013). Julie's story raised awareness about the realities of pregnant women behind bars. Julie had a history with the criminal justice system and through an ongoing struggle with substance abuse Julie found herself in the Ottawa-Carleton Detention Centre (a provincial jail) where she was given a routine pregnancy test which indicated that she was pregnant (CBC News, 2013). After her initial period of incarceration Julie was remanded at thirty-six weeks and brought to the provincial jail to serve the rest of her sentence. Prior to being remanded (awaiting trial after being charged), she was seen by a doctor at a local hospital in Ottawa, who identified her pregnancy as high risk (CBC News, 2013). Early on the day of Gionni's birth, Julie complained of feeling unwell and was provided with an ultrasound and some Tylenol as medication for her pain, but no physical exam was performed despite her concerns of pain and her imminent due date. After several hours of complaining and concern from her cellmates Julie was moved to a segregated cell so as not to disrupt others. In this time Julie's water broke. She

² Although the terms are often used interchangeably, they serve different purposes. Jail is intended for short term stays and for individuals awaiting trials and sentencing, prison is intended for individuals serving longer sentences (in Canada this is sentences over 2 years) (The Correctional Investigator of Canada, 2015).

was not provided with any further examination (CBC News, 2013). Upon further investigation, Julie discovered the feet of her unborn child in the birth canal and called for help, the guard came to notice that there was an entire foot visible and Julie screaming for help (CBC News, 2013). An emergency page was called, Julie was taken to the hospital only after nine hours of distress. When Julie delivered her son Gianni the umbilical cord was wrapped around his neck. In the hospital Julie was shackled to her bed and Gianni was placed in Neonatal Intensive Care (Gilna, 2018). Over the course of Gianni's short life, he was placed in foster care and had many visits to the hospital due to respiratory illness from his birth (CBC News, 2013).

The story of Julie Bilotta is traumatic, it paints a painful picture of criminalized women. The experience highlights the need for change and better standards for prison healthcare. Julie's story sparked the interest of many advocates to push for change within the criminal justice system for women. Julie was not only a mother who lost her child but a woman who did not receive the adequate support from the community she needed. Julie's story managed to gain a significant amount of attention, including from Canadian Senator Kim Pate. Senator Pate has been instrumental and outspoken about the state of care and the challenges that many women face in corrections in Canada, and in particular Indigenous women (Parkes & Pate, 2006). She is the previous executive director for the Elizabeth Fry Society and serves and an advocate for women who are navigating incarceration currently or who have been incarcerated in their lifetime (Parkes & Pate, 2006). Much of her work is focused on "decarceration," which is the initiative to have women serve their sentences through community-based programs and supports instead of in traditional prisons (Parkes & Pate, 2006). She has noted on many occasions that most women in Canada are not a significant 'threat' to public safety and it would be possible for so many of them to serve their sentence in the community (Parkes & Pate, 2006). Currently there are about

700 women incarcerated at the federal level compared to almost 7000 men. While there are fewer women in prison, this has also meant that there are less supports for them at the federal level even though they are the fastest growing prison population. It is estimated that between four and ten percent of women are pregnant while incarcerated in the US (Sufrin, 2019), there is no specific number or statistic to support this in Canada.

Most studies exploring the effectiveness and the level of care available in prisons are in the US, leaving many potential questions about the Canadian carceral landscape for women. Despite our understanding that women in prison are vulnerable, the access to healthcare services in prison is often limited and unregulated (Brennan, 2014). Many scholars in both Canada and the US have argued that the existing health care for women is entirely inadequate and fails to meet the needs of the women it serves, in particular pregnant women (Clarke et al, 2006 & Ferzt, 2012). Pregnant women who are incarcerated are more likely to develop mental illness, yet most research only notes the prevalence of mental illness, not addressing why women are increasingly showing signs of mental illness (Paynter, 2018). Over sixty percent of women in prisons are taking an anti-psychotic medication to manage their mental health. Again, despite our understanding that there needs to be a change, women continue to struggle to be supported by the health care system in prison (Paynter, 2018).

Studies have explored the effectiveness of a care-based model for women in corrections. Care based healthcare models serve to provide women with security and autonomy with their medical care within the carceral space and provides physical and mental healthcare to women and mothers (Clarke et al., 2006). Martin et al, (2005), proposes that an attachment-based³ care

³ Attachment parenting focuses on the nurturing connection that begins in pregnancy to nurture a relationship with their children. This relationship not only has shown to support positive mental health but also can be an indicator of good physical health in newborns. Proponents of this philosophy include the well-known pediatrician William Sears, MD (Hoffman, 1998, p.42)

model aligns with both the needs of the baby and the mother. This is supported by understanding that the established connection between mothers and babies is important for founding relationships. The broader understanding of attachment theory seeks to unpack the relationships between parents and children from birth, Sears argues that the importance of mother child bonding is based on the psychological and evolutionary considerations for young children (Hoffman, 1998, p. 42). The absence of this model has shown negative impacts on children with incarcerated parents and the intergenerational implications of incarceration (Goshin et al., 2014). Other studies have provided support on how doula and midwife-based models can identify some of the specific needs of incarcerated pregnant women and many find that this model supports an environment where many incarcerated women feel more physically and emotionally comfortable (Shlafer et al., 2015). Similarly, the proposed attachment-based care model suggests that prison nursery programs are an alternative that attempts to house families , reducing the concern of separation of baby from its mother (Brennan, 2014). Mary Byrne, a carceral researcher in the eastern US cites that “most mothers don’t have secure attachment to begin with” stating the importance of prison nurseries within the correctional system (Goshin et al., 2014). In her own work, she found that the first two years of a baby’s life were imperative for them to be with their mother in order to develop a secure attachment style and the separation of mothers and babies disrupts the process of attachment (Shlafer et al., 2015).

Given the literature available and the research potential, this project provides a qualitative look at the realities of individuals working and advocating for women in Canadian federal prisons. In consulting this work, I establish that women in Canadian federal prisons should have access to the same level of care as non-incarcerated women, be empowered to be mothers (should they so desire) and be supported in their return to the community. In chapter three I

explore the themes that emerged from the qualitative interviews as supported by the grey literature in the previous chapter that supports the claims and themes. Lastly, in my final chapter I will summarize the findings of this study, discuss limitations and present potential directions for future research.

Chapter 1 - Theory and Methods

In this chapter, I will discuss the three theoretical frameworks that form the methodological underpinnings of this project as well as the methods I employed for data collection. In arguing throughout this thesis for a higher standard of care for pregnant and incarcerated women in Canadian federal prisons, I draw on three theoretical frameworks: medical anthropology, Foucauldian biopolitics and feminist criminology. I use these literatures to develop a critical understanding of pre-natal care and motherhood among incarcerated women in Canada. Although many theorists have dealt with women's incarceration and pregnancy separately, these theoretical traditions offer helpful conceptual tools for understanding +how the experiences of pregnant and incarcerated women are shaped and understood through reproductive control, biopolitics and theories of care.

Medical Anthropology: Structural Competence and Structural Vulnerability

Medical anthropology seeks to examine how the health of social groups is affected by relationships between humans and social institutions. Consider the following definition by anthropologist Kenneth J. Guest (2020: 593):

"Critical medical anthropology explores the impact of inequality on human health in two ways. First, it considers how economic and political systems, race, class, gender, and sexuality create and perpetuate unequal access to health care. Second, it examines how health systems themselves are systems of power that promote

disparities in health by defining who is sick, who gets treated, and how the treatment is provided.”

Drawing on the work of Dr. Paul Farmer, Dr. Carolyn Sufrin and Dr. Kimberly Sue, I explore how medical anthropology provides insights into the incarceration of pregnant women. The prison itself is a social institution and when studying how the prison atmosphere affects health, this field of study is useful in many ways. For instance, anthropologist and physician Paul Farmer has extensive ethnographic research on imprisonment in Russia and his continued work on infectious diseases in Haiti (Farmer, 2003). Through this work he has uncovered relationships between the relative powerlessness of incarcerated people in relation to the institution of the prison. Farmer sees prison as a form of social control, where “problems” like poverty and addiction are sequestered (Farmer, 2003). Because of this social control, individuals of lower socioeconomic status often fall into the confines of this system (Farmer, 2003). Dr Carolyn Sufrin has dedicated much of her work in the United States to studying incarcerated women and how healthcare policy can better support them (Sufrin et al, 2019). In her 2017 book, *Jailcare*, she examined reproductive justice and health care for women in San Francisco County Jails and she now leads the Johns Hopkins initiative for Advocacy and Research on Reproductive Wellness of Incarcerated People (Sufrin, 2017). Finally, Dr. Kimberley Sue’s research is primarily on harm reduction where she runs a national advocacy organization in the US promoting health and dignity for individuals impacted by racialized drug use (Sue, 2017). Sue works specifically with incarcerated individuals at Rikers Island and offers expertise on how healthcare providers can support people who have been and are incarcerated in more meaningful ways (Sue, 2017). Altogether, the insights of these medical anthropologists have proven to be pivotal for this project.

The literature on incarceration does not always overlap with the literature on healthcare. Farmer's approach to health care addresses epidemics in prisons, and the particular ways that race, class and gender intersect in calculations about the value of human life (Farmer, 2003, p. 126). This draws specifically on Farmer's research on tuberculosis and imprisonment. Farmer argues that "Arresting the impoverished is one of the oldest tricks in the book," indicating that there is a clear divide socioeconomically in terms of using prisons as a method of social control and the use of prison management as a tool for managing poverty, specifically (Farmer, 2003, p.127). Farmer's insight extends to mental health struggles as well. The documentary film *Conviction*, which follows the incarceration journey of women imprisoned in Central Nova Scotia Correctional Facility and Nova Institution for Women, offers a stark example of this. One young woman named Caitlin who is chronicled in the documentary lives in a cycle of incarceration, which she deliberately pursues, because she requires institutional supports but has maxed out her allowable time in provincial mental health institutions, which will therefore no longer accommodate her. In the absence of adequate mental health supports, prison becomes a catch-all solution (Ackerman et al., 2019). The mother of this young woman summarizes her daughter's situation: "Mommy will always care but she needs to feel the system is there for her" (Ackerman et al., 2019). In this quotation from Caitlin's mother, she is referring to going back into forensic⁴ care after a short period of time being out of prison. While in prison she was prescribed new medication to manage her mental illness but upon her release, the medication was not covered by provincial health care, forcing her to go off of it (Ackerman et al., 2019). Her mother explains that her family has tried to support her in every

⁴ "The mental health system is the network of people and services that care for people with mental illness. The criminal justice system includes the courts, the institutions and the professionals that deal with people accused or convicted of crimes." (Bettridge et al., 2015)

way possible but there is only so much that they can do, at this point she is leaving to go back into the prison as it is the safest place for her (Ackerman et al., 2019). This example does not stand alone. It is similar to the case of Ashley Smith, another young Canadian woman who was incarcerated at the federal facility of Grand Valley institution in Kitchener Ontario in 2012. She spent over 1000 days in segregation and died from complications due to self-strangulation (Stienstra, 2012). It was noted that she had very limited access to mental health support and the correctional system failed to provide her with the treatment and support she desperately required (Steinstra, 2012).

Farmer offers an interesting approach to the study of health care, specifically in terms of epidemics and in particular within systems where the cost of human life is considered to be simply one factor in calculations of cost-effectiveness (Farmer, 2003, p. 135). “The poor are more likely to fall sick and be denied access to care” (Farmer, 2003, p. 138). In Farmer’s work on tuberculosis in Russian prisons, he illustrates the cells as ‘cramped cattle cars’ and he raises the rates of tuberculosis in Russian prisons as a question of social or economic rights (Farmer, 2003, p. 215). He further discusses the violations which include lengthy pre-trial detentions where conditions are deplorable (Farmer, 2003, p. 215). In 2003, Farmer (215) asked:

“[W]here does the blame lie? Interview medical staff in these prisons, and you will find them distraught about the funding cuts that have followed the restructuring and collapse of the Russian economy. In the words of one physician: “I have spent my entire medical career caring for prisoners with tuberculosis. And although we complained about shortages in the eighties, we had no idea how good we had it then. Now it’s a daily struggle for food, drugs, lab supplies, even heat and electricity.”

The prisoners were not provided with a globally accepted bare minimum of care (including drugs that effectively treated their tuberculosis). Farmer notes that if there was shared

investment from wealthy donor countries in treating prisoners then the efforts for penal reform and the promotion of the human rights of Russian prisons would be greater (Farmer, 2003, p. 216). Farmer's discussion of the carceral system's power over the bodies of its prisoners, and the complicity of privileged groups in ignoring their plight applies also to the many women who are unable to exercise their own right to bodily autonomy, make formal decisions and interact with their right to their body given the confines of the carceral processes. This work draws upon the insight that the prison system is a method of control—a mechanism for avoiding humane solutions to poverty and marginalization, and their associated harms, such as illness. As I discuss in the literature review and in my analysis of the interviews conducted for this project, this insight is apparent in discussions women, especially mothers, and their experiences in corrections (Schaffner, 2006, 126).

Medical anthropologists have developed two concepts for building an ethical approach to healthcare: *structural competence* and *structural vulnerability* (Sue, 2017). Structural competence refers to how clinicians need to understand structures of inequality such as class, race and gender, and how these aspects of a person's identity can influence their (in)ability to access good and resources. This concept is important as it helps clinicians understand the structures of inequality that affect a patient and can help health care providers to provide care that is specific to their situation or challenges. They may be experiencing factors including substance abuse and poverty (Sue, 2017). Similarly, structural vulnerability focuses on an individual's well-being and their chances at good health over the long term (Sue, 2017). It addresses vulnerabilities caused by social political and economic structures that have an impact on health and increase an individual's risk of poor health. This allows health care providers to support their patients through care and advocacy that addresses their individual needs. This takes

into account their previous medical needs and their current health, for folks who have been incarcerated it is important to understand that their structural vulnerability is higher as they likely have an increased number of vulnerabilities. From this perspective, an ethics of care⁵ is important within a medical and specifically correctional setting. Structural competence and structural vulnerability should also be considered through the lens of intersectionality. Kimberley Crenshaw developed the notion of intersectionality as an exploration of where and how power and privilege interlock and intersect (Crenshaw, 2019). Addressing structural vulnerabilities aims to use a framework that also adopts these intersections by identifying vulnerabilities. “Adoption of a structural vulnerability framework in health care could also justify the mobilization of resources inside and outside clinical settings to improve a patient's immediate access to care and long-term health outcomes” (Bourgois et al., 2017).

Sue approaches the subject of incarceration from the perspective of a physician, exploring how doctors can better treat their patients knowing they have a history of incarceration or are currently incarcerated (Sue, 2017). The literature on incarcerated folks has consistently determined that they experience higher rates of violence and are disproportionately affected by poverty. She notes that individuals who have a history of incarceration are frequently affected by this, and it can hinder their access to equitable medical care. Her work draws on structural violence and the factors that can harm and discourage individuals from accessing medical treatment who use drugs (Sue, 2017). Her work has stemmed into advocacy for global public health research to reproductive health in Tanzania and South Africa through bridging the space between access to medical care and health advocacy for vulnerable communities (Sue, 2017).

⁵ Ethics of care is defined as an ethic grounded in voice and relationships, in the importance of everyone having a voice, being listened to carefully (in their own right and on their own terms) and heard with respect (Gilligan, 1993).

The primary consideration of Sue's work with women is to understand the structural violence and gender inequalities that lead to substance abuse and incarceration.

She works in Boston Massachusetts as a primary care physician working with individuals with substance use disorders and providing harm reduction care (Sue, 2017). This work is highly important in corrections and encourages us to consider to the long-standing history of racial, gender and socioeconomic disadvantages that many incarcerated women face (Sue, 2017). While discussing incarceration with patients can be a challenging experience, these discussions are important. The isolation experienced while incarcerated can have lasting effects on physical and mental health as well as relationships with family and children (Luke, 2002). Given the nature of mass incarceration and the overcrowding in many correctional facilities, many patients might find themselves at a higher risk for contracting disease, increased risk for heart disease (heart disease is specifically associated with high salt diets that are common in correctional facilities), and higher rates of mental illness (Carter et al, 2020).

When exploring these topics with incarcerated people, Sue (2017) suggests that physicians use open-ended questions to help guide the conversation, such as, "what barriers have you faced in securing a steady supply of medication," and foregrounds the importance of asking without judgement (Sue, 2017). Clinicians should be empowering, advocating for their patients to ensure that structural competence is in place. Individuals who are incarcerated or who are previously incarcerated face many interrelated challenges, especially in terms of their health and wellbeing. The effects of incarceration are present both during the period of incarceration and after release. The structures that affect one's health in prison will likely affect their health and well-being later (Sue, 2017). Sue (2017) indicates the importance of non-judgmental care and informing patients

that they should disclose information pertaining to incarceration as it has been shown to have lasting effects on their health (Sue, 2017).

Drawing on Farmer's and Sue's work, I glean an insight that informs this thesis: correctional facilities tend to house vulnerable people, who face multiple and complex barriers to social inclusion, including racism, addiction, poverty, disability, and multiple co-morbidities. In fact, the prison is used as a mechanism to (not) deal with these social problems. Health care providers (HCPs) in prisons, therefore, must foreground a sense of these vulnerabilities (i.e. structural competence), remembering that the corrections system is part of a broader "system of power that promotes disparities in health by defining who is sick, who gets treated, and how the treatment is provided" (to draw again upon Guest's definition of medical anthropology, cited above). In order to apply this insight to pregnant women and new mothers who are incarcerated, I draw on the work of Dr. Carolyn Sufrin, Medical Anthropologist and Obstetrician. Sufrin's research emphasizes the need for increased care and support for pregnant women in prison (Sufrin et al, 2019). Drawing on her ethnographic research focused on pregnant women in a San Francisco County Jail, she is an advocate for reproductive wellness for incarcerated women and is researching pregnancy outcomes in prisons as well as contraception access for incarcerated women (Sufrin, 2017) "The ambiguity of jailcare asks fundamental questions about the moral worthiness of prisoners receiving care—people who, on the one hand, have ostensibly violated legal-social norms and may be seen as less deserving of services; and who, on the other hand, are marginalized by poverty, addiction, and racism, and deserve care because of their structural vulnerability" (p. 84). Sufrin continues to explore the notion of structural vulnerability in her

own research by noting how prisoners that she was seeing felt as though they did not deserve the care they were receiving.

In 2019, Sufrin published first of its kind, national-scale investigation on pregnancy frequencies and outcomes in prison covering fifty-seven percent of the female prison population in the US. Partnering with her work at Johns Hopkins, she determined that a majority of prison pregnancies resulted in either live birth or miscarriages. She notes that “prison pregnancy data are critical in ensuring that incarcerated women’s pregnancy-related health care needs are addressed and in helping optimize outcomes for them and their newborns” (Sufrin, MD et al., 2019). In order to better support women who are pregnant in prison, we must first understand what needs must be addressed. With such a large percentage of women incarcerated who were mothers prior to their incarceration, normalizing the prospect of ‘mothering behind bars’ is in keeping with the lived realities of incarcerated women (Sufrin et al, 2019). According to a 2016 – 2017 study, three quarters of the women in prisons in the US are of childbearing age and eighty percent reported being sexually active prior to incarceration, with less than twenty percent using reliable contraception (Sufrin et al, 2019). In the US there is no systematic reporting for pregnancy outcomes and no federal agency collects incarceration statistics with regard to pregnancy. Most of Sufrin’s research is in the US, but still provides insight into Canadian Federal institutions. Women are still the fastest growing prison population in Canada, and specifically Indigenous women. The comparison states that even though the number of incarcerated women in Canada is smaller than the USA, there is still significant need for change towards equitable health care (Carter Ramirez et al., 2020a). These insights are provided on a smaller scale based on population and the number of women who are incarcerated but does allow for a comparison

between both countries. In both, structural determinants of health and vulnerabilities appear to be factors that indicate failure in the prison-based healthcare system.

Foucault - Biopolitics, Surveillance and Governmentality

The concept of carceral society refers to the regulation of human behaviour, surveillance, and the processes and landscape typical of modern prisons throughout society as a whole. Michel Foucault made the relationship between power and surveillance his central point of observation within carceral spaces making it a primary focus of his work (Foucault, 1979). Given the coercive nature of the prison and how power relations are perceived with the institution and their effect on women, a theme in my research is the notion of biopolitics or biopower, as described by Michel Foucault, and its link to governmentality and surveillance within the penal system. Biopower, or the concept of “power over life” is the supposedly ‘positive’ or productive power employed over a population and associated mechanisms of control specific to the human body (Bunton, 1997). The role of biopower, however, is much more subtle than general domination over the bodies present in a given space, but the very *mechanisms* that enable power over life. Foucault’s book “Discipline and Punish” (1979) follows the emergence of the modern prison, the systems of power and punishment within carceral spaces, and the impact that these systems of power have on the bodies of individuals who are incarcerated. As Foucault puts it: all citizens within the state are subject to carceral logic even though they are not incarcerated. According to Foucault, the physical layout of the prison offers a ‘space’ which is important for the operation of biopower, but equally important are the disciplinary mechanisms to that operate within this space. This nuanced operation of power is present in the interactions that inmates have with physicians, medical professionals and correctional staff within the prison setting, which create a construction of ‘targeted power over the individual body’ of the prisoner (Foucault, 1975, p. 295). Biopower operates within the prison setting through action and interaction, for example,

for Ashley Smith, the state control that she was under within the carceral system was the same space that had her placed in solitary confinement.

Biopolitics

In approaching the theoretical underpinnings of this project, I was particularly inspired by the work of Michel Foucault and his acknowledgement of how the prison space, carceral rhetoric and the human body itself interact within the prison atmosphere (Foucault, 1975, p. 295). In acknowledging Michel Foucault's contribution to the greater scope of literature on incarceration, it is important to recognize that several elements must be understood in order to make sense of the prisoner within the space of the prison (Foucault, 1975, p. 196). For Foucault, biopower is defined as a technology of power that is used to manage humans in large groups ("populations") and is distinctive as it allows for control of populations. As within medical anthropology, biopower also focuses on both power and the body, highlighting the oppression individuals confront when facing particular, institutionalized regimes of discipline that encourage them to practice self-regulatory health (Hancock, 2018). According to Foucault, order (and specifically political order) is maintained through the production of docile bodies, this term meaning passive and productive individuals. This is again maintained through the use of institutions, such as schools, hospitals and prisons. All of these institutions apply order in some way, thus maintaining this level of political organization within the population. For example, in a hospital, a pregnant woman would embody the 'docile' aspect that Foucault is describing through her own adoption of this regulatory system, her trust in the physician is applied through the consent to be present in the hospital space (Foucault, 1979, p. 135). It is through these regulatory powers that we see the emergence of institutional discipline and surveillance of the body occur. Specifically,

is Foucault's work in *The Birth of the Clinic*, he describes the medical profession's power to define reality (1973): "All theory is always silent or vanishes at the patient's bedside" (p. 107). Foucault refers to the medical gaze as a method of separating the patient from their identity, this detachment or dehumanization is the power of the medical system or medical gaze to define their power within the profession (Hancock, 2018). This is not only present in hospitals but through medical practices in carceral spaces.

Other forms of power identified by Foucault are sovereign power and disciplinary power. Sovereign power is exercised through physical punishments and rewards (Lemke, 2011, p. 59). Disciplinary power refers to the level of power that is executed through mechanisms that differ from sovereign power, such as through surveillance and knowledge. The medical profession marks the differences between normal and deviant, justifying the norms behaviors and practices that it subjects to disciplinary strategies. "The reproductive body has been a prime target of institutional regulation" (Pylypa, 1998, p. 30). The ability to make decisions is essentially taken away from the mother, the trust is placed in the hands of the medical profession. This transfer of control to medicine is seen as both a risk and a norm (Davis-Floyd, 1990). Risk is associated with the trust the mother places in the medical professional and the normalization of this tactic, normalization referring to the social process where actions are seen as "normal" or "ordinary". The regulation of women's bodies is not only subject to the hospital walls but the authority of medical professionals stems far beyond this and is extended, in this care, into the prison space through the rigidity of fixed schedules and the emphasis the regulation of the mother (Bunton & Peterson, 1997, p. 221). The health care system provides its own form of disciplinary power and for Foucault, the focus on the exercise of disciplinary power or the social body is identified

through health professionals and their entitled scientific knowledge (Bunton & Peterson, 1997, p. 221).

Foucault distinctly refers to the functionality of the prison or institution as an organization that “is supposed to apply the law and to teach respect for it.” But this system of power often creates its own relationship to power that in many cases is problematic and demonstrates no real opportunity for humanity within care (Foucault, 2010, p. 227). Foucault notes the resilience of the modern prison, governed by the logic of biopower: even “after a century and a half of failures, the prison still exists, producing the same results and there is the greatest reluctance to dispense with it (Foucault, 2010, p. 232). Foucault developed the concept of biopolitics through studying the concepts of disciplinary power and its relationship to political life (Lemke, 2011, p. 117). He used the notion of biopolitics to describe the shift from sovereign power as (negative) power over death to the (positive) power to “make live or let die” (Diprose & Plonowska Ziarek, 2018, p. 174). His work is specifically related to incarceration as an integral focus to biopolitics in terms of regulation of biological “population” (Diprose & Plonowska Ziarek, 2018, p. 174). Foucault uses the prison as a vector of power and seeks to understand the carceral system, ultimately normalizing disciplinary power both at an individual and institutional level (Lemke, 2011, p. 59). To build on the work that Foucault started, Lemke argues that there is more to biopolitics than can be recognized in a Foucauldian approach. Lemke thus introduces race and gender as other influencing factors that play into an analysis of power. Foucault’s work is often critiqued for overlooking the various overlapping aspects of identity, now accounted for by intersectional theoretical approaches. Lemke’s work is useful as it applies Foucault’s theories but critiques the absence of gender and race, and ultimately the importance

they have in understanding disciplinary power and control (Lemke, 2011, p. 59). Lemke clarifies Foucault's work and connects the concept of governing with the justification of power.

Governmentality is defined by the art of government or governance and includes the techniques of control that make people—in this case prisoners—governable (Davis-Floyd, 1990). Similar to Foucault's work on biopolitics, his concept of "governmentality" is a central focus of his study of power, discipline, and institutions. Governmentality refers to the concept of "being governed". Through a series of lectures, Foucault discussed the relationship of biopower to politics. Biopower refers to the productive management of populations. Governmentality is a mechanism for subtly asserting control over bodies and populations. "[G]overnment means to conduct others and oneself, and governmentality is about how to govern. 'The concept of government implies all those tactics, strategies, techniques, programmes, dreams and aspirations of those authorities that shape beliefs and the conduct of population' (Nettleton 1991, p. 99). Hence, government is an activity that aims to shape, mould or affect the conduct of an individual or a group, that is, to conduct the conduct of people (Gordon, 1991)" (Holmes & Gastaldo 2002: 559).

Ideally, governmentality instills an ethic of self-governance, so that individuals not only "police" others, but themselves. The system of the prison is primarily focused on punishment through the relationship of power, knowledge and discipline towards the body (Bunton & Peterson, 1997, p. 14). The main concern of governmentality is the institution, discipline and power and how these concepts converge to create an ensemble or government. Within the carceral space, the roles and hierarchy are presented through this ensemble or power relationship between the staff, regulations and pregnant women. Women are under the "power" of this relationship or authority (Bunton & Peterson, 1997, p. 14).

Surveillance

Perhaps one of the most influential roles that Foucault had was his contribution to criminology and specifically the focus on control and surveillance. Foucault focused his work on power in two main areas, disciplinary power and sovereign power (Foucault, 1975, p. 302). Knowledge is of most interest to this project as it employs the techniques of monitoring and surveillance of populations, and is often applied to studies of penal systems (Foucault, 1975, p. 303). Foucault extended his focus of disciplinary power beyond the carceral state, claiming that power is everywhere, and all spaces are subject to some form of disciplinary power or monitoring. Foucault uses this state of control within the carceral system to build a nuanced look at systems of punishment and how they are used to govern the bodies within them. “Punishment in general and the prison in particular belong to a political technology of the body” reinforcing this notion that the prison *itself* or in particular control that it embodies is its own targeted form of power (Foucault, 1975, p. 30). The oppression within the actual prison structure is only supported by the systems of power that maintain it. The systems of power within the carceral space are maintained by the individuals working within this structure, it is held up by the prison staff and the workers providing the care but most of all by the landscape of the prison itself, the general environment of the prison perpetuates oppression through the way that prisoners are viewed and housed. This power is then maintained by the surveillance of the guards, the confines of a prisoner’s cell and the inability to have “freedom”. This is not meant to blame those who work within the system, but the systems of control that perpetuate this environment (Foucault, 1975, p. 303). The power over prisoners not only is subject to the individuals within the prison space but this surveillance is continued beyond the prison walls and follows them into community as they navigate the impacts of post-incarceration. Scholars have noted that even post incarceration, people still feel the effects of surveillance within the community and as though

they are not prepared for reentry. The power of the carceral state has essentially caused them to be seen as if (or made to feel as though) they are always being surveyed (Whatcott, 2018). Even for individuals who are not criminalized or incarcerated, the value of disciplinary power is a practice which we can see normalized (Foucault, 1975, p. 303). This can be seen even through daily events such as work email addressing or adhering to a time in and time out method in ones occupation. Carceral rhetoric remains to be continuously normalized and as seen through this system of power the punitive ideology supports the notions of surveillance and discipline within a power-driven state.

Foucault's work specifically in *Discipline and Punish* as well as his lectures on biopolitics can be used as a strong theoretical foundation for work on women's incarceration. Foucault traces the "birth of the prison" through *Discipline and Punish* by deconstructing the systems of punishment within carceral spaces and how these spaces impact the bodies of prisoners. The prison in a very basic sense is an "instrument and vector of power" (Foucault, 2010, p. 178) and exerts its power through the correctional staff, physical space of the prison and the policy that enforces the power. The use of state power is collectively the agent that contributes to the surveillance of criminalized individuals in the prison and in the community through the mechanisms that reinforce power dynamics. Penitentiary techniques are promoted, according to carceral logic, as the only means of "overcoming their perpetual failure" (Foucault, 2010, p. 230). Taken in the context of incarcerated pregnant women and mothers, this means that the carceral system is a perpetual reminder of "failure" for the women who are incarcerated. This perceived failure stems not only from the fact that they are incarcerated but also the supposedly "natural" failure of motherhood for women who have lost children or are seen to be unfit mothers (Solinger, 2005, p. 244).

In relation to pregnant women in prison, the confines and isolated nature of the prison combined with the uncertainty of pregnancy are overlapping systems that reinforce this biopolitical power. This extends beyond just the notion of physical and individual power, but the idea of surveillance and how the continued surveillance of criminalized individuals—in this case criminalized women—has lasting impacts (McCorkel, 2003, p. 58). Post – incarceration, the navigation of motherhood is challenged as a condition of problematic behavior and reinforces the idea that mothers interacting with the criminal justice system are deemed “unfit” to be parents (Whatcott, 2018). Whatcott is referring to the racial discourse she observed in her work in biological power and population control in California prisons with the control of welfare policies destroying public safety nets (p. 137). Incarcerated mothers are typically seen as “unfit” mothers and this is a “fast-track [to] termination of their parental rights” (Solinger, 2015, p. 245). The policies (or lack thereof) often reinforce beliefs that criminalized women are unfit mothers. In its more extreme version, this extends to eugenic-like attitudes about criminalized and incarcerated women, Whatcott uses this example to discuss the dangerous forms of birth control such as sterilization used in the 1980’s to control “poor women” thus exhibiting more control from the state over women’s bodies (Whatcott, 2018, p. 138). Whatcott explains that the use of forced sterilization in California prisons, directly ignoring informed consent and continuing this notion that is further supported by Solinger (2015) of controlling unfit mothers in the criminal justice system.

Feminist Criminology

“What does it mean to be a feminist criminologist?” Claire Renzetti asks this question in her book *Key Ideas in Criminology*, which seeks to unpack theories about how women offenders

fit into feminist politics from the 1970's to the present (Renzetti, 2013, p. 1). In this section I will explore the concept of feminist criminology through the work of Rickie Solinger and Rachel Roth with the support of other feminist criminologists. First, defining feminist criminology is to understand the causes and results of women and girls' interactions with the criminal justice system. One of the core principles within feminist criminology is the inclusion of women in criminology research. Until the 1970's women were largely ignored from this research as women were not seen to "commit crimes" (Renzetti, 2013). The primary reason for this was largely that women just do not commit the same types of crimes as men, and while women's rates of incarceration are significantly lower than men's, since the 1970's there has been a steady increase in the number of women offenders. I use this theory to unpack some of the implications of this research project. Feminist criminologists such as Renzetti often take a critical approach, supporting research and care for incarcerated women that expands beyond the male-centered focus of prison research (Belknap & Holsinger, 2006). The androcentric approach of corrections is merely a reflection of the gendered structure that we see within society, just within its own hierarchal scale (Renzetti, 2013). Using the work of Solinger and Roth, I am able to draw on the work of past and present feminist scholars. Using a critical feminist perspective, this research draws closely on the notion that prisons are institutions aimed at enforcing social conformity. Prisons operate according to a gendered logic. The traditional understanding of Canadian corrections and the understanding of the carceral landscape of men has shaped the trends in prison (Davis, 2003). Davis (2003) continues to employ this logic, reflecting that the gendered structure within prisons is essentially entrenched in the gendered structure of society as a whole. Reinharz states that using a critical feminist lens could "help social researchers see the relations between gender and power in all social settings" (p. 1992).

“Women’s rights don’t stop at the jailhouse door,” says Roth (2011). Roth identifies two avenues of discussion when referring to pregnancy in prison: either to keep the pregnancy or opt for a medical abortion (p. 243). Roth’s work is women-focused, speaking to the environment that women are in when they must make this decision and the isolation that they are typically in. Roth approaches this issue with the understanding that most women who are entering the prison system are likely poor or struggling in some sense socioeconomically. This places a greater financial burden on women to make decisions based on their financial situation; they may feel as though they cannot afford to support a child (Roth). As Roth notes, many women have felt pressure to make a particular decision, and feel scrutinized for their pregnancy. She also notes women feeling pressured into abortion because they are treated as a “drain” on the system. The general uncertainty of prison life for many women creates a sense of fear in women and concern of having parental rights terminated (Roth, 2011, p. 243). Concern about whether they will be able to keep and parent their child causes significant mental health distress for the woman who is incarcerated. “If you are pregnant, being in prison or jail does not mean you lose your right to decide whether to continue your pregnancy or have an abortion” (Roth, 2011, p. 244).

Rickie Solinger is a historian and advocate whose work focuses on reproductive rights, including the context of incarceration. In her work *Interrupted Life: Incarcerated Mothers in the United States*, she uses an exhibition of work from advocates, academics and previously incarcerated women focused on increasing public knowledge and activism. The increase of incarcerated women is estimated to be rising for a variety of reasons but requires more in-depth research to understand the underpinnings of why. Solinger (2005) explains this increase with reference to mandatory drug sentencing laws in the US, as well as states’ interests in growing state economies, which rely on the prison industrial complex. The prison industrial complex

refers to the mutual interest that private prisons and lawmakers have in keeping people incarcerated. This is because in the US, prisons create many jobs and generate large amounts of cheap, prison-based labour, while ultimately benefitting the private organizations that run the prisons. With respect to the notion of pregnancy and power, Solinger (2005) notes that prisoners are the “ideal” pregnant women as they essentially are forced to give up their rights to the state (p. 243). This notion was originated by Roth (2004) who was commenting on the effects of *Roe v. Wade* on women incarcerated in the US. While there are no laws impeding women’s reproductive right to choose, they are rendered nearly choiceless by the state policies which fail to support them and are nearly unregulated. With the lack of standardized policies in place to protect women who are pregnant in federal institutions, there is no evidence of state regard for their health and the health of the child (Roth, 2004, p. 422).

Generally in prison, the relationship between the mother and child is almost started as a broken relationship. The criminal justice system claims to focus their authority on “protecting the child” (Solinger, 2005, p. 246). This is then supported by punishing women for substance use and immediately claiming that she is an unfit mother. The interest of “the child” is an open-ended question. As Solinger notes, the interest of the child can sometimes consist of removing mothers’ right to access an abortion or being forced into having an abortion based on the notion of being an “unfit” mother (Solinger, 2005, p. 246). The discrepancy in these narratives allows very little space for an actual focus on care and virtually ignores the possibility of a care-based model for incarcerated women. According to Arendell (2000), the expectation of women is to not only fulfill their “natural” function of being a mother but to also excel within their role of motherhood regardless of social constructions at play (p. 1192). However, as the literature clearly shows, when both women and girls are involved in the criminal justice system, their identity is tainted

by criminalization and thus their reputation as a mother is tarnished by this experience (Schaffner, 2006, p. 136). Schaffner also notes that criminalized women, and in particular mothers, are labelled through public perception as “bad” or “troubled” and they are often seen as unfit to care for their children. As noted by Derkzen and Taylor, (2013), the normalization of control over women’s bodies through pregnancy and motherhood is capitalized outside of the carceral space, the complications that arise for women who are in custody allow very little autonomy for women through the confines of incarceration. “The longer a woman is incarcerated the more difficult it becomes to fulfill and maintain her role as a mother. [...R]ole strain is a major aspect contributing to this disconnect” (Berry & Eigenberg, 2003, p. 30).

Using research on feminist criminology, the notion that prisons are inherently gendered spaces is supported by the literature. The traditional focus of corrections on men’s incarceration created distinct discrepancies in a system that was not built to support women and continues to reflect the gendered structure of many societal structures (Davis, 2003, p. 61). “Women’s prisons have held on to oppressive patriarchal practices that are obsolete in the ‘free world’” (Davis, 2003, p.64), further supporting the notion of an androcentric system. The work of Solinger and Roth being specific to women’s incarceration and women’s health is crucial in furthering the argument and support for critical feminist studies and supporting the themes present in this project. Both Solinger and Roth have highlighted the need for further understanding of women’s space and interactions within the criminal justice system.

Methods

Research questions

The central guiding questions for this project are:

1. What is the current state of prenatal care for pregnant incarcerated women in Canadian Federal prisons? Can it be enhanced to meet women's right to the highest attainable standard of health (the global standard as articulated by the United Nations)?⁶ If so, how?
2. How can pregnant women in Canadian prisons be better supported by healthcare policy?

Study Design

The overall goal of this project was to have a greater understanding of the policies and practices in place that contribute to the wellbeing and experiences of pregnant women navigating the justice system in Canadian federal institutions. The decision to study Federal institutions is based on a variety of factors including length of sentence, number of federal institutions in Canada and lack of research currently on female federal offenders. While there is a clear need for oversight and change at both the provincial and federal level, the concerns of pregnancy and motherhood as they pertain to women serving longer sentences and being separated further from their families informed this decision to pursue the concerns of federal prisons. Although there are significantly fewer women incarcerated federally compared to provincially, the average stay in a provincial jail is usually quite short in length. Federally, women will be incarcerated for at least

⁶ "States should enable women to have control over and decide freely and responsibly on matters related to their sexuality, including their sexual and reproductive health, free from coercion, lack of information, discrimination and violence." In addition, states should empower "women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (Office of the United Nations High Commissioner et al., 2008, p. 13)

two years, increasing the concern for newborns to be separated from their mothers, potential time away from existing children as well as an increased risk of health concerns associated with being incarcerated.

In order to find answers to my research questions, I conducted a review of scholarly and grey literature, and successfully recruited three interview participants. I transcribed the interviews and used NVivo software to identify themes present throughout by sorting the data by the themes that were present through two rounds of qualitative sorting (or coding). This research was complicated due to the fact that it overlapped directly with the onset and most intense period of the COVID-19 pandemic, which I describe further in a subsequent section of this chapter.

Recruitment & Qualitative Interviews

I recruited participants through my own in-depth research of individuals who publicly are involved in and advocate for the rights of mothers and women in prison. This involved both experience with the Federal and/or Provincial prison systems in Canada and was largely focused on their own experiences with care and their own understanding of care in a prison environment. Individuals approached were either advocates for incarcerated women, or physicians who work in women's prisons, since they offer a firsthand approach and real stories to understanding the experiences of women in prison. I also reached out to nurses and nurse practitioners working in prisons, but received no responses.⁷ The stories provided by the three participants (two physicians and one advocate) were based on their experience in both research and practical settings. Through their own lived experience, they shared stories about their work, and reflected on their perceptions about women living in prisons. I did not attempt to interview incarcerated

⁷ Additionally, given the challenges of healthcare workers during a pandemic, the stress on the healthcare system and COVID-19 prevalence in prisons.

women themselves, since prisoners have limited phone and internet privileges, and in-person research was forbidden by Memorial University during most the data collection period, because of COVID-19. This research received clearance from the Memorial University of Newfoundland Interdisciplinary Committee for Ethical Human Research (ICHER). The individuals who participated in the interview process remain anonymous; I use pseudonyms to refer to them, and I do not identify them by the region or the specific institutions in which they work.

I conducted semi-structured qualitative interviews with three individuals involved with advocacy and health care within the Canadian prison system. The interview guide was a set of predetermined questions that allowed for open ended and in-depth conversation regarding each individual's experience with the penal system and how they viewed the lived reality of incarcerated mothers. In general, qualitative research is a characterization of descriptive findings rather than quantifiable or numeric data. "The purpose of in-depth interviews is to allow people to explain their experiences, attitudes, feelings and definitions of the situations in their own terms and in ways that are meaningful to them" (Van den Hoonaard, 2012, p. 78). This approach allowed me to have an adaptive mentality when interviewing. I interviewed two physicians and an advocate, each of whom reflect on their own experiences. These experiences help shape their responses, direction and attitudes towards my research question and the interview as a whole. The approach I used in my interview process was semi-structured and semi-grounded, meaning that I had identified questions pertaining to my research interest but was not specifically looking for the conversation to be very structured.

Coding and Analysis

When interpreting interview transcripts, “[t]he goal is to remain open to all possible theoretical directions indicated by your readings of the data (Charmaz, 2006, p. 46). This approach to qualitative coding allows for themes to present themselves organically. Following the interview process, the next stage was to analyze the data that I had collected. Given the limitations discussed above, three interviews were conducted but served as primary tools to support the otherwise collected literature and grey literature. The interviews were audio recorded (with consent) and transcribed by hand, by me, to provide the individuals who participated with anonymity and security in their answers. For the purposes of analyzing the interviews, NVivo was used. This is a qualitative software program with the purpose of sorting and organizing qualitative data. While synthesizing the data, I conducted two rounds of qualitative analysis one to identify major themes and the second to identify sub-themes throughout the interviews. Many of the themes were anticipated prior to the interview, based on findings from literature reviews, but the semi-structured and semi-grounded atmosphere of the interviews had the primary purpose to immerse myself in the data and see what themes would be present without an underlying idea of what would appear (Charmaz, 2006, p. 47). Of course, this is not entirely possible because we enter data analysis and research with various biases to begin with, but I chose to identify the themes as they presented themselves throughout the transcripts but also through implementing a second round of focused coding, I was able to pinpoint and develop clearer themes present within the data.

Statement of Reflexivity

As qualitative researchers, the ability to understand ones relation to the research is known as reflexivity. This term, as defined by Charmaz (2006), is the ability of the researcher to

scrutinize their own experience and decisions within the research process and how it influences the positions and assumptions made by the researcher (p.188). The assumptions I make about this work are based only on my experiences as a researcher. While I am deeply passionate about the work and this field of study, I have not experienced the direct processes of criminalization or motherhood in any capacity. However as a feminist who has been involved in community-based social justice activism [you may want to cite a couple of examples here], the fate of incarcerated women is important to me.

COVID-19 Challenges

Originally in my methods proposal, I had envisioned interviewing between ten and twenty prison-based health care providers (HCPs). In spite of this hoped-for outcome, only three interview participants responded and agreed to participate. I also designed and disseminated a survey to nurses working in correctional institutions, in order to provide a larger health care perspective across institutions. Although it was sent out across Canada, the survey did not receive any responses. Survey responses would have been helpful and added welcome context, however both nursing and correctional staff have endured significant challenges as frontline workers during the COVID-19 pandemic (Talaee et al, 2020, p. 3). The isolated nature of the prison has posed challenges for prisoners and prison staff alike during COVID-19. Nurses providing care were on strict time rotations and the overwhelming stress and concern of becoming ill was likely a stress for many. The stress that nurses endured over the course of the pandemic will likely have a lasting effect on the future of nurses and nursing practices in prisons (Talaee et al, 2020, p. 6).

I also note that the unfolding COVID-19 pandemic raises important questions about incarcerated pregnant women and mothers which may take years to answer fully. In the meantime, I summarize some early findings here. Canadian prisons saw unusually high rates of COVID-19 spread through their inmates, not only putting them at risk but also their staff and the families of their staff (Paynter & Mussel, 2020). As well, the isolated nature of the pandemic changed many features within the prison, with the cancellation of programming, loss of family visits and the need for inmates to stay in their cells, many individuals likely found it increasingly taxing on their mental health (Paynter & Mussel, 2020). For mothers, the inability to see their children from outside the prison and the uncertainty of whether their families were safe and healthy and many women in federal institutions had concerns of separation from their children following the cancellation on programming (Paynter & Mussel, 2020). First, the overall uncertainty and general stress that pregnant women were under during a pandemic is not unnoticed, but with the changes to hearings, court times and the overall isolation, it is not uncommon that pregnant women would be struggling and concerned for their future and their child's future (Paynter & Mussel, 2020). The time sensitivity that pregnancy depicts for individuals is of course a major consideration. For many women, the hope that they will be released prior to giving birth is important. Women need the ability to plan and determine what supports they have or will need to have for the birth of their child (Paynter & Mussel, 2020). This leads to the question: "how did the COVID-19 pandemic affect the standard of care for pregnant women in prison?" I continue to ponder how the covid-19 pandemic affected women in prison in general, but fully answering this question remains a significant challenge for the time being. I would like to hear more from both incarcerated women, and the HCPs and advocates who work with them and on their behalf. With vaccinations becoming more common and more

jurisdictions beginning to resume normal operations, I plan to continue pursuing answers to these questions in my PhD research.

Conclusion

In this chapter I have identified the main theoretical foundations that support the work in this thesis as well as the study design and methods that I have employed to conduct this research. The work of medical anthropologists, Foucauldian theory and feminist criminology create the theoretical foundations for this work. Through the implementation of a qualitative interview process, I assessed the themes present throughout the semi-structured interviews. In the next chapter I will conduct a literature review as well as consult grey literature pertaining to pregnant and incarcerated women.

Literature Review

History of Canada, Women and the Law

In this chapter, I will discuss the literature available on incarcerated and criminalized women in Canada, navigating motherhood in prison and how systems of care are interweaved in this narrative. Additionally, I have consulted grey literature which will further support the argument that women in Canadian federal prisons should: 1) have access to the same level of care as non-incarcerated women; 2) be empowered to be mothers (should they so desire); and 3) be supported in their return to the community.

The first women's prison in what is now known as Canada was founded in 1835 and was located in Kingston, Ontario (Corrections Service Canada, 2008a). This was only a separate wing in the original Kingston Penitentiary for men. According to a Corrections Service Canada (2008a) document regarding the institution and prison reform for women "Conditions for the women were similar for men, or worse." It was not until almost a century later in 1935 that the first women's only facility was built and called "Prison for Women" or commonly known as "P4W", also located in Kingston, Ontario (Corrections Service Canada, 2008a). Although separated by sex, incarcerated women are subject to the same criminal justice system that has been designed for men while ignoring the clear gender differences that separate men offenders from women offenders (Montford, 2015, p. 285). The male-centered approach to corrections was clearly not serving the female inmates in the same way and growing concern about the conditions of women's facilities sparked the interest and scrutiny for Corrections Service Canada (Montford, 2015, p. 288). A "Male centered" approach is determined as a gender-neutral approach to corrections (p. 288). Montford describes it as an "add women and stir" (p. 306) approach. It not only assumes that women are incarcerated for the same reasons as men but that they have the

same needs while incarcerated. The correctional investigator in 2008, Howard Spears, notes that men and women are involved in the criminal justice system for different reasons and ignoring the gender differences could hinder the ability to provide safe and humane custody (Montford, 2015, p. 288). Between 1988 and 1991 there were seven suicides in the Penitentiary for Women, six of the seven were Indigenous women (Montford, 2015, p. 287). This was seen as signaling a need for prison reform and triggered a massive change for women's imprisonment in Canada, leading to the development of five federal institutions and one healing lodge in six Canadian provinces.

Currently in Canada, correctional facilities are separated by federal and provincial jurisdictions. Federally there are five multilevel institutions for women across the country located in the Fraser Valley (British Columbia), Edmonton (Alberta), Kingston (Ontario), Truro (Nova Scotia), Montreal (Quebec) and the Okimaw Ohci Healing Lodge designated for Indigenous women which is located near Maple Creek, (Saskatchewan) (Corrections Service Canada, 2008b). The Fraser Valley Institute opened in 2004, the Edmonton Institute opened in 1995, Grand Valley Institute (Kingston) opened in 1997, Nova Institute (Nova Scotia) opened in 1995, Joliette Institute (Quebec) opened in 1997, and Okimaw Ohci opened in 1995. Women who are sentenced to serve two years or more are incarcerated in federal institutions, and those who receive sentences less than two years are incarcerated in provincial institutions (Corrections Service Canada, 2008b). Provincial correctional facilities are managed by the province and through their provincial department of justice. Women who are sentenced provincially are more likely to be serving in a correctional facility closer to their home based on the higher number of provincial jails and remand programs. The challenge with federal corrections is women can be far away from their loved ones and transported hundreds of kilometers away from family, posing specific risks to women who are already navigating motherhood (Hannem, 2009). "Canadian

families incur much higher costs for travel to visit their incarcerated loved ones, if they can afford to visit at all” (Hannem, 2009). This is not only a financial burden, but considering the loss of family support systems and lack of support from the community at a time when individuals need a support system.

Even today, given that women are the fastest growing prison population in the world they still remain largely unnoticed, beyond studies of the gendered nature of criminal activity (Alirezaei & Roudsari, 2020). Women often come into conflict with the law for different reasons than men and they are twice as likely to be incarcerated for drug related offences (OCI, 2015, p. 50). Nevertheless, they appear to be an afterthought in the world of corrections. Historically, the criminal justice system was structured around crimes typically committed by men, and men have largely been the primary targets of the penal system. Yet, even with the growth of female offenders there is still relatively little attention to women and the law in comparison to men. In Canada, women make up about twenty-five percent of police-reported crimes with the largest percentage drug related offences (OCI, 2015, p. 50). Men are statistically more likely to be convicted of a violent crime than women. Homicide is considered to be the most serious criminal offence and over the last decade eighty nine percent of convicted homicides were committed by men which has remained stable since the 1960s (Kong & AuCoin, 2007). From what we understand about criminalized women, we know that they make up a distinctly marginalized portion of society (Montford, 2015, p.284). In Canada this is largely related to the realities of Indigenous women and their interactions with the criminal justice system as well as poor women and women who are survivors of violence throughout childhood and adulthood (Pate, 2006). Eighty six percent of women in federal facilities self-report experiencing physical abuse and sixty-six percent report sexual abuse (OCI, 2015, p. 50).

When incarcerated women happen to be pregnant, correctional facilities in Canada prioritize keeping incarcerated women in prison until after they give birth, but many find challenges when they are released if community supports are not presently accessible to them through organizations outside of the prison (Martin, R. et al., 2013). Organizations such as the Elizabeth Fry Society (EFS) have community-based homes and supports in many cities but the number of women that need these supports is greater than what is available. Some of the programming available from EFS includes legal support, community outreach and housing assistance, family planning and programs for children of previously incarcerated parents and transitions for women struggling with substance use. The importance of supporting women and their babies to ensure the best possible outcome is crucial (Corrections Service Canada, 2008a). However, the expectation that correctional facilities should provide women with the same level of care they would receive in the community is challenging when correctional facilities are not equipped to handle medical emergencies (Corrections Service Canada, 2008a). That correctional institutions often can not provide the same level of care that a hospital can provide, this is shown through the story of Julie Bilotta and the necessary actions that should have brought her to a hospital as soon as she showed signs of labour, this story is highlighted at the beginning of this thesis. While women are the fastest growing prison population, in Canada they do not make up a significant portion of the overall prison population compared to men (Corrections Service Canada, 2008a). In spite of this, correctional institutions must consider the needs of the women who are incarcerated within their facilities.

Criminalizing Women – Trouble with the Law

Numerous studies in the US have noted the lack of research on women's prisons. Schaffner notes in her book, *Girls in Trouble with the Law*, the lack of research into female incarceration and a generalized lack of understanding with respect to the underlying gendered tactics used in corrections (Schaffner, 2006, p. 3). The percentage of women incarcerated for violent crimes is significantly lower than the number of men incarcerated for violent crimes. As victims, women are most likely to be victims of violence and sexual assault (Kelly & Ramaswamy, 2012). More than seventy percent of women in prison have experienced violence prior to incarceration (Ferzst, 2011 & Pate, 2006). While there are many stark statistics related to violence, sexual abuse and substance use, a common theme is that many of these women are mothers and are experiencing decades of trauma, yet still much research remains focused on male institutions (Luke, 2002). This can be problematic for a variety of reasons. The research on male institutions is specific to them alone and cannot be simply duplicated for women. The lack of understanding of female prisons makes it challenging to have policies that support women effectively, specifically in terms of pregnancy when the policies are then also affecting the child (Moloney et al, 2009). Marginalized groups are represented at high rates amongst criminalized women, and incarcerated women constitute a vulnerable population. In most literature regarding incarcerated women, they are often deemed as “deviant” for engaging in criminal behaviors (Schaffner, 2006, p. 133)—which is an example of how, according to Foucault, discourses “normalize” some behaviours and subject others to disciplinary techniques such as pathologization. Incarcerated women are usually depicted according to one of two characterizations: either ‘bad’ or ‘victim.’

This oversimplification makes it difficult to understand and distinguish the distinct experiences of incarcerated women (Sufrin, 2017). Women who are incarcerated are more likely to be from a lower socioeconomic class than women who have not experienced incarceration. They often lack vocational training and report coming from histories of abuse, sexual violence and substance use, which are usually cited as factors leading to their incarceration (Cormack, 2006). Incarcerated women are disproportionately more likely to struggle with mental illness, which is only made worse by a prison environment which tends to increase stress and anxiety levels for many women (Paynter, 2019). Women are more likely to cause physical harm to themselves as opposed to one another (the latter of which tends to be more common in male prisons) and are very prone to self-injurious behaviors. Despite knowing that criminalized women are likely to experience many disproportionate challenges based on these vulnerabilities, they still do not receive an adequate amount of support to mitigate these risk factors (Suter et al., 2002). Given all of these challenges, when female offenders are released, they often lack much of the vocational training needed to gain employment upon release and escape the cycle of incarceration (Suter et al., 2002).

Incarceration & Advocacy for Improved Health Outcomes

In recent years there has been research exploring some considerations that should inform guidelines for the care of pregnant and post-partum women in prison. The most important consideration is the increase in the number of female prisoners worldwide, with the majority under the age of 50, meaning a large increase in incarcerated women who are of reproductive age (Alirezai & Roudsari, 2020). Women in the criminal justice system are considered inherently more vulnerable, in high numbers, they are subject to poor nutrition, domestic violence and

sexual assault (Carter et al, 2020). The combination of sociodemographic factors and potential pregnancy means that women have specific care-related needs within the prison system (Carter et al, 2020). A recent US study, points to a lack of care for women in prisons in thirty-eight states, indicating that forty-six percent of female prisoners did not receive prenatal care (Alirezai & Roudsari, 2020). In the US, the differences among state policies have made it more challenging to have any cohesive policies relating to prenatal care for incarcerated women. Individuals in prison are more likely to experience physical health problems, this can be caused by a variety of factors including stress, diet, exercise, mental health and substance use (Carter et al, 2020). Research done on a high salt diet has been linked to greater risk of cardiovascular disease in incarcerated people, whose diet is typically unhealthy, and specifically with respect to women who are pregnant (Carter et al, 2020). Within the Canadian context, a recent study in Ontario shows that women who are incarcerated or have experienced incarceration are far more likely to go without appropriate prenatal medical follow-up and this is often linked to low birth weight in babies and higher risk pregnancies (Kouyoumdjian, et al, 2016). The “unhealthiness” of incarcerated women is often attributed to their life prior to incarceration, specifically as regards substance abuse, victimization, “unhealthy” lifestyle habits, and poverty (Smith, 2000).

With the US still reporting the highest number of incarcerated women, and the numbers in Canada rising, the risk to women and their maternal outcomes should be considered through pregnancy, labor, delivery and the neonatal outcomes (Beal & Mosher, 2019). High risk pregnancies, low birth weight and late term complications are all common. These phenomena occur at higher rates among incarcerated women and are disproportionate based on the exposure to violence, poverty and mental illness (Paynter et al, 2019). Paynter (2019) notes that nearly

63% of incarcerated women in Canada are prescribed anti-psychotics to cope with extreme isolation, Post-Traumatic Stress Disorder (PTSD) and related concerns while being medically treated for mental illness (Paynter et al, 2019). Considering the gendered construction of mental illness, Kilty (2012) argues that the carceral system pathologizes women as “mad” when they appear to be struggling with the structures of prison life, such as isolation and uncertainty. Consequently, they are categorized as mentally unhealthy (Kilty, 2012), rather than as simply reacting with anxiety and depression to a system designed to invoke anxiety and depression. The over-representation of Indigenous women and women of color underscores the necessity of employing an intersectional feminist lens that recognizes race, economic status, (dis)ability and age, in addition to gender, to further understand the overlapping layers of identities and discrimination that inform the experiences of incarcerated women (Paynter et al, 2019). Gender and racial inequities are all significant factors that contribute to the operation of institutional power, forcing many pregnant women to confront multiple complex challenges while incarcerated (Paynter et al, 2019). Socioeconomic factors, greater risk for mental illness and the lack of rights comprise the central issues for women and the (lack of) care that they receive.

Mothering Behind Bars: Structural Power(lessness)

The current research on maternal health is quite limited in the context of incarceration. There is a disproportionate exposure to violence and systemic challenges such as high rates of communicable disease and low levels of education for incarcerated women, making their experience in prison, coupled with being a parent or new parent, significantly challenging (Carter et al, 2020). The notion that better “health care for all will be better health care for incarcerated women” is really at the forefront of the discussion surrounding a better care-based model (Carter

et al, 2020). In looking at the institutional structure of the prison, the first notion of power that makes it considerably challenging for women is the gendered component. While pregnant women will likely all face challenges while incarcerated, it is important to understand that these factors disproportionately affect women of color and minorities because they represent a large majority of the prison population. Women entering custody already appearing with other socioeconomic disadvantages are likely to face institutional challenges related to childcare before and after giving birth (Moloney, 2009). With women often being the primary caregivers (or only caregivers) for their children, it is important to understand the position that the children have in terms of maternal incarceration (Moloney, 2009).

There is an overwhelming number of women who are incarcerated who are mothers (Derksen & Taylor, 2013). Women are far more likely than men to have custody and be the primary care giver to their children prior to their incarceration (Berry & Eigenberg, 2003, p. 111). It is estimated that more than seventy percent of women in federal prisons in Canada are mothers to children under the age of 18 (OCI, 2015, p. 50). Even with this knowledge, mothering behind bars is still under-researched and little is known about imprisoned parents and even less about women who are pregnant while they are incarcerated (Brennan, 2014). “The prison experience often is described as more painful for women than for men because it cuts off ties to the family and loved ones, especially children” (Jiang & Winfree, 2006, p. 37). Even though many men who are incarcerated have children, it is more likely for the parental role to be expected of the mother (Jiang & Winfree, 2006, p. 37). Despite the aforementioned challenges that criminalized women face as a whole in considering the portrayal of the ‘unfit mother’, the responsibility is still placed on the mother to be a caregiver even though lack of supports make it difficult for criminalized women to retain custody of their children (Berry & Eigenberg, 2003). If

they do not have another family member to go to, many children are apprehended by children's aid and placed into foster care while their mothers are incarcerated (Berry & Eigenberg, 2003). Because families have deep-rooted connections, incarceration creates stress for mothers, children and families (Foster, 2011). The literature on this topic is in agreement that the separation of children from their mothers has lasting effects on the mental and physical health of both mother and child, once again supporting the notion of attachment theory (Foster, 2011).

The constraints on women who are planning a birth within the correctional setting establish significant boundaries to motherhood. They do not allow for the safety of both mother and child bonding and ignore important needs for mothers to bond with their child (Paynter et al, 2019). The shift toward a woman-centered approach is spearheaded by advocates for correctional change, encouraging a shift from a subjugated role to a care-based model focusing on midwifery and community-based doula programs to be implemented in correctional facilities (Shlafer et al., 2014, p. 323). Examples of these partnerships are supported by Schlafer in using doula based programs for incarcerated women in the US. They established that the importance of a doula is to provide "a woman who provides physical, emotional, and informational support to the laboring mother throughout her entire labor [and earlier in the pregnancy as well]" (Shlafer et al., 2014, p.3 & Simkin & Way, 1998). This approach is meant to provide support for women during pregnancy and allow them to explore motherhood (should they desire to). The partnership would likely allow for marginalized women to have increased pregnancy literacy and understand how their pregnancy and how motherhood can have a positive impact on their life (Shlafer et al., 2014, p. 323).

Establishing a clear sense of who determines the rights of prisoners may allow us to begin to fill in a number of gaps within the literature on female reproductive care. Maternal

outcomes are important, but research shows that the health of the child is also linked to the health of the mother, meaning, new mothers who are able to parent or have a relationship with their baby see lower rates of recidivism (Ferzst, 2011). The gaps in the literature are noted by many authors who come to the same conclusion: there is a lack of understanding of the policies responsible for providing women with adequate prenatal care as determined by the assumption that incarcerated women are unfit mothers and perpetuates the oppression of marginalized women (Ferzst, 2011). In other words, it is perpetuating negatively racialized, classed and gendered assumptions surrounding who can and who should be a mother. This appears to color the kind of health care that new mothers receive, particularly if they have a history with law enforcement. Typically, they are seen as factors that make women unable to be suitable mothers (Schaffner, 2006) but women in custody are often already mothers when they enter the criminal justice system (Martin et al, 2013). This being noted, the system should be supporting women to continue to be mothers, and to be successful mothers after their pregnancy (Martin et al, 2013). In the next section I will consult grey literature including policy documents and position papers highlighting the work of advocacy organizations in Canada and the relevance of the rights of incarcerated women as a human rights issue in order to frame how incarcerated women's access to health care can be improved when it comes to pregnancy and motherhood.

Review of Grey Literature: The Human Rights of Incarcerated Women

The importance of the human rights of incarcerated women has been recently affirmed by the Canadian Senate's Standing Committee on Human Rights. In a June 2021 report on the human rights of incarcerated people in Canada, the committee noted important differences among incarcerated people, and the need for different practices towards incarcerated people,

which recognize those differences. For individuals who are incarcerated, the “crimes and motivations that landed women in federal penitentiaries are much different than those of men” (p. 234). This highlights the importance for specific care and research for female offenders. They continue by noting that “for example many federally-sentenced women were victims of a sexual assault, thus, some feared being stripped searched following an escorted temporary absence.” In 2004, Ruth Gagnon, the director of the Elizabeth Fry Society at the time advised the committee that strip searches should be eliminated but this was rejected from the CSC at the Commissioner’s level. In this 2021 report from the Standing Committee on Human Rights, “the recommendation recognizes the histories of abuse of federally sentenced women, the resulting negative impact on the mental health of women and the deleterious impact on prisoner-staff relationships. Given the negligible contribution to the safety and security of penitentiaries, the Correctional Service of Canada cease the use of routine strip searching of federally sentenced women” (p. 28).

There have been previous impacts on the federal incarceration practices for women in Canada with some progressive change. The changes and previous issues will be outlined throughout the rest of this chapter noting documents such as *Creating Choices* and *Roadmap* as well as the Commissioner’s directive in terms of the Mother-Child Program followed by the importance and impact of advocacy organizations on the rights of incarcerated women.

Creating Choices

In April 1990, Corrections Service Canada, under the Progressive Conservative Government led by Brian Mulroney, published a task force report about the experiences of federally sentenced women titled “Creating Choices” (Government of Canada, 1990). The document was published after a task force conducted a review of Prison for Women after several deaths in

1988. This document claims that “The task force developed a women-centered approach” (Government of Canada, 1990). This approach is defined as encouraging women’s empowerment through listening to the voices and insights of women with lived experience in the Kingston Prison for Women (Government of Canada, 1990, p. 9). The purpose of the task force was to listen to prisoners from federal institutions. Consider two of the statements from the women consulted:

“We need a chance to earn the trust of our children. Distance and money are big barriers to achieving that.”

“We need to provide childcare and parenting classes to all mothers in prison. You are virtually crippled [sic] on release in terms of caring for your children.” (p. 14)

An obvious concern for women was the lack of ability to see their children. Many women who are federally sentenced will lose the opportunity to see their children for extended periods of time due to challenges associated with Canadian geography. At this time, Prison for Women in Kingston was the only facility for Federally sentenced women (Government of Canada, 1990). “It is through our shared commitment to reduce the pain and to provide a full range of choices to federally sentenced women..”(Government of Canada, 1990, p. 10). The notion of “*Creating Choices*” was developed through this standard, listening to the stories of women who are federally sentenced and with the goal of closing Prison for Women and providing smaller federal institutions across Canada (Government of Canada, 1990, p. 14 - 16). This document was the start of the change for federal facilities to be located in five Canadian provinces and bring federally incarcerated women closer to their home communities

Taking a more critical approach to the task force as a whole, Montford (2015) argues in an analysis of this document that it can and should be understood as a feminist document. *Creating Choices* was the first document to be “woman-centered,” with a partnership between the Elizabeth Fry Society and Corrections service Canada offering a different perspective for women and the experiences of women who are incarcerated federally (Carter Ramirez et al., 2020). The report led to specific changes including the implementation of the Mother-Child Program and attempts to improve prison conditions for women and offering equity rather than equality with men (Montford, 2015). An emphasis on responsibility for women was the focus of the task force in providing meaningful changes from the male institutional model. The basis of much of this is from the socio-economic inequalities faced by many incarcerated women with a specific emphasis on inequities faced by Indigenous women. The mandate of *Creating Choices* was to allow women to break the mold or dependence on men, substances and financial assistance, the prison should mimic their life and provide an environment that fosters responsibility (Montford, 2015). The implementation of changes from *Creating Choices* was also seen through the closure of Prison for Women in Kingston and the building of new federal facilities with the intention of more communal space, natural light and cottage style living.

Contrary to *Creating Choices* is the document entitled *A Roadmap to Strengthening Public Safety* created by the Correctional Service Canada Review Panel in 2008 under the Conservative Government and written by the Correctional Service of Canada Review Panel (CSCR). It had a “transformative agenda” to improve offender accountability and eliminate drugs in prison. The gender-neutral approach of *Roadmap* was described as “puzzling” by the Correctional

investigator of Canada Howard Spears (Montford, 2015, p. 288). The language is described as aggressive, and while it acknowledges the socioeconomic challenges that many women are coming from, it places significant blame on substance abuse, negativity towards mental health and violence (Montford, 2015). Montford (2015) goes on to state that “in fact, of the 241 pages that comprise *Roadmap*, only four pages are devoted to a section on “women offenders.” Thus, the CSCRP largely assumes that a male-centric approach can apply to all prisoners. This agenda reflects law and order policies and aims to rehabilitate prisoners according to neo-liberal values (that is, to be self-sufficient, productive, and not reliant upon state aid)” (Montford, 2015, p. 288). The comparison that Montford makes between the language in the *Creating Choices* document and *Roadmap* are to acknowledge that the language surrounding female offenders is often forgotten and argues that the presentation of *Roadmap* only offers a gender-neutral tone and assumes that women and minority groups can have the same needs and requirements as male prisoners (Montford, 2015, p. 289). The depiction of female offenders in *Roadmap* is similar to the way that Schaffner describes, comparing women as “aggressive” in attempts to put women on the same plane as male offenders in terms of needs in the prison and reasons for committing crimes (Schaffner, 2006, 126).

Commissioner’s directive 768 - Mother-Child Program

Ultimately, the work of *Creating Choices* was the inspiration for developing the Mother-Child Program in federal institutions (Corrections Service Canada, 2020). Corrections service Canada or CSC provides a publicly available document explaining the purpose and applications of the Mother-Child Program in Canada. The information available provides insight into the roles of individuals involved in the program and generally how women can get involved at their

institution. There are Mother-Child programs at all federal institutions, and they are structured under the CSC. The programs began in 2001 and were utilized fairly consistently until 2008, CSC notes that records may be incorrect as they were noted manually. In 2008, the “tough on crime” work of the Conservative government changed the eligibility criteria from twelve years to five years of age for participating children and the overcrowding in federal prisons made it challenging for the programs to work to their full capacity (Brennan, 2014, p. 13). Children over the age of 5 were able to participate part-time (weekend and holidays), allowing them to continue to foster a relationship with their mother (Brennan, 2014, p. 13). The mothers are held in an independent structured living or ‘cottage’ style unit which provides a private room and all of the necessary supplies for babies and children in the program (Corrections Service Canada, 2020).

Outside of this document there is not a lot of information available on the Mother-Child Program in Canada outside of media coverage. It defines the purpose as such: “To foster positive relationships between federally incarcerated mothers and their child, by keeping them together where appropriate, and providing a supportive environment that promotes stability and continuity for the mother-child relationship” (Corrections Service Canada, 2020). This statement from the Commissioner’s directive clearly aligns with the general support and wellbeing directives of the healthy mother child relationships and how they are important to the support of the child and decreasing recidivism in mothers (Corrections Service Canada, 2020). The document is broken down to indicate the responsibilities, eligibility and processes involved in all aspects of the Mother-Child Program federally. The deputy commissioner for women is authorized to establish the guidelines as it pertains to the Mother-Child Program. The roles of staff within this program will include an Institutional Head, mother-child coordinator, chief of health services, chief of

mental health, elder or spiritual advisor, Indigenous liaison, parole officer, review board and primary worker (Corrections Service Canada, 2020). These roles assign responsibility to staff and review boards and overseeing all components of the residential and non-residential aspects of the Mother-Child Program for children to participate in. A Mother-Child Coordinator will be the first point of contact for all mothers in the program and responsible for applications, follow-ups with child welfare agencies and arranging any issues for mothers and individuals involved in the program (Corrections Service Canada, 2020).

Mother-Child Program Eligibility

The eligibility criteria are important as much of it was changed in 2008 under the Harper Conservative Government after Public Safety Canada requested a review of the program due to overcrowding in women's prisons. The four main changes included excluding any offenders convicted of serious crimes involving violence, limiting the part-time program to age six and under (and under the age of four years old to participate in the full-time program (Corrections Service Canada, 2020)), requiring the support of Child and Family Services and requiring children to be searched for contraband prior to entering the institution (Brennan, 2014, p. 19). The changes are specific to the safety of the child, but one very notable challenge is due to the housing style of women's institutions, if a woman was housed with an inmate with an offence against children, a child would not be allowed to be placed in the same structured housing unit (Brennan, 2014, p. 19). Mothers are considered for the program if they are in a minimum or medium security classification. Note that all prisons in Canada are multilevel, but women with a maximum-security classification are not eligible for a Mother-Child Program unless they are being considered for a move to medium security (Corrections Service Canada, 2020). They must

be screened with the relevant provincial child welfare agencies for any information that could be relevant to their placement in the program including other children that may be in custody of family members or if they are mothers to children apprehended by the welfare agency. As well, the agency must support the participation of the mother. A medical professional will administer a mental health assessment and conclude whether they are capable of caring for a child and have no serious mental health concerns that could hinder this. The implications of this screening process provide significant examples of structural power and surveillance for criminalized women. Women must have no convictions relating to children or any concerns of possibly endangering a child (Corrections Service Canada, 2020). Women who are in Structured Intervention Units (SIU) will not be considered for full time residency in the Mother-Child Program. “Full time” indicates that children would be living onsite with their mother all of the time and “part time” is usually specific to weekends and holidays (Brennan, 2014). Additionally, other women in the prison who wish to participate in the “Inmate Babysitting program” must also be approved by a review board under the same criteria and complete a parenting skills program along with a first aid course in addition to being assessed as posing no indicated risks to children (Corrections Service Canada, 2020). Communication with Provincial Child Welfare agencies is a crucial aspect of the eligibility and determines the mother’s ability to continue with the program and support women upon release. If at any point termination is considered, a mother is reviewed by the agency, parole officer and mental health coordinator to make a decision in the best interest and safety for the child (Corrections Service Canada, 2020). The Mother-Child program is a program that should be used and utilized while women are incarcerated. Alternatively, there are several advocacy organizations that run programs both in and out of the prison.

Canadian Standing Senate Committee on Human Rights Response to Mother-Child Programs

In June 2021, the Canadian Senate Committee for Human Rights provided insight to the underutilization of the Mother-Child Program by stating that “the program is intended to provide a supportive environment that promotes stability and continuity for the mother-child relationship, the committee was informed however, that spaces are limited and the approval process is stringent” (The Standing Senate Committee on Human Rights, 2021, p. 104). The report states that the committee was informed that the separation of mothers from their children, especially newborns is traumatizing for both the mother and the child (The Standing Senate Committee on Human Rights, 2021, p. 104). They note that mothers express an immense amount of shame toward losing their child and the committee raised the question of whether it is just to separate the child from their mother, especially when the child is likely to be placed in the foster care system (The Standing Senate Committee on Human Rights, 2021, p. 104). The committee also noted that CSC does not track the number of federally incarcerated women who are mothers and 2017 a report from Community Justice Initiatives noted that sixty six percent of incarcerated mothers are separated from their children. The committee states and believes that the CSC should consider community-based programs for the release of mothers and change the mandates of the Mother-Child program to make it accessible (The Standing Senate Committee on Human Rights, 2021, p. 105). The committee continues to state the important role that family plays in an individual’s journey to reintegration and the stability that this provides further supporting that motherhood is a human rights issue.

This report was published in 2021 and has made similar claims that have been noted in previous studies on the Mother-Child Program, the program is necessary to support mothers but it is not accessible and is still underused despite being available in federal prisons many mothers are unable to access it (The Standing Senate Committee on Human Rights, 2021, p. 104). While the program exists to support mothers, it appears that it is not supporting them adequately, and has not been for several years. They continue to state in response to the findings that the program is underutilized “that the Correctional Service of Canada [should] facilitate parenting via section 81⁸ agreements for federally-sentenced Indigenous Peoples and non-Indigenous persons, in addition to providing full access to the Mother-Child Program by working with the provinces and territories to eliminate barriers preventing federally-sentenced women from accessing Mother-Child Programming” (p. 107).

Advocates and Organizations

Advocacy organizations serve an important role for improving the care for incarcerated women. Without the help of advocacy organizations (such as Elizabeth Fry Societies which are mentioned below), there would not be documents such as *Creating Choices* crafted to support the bettering of care and support for incarcerated women. Programs such as the Mother-Child Program, in prison doula programs and general advocacy for women who experience incarceration are influenced by the support of these advocates. The Elizabeth Fry Society is instrumental in supporting women in their communities who are involved with the Canadian Criminal Justice system, they have locations in most major cities in Canada and seek to provide

⁸ Aboriginal Alternatives to Incarceration and Aboriginal Parole Supervision (Section 81) of the Corrections and Conditional Release Act (Correctional Service Canada, 2015).

equitable care and support to women throughout their journey in corrections and supporting them after release. The importance of advocacy organizations and civil societies is supported by the Canadian Standing Senate Committee on Human Rights in stating “that the Correctional Service of Canada ensure consistent and transparent application of its security protocols so that the access of civil society organizations working with federally-sentenced persons is facilitated to federal penitentiaries and their important work is not only continued but enhanced” (The Standing Senate Committee on Human Rights, 2021, p. 239). This quotation explains the importance of civil society organizations to continue their work with federally sentenced prisoners and to provide better support where needed. “Given that women tend to have less family support than men during and following periods of federal incarceration, civil society organizations can play a very important role in their reintegration” (p. 237).

In this next section, I explore some advocacy organizations and the work they do to support women in prison and post incarceration. Their work aims to help women in Canadian federal prisons: 1) have access to the same level of care as non-incarcerated women; 2) be empowered to be mothers (should they so desire); and 3) be supported in their return to the community. Specifically, by supporting women in their return to the community and helping them find resources post incarceration.

Elizabeth Fry Society (EFS)

The Elizabeth Fry Society has locations in most major cities or regions in Canada and serves to provide support to these regions based on their proximity to provincial and federal prisons. The community supports can differ based on the region and how much support the region is getting from local volunteers and other community organizations, but they tend to be fairly

similar (*Elizabeth Fry Society of Ottawa*, 2018). Most EFS locations have court support, housing support and many are partnered with residential programs. To highlight one residential program, in Ottawa at the JF Norwood House, Correctional Service Canada provides support for a transition home that supports women who are provincially or federally sentenced and served as a reintegration tool with safe community support that helps women focus on education and employment (*Elizabeth Fry Society of Ottawa*, 2018). Some challenges in community-based support programs are that they are usually very difficult to get into, and programs such as JF Norwood only have fifteen beds available. This indicates that community-based groups can only make limited positive change without widespread structural change and investment in supports for criminalized women.

The Elizabeth Fry Society (EFS) offers a unique role in supporting women and girls in the Canadian Criminal Justice System, they are a not-for-profit organization with a range of services to support women who are, and who are at risk of being criminalized. They provide unique programming across Canada to support women and their children. Programming such as Mom and Me (which is essentially a Mother-Child Program at the provincial level) is in place to support the long-term success of incarcerated mothers. Elizabeth Fry Society provides partnership with a variety of organizations to support housing, relief and options to help women navigate sentencing, charges and their future after incarceration.

We know that women are likely to be impoverished and many of these women are mothers. The challenges that women are negotiating are significant and still require significant changes. Additionally, based on Statistics Canada “48% of children in state care (foster care) in Canada are Indigenous (more than 85% in Manitoba); the number of children in care has “increased rapidly” (Kong & AuCoin, 2007). EFS’s recommendations for the government of Canada include

developing new protocols to decarcerate⁹ women, in particular Indigenous women and those with mental health concerns, an increase to community supports for women with mental health concerns, ending male staff working on the frontlines in women's prisons and ending the practice of solitary confinement (Kong & AuCoin, 2007). They echo continuously throughout the document that many criminalized women and girls pose no threat to the community and could live in the community with the right supports. This is particularly important for Indigenous women who are disproportionately incarcerated and often imprisoned away from their home communities. Their ability to live in their communities would mean that fewer Indigenous children would be removed from their communities and placed with non-Indigenous communities.

In participation with the Committee on the Elimination of Discrimination Against Women (CEDAW), Canada is a state party to the CEDAW, meaning they agree to abide by the principles outlined in CEDAW. During periodic review, civil society organizations within Canada submit their own reports to be reviewed by the UN (Canadian Association of Elizabeth Fry Societies et al., 2016, p. 6). During Canada's 2016 UN periodic review with respect to their CEDAW obligations, the Canadian Association of Elizabeth Fry Societies submitted their own report, as a key civil society actor on women's incarceration in Canada. In their report they state:

"Imprisoned women are more likely to be impoverished, under-educated and unemployed than the general public. 64.2% of federally incarcerated women are single mothers; 57.1% had primary responsibility for their children before they were imprisoned; and the majority of their children end up in the care of the state. Most women are criminalized for behavior occasioned by their attempts to negotiate poverty, violent racism, and other forms of discrimination related to their marginalization and victimization. So slight is the risk that women pose to public safety that this risk can and should be managed in the community" (p. 10).

⁹ Decarceration is the process of removing people from institutions (such as prisons), the opposite of incarceration (McMahon, 2019, p. 207).

Given how prominent an organization EFS is, the submission of their report and the stark statistics that they have presented indicate that there is need for change for incarcerated women (Canadian Association of Elizabeth Fry Societies et al., 2016, p. 10). They are not only sharing that woman who experience poverty are far more likely to be incarcerated but that they are also highlighting the importance of women being the primary caregivers for their children. The number of women convicted of serious crimes is so low that managing sentences in the community could be an important transition to make in terms of decarceration and community-based programs (Canadian Association of Elizabeth Fry Societies et al., 2016, p. 13). In addition to the Elizabeth Fry Society, other organizations in Canada are providing support for decarceration and supporting women and mothers who are incarcerated and have experienced incarceration.

Wellness Within (Nova Scotia Based Advocacy Organization) - Formerly Women's

Wellness Within

Wellness Within serves as an advocacy group for incarcerated women in Eastern Canada. While their primary work is in Nova Scotia, they strive to work towards reproductive justice, prison abolition¹⁰ and health equity for women who experience incarceration in Canada (Wellness Within, 2017). They are a collection of nurses, doctors, midwives, physicians, policymakers and more who are committed to provided support for criminalized pregnant women seeking medical care (Wellness Within, 2017). They provide partnerships for women in Nova Scotia in both the Federal and Provincial institutions and resources for criminalized

¹⁰ “What prison abolition means is the struggle to do away with imprisonment and to find alternatives to incarceration as a way of responding to social harm.” The purpose of abolition is to recognize that the current prison system is failing to meet its own objectives of justice and rehabilitation, incarceration often leaves offenders without support and separated in the community (Wellness Within, 2021a)

women to find support. They offer doula training and match doulas with expectant mothers who may need additional support, with a particular focus on BIPOC (Black, Indigenous, People of Colour) doula training (Wellness Within, 2017). As an organization they are supportive of prison abolition, but most importantly reproductive justice and an approach that supports women within the criminal justice system.

In April of 2021, Wellness Within penned an open letter written to the Minister of Health and Wellness in Nova Scotia regarding the support of Private Members Bill no. 73: the Free Birth Control Act. The letter states that as supporters of people experiencing pregnancy and criminalization, the lack of affordable contraception is harmful (Wellness Within, 2021a). “One in two women who experience incarceration has an abortion, on average incarcerated women have had four children” (Wellness Within, 2021a). The letter goes on to state that the cost associated with accessing affordable contraception provides a clear inequality for women. Unintended pregnancies are often associated with later presentation in prenatal care and usually have increased rates of tobacco and substance use as well as low birth rate and infant mortality (Wellness Within, 2021a). In Canada the average age of women in Canadian prisons in 2011 was 33 years old which is similar to age related statistics for female prisoners in the US (Corrections Service Canada, 2020). Other recent statistics from the US indicate that in 2016 – 2017 three quarters of the women in prisons are of childbearing age (Sufirin et al, 2019). Wellness Within note gaps in the current prescription services for lower income women and that they hope to provide universal coverage for contraception. These changes are proposed in the Private Members Bill no. 73. Upon further research into the details of Private Members Bill no. 73 (Free Birth Control Act), the report details the importance of accessible contraception with specific

emphasis on a woman-centered approach (Wellness Within, 2021a). The aim of this bill is to amend Chapter 197 of the Health Services Insurance Act of Nova Scotia aiming to “expand the range of such services, with a view to reducing the number of unintended pregnancies and empowering people to make their own decisions about when to procreate” matching the input (Wellness Within, 2021a). “Reproductive autonomy,” which is a focus of Wellness Within, means the power of women to decide and make their own choices in all terms related to reproduction (Purdy, 2006). This is not a right that is enjoyed by all women. The specific call for support to incarcerated women highlights the gap in reproductive health care and is frequently reiterated by the organization. The relevance of this letter and the push for this bill is the impact of unintended pregnancies and lack of affordable contraception (Wellness Within, 2021a).

In another report and subsequent petition (Wellness Within, 2021b), Wellness Within called on the Canadian Criminal Code to be amended to provide changes in pre-trial measures for pregnant women and primary caregivers to not be remanded¹¹. “Many people who are remanded do not go on to be convicted” and additionally many of these people are serving sentences in the community. “We call on the federal government to amend the provisions of the Criminal Code regarding Judicial Interim Release to provide that pregnant people and primary caregivers of young children or people with disabilities, who would otherwise be remanded to prison, be instead placed under house arrest” (Wellness Within, 2021b). Wellness Within points to several other countries including Iceland, Norway and Sweden which recognize women as primary caregivers and have taken measures to keep women out of prison who care for young children (Wellness Within, 2021b). Additionally, Women’s Wellness Within respond publicly to the story

¹¹ Remand is the temporary detention of a person while awaiting trial, sentencing or the commencement of a custodial disposition (The Correctional Investigator of Canada, 2015, p. 13).

of Julie Bilotta, centering their response around the issue of support for mothers in attachment parenting. The main messages were that “babies do best when breastfed and when contact with their mother is constant” while recognizing that this must be in the best interest of the child’s safety but facilitating as much contact as possible is ideal (Paynter & Snelgrove-Clarke, 2017). The report emphasizes the mother-baby dyad as fundamentally relational, especially with respect to feeding, and uses this as a basis for adaptability and flexibility when it comes to keeping mothers and their children together:

“We also know that breast milk is best and that direct baby-to-breast contact is ideal. We advocate for mothers to be provided with an electric breast pump and time and space to pump if they are separated from their baby by law. We advocate for proper supports to be in place to appropriately store and transport the pumped milk to the baby. We advocate for frequent access visits between mothers and babies when the law requires separation. We advocate for decarceration of pregnant and breastfeeding mothers as our long-term goal.”(Paynter & Snelgrove-Clarke, 2017)

The underpinnings of this excerpt are specific to the woman-centered approach that many feminist criminologists and medical anthropologists are familiar with. Advocating for mothers to be present in their babies’ lives while still adhering to the safety standards and rules as defined by the law, advocating for babies to have as much contact with their mothers can safely facilitate this attachment.

This is further supported by the recent changes and advocacy in many provinces to end birth alerts. A birth alert is when a social worker flags a mother as a potential problem or unsafe parent, raising the possibility of apprehending their child without their consent. Birth alerts are problematic because they frequently flag racialized individuals and are incredibly discriminatory in nature (Wellness Within, 2021c). Birth alerts can affect women in future pregnancies as surveillance is increased if they have already been flagged in past pregnancies. This can potentially affect future births and risk of losing children when they are newborns. British

Columbia, Manitoba and Ontario have all determined that they are phasing out and eliminating birth alerts. British Columbia has implemented more supportive housing programs to help mothers who may need extra support before and after they give birth regarding safe housing and concerns of substance use (Wellness Within, 2021c). In an article published in Nova Scotia, the president of the Native Women's Association of Canada has spoken out against birth alerts, noting that they often target parents who were involved in the child welfare system in the past (Smith, 2021). This perpetuates the cycle of criminalization and profiling of marginalized women, and frequently puts Indigenous parents and children at risk. The changes proposed by groups like Elizabeth Fry Society, Wellness Within, and the Native Women's Association of Canada aim to keep mothers and babies together and break harmful cycles within the welfare system and incarceration.

Another individual who has made significant contributions as an advocate is Senator Kim Pate. She has been instrumental in advocacy for Indigenous women within the Canadian justice system. Senator Pate is a lawyer as well as an advocate for the rights of vulnerable populations. Of particular note is her role as Executive Director of the Canadian Association of Elizabeth Fry Societies (CAEFS) for fourteen years (1992-2016). Her work primarily focusses on Canadian women's prisons and how these institutions lack accountability (Parkes & Pate, 2006). She notes that female prisoners are frequently in unique circumstances compared to male prisoners and pose relatively low risk to the community. In the words of Canadian jurist and human rights advocate the Honourable Louise Arbour, "The history of Canada's treatment of women prisoners has been described as an amalgam of: stereotypical views of women; neglect; outright barbarism and well-meaning paternalism. From the beginning, the welfare of women prisoners was secondary to that of the larger male population" (Arbour, 1996, 239). The words of justice

Arbour are frequently echoed by Senator Pate as she refers to the under-representation of women in comparison to men as prisoners and how this is the primary justification for the state's failure in its duty of care to incarcerated women (p. 256). In numerous interviews, Pate drives home the point that "we're doing something really wrong" in terms of incarceration, specifically with her work on the rising rates of Indigenous women in prison. "Now 42 percent of women in federal prison are Indigenous means that we're doing something really wrong. If you're truly committed to reconciliation, we need to be considering this an emergency and doing as much as we can to rectify it." Senator Pate has pushed for policy change specifically in terms of inmates with mental health concerns and their placement in segregation and she was involved heavily with the Ashley Smith case (Pate, 2019). With the support of the new Chief Executive Director of the Elizabeth Fry Society, Emilie Coye, she has encouraged decarceration for incarcerated Canadian women, and specifically for Indigenous women (Pate, 2019).

Discussion of Research Gap

Given the challenges identified in the literature, which I have just discussed, there several themes emerge with respect to the needs of incarcerated women in Canada. According to Alirezaei & Roudsari (2020), most current academic studies on incarceration, pregnancy and motherhood are published by medical and healthcare related journals, making them less focused of women's experience and more about a bio-medical approach to the pregnancy and post-partum needs of incarcerated women. The challenges faced by women inmates are frequently attributed to their lifestyle before incarceration. Smith (2000) describes, "unhealthiness" as a dominant way of characterizing incarcerated women in these literatures. This "unhealthiness" can also be related to specific vulnerabilities that incarcerated individuals face including

socioeconomic challenges and higher risk for disease due to both circumstance and potential substance use (Sue, 2017). There is a medicalized literature to support the need for research focused on infant health and birth outcomes, but outside of high-risk pregnancies and obstetrics risks there is little to do with the health and well-being of the incarcerated mother in a broader sense. The primary belief of individuals in advocacy appears to be that criminalized women, even those serving time at the federal level, do not pose significant threats to the community and their sentences could be managed within the community. This speaks significantly to the support for community-based programming that keeps mothers with their babies. As also noted, over half of the women who are incarcerated are also mothers. Given this, most of the literature that is available on health outcomes is heavily quantitative and does not effectively respond to women's emotional experiences of the realities of motherhood in prison outside of a few key researchers and the portrayal of incarcerated women in mainstream media. This research therefore attempts to highlight a significant gap in the knowledge of Canadian federal women's prisons and the challenges associated with navigating motherhood therein.

In the next chapter, I will draw on my semi-structured interviews and the data that I collected in order to support the claims made through the literature review and review of grey literature.

Data & Discussion

This chapter will analyze three qualitative interviews with two prison-based physicians and an advocate on what the state of prenatal care is for incarcerated women in federal institutions and the care that is available to women in these settings. This chapter will begin by describing the current standard of care for women who are pregnant in prison compared to women in the community, followed by an argument in favour of health literacy and accessible knowledge as an integral part of meeting the highest attainable standard of care for incarcerated women.

Following this, I turn to a discussion of the ideal type of supports that support women's success and well-being in pregnancy and motherhood. This includes Mother-Child programs, and programs that bridge the community and the prison. I conclude the chapter with reflections on how to move forward. The themes that will be discussed throughout this chapter include 1) discrepancy in care; 2) lack of access to knowledge, including literacy, self-efficacy, and informed consent; and 3) the importance of bridging prison and community care. These themes support the central argument that women in Canadian federal prisons should: 1) have access to the same level of care as non-incarcerated women; 2) be empowered to be mothers (should they so desire); and 3) be supported in their return to the community.

In considering the needs of pregnant and post-partum incarcerated women, the subject of care is central and is the first theme that arose in the interviews I conducted. Care can be “viewed as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible” (Tronto, 1993, p. 19). This definition of care is from Joan Tronto (1993) and provides a basic understanding that care should be established at a very basic level to live as well as possible. Writing a decade before Tronto, Carol Gilligan defined care “as an ethic grounded in voice and relationships, in the importance of everyone having a

voice, being listened to carefully (in their own right and on their own terms) and heard with respect. An ethics of care directs our attention to the need for responsiveness in relationships (paying attention, listening, responding) and to the costs of losing connection with oneself or with others” (1982). I chose to use Tronto and Gilligan’s definitions of care as they provide a critical feminist lens to understanding care ethics, through a care-based morality. The idea of an ‘ethic grounded in voice’ supports the work of medical anthropology, specifically by emphasizing respect and care provided for incarcerated individuals and examining their responses to the care that they receive. Addressing the disparities in healthcare for incarcerated people so that ‘we’ can live as well as possible means being attentive to structural vulnerabilities of incarcerated people. Feminist criminologists draw attention to the gendered logic of prisons and the connection between care and the prison space through the traditional androcentric focus of the prison (Davis, 2003), thus encouraging us to pay attention to how incarcerated women need their own, specific forms of care.

Prior to the interview process it was clear that standard of care, community supports, and institutional barriers to care would be a notable theme throughout the project as it appeared in the literature and supported by previous cases such as Julie Bilotta’s. Unsurprisingly, standard of care was a theme that was raised frequently throughout the interviews. Overall, a clear message emerged: better care in the community will ultimately lead to better care within prisons; and the standard of care for individuals in prison should be on par with that enjoyed by non-incarcerated people. In fact, community programs can be used to support both incarcerated and non-incarcerated women, bridging the gap between them. This was a considerable area of focus in the interviews and also was consistent with the grey literature. When they are able to receive support from advocacy programs, women tend to find the community supports they need to be successful

as mothers (Wellness Within, 2021c). When women were provided with community supports, they ultimately experienced greater ‘success’ as mothers and were less likely to be re-incarcerated (Martin et al, 2013). I will first lay the groundwork for this discussion by defining the concept of standard of care, and considering how standard of care differs between incarcerated and non-incarcerated women.

Standard of Care or Sub-Standard Care?

Current research in Canada determines that there is a need to better understand the experiences of women in the Canadian correctional system (Carter Ramirez et al., 2020a). The needs and experiences of pregnant women in prison are very often overlooked and present great challenges. Universal access to an adequate “standard of care” for women in prison should be the equivalent to the care available to non-incarcerated women in the community. Women experiencing both pregnancy and motherhood while incarcerated do not benefit universally from this same standard and it is the individuals working within the prison that often determine the level of care, not a universal policy standard (Carter et al, 2020). The nurses, doctors and correctional staff should not be responsible for the determining the standard of care within an institution, the care should be determined based on a policy standard to ensure that variability between institutions is lessened. While navigating prison life is challenging in its own right, many women in prison are already navigating motherhood or pregnancy and doing so while in an isolated and turbulent environment. Advocates and physicians working within prisons provide the best care and support they can in order to fill in the gaps in women’s care. As reproductive justice and incarceration advocate Rickie Solinger (2005) states “[w]hen incarcerated women are denied prenatal health care, this is a sign that the system finds them unfit and doesn’t care if they

stay that way” (p. 245) Solinger is specifically alluding to one California study indicating that women who were incarcerated were fifty times more likely to have a miscarriage (p. 245). She continues to contextualize the dangers of pregnancy in prison and the attitude that incarcerated women “do not deserve to be mothers” (p. 245). Navigating the stress of isolation and incarceration is already a considerable task—the accessibility of care should not be an additional concern for women who are already navigating the uncertainty of pregnancy, motherhood and the criminal justice system. This means ensuring a standard of care consistent with women’s ability to thrive. But what is standard of care?

“Standard of care” in the medical context can be approached in a variety of ways, for instance through advocacy, clinical practice, research and education. According to the World Health Organization, “standard of care” refers to the appropriate level of care that should be expected from one’s physician or health care provider (WHO, 2009). The standards of community medical care, and specifically the care that pregnant women receive is of the utmost importance for their overall health (Kouyoumdjian, et al, 2016). Dr. Kimberley Sue (2017), medical anthropologist and prison care advocate, states that from an ethical perspective it is clear that physicians should approach all clinical encounters with care, and that it should matter that inmates are in good physical health (Sue, 2017). Ensuring good physical health also means attending to the identities and life histories of incarcerated people or being aware of intersectionality.

Intersectionality refers to social categorizations such as race, class and gender and the ways in which they interact and overlap to create disadvantage and discrimination on the one hand, or privilege on the other—or a complex mix of privilege and disadvantage (Hankivsky, 2014). Intersectionality uses a more context-specific organization of axes of identity such as race,

gender and class, but focuses on the meanings and processes of the power structures within these interactions. Tronto (1993) has argued that the ethics of care should be taken seriously as a political issue (Hankivsky, 2014); and Hankivsky (2014) reads care ethics through an intersectional lens, demonstrating that intersectionality can be a useful lens for care ethics as it “moves beyond a single category of analysis.” The intersections of several axes of identity (gender, sex, socioeconomic status, age, ability, race, status, etc.) inform the institutional dynamics of incarceration and create significant challenges for women who are navigating both pregnancy and custody.

There is no specific standard of prenatal care for non-incarcerated women in Canada. The Public Health Agency of Canada states that “there is no consensus in the literature--nor are there any Canadian guidelines--about the optimal number of prenatal visits.” It also states that the number of visits should be determined by “the need for care,” or more generally the health of the mother, which as we have established is often lower for women in custody (Public Health Agency of Canada, 2020). Furthermore, it does state that women, on average should receive eight or more prenatal appointments over the course of their pregnancy, including a scan before the twentieth week of pregnancy. Generally only 30% of women in custody receive an ultrasound prior to the twentieth week of pregnancy (Carter Ramirez, et al, 2020). A study at McMaster University shows that 48% of women incarcerated in Ontario received less than eight prenatal visits, compared to 85% of women in the community. Only 38% percent of women incarcerated during pregnancy received a prenatal appointment in their first trimester compared to 80% of women in the community (Carter Ramirez et al., 2020a). Compared to women in the community, women in prison populations have significantly lower odds of being seen by a physician for a first trimester visit (Carter Ramirez, et al, 2020). Additionally, the information

provided by the Public Health Agency of Canada notes that women in low-income circumstances or minority groups (the reader can assume this means non-incarcerated women as they do not mention incarceration) felt that there were additional barriers to care and felt that the education available about pregnancy was lacking (Public Health Agency of Canada, 2020). Women had expressed need for counselling and education as well and involvement in decision making in regard to prenatal care. Barriers expressed included experiencing discrimination and stereotyping as well as “external barriers to care” without any further discussion of what these might be (Public Health Agency of Canada, 2020).

Interview Discussion

The information that participants shared with me through the telephone interviews was consistent with the trends identified in the scholarly and grey literature. Moreover, interview participants reflected on healthcare literacy, institutional supports, and the challenges of providing a caring environment for incarcerated women. First, I will introduce the interview participants, I have provided them with pseudonyms for their privacy. Helen is a family physician whose previous work has been as a primary care physician in women’s correctional institution. Her work in the prison was as a physician providing non-judgmental care, and she also acted as an advocate for pregnant incarcerated women. Mandy is also a family physician and researcher working with incarcerated women. She is interested in innovations to provide better care for women in corrections. Her work is motivated heavily by care and quality of care for individuals who are vulnerable and need access to quality care. Lastly, Chloe is an advocate who has worked primarily in advocating for incarcerated women struggling with substance use, her work emphasizes non-judgmental care for women in both the community and in custody.

The first theme that was prominent throughout all three interviews was that there is a discrepancy in the standard of care enjoyed by non-incarcerated women, and the level of care received by incarcerated women. In her interview with me, Mandy noted her sense that the accessible antenatal care for women in corrections is less than the community standard:

“Health care should be equivalent for people in custody as it is for people in the community and it’s not – and arguably it should be better because people in custody are sicker – I think more about that.”

Mandy’s sense that there is a gap between the standard of care experienced by incarcerated and non-incarcerated women is supported by a study in Ontario, which “found significant deficits in the care of pregnant women, including unmet nutritional needs, lack of access to primary care physicians, lack of access to lower bunks, and the routine use of restraints during transport and during labor” (Carter et al, 2020). The central message of the findings was that women in custody receive a lower standard of prenatal care. In trying to find a clearly articulated standard of care for women in federal prisons, I found that in Canada, “there are currently no analogous national standards for prisons and prison health care services, although jurisdictional or institutional policies may exist and health care professionals in prisons are obligated by their regulatory bodies to meet professional standards of care” (Carter Ramirez, et al, 2020). The point is that the standard of health care is not equivalent between incarcerated and non-incarcerated women. The reality is that incarcerated individuals are sicker, they often require more medical attention and are dealing with co-morbidities and complex issues. As Mandy further noted:

“There are medical complexity issues, there are social complexity issues, and then there are environment issues, which is inherently stressful and you have issues with quality of care and I think with all of these issues combined you would treat each pregnancy as a high risk, but seeing an OB [Obstetrician-Gynecologist] doesn’t address some of those risk factors.”

This means that in order to meet the same standard of health as the general, non-incarcerated population, incarcerated people need more, not less, care. Feminist theorists of care remind us that care is relational. For example, in this context a care-based lens encourages us to consider the mother's health in relation to the health of her child(ren). Chloe, an advocate for incarcerated women, echoes Mandy's point by noting that often, conditions affecting infants thought to be the result of an irresponsible mother, are more likely the result of inadequate care:

“The things that many assume to be the effect of drugs on a fetus are actually to do with poverty. So its poverty that is dangerous to a fetus. And with the exception to alcohol, which is the substance that no one is talking about.”

The risks that Chloe is referring to are primarily related to substance abuse. Her point is that the impact of poverty and other social challenges is often overlooked and other issues such as substance use are blamed out of context.

Chloe further discusses stories of women being punished for their honesty in regard to their substance use and made to feel ashamed. She continues with the statement that *“When it comes to the criminalized drugs, the main disruption we see is related to poverty”* Chloe also points out the lack of community supports for women who have experienced incarceration and may be struggling with substance use. Chloe feels that community supports are incredibly important and can support incarcerated women as mothers. Her notes on the relationship between incarceration, poverty and criminalized drugs relate to the primary reasons why we see women who are incarcerated. The vulnerabilities that individuals face who are incarcerated are largely related to their socio, political and gender-based marginalization. This relates closely with both structural vulnerability and structural competence, which are factors in understanding the health of an individual both through environmental factors and overall chances of good health (Sue, 2017).

Roth (2010) points out that all women who are pregnant in prison are high risk. This is because the environment of the prison is inherently higher risk than the community, in most cases. Factors, such as diet and stress level have been contributing factors to why incarcerated women have clinically worse health than women in the community, and this combined with pregnancy can put serious strain on both mother and baby (Kouyoumdjian, et al, 2016). In this context, the importance of “standard of care” becomes clear. Mandy points out here that there is potential for the community provide support for women in corrections. Pate (2006) states that women in custody are often very low risk offenders and that many of their sentences could be easily managed in the community which Mandy echoes by asking the following question: *“[T]here aren’t that many females in custody across Canada so to what extent does corrections have to take this on versus combining resources with the community?”*

The appropriate standard of care that meets Canada’s national and international human rights obligations must be established by implemented national standards that apply to all correctional institutions. In other words, care must first and foremost be met by a universally articulated and enforced standard. As Mandy pointed out, women have greatly differing experiences: *“If you look across Canada that [standard of care] is really variable across systems.”* She describes that while women may be incarcerated at federal institutions across Canada, they can face very different experiences. That there are significant differences from one institution to the next is obvious between provincial and federal jurisdictions but is also the case between provinces. The supports that are available to women in different provinces may be different. In addition, the geographical size of the province can have a large effect on where women are incarcerated. For example, if a woman in Northern Ontario is sentenced federally, she would be incarcerated at Grand Valley Institution in Kingston, Ontario, which could not only

be several hours away from home but could greatly hinder her ability to see family and children. If she were to be pregnant and unable to bring the baby back to a mother child unit, she could be separated from her baby for a considerable amount of time. This is an issue that requires significant attention, considering what is at stake. As Mandy puts it, “...it is variable across institutions but I would be surprised if there are facilities that have taken an interest in supporting women who are pregnant. But I don’t know of any policies that are like progressive supports.”

The extent and quality of supports for pregnant and post-partum women varies in quality and extent, based on the individuals working in the prison and the power dynamics in the institutions in question. Additionally, inmates’ geographic proximity to their hometown and whether they can see their family affects their well-being and ability to thrive and should be understood as one aspect of access to an appropriate standard of care. Carter Ramirez et al., state that the lack of policy determining the standard of care also explains the variability across different jurisdictions for correctional institutions in Canada. With the lack of oversight (which Mandy refers to later), there are significant discrepancies between institutions.

Ultimately, the standard of care is far more than just the care that women receive in a clinical setting. Thinking in terms of “standard of care” is a broad-based approach that has space for considering how social factors impact biomedical issues, remaining sensitive to structural competence and structural vulnerability. While standard of care was a clear theme present in interviews, the prevalence of mental health struggles appeared consistently throughout the interview process. Over two thirds of women in custody are dealing with some kind of mental illness and the complexities of dealing with their mental health, the physical isolation of being in

prison and the potential strain of a pregnancy should be approached as a whole issue, not one specific challenge she is facing but a compound of factors (Paynter et al, 2019).

What to Expect when you're Expecting (In Prison)

The responsibility of correctional facilities is to provide prisoners with adequate quality of care equivalent to the community standard. In general, prisons are not capable of handling medical emergencies and any major concerns must be brought to the attention of a healthcare professional who decides whether the prisoner should go to a hospital. The following section will address what the general practices are for pregnant women in custody and the options that they may be presented with. I follow this with a discussion of the challenges that women face in addition to being pregnant and how this can affect their mental and physical health when choosing what to do about their pregnancy and the inherent risks involved with pregnancy. Mandy leads us through the general practices she uses as a family physician in a prison. *“One of the big differences [i.e. between incarcerated and non-incarcerated patients] is almost every female that is admitted to a correctional facility has a urine dip for pregnancy.”* As a physician in a correctional facility, Mandy notes here that when any woman is brought into custody they are given a pregnancy test. This protocol is beneficial as it allows caregivers to know that a woman needs pregnancy-related care. Mandy continues: *“... there is a lot of grey area, how care is structured, the pregnancy dating may or may not be possible from the time they arrive.”* Determining the stage of a pregnancy can be challenging for women if they are unsure or unaware of their pregnancy upon entrance into custody. Helen notes that whether a woman is pregnant or not it is important that they get assessed quickly so their care can be determined as soon as possible. *“I think that there are objective criteria that we could look to. Things like*

somebody comes into custody—how quickly do they get assessed.” It should be crucial for women to see a physician as soon as possible when it becomes clear that they are pregnant. This can help date the pregnancy as well as help women to decide what next steps they would like to take and make the necessary arrangements. For women in federal facilities, based on the fact that they are serving sentence of over two years, they would likely still be incarcerated after they give birth to their baby. While this is the common reality, many women who are incarcerated federally could serve their sentences in the community, as they do not often pose a threat to the public (Parkes & Pate, 2006).

The normalized control over women’s bodies in corrections is presented through the literature related to care in an androcentric atmosphere. While women should be entitled to immediate attention from a physician once it becomes clear that they are pregnant, the medical care provided to women should not be impersonal, reducing them to medicalized objects (as is the case with Foucault’s “medical gaze”). Rather, a woman-centered approach to care prioritizes the following principles: providing women with the care and autonomy to be mothers if they so choose as well as providing them with safe and appropriate care. Many argue that obstetric care has been intensely medicalized and through this the foundations of women’s experiences in childbirth and motherhood have been altered. We can use Foucault’s notion of the ‘medical gaze’ to understand this better, the separation between one’s body and their identity can be explored through their experience in medicine. The separation between the mother and prisoner provides the alteration from childbirth (Hancock, 2018). Given a woman-centered approach to care, the impacts on both mother and child could be different (Rothman); pregnancy should not be seen as a medical ailment but an individual experience. Mandy notes a few key points to the challenges many women face with their own lack of control as well as the risks they face in the

prison setting. Many of the challenges associated for women in prison, as already established in this thesis, are related to the stressful prison environment. Mandy unpacks this further by suggesting the challenges for many women are related by a multitude of factors and the lack of control that women have in navigating these challenges can be stressful in itself.

“That ability to control—especially with pregnancy you have specific windows for a lot of these tests—and so that is for the average pregnancy, but of course [there is a] prevalence of substance use and medication that may contraindicate in pregnancy or need to be closely monitored.”

In spite of these complications and possible contraindications, Mandy notes that many women have long wait times to see a physician. While there is not any direct literature related to this, it can be assumed based on these conversations and based on the available literature that this is largely based on overcrowding but could also be explained by the general shortage of physicians in Canada. I base this assumption in part on Paynter (2019), who notes that when women are first in custody there are a lot of important aspects to consider including their mental health and potential need for medications. Concerns of overcrowding can make it difficult, as Mandy is suggesting, for women to see a physician or nurse practitioner immediately, for pregnant women this is even more crucial as there are specific times throughout the pregnancy when specific tests or assessments must be performed for both the health of mother and baby.

In this next quotation, Helen discusses the importance of respecting and adhering to these specific windows for receiving care:

“But also emotionally, I have talked to several women who have decided, they don’t want to be sitting waiting two weeks for a termination. I think that it should be once a person determines they want a termination it should be prioritized, that would be the big change. And I don’t know if people get different kinds of responses when they say they want a termination, I mean like people trying to discourage them. But I have also seen the opposite, where people are pushed towards a termination, for example if they have used substances.”

Beyond receiving care in a timely fashion, Helen raises the concerning possibility that incarcerated women are also pressured into particular decisions about their pregnancy within the correctional setting. This is also a failure of care and a red flag about the human rights of incarcerated pregnant women.

The emotional toll of incarceration has been explored through some of the narratives of women that have experienced imprisonment (Sufrin, 2017). Sufrin uses her ethnographic approach to observe how finding out they are pregnant is emotionally taxing for many women. She notes one of her patients, Kima, who had been incarcerated frequently for drug possession. When she found out she was pregnant with her fourth child in prison, she notes that it was the prison environment and the desire to have a ‘clean baby’ that encouraged her to pursue a harm reduction route¹² (p. 136). She also notes that “incarceration can shape maternal desire in many directions other than the desire to give birth and be a mother” (p. 160). This is to note that many women chose to have an abortion for various reasons;; Sufrin states some of them were similar to non-incarcerated women - they would not be able to afford to care for a child. Sometimes, she notes that these reasons were specifically because of the ‘carceral environment’ (p. 160). Moreover, concern about the carceral environment in this quote is particularly intertwined with the notion of biopolitics and the management of populations. Foucault identifies how the regulation of health and reproduction is key to managing populations. This includes the positive use of power (i.e. to promote life and health by making strategic interventions), but it also includes disciplinary power, involving negatively-inflected actions against bodies that are “out of control.” Concerns about women who are “out of control” is a discourse that appears through the

¹² “Harm reduction is a health-centred approach that seeks to reduce the health and social harms associated with alcohol and drug use, without necessarily requiring that users abstain” (Thomas, 2005, p. 1).

literature on criminalized women (Sufrin, 2017). Research from the US has demonstrated the challenges that women face in making informed decisions about keeping their pregnancies and whether they have access to make this choice or are forced to make this choice (Paynter et al., 2019). Helen reflects on this: “...*I think ideally there should be a health-centered approach, like what is best for mom and baby because we are health care providers, and how do we achieve that or get as close as possible.*” Carter et al, (2020, p. 8) note that “this could further explain the difference between prison pregnancies and prison control pregnancies (ie, worse antenatal¹³ care for women during prison pregnancies may be associated in part with a challenging period in women’s lives as well as with imprisonment itself).” The relevance of Carter et al’s comment is that not only can pregnancy be a challenging period for many women, experiencing it in prison is an added complication. Ideally there should be a health centered approach, and this approach should be what is best for both the mother and baby. This approach should also include the mother feeling as though she is informed and understands each stage of the pregnancy. In the next section, Mandy echoes the point that Helen is making in regard to a health-centered approach by discussing the importance of health literacy for women in prison.

Literacy: Making Parenting Accessible

One theme that arose while analyzing the interviews was the idea of pregnancy literacy. I found this particularly interesting because much of the research is published in nursing journals and medical journals, but there is not much published academic work on the practice of mothering while incarcerated. How do incarcerated women access information about how to parent? A ‘pregnancy literacy rate’ refers to “...people’s knowledge, motivation and

¹³ “Antenatal” refers to the care received from a health care provider during pregnancy. It provides the same meaning as prenatal (Carter Ramirez et al., 2020, p. 8).

competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course” (Sørensen et al, 2012, p. 80). In general, the assumption is that pregnant, middle class women who are not incarcerated will know all of the steps that need to be taken before they give birth, but this is very likely not the case. Women must seek out such knowledge from books, websites, healthcare providers, other women, and peer support groups, among other sources. Women in a correctional setting do not have the same support systems in place to understand the transition to motherhood. Throughout our conversation, Mandy spoke about providing women with the information they need to be successful in their pregnancy and post-partum period. Upon diving deeper into it throughout the conversation, I found this comment particularly interesting:

“You know those books that I expect are out of date, like how to expect when you’re expecting¹⁴ it talks you through how the fetus is changing. It talks about things you should be anticipating and what kind of medical care you should be expecting. Like some of it is hokey, you might want to think about going to get diapers now or something. But my point is that it’s not something that clinical, it’s more accessible information so that a person can have a feeling of control and then matching is that they actually have some kind of feeling of control to ask for the things they need.”

The notion of pregnancy literacy became popular in the mid 1980s with books and infographics telling women what they “should expect when they’re expecting” in accessible language. There is likely some literature available to women in prison through their library but the information provided could be dated and would likely not include discussion of the risks that pregnant women in prison experience. The mere provision of books in a prison library also

¹⁴ The first edition of “What to Expect when you’re expecting” was published in 1984. It became a popular phenomenon for women as it is structured in a question and answer style in chronological order throughout the pregnancy period. Several have been published since including postnatal care and expectations (Maclean, 2014, p. 580).

would fail to account for general health literacy—and general *literacy*—amongst this population. This is an important consideration, given poverty and structural inequalities and their adverse effects on literacy. A medical anthropology lens encourages us to consider the challenges for women who are pregnant in prison and how to combat some of these, including managing stress levels and having a birth plan. The structure of a prison-based pregnancy can be similar to a pregnancy in the community by providing a level of structural competence to the information available to incarcerated women can make it more accessible to specific challenges. “What to Expect When You’re Expecting” it, breaks down the specifics of each stage of pregnancy. Such resources would be helpful to incarcerated women, especially given their limited access to online sources of information, as Mandy indicates: *“You can’t do a google search! All of that is really challenging in correctional facilities and that’s throughout the period of pregnancy.”*

In terms of information that is readily available to women in the community, The Public Health Agency of Canada provides a comprehensive resource for expectant families online in what they call a ‘family-centered approach’ or ‘family centered maternity and newborn care’ (FCMNC). This is an online resource that is readily available to women in the community and provides information based on what they should expect through each stage of their pregnancy and what they should be looking out for at each stage. They provide an informational sheet on the ‘seventeen principles’ of maternal and newborn care. In this document, The Public Health Agency of Canada states that ‘FMCNC is a complex, multidimensional, dynamic process providing safe, skilled and individualized care.’ Specifically, section eleven states ‘women and their families require knowledge about their care.’ This again relates to the notion of informed consent and requiring women to have knowledge about their care. Each principle is focused on providing care to the family and the newborn and uses language like ‘respects reproductive

rights” and “holistic approach.” This kind of language is important when considering developing accessible and comprehensible obstetric care. Additionally, in reviewing the Public Health Guidelines listed above on prenatal care (Public Health Agency of Canada, 2020), there is no information pertaining to women who are incarcerated or who have previously been incarcerated. There is a section dedicated to risk assessments which covers substance use, weight, intimate partner violence, workplace safety, prescriptions and food safety, but does not provide any additional information for women who have been incarcerated or are currently experiencing incarceration while we know that even for women who have been previously incarcerated, there are risk factors associated. Moreover, since the resource is internet-based, it may not be readily inaccessible to incarcerated women at will. This further underscores the discrepancies in standard of care between incarcerated and non-incarcerated women. Sue (2020) notes that patient care for anyone who has been previously incarcerated should always be noted in the structural vulnerabilities for the patient.

Having accessible knowledge-based resources can help women in correctional centers increase their health literacy. This can be done in a variety of ways. For example, organizations like Wellness Within have doula training programs and are partnered with Nova Institution for Women in Nova Scotia, as well as a handful of provincial jails to provide doula support to women in these facilities (Wellness Within, 2021a). This program can help women understand the course of their pregnancy with non-judgmental care. They are partnered with the Nova Institution (Federal prison in Eastern Canada) and provide doulas to women who are pregnant at this facility. Additionally, anecdotes from the Mother-Child Program showed that there were significantly better relationships among inmates when they were able to share their own stories

of being mothers (Brennan, 2014). Considering that 67% of women incarcerated in Canada are mothers (Elizabeth Fry Society, 2018), being a mother is common ground for many of them.

Incarcerated women's lack of access to information about their experiences of pregnancy and motherhood seemed to weigh heavily in Mandy's considerations about their lack of health literacy related to pregnancy. As Mandy notes, even being able to speak with a health care professional who might answer basic questions is a struggle: *"Women don't have control over this. If I were to become pregnant, I would book with my family physician and sure I may have to wait some time, but I could go to urgent care or a walk-in, but women just don't have those kind of options in a correctional facility."* Women have considerably less access to autonomous care while incarcerated. It is important for women to not only have the information available to them about their care but to have access to high quality care (Debessai et al., 2016). Below, Mandy discusses the need for accessible information to be made available for women to make informed choices about their care and be able to advocate for themselves. It is of course important for women to have accessible high quality care, but having the information about their care presented to them in an accessible way can allow them to further make informed decisions.

"For women who are pregnant in particular, I think as much as we can give people information so they understand what health care should look like and why it is important, then they will be able to make informed choices and advocate for themselves about if something is missed. You want it to be [something] that everybody knows—having high pregnancy health literacy rate."

This idea of literacy that Mandy references involves allowing women to exercise their own informed consent while in custody (Whatcott, 2018). If women know what they can expect and the care that they should be receiving they are more likely to be empowered to have a successful pregnancy and birth outcome. A high pregnancy literacy rate can stem from multiple areas:

"[B]etter health care would mean better health care for pregnancy—support women's literacy. If they're 'literate' and they know what to expect' sounds more judgmental than I mean it to be."

But it comes with a certain amount of knowledge. If they don't have the control it doesn't really matter right? So it has to be matched with accessible high quality care”(Mandy). In other words, health literacy on the patient's part must be matched by accessible, timely, competent and attentive healthcare from health care providers.

It is not simply the mother's health that is at stake when we speak of health literacy. Chloe notes the importance of mother and baby bonding for the health of both. She expressed the importance that mothers will be more 'in tune' or 'cued' to their baby and if they have the right kind of resources to support them. *“And instead (of separating mothers and babies) we say, you are going to be the person more cued into your baby than anyone else in the world, let's give you some information about what you can look for to show that your baby might be experiencing.”* In this context, Chloe is specifically discussing separating mothers and babies. Additionally, anecdotes from the Mother-Child Program showed that there were significantly better relationships among inmates when they were able to share their own stories of being mothers.

Control and Autonomy - Institutional Power Struggles and Informed Consent

Lack of health literacy related to pregnancy and motherhood has direct implications on the question of informed consent. If women do not understand their pregnancy and what to expect as a mother, nor even when and what type of care they will receive, how can they grant informed consent¹⁵ with respect to the care they receive? This question, which revolves around agency and consent, is the third major theme that emerged from interviews. The inability to make one's own informed decisions about one's body and reproductive autonomy (Purdy, 2006) adds additional layers of complexity to carceral challenges. The correctional setting is already a

¹⁵ Informed consent refers to the permission granted to a health care provider and that all of the information about the medical treatment or condition is available to the patient (Whatcott, 2018).

high anxiety place to be pregnant, but the challenges and fears associated with lack of control can make it even more stressful for women to navigate. Many women may have questions, concerns and plans that they would like to discuss with their physicians but the keeping women incarcerated, and ignorant about what is happening in their body erects barriers to their informed consent (Whatcott). Consider this quote from Helen:

“Of course, the interim partum period is just fraught with challenges. You probably have a sense of this already, but anytime you need to go to an appointment in the community you are not supposed to know the time or date or the appointment so if you’re coming up to being term in your pregnancy you don’t know when the next time you will see your physician, if you’re going to be induced, when you’re going to be induced. Like, you can’t have any of that information, which is just horrible, you’re just sitting and waiting. It’s not just that you don’t have control, but you don’t even have basic knowledge about what’s happening, especially when other people are making decisions.”

The ability to exercise agency is challenging within the institutional power structure of prison. Based on this quote, the interest in keeping the woman incarcerated (and preventing her from making a plan to escape) takes precedence over the pregnancy. Not allowing them to have the power to determine their timeline exacerbates this. Many women face a cyclical structure of pre-trial hearings and uncertainty while waiting for sentencing to determine what the outcome of their incarceration will be:

“For example, if they’re a week before they need to have a certain test done and they can’t see a physician for several weeks, so in many ways that first step is how far a long they are. But even if we know and everything is set up and schedule them for all of their appointments then maybe someone has to go to court on the same day as their appointment and that takes precedence” – Mandy

Creating barriers for women to exercise their own autonomy is part of how biopower operates—negating the humanity of vulnerable or criminalized women (Whatcott, 2018, p.7). This perpetuates the idea that criminalized women are unfit mothers and seems to legitimize the limits on the autonomy of imprisoned women. Foucault notes that “Punishment in general and

the prison in particular belong to a political technology of the body” (Foucault, p. 177). This means that power operates within the logic of the system, through staff and individuals in positions of power, rather than through conscience action. The bodies of individuals (women who are incarcerated) are the object and target of this power (p. 178). The aspect of normalization within this is through the apparently legitimate loss of control - pregnant women are not subject to their own autonomy within this system. Mandy provides her own insight into this by discussing how the institution she works in tries to cope with pregnancies and discusses how women should be taken to the hospital immediately, that a prison is no place for deliveries:

“In my work when there is someone who is pregnant and close to term we try to have ongoing discussions to frame, like in a correctional setting we try to have a low threshold for sending a woman out that is close to term out of the facility to a hospital for assessment, because the appropriate place for someone to be in labour is not in a correctional facility it’s in a hospital, and we certainly don’t want any deliveries.”

This low threshold that Mandy is alluding to means that as soon as a woman shows signs of labour she is taken to the hospital for assessment. While this is clearly a beneficial approach, and considers the well-being of the woman (especially important considering the lessons from Julie Bilotta’s case), it is also noteworthy that the woman is the object/target of the intervention rather than the leader in her own birth-giving experience. It is a stark contrast to the ‘birth plans’ typical of many non-incarcerated women’s birth experiences. In the next section, Chloe begins to discuss the importance of community-based programs and their impact on the outcomes for women in prison.

Bonding Together – Mother-Child Programs

“The fact that the Mother-Baby Program can exist, is because there was a policy that said have this program, but also it was networked within a larger web of services within the community, they weren’t islands.” - Chloe

In determining the health of the child as well as the health of the mother, it is important to consider that there are programs that allow incarcerated mothers to act as mothers, supporting them however possible. In Canada, “Mother-Child Programs” allow mothers to live in a housing unit with their baby. These programs also involve other inmates as caregivers for the children of incarcerated women in community or cottage style living spaces. The Mother-Child Program seeks to support mothering for women in institutions in Canada. The program uses full time, onsite residency in structured living units to create a supportive environment and shared responsibility for women to focus on mother-child relationships as well as relationships with other inmates. As previously supported by the grey literature, the program received lower levels of enrolment in over the last decade and seen some controversy to its continuation (Brennan, 2014). With the lack of mothers enrolled in the program, regardless of the reason, it reflects poorly on the programs’ potential and whether mothers are able to participate. Research has consistently shown that both children and mothers benefit from the use of prison nurseries. In bonding, attachment, recidivism and behavioral development, it is considered the best practice for mothers and babies (Dowling & Fulton, 2017 & Martin et al, 2013).

Mother-Child programs may provide a helpful starting point for reconceiving approaches to health care for incarcerated pregnant and post-partum women. Positive experiences in this program have been transformative for incarcerated women beyond the health of their bodies. Consider this comment from Chloe, about a Mother-Child Program that she had direct experience with:

“It helped some, not all of those women to reclaim that identity, knowledge and skills and they described this as a healing experience. And for the women in the program they also talked about experiencing a sense of community from what they experienced on the outside, people coming

together in a shared way around a shared goal. Um, yeah, with something that was future oriented.”

In this quotation Chloe notes the sense of belonging and community the Mother-Child Program brought to not only the women involved, but other women in the institution. Chloe notes that pregnant women often provide a sense of belonging and purpose to the other women in the facility. Not only do many pregnant women successfully navigate their isolation and uncertainty with the relationships they foster in the institution, but many of them are also supported by the staff at the facility. All three participants noted that correctional staff, physicians and social workers can really make a difference in the quality of life, standard of care and sense of belonging that the women had while in the institution.

Beyond these promising resources, Chloe emphasizes the importance of correctional institutions combining resources with communities in order to pool resources to support incarcerated women. It is not enough to only rely on the support of health care providers, it is a lot of pressure on HCPs and other inmates to create the conditions for a high standard of care. But involving community-based programs appears to be a promising approach. It relieves the individual burden on HCPs and makes publicly funded programs accessible to incarcerated women. “[...T]here are definitely people who go above and beyond and there are women where we have really done our best to get them released before baby comes [...] but it is not the thing that someone in every correctional facility would do” (Mandy).

In Chloe’s case, pregnant women at the institution she was referring to were also involved by referral in community-based programs, these programs were aimed to support women who were working through substance use challenges and specifically women who would likely have lost custody of their children had they not had the support of these programs. She notes that the

babies born to mothers involved in this program were meeting all of their health markers with positive outcomes. All of the babies involved in this Mother-Child Program received their infant vaccinations on time, and at the one-year mark had reached all of their health indicators. This is a clear example of why community supports are helping pregnant incarcerated women, especially mothers who would be at risk for losing their babies. This institution had a very small cohort of women who were participating in a Mother-Child Program which was partnered with a local community support organization working with women and addictions. Chloe noted that most of these women would have been at risk for losing their children had they not had the support of this program. They would have been ‘flagged’ and at risk for losing their children but the support of a Mother-Child program was able to provide them with a supportive environment to complete their sentences and have healthy babies. Even so,

“there did need to be some sort of reasonable plan after release. Did they have a good transition plan? Or are you connected to an agency to help you? And of course, part of this assessment there also needed to be from a criminal legal perspective that there were no charges pending and the woman would not be a danger to any children including her own. Um, and there had to be a no history of offences related to children. So that is how [to] enter the program.”

Chloe also notes that the planning involved for women to participate in the program was for the safety of the child and to ensure that all measures were taken from a legal perspective that the babies would be safe and cared for. The main importance is placed on how the Mother-Child Program supports women and babies to do well. The main focus is almost always placed on the health of the baby and what is in the best interest of the child. Sufrin (2008), a medical anthropologist endorses the practice of mothers and babies being kept together. Her own research in a San Francisco prison notes similar trends, with women faring better with the presence of babies in the facility. In her ethnographic work she notes that many of her patients in the institution were also struggling with substance use, and the drive to have a ‘clean’ pregnancy was

a positive goal and motivation for the mothers to continue to stay healthy for their baby and retain custody (Sufirin, 2017).

Mothers Helping Mothers - A Family Affair

When asked about why babies and mothers should remain together, Chloe shared the following enthusiastic response: *“Oh gosh, lots [of reasons]. So there’s what the literature says, and that is clear that mothers that are able to keep their babies with them while incarcerated are less likely to be re-incarcerated, we definitely saw that.”* Arendell (2000) described the definition of motherhood as the “social practices of nurturing and caring for dependent children” (p. 1192). For better or worse, the relationship of motherhood and womanhood are often considered synonymous, according to Arendell. This is due to gendered beliefs about women’s social role. This essentially means that the expectation of mothers is that they will be dedicated to their children and place all needs of the child above their own (P.1194). Not only are women expected to know how to be a mother, but they are expected to be “good” mothers. Criminalized women are the exception to this stereotype. As the literature on female offenders demonstrates (Belknap & Holsinger, 2006), criminalized women are framed as deviant, which of course is seen as counterintuitive to the role of the mother, thus labelling them as ‘bad’ mothers (Derkzen & Taylor, 2013). Mother-Child Programs provide incarcerated women with an opportunity to resist the label of “bad mother”: *“All of the women that I spoke with understood very clearly that the Mother-Baby Program was providing them with the opportunity that they could be good parents and most were very grateful to the program and to the staff”* (Chloe). Chloe shared several stories of the women who participated in the Mother-Baby Program and how the framework allowed other women who were not mothers to support and care for the babies in a role of a ‘babysitter’. As per the CSC guidelines, women who wish to be ‘inmate babysitters’

must also complete a test to assure that they are not a risk to the child and can have no prior offences including children.

Contrary to positive outcomes for mothers enrolled in Mother-Child Programs, outcomes are less bright for women who are not extended such an opportunity: *“The other thing [about] anecdotal stories of women not in the program, was that um, they were there while the program was happening, and these women had all lost custody of their children, and this was a source of enormous trauma and also shame”* (Chloe). The loss of a child for many of these women is traumatic. Women are generally the primary caregivers for children, and it is estimated the 70% of women who are incarcerated are the primary caregiver to at least one child prior to their incarceration. The sense of community that was created and can be created for women in this setting can help with these feelings of trauma and shame: *“...we would see similarly that when moms were not able to take their babies home from the hospital, the consequences afterward would be devastating, there would be more overdoses, deaths, injuries, we just weren’t seeing that in this cohort”* (Chloe). As noted here by Chloe, the consequences of not being able to take baby home include the possibility of self-harm for the mother. As supported by the literature on female offenders, women are more likely to ‘go inward’ as opposed to lashing out physically (Suter et al., 2002). *“[W]here there is no mother-child unit, supporting women when they come back without baby is critical, and sadly is about suicide prevention and women who are so sick because of how horrible that is.”* This quote from Mandy shows really how important it is for women to have contact with their baby. Mandy does offer an interesting perspective on how challenges like this can be potentially mitigated:

“It’s not that I think there needs to be [a Mother-Child Program] at all female facilities but I think that any woman who is pregnant should have access to one-- should have it, even if that means coming up with an alternative. I have seen it before with women who are provincially sentenced and have a long wait time to trial get into a mother baby unit in the federal system

even though they aren't in the federal system and the province can pay for it. Like, can we come up with models where mothers can have access to a mother baby unit and the jurisdictional issue could be sorted out."

As Mandy is noting here, there are Mother-Child Programs available at federal institutions, and if a woman is waiting for trial or sentencing even at the provincial level, she could be accommodated in a federal prison. Her solution proposes that a woman could access the Mother-Child unit in a federal institution even if they are sentenced provincially and have the province provide the funding for the woman to access the program federally.

On the Inside

When considering 'what is going on inside' I considered the ideas of accountability of care. Specifically, who is responsible for 'caring' within an institution? Can institutions really care? Correctional staff clearly have an individual responsibility to provide care. How does one determine the distinction between individual and institutional responsibility? *"Is there ongoing assessment, is anyone actually watching what is going on in correctional facilities?"* (Helen). With the absence of specific guidelines, Helen notes here that there is indeed a need for someone or some policy to provide structures for physicians, staff and individuals working in correctional facilities to know how to support women through their pregnancy and post-partum period. Remembering the story of Julie Bilotta, it seems that correctional facilities are not the appropriate places for women to labour and give birth (Gilna, 2018). Women should be triaged and taken to a hospital as soon as they are showing signs of labour, this is notable in Julie Bilotta's story where she was in labour and waited several hours before she was taken to the hospital. All three interview participants noted the importance of having staff that are present and able to provide a level of empathic understanding of the prisoners:

“[W]e need to partner with people who have more expertise, because it is a primary care setting. I consider the staff are probably care staff but with enriched expertise in mental health because there are so much mental illness in correctional settings. But pregnancy is always an exception” (Helen). The very notion of a prison as a “primary care setting” seems to be a radical, and potentially positive way of rethinking prisons, even for those who might only imagine this as one step on the road to decarceration or prison abolition. The notion of ‘partnering’ with people who have the expertise is crucial. There is need for individuals to understand the structural differences for women who are incarcerated and pregnant versus in the non-incarcerated community. Staff with the expertise and ability to provide care in these environments relates back to the notion of structural competence. They must be able to provide care in a correctional setting because they understand the vulnerabilities that these women are facing and are able to provide them with the care they need.

Further underscoring the need for structural competence within corrections, the need for accessible non-judgmental care is important. Physicians should be able to provide this care when working in a correctional setting: *“On average people in corrections have more medical problems, they’re sicker people, so we make sure the sicker people have access to high quality care. [This] is arguably more important than super healthy people having access to high quality care”* (Mandy).

The Blame Game

All three interview participants confirmed that where there are supports available within the community and in corrections, women are able to succeed. Helen unpacks this below as she

discusses how it is not just about ‘good and bad people’ but it is about supporting women and their babies to be healthy through supportive programming:

“I think for everyone in corrections, I think that for the most part everyone wants them to be happy and healthy and do well. But how far do you go, and how far do you support that and safety? And to what extent is funding allocated, and it is expensive to implement innovative programming? And so all of these things are real barriers. So it’s not about bad people and good people.”

This reference to programming instead of prison employees directs attention to the necessarily systemic nature of any solutions. The barriers present are not entirely about punishment, they are related to barriers that women face in prison. This claim is supported not only by feminist criminologists who advocate for a woman-centered approach to corrections but by the Canadian Standing Senate Committee on Human Rights, which states that “nothing specific was given to women. We were still using programs that were developed for men...” (p. 235). Similarly, Davis (2003) Confirms this gendered divide between male and female corrections and the lack of support that is available to women in prisons. Male prisons receive more programming and opportunities, making it even more challenging for women to succeed after their sentence since statistically they tend to lack vocational training. Since there are fewer women incarcerated federally (and in general) versus men, it makes sense to consider alternatives to how women can access better programming in prison.

As Helen states below, the natural course of action could be to provide both support from the community and combine it with supports available within the correctional setting. Based on the number of women in correctional facilities in Canada, the need for care could easily bridge across both jurisdictions, thus including incarcerated people in communities, and humanizing them. Helen frames the issue as follows:

“[T]he community has so many resources. And I think that’s an important point because it’s easy to blame corrections for not having high quality care, but I also think there is shared jurisdiction to develop policy and shared programs across community and corrections and that’s the best—making sure we do meet community standards and making sure we do leverage what’s available in the community.”

As Helen notes, while it may be easy to ‘blame corrections’, this finger pointing may be too simplistic. As pointed out by both Helen and Mandy, both physicians in different jurisdictions with practical knowledge from working in prisons, many of the staff are the driving force for provision of quality care. This approach indicates attempts to attain a certain standard of care. The standard of care moves past what we may think is just how patients are treated in a clinical setting, it should consider their well-being and how they feel they are viewed in the clinical and correctional setting.

One challenge I noted in interviews relates to lack of oversight. It is not always clear whether the problem is with the system or with the facility, and there is no clear strategy for improving this, as this Mandy points out: *“I am concerned by the lack of oversight and even then, we don’t even know when there is a problem—not just for problems but to have a system of approach for quality improvement or new innovations or new treatments or patient interaction”*. She argues that there is a need for oversight that flags problems and also goes beyond that by envisioning new innovations for patient health care in prison. “We should be adapting our models of care in corrections” (Mandy). The care that women receive, especially while pregnant, seems to differ based on the institution but also seems to have a very specific relationship to the individuals providing them with the care they are receiving. The need for oversight within the system is clear, given all of the information reviewed here regarding how women fare with community supports and also the challenges that they face while being incarcerated. The statement “we don’t even know when there is a problem” is a cause for concern. If the problem

is not clear then it is important to look further into why there are cases like Julie Bilotta's, and why programs like the Mother-Child Program are not being used by women who need them. The effort to improve the system will not come from one person in one institution or several people working across several institutions, but through policy and practices that continuously support the women in these facilities.

In the final chapter which follows, I provide my concluding thoughts on this research project. I will reconsider the central argument of this thesis which is that women in prison should have the same access to health care as women in the community, be empowered to be mothers (should they choose), and be supported in their return to the community. First, I will discuss the previous chapters and what has been learned over the course of this thesis followed by an overview of the study limitations and include suggestions for future research directions. Finally, I will conclude with a summary of my findings and general insights into the themes explored throughout this thesis.

Conclusion

Considering the challenges of incarcerated women in Canada there are still many areas requiring exploration. The importance of adequate health care for women in prison is of the utmost importance, as affirmed by the Canadian Senate's Standing Committee on Human Rights in their review of the human rights of prisoners. "The Mandela Rules specify that "[p]risoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status (Senate Standing Committee on Human Rights p. 108)." This supports the central argument that women in Canadian federal prisons should: 1) have access to the same level of care as non-incarcerated women; 2) be empowered to be mothers (should they

so desire); and 3) be supported in their return to the community.” The findings of this recent report support the findings within this thesis that there is a discrepancy in care and it is crucial for prisoners to be provided with the same level of care that is available in the community. “The committee learned how federally-sentenced persons are particularly vulnerable as they depend on the CSC to meet all of their health care needs. When those needs are not taken seriously, the repercussions can be disastrous. Access to health care is not a privilege; it’s a right” (Senate Standing Committee on Human Rights p.114).

Throughout the first chapter of this thesis, I have discussed the theoretical foundations that support my main argument that incarcerated women should be provided with the same level of care throughout their pregnancy as they would in the community. Through the work of medical anthropologists Dr. Paul Farmer, Dr. Kimberly Sue and Dr. Carolyn Sufrin I synthesize their work to provide connections to my own work and the importance of providing adequate care for individuals in prison and the importance of the role of adequate care by recognizing both structural competence and structural vulnerability. Additionally, I used the work of Michel Foucault in situating the importance of understanding biopower, surveillance and governmentality and mechanisms that control women within the carceral state and how pregnant women are affected by this notion. Lastly, the work of feminist criminologists provides a source of critique that informs the gendered differences between male and female prisoners and the importance of recognizing this gendered divide. The connections made through each of these foundations aids in situating the work and its analysis. The importance of acceptable and accessible care is supported by each of the medical anthropologists discussed. They each offer perspective to the importance of equitable care. Understanding the mechanisms that inform these systems of care is not only crucial but helps us understand the impacts of surveillance and

systems of control that are present within the carceral landscape and how they mediate access to necessary medical care. Understanding and synthesizing the gendered component of incarceration and criminalization, especially as it relates to motherhood, provides context to how the experiences of female prisoners may differ from those of men. It reminds us that the experiences of male and female prisoners should not be approached as monolithic.

As noted by the recent report from the Canadian Senate's Standing Committee on Human Rights, this quotation from Ruth Gagnon, the Elizabeth Fry Society Director for Quebec states "nothing specific was given to women. We were still using programs that were developed by men... Personally and even as a regional advocate I (Ruth Gagnon) don't see any specifically women-based programs at all in the prisons" (The Standing Senate Committee on Human Rights, 2021, p. 235). Chapter two provides a literature review which considers some of the more recent information and studies available on female prisoners, motherhood in prison and the specific challenges that women face in the Canadian criminal justice system. In addition, the review of grey literature highlights that adequate care for pregnant women is indeed a human rights issue and as supported by the Canadian Standing Senate Committee on Human Rights report on the Human Rights of Federally-Prisoners, it is crucial that women are supported within the institution. The final chapter analyzes three qualitative interviews from individuals working and advocating for federally incarcerated women in Canada and their insights support the claims made in the previous chapters through the represented themes of discrepancy in care, lack of access to knowledge including literacy, self-efficacy and informed consent and the importance of bridging prison and community care.

Study Limitations

One of the clear challenges in this project was the sample size. While I was able to explore these conversations with an in-depth approach, I recognize that this is not a representative sample. Each participant was able to provide their own lived experiences within the conversations, but it fails to provide an overview of the entire system. Additionally, I had intended on administering a survey for correctional nurses as mentioned in the study methods section, but as challenges arose with working with health care providers during a pandemic, the survey received no responses. In the future, I would intend to use the survey to study this population working on the frontlines in prisons.

Future Research

The lack of services available within institutions and the need for there to be support from the community is thematic throughout this thesis. “There is a need for oversight” meaning that there is considerable work to be undertaken in order to mandate this healthcare oversight in correctional institutions. Considering the importance of mother-child bonding and attachment, it would be beneficial to explore potential alternatives for women who are pregnant and mothers for sentencing. This project approached individuals who have not experienced incarceration. While their stories and anecdotes are important to the story, they are unable to tell the story of the women who have experienced the realities of isolation and loss while incarcerated. Moreover, it would be important to approach the access to healthcare from the perspective of women who have navigated pregnancy and motherhood firsthand while incarcerated.

I intend to continue this research in the future and hopefully consult the lived-experiences of women who have been incarcerated and their insights obtained while navigating pregnancy in prison. Considering the importance of mother-child relationships, the importance finding

potential alternatives for mothers who are pregnant would make the range of care provided and the structural barriers more present.

Conclusions

The primary goal of this thesis was to explore the access to prenatal care that women in Canadian Federal Prisons have. In doing so, I have explored important insights into the regulations of incarcerated women's bodies and the marginalization that incarcerated women and mothers face whilst navigating the Canadian prison system. Evidently, there is still a significant amount of information lacking in terms of statistics and understanding of the carceral landscape as well as the glaring oversight that is experienced by women in incarceration that must be addressed by advocates and policymakers in the future. Scholarly literature and grey literature are consistent in determining that imprisoned pregnant women and mothers are marginalized. The need for a cohesive care model, supported by policy that applies to all correctional institutions, is evident through the discussions with interview participants and the stories shared throughout the thesis of women's experiences in custody. In reviewing my interview data, examining the publicly available literature and documents regarding this work, I have gained a greater knowledge for the very distinct struggles of pre- and post-natal care for women in custody. Moreover, throughout this research I have found insights to the regulation of women's bodies through discipline, bio power and marginalization of pregnant women and mothers. Finally, this project has allowed me to highlight many of the uncomfortable realities that governing institutions have and the importance of their accountability in a system that fails incarcerated women. The lack of information available on pregnancy for women in Canadian

correctional facilities is problematic and highlights the need for oversight and for there to be more care provided to women in custody who are pregnant and mothers.

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