Invisible women: correctional facilities for women across Canada and proximity to maternity services

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Abstract

Purpose – *This paper aims to describe the process to create an inventory of the facilities in Canada designated to incarcerate women and girls, health service responsibility by facility, facility proximity to hospitals with maternity services and residential programmes for mothers and children to stay together. This paper creates the inventory to support health researchers, prison rights advocates and policymakers to identify, analyse and respond to sex and gender differences in health and access to health services in prisons.*

Design/methodology/approach – *In spring 2019, this study conducted an environmental scan to create an inventory of every facility in Canada designated for the incarceration of girls and women, including remand/pretrial custody, immigration detention, youth facilities and for provincial and federal sentences.*

Findings – *There are 72 facilities in the inventory. In most, women are co-located with men. Responsibility for health varies by jurisdiction. Few sites have mother-child programmes. Distance to maternity services varies from 1 to 132 km.*

Research limitations/implications – *This paper did not include police lock-up, courthouse cells or involuntary psychiatric units in the inventory. Information is unavailable regarding trans and non-binary persons, a priority for future work. Access to maternity hospital services is but one critical question regarding reproductive care. Maintenance of the database is challenging.*

Originality/value – *Incarcerated women are an invisible population. The inventory is the first of its kind and is a useful tool to support sex and gender and health research across jurisdictions.*

Keywords *Canada, Women's health, Incarceration, Prisoner health, Maternal health*

Paper type *Research paper*

Background and purpose

Canada has one of the highest rates of incarceration in the Western world, at 136 people in prison per 100,000 population (Malakieh, 2019). People incarcerated in facilities for women are the fastest-growing population in Canadian corrections (Public Safety Canada, 2019). Currently, there is no central inventory of all the correctional institutions for women in Canada. For health researchers, prison rights advocates and policymakers to identify and respond to sex and gender differences in health indicators, access to services and supports for the children of incarcerated women, a clear picture of where women are incarcerated is required. The incarceration of women threatens reproductive health service access and reproductive autonomy (Sufrin, 2018). One critical aspect of reproductive health-care is hospital maternity services: birth is the most common reason for hospitalization in Canada (Canadian Institute for Health Information, 2020). Increasing numbers of incarcerated women, most of whom are mothers, also have significant harmful impacts on children (McCormack *et al.*, 2014). Residential programmes for mothers to keep their children with them when incarcerated are one approach used to address that harm (Elwood Martin *et al.*, 2012).

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Overview of Canadian correctional facilities

In Canada, incarceration can be divided into four main categories, namely, federal corrections; immigration detention; provincial/territorial corrections; and youth corrections. Correctional Services Canada (CSC) governs federal institutions under the Minister of Public Safety. A sentence of two years or more results in federal incarceration. Immigration detention is the purview of the Canada Border Security Agency, also under the Minister of Public Safety. Each province and territory have their own correctional systems. Provincial/territorial facilities include remand/pretrial custody and provincial sentences of up to two years less a day. Youth incarceration is also under provincial jurisdiction.

Incarcerated women in Canada

Although the overall number of people experiencing incarceration in Canada has declined over the past five years (Malakieh, 2019), the number of women experiencing incarceration is increasing. The population in federal prisons for women increased by 32.5% from 2009 to 2019 (Office of the Correctional Investigator (OCI), 2020). Women form a small proportion of people experiencing incarceration: 7% of the 14,742 people in federal prisons and 16% of the 25,405 people in provincial custody (Reitano, 2017). This works out to about 4,065 people in provincial facilities for women. On a given day, Public Safety Canada reports 676 women on average are federally incarcerated (Public Safety Canada, 2019). On a given day there are 792 youth experiencing incarceration, 24% of whom are girls (Malakieh, 2019).

Incarceration is a gender-enforcing system (White Hughto *et al.*, 2018). Recent policy shifts have supported some trans and nonbinary people to be incarcerated according to gender identity or individual assessment Correctional Services Canada (CSC, 2017). The available research and statistics in Canada on the health of people in prisons for women does not distinguish between cisgender and transgender women. There is a serious and troubling gap in information about and services for trans and nonbinary people experiencing incarceration.

A history of colonialism and racism in Canada results in the disproportionate incarceration of Indigenous people. Although only 4.9% of the general population (Statistics Canada, 2016a, 2016b), Indigenous women represent 42% of women admitted to provincial/territorial facilities (Malakieh, 2019) and 41.4% of women in federal prisons (OCI, 2020). Federal incarceration of Indigenous women increased by 60.7% from 2008–2018 (Public Safety Canada, 2019). As Smylie and Phillips-Beck (2019) have discussed, colonial and racist policies have resulted in differential and inhumane treatment of Indigenous women with respect to reproductive health care, including the dismantling of traditional maternity care practices. Incarceration is described as having replaced the Residential Schools regime as a colonial system to separate Indigenous people from their communities (MacDonald, 2016) and over-incarceration as a public health crisis (Singh *et al.*, 2019).

An inventory of facilities in which women are incarcerated is required to compare health status and access indicators across systems of corrections. There are five federal prisons for women, as well as one large and one small healing lodge (CSC, 2020b). In the federal system, women may also be co-located with men at psychiatric facilities. The three federal immigration detention centres hold men, women and children, approximately 8,781 in total per year Canada Border Services Agency (CBSA, 2020). In provincial and territorial systems, women may be co-located with units for men.

Health care in correctional facilities

Health-care is among the most frequent concerns expressed by people in prison (Public Safety Canada, 2019). The United Nations *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders* (the "Bangkok Rules"), adopted unanimously by the United Nations General Assembly (UNGA) in 2011, outline international

responsibilities for the treatment of incarcerated women [United Nations General Assembly (UNGA), 2011]. These rules recognize that women experiencing incarceration have different needs from men and require access to appropriate health services to meet those needs (United Nations General Assembly [UNGA], 2011).

In Canada, hospital and physician-based health services are publicly funded and administered (Canada, 1985). Provincial and territorial governments have responsibility for the health services of people experiencing provincial incarceration (remand and sentences). Health service arrangements across the adult and youth facilities in the provincial and territorial systems may be provided by provincial and territorial Departments of Justice, provincial health authorities, contractors and other bodies. The federal government is responsible for health-care delivery for those serving federal sentences. Health-care professionals working in federal prisons are used by CSC (CSC, 2020b). Health services available in immigration detention centres are the responsibility of the Canada Border Services Agency (Global Detention Project, 2018a).

The high health needs of women experiencing incarceration are well-documented. Most women in prisons in Canada have experienced childhood abuse (Bodkin *et al.*, 2019), mental illness and substance use disorder (Farrell MacDonald *et al.*, 2015). Women in prisons have high rates of chronic illness (Nolan and Stewart, 2017), blood-borne and sexually transmitted infectious disease (Kouyoumdjian *et al.*, 2016; Kronfli *et al.*, 2019) and PTSD (Jones *et al.*, 2018).

Although most women incarcerated in Canada are of child-bearing age (Malakieh, 2019), an extensive narrative review of health research among people in prison in Canada has found little specific to reproductive health (Kouyoumdjian *et al.*, 2016). Only two studies, Carter Ramirez *et al.* (2020a) and Carter Ramirez *et al.* (2020b) address perinatal and neonatal health outcomes of incarcerated women in Canada, both finding poorer outcomes than are observed in the general population. In a survey of 89 provincially incarcerated women in Ontario, Liauw (2016) found 82.4% reported having ever been pregnant.

Maternity services for incarcerated women

The increasing number of incarcerated women heightens the need for the provision of gender-specific reproductive health care including contraception, abortion and maternity care. While prison pregnancy and reproductive health statistics are unavailable in Canada, a major recent initiative in the USA to capture such data found 3.8% of women newly admitted to prisons to be pregnant (Sufrin *et al.*, 2019). Of these 1,396 pregnancies, 92% resulted in live births, 6% in miscarriages, 1% in abortion, 0.5% in stillbirth and 0.2% in newborn death.

Like most facilities in which women are incarcerated are co-located with men, and approximately 10 times as many men are incarcerated as women, prison health services are unlikely to be operationalized to provide gender-specific services including reproductive health care. For people in prisons, access to care can be hampered by security concerns (Olds *et al.*, 2016) staffing issues (Morgan *et al.*, 2007) and communication barriers between corrections and health-care providers [World Health Organization (WHO), 2014]. Poor access to reproductive health services can result in disease transmission, unwanted fertility, inadequate prenatal care, as well as maternal and neonatal complications (Stover *et al.,* 2016).

Most incarcerated women in Canada have elevated health service needs; women who are incarcerated in the perinatal period have additional and significant needs that must be met to ensure the health of their children (Knittel and Sufrin, 2020). Health care is often in conflict with security operations in prisons: people may be strip-searched before and after appointments, triggering PTSD (Human Rights Law Centre, 2017); transport to and from the prison to the hospital may involve the use of restraints and be forced to wear humiliating

orange jumpsuits (Van Veeren, 2015); and access to care may be interrupted due to security lock-downs (World Health Organization, 2014). When care is necessary but not emergent such as routine prenatal assessment and ultrasound, it is vulnerable to being overlooked in the chaotic, violent and stressed context of prisons, particularly those populated mostly by men. Furthermore, security-related delay or denial of care can cause significant harm to both mother and infant. Longer distances to the hospital are associated with higher rates of maternal and neonatal mortality (Ravelli *et al.*, 2011).

Mother-child programmes in correctional facilities

Available research demonstrates most incarcerated women are mothers of children under the age of 18 (Glaze and Maruschak, 2010). To reduce the harm to children associated with the incarceration of their mothers, many jurisdictions have residential programmes in which children can live with their mothers inside the prison (Paynter *et al.,* 2020). In 2015, 70% of federally incarcerated women in Canada reported being mothers to minors under the age of 18 (Sapers, 2015). There is no reliable provincial/territorial data about the numbers of people reporting to be mothers or parents.

CSC policy stipulates that the mother-child programme must be offered to all federally incarcerated women (CSC, 2016). The eligibility requirements for full-time participation require participants to be classified as minimum or medium security and be willing to involve Child Protection Services in their families, and children must be under the age of five (CSC, 2016). Brennan (2014) found the programme to be underused due to access barriers including prison overcrowding and the increasingly strict eligibility to participate. Over the past 17 years, only 125 women have applied to the programme, with 108 applications accepted (Office of the Correctional Investigator [OCI], 2019). Participation information is not published by CSC.

The only provincial institution with a full-time residential mother-child programme is the Alouette Correctional Facility in British Columbia. This programme was closed from 2008–2016, reportedly because of administrative concerns that children could be endangered by the prison environment (Inglis v BC, 2013, BCSC 2309). It reopened after a 2013 ruling that its closure was unconstitutional (Inglis v BC, 2013, BCSC 2309), however, there remain concerns that it is infrequently used (Stueck, 2015). In 2013, an international roundtable was convened to develop guidelines for the mother-child programme to support maternal-child bonding (CCPHE, 2015).

Objectives

The authors of this paper are volunteers with a non-profit organization in Canada that provides support, education and advocacy for the reproductive health of people experiencing criminalization. The organization has found the lack of publicly available information and research about the maternity care experiences of women experiencing incarceration, their children and their access to health care and support services impedes the organization's service delivery and advocacy efforts.

The purpose of this scan was to create an inventory of correctional institutions for women that identifies access to maternity care and mother-child programmes. This project begins to fill the significant gaps in our knowledge about the health and parenting experiences of incarcerated people. Our aim was to create a baseline from which to build future policy, research and advocacy initiatives to enhance health care for people experiencing criminalization. In this project we asked four overarching questions:

- Where are incarcerated women and girls incarcerated?
- Who provides their health care?

- How physically close are these facilities in relation to maternity hospital care? And
- Do these facilities allow mothers and infants to remain together at the facility after birth in a residential mother-child programme?

Methods

This scan was conducted in partnership with a volunteer, community-based, non-profit organization. The organization works to advance the rights of women experiencing incarceration to health. In conducting this scam, we are informed by the values of that organization. We valued different types of knowledge, including knowledge provided by people with lived experience of incarceration, institutional staff and community volunteers. The environmental scan was conducted by a research intern for the non-profit organization.

Methodology

Environmental scans allow for the collation of various types of sources of knowledge (Graham *et al*., 2008). The environmental scan method we used is described as Searching (Choo, 2001). This method relies on the assumption that the environment is analyzable, the search requires an investment of resources and that the scan actively intrudes on the environment. From a broad search involving detailed questions in a formal process, the output is described as Discovery (Choo, 2001). The goal of the scan is to make sense of the objective reality of the environment and to shift organizational processes in response to this new knowledge. For the non-profit organization supporting this scan, these shifts in organizational processes could include: referring to, imitating or advocate *against* the approach to maternity services taken in a jurisdiction; or collecting data about how a particular health concern differently affects women experiencing incarceration. We sought information from internal and external sources using our existing relationships with stakeholders in the fields of women's health, prisoner rights, prison health research and by forging new connections. We did not concern ourselves with organizational hierarchies but rather sought our answers directly from representatives of these public institutions. We maintained an audit trail of contacts made and responses.

Content

For this active environmental scan, we sought to create an inventory of institutions where women are incarcerated in Canada, including the following details: name, type of facility (federal, provincial, territorial, immigration detention, psychiatric and/or youth), the province or territory where it is located, whether the women's unit is co-located with men, total capacity (number of people the institution can incarcerate), capacity for women, presence of a mother-child programme, government body responsible for health care and distance to the nearest hospital with maternity services.

Process

The first step in the environmental scan was to sketch out what we already knew from our experience in this sector. For example, we knew that every federal prison for women must, according to policy, include a mother-child programme (CSC, 2016). Then, working from the federal to the provincial level, we conducted an online search of the CSC website(s) (CSC, 2020b) and the websites of the Provincial and Territorial Ministries or Departments of Justice (BC, no date; Alberta, 2020; Manitoba, 2020; Saskatchewan, 2020; Ontario, 2020; New Brunswick, 2020; PEI, no date; Nova Scotia, 2020; Newfoundland and Labrador, 2020; Office of the Auditor General, 2015; Northwest Territories, 2020; Yukon, 2020). The degree of detailed information available about each facility varied according to jurisdiction. Few websites clearly stated which institutions were designated women-only or in which women

were co-located with men, and few stated facility size. None of these websites stated which government department was responsible for health care in the facilities. Addresses and phone numbers for the facilities were readily available.

The next step in the environmental scan was to contact employees of CSC and the responsible Provincial and Territorial Ministries or Departments by phone and email. In every instance, the request for information by phone was redirected to a different person. Responses to queries varied by jurisdiction. Some employees returned calls and emails, answered all the questions and sometimes even volunteered supplementary information. In other cases, no response was provided despite repeated attempts and leaving several messages.

In cases where it was impossible to reach a representative of correctional services for jurisdiction, we contacted the local Elizabeth Fry Societies. Elizabeth Fry Societies are dedicated to supporting women and girls who experience criminalization and involvement with the justice system (CAEFS, 2018). Services offered to vary by society. When contacted, these employees were well informed about prisons in their areas and were generous in sharing that information.

To determine how far women experiencing incarceration must travel for maternity care services we used the correctional facility addresses and Google Maps to determine nearby hospitals. Whether the hospital provided maternity services was determined by visiting the individual hospital websites and verifying their services, and telephoning the hospital if necessary.

Results

Correctional facilities for women

In total, the scan includes 72 facilities across the country in which women are incarcerated (Table 1). There are seven federal facilities for women including two healing lodges; none of these are women co-located with men. There are two federal psychiatric facilities, in Saskatchewan and Quebec, with capacity for both women and men. The three facilities specifically dedicated to immigration detention in Canada are located outside Montreal and Toronto and at the Vancouver Airport. The latter may hold people for up to 48 h. In each of these facilities, children are also held. There are 44 adult provincial facilities in which women are incarcerated; of these, 34 (79%) are co-located with men. Ontario has the most provincial/territorial facilities in which women are incarcerated, at 15.

There are 16 provincial/territorial youth facilities, all generally are coed. We did not include Paul Dojack Hall's youth facility in Saskatchewan because we learned through discussion with a nurse there that girls are all sent to Kilburn Hall (personal communication, staff nurse, Sept 30, 2020). The Manitoba Youth Centre specifies that it reserves 45 spaces for girls out of the total capacity of 150. Individuals in youth facilities may be older than 18 if they are serving a sentence that would take them beyond 18 years of age. Youth in custody are sometimes handled by different departments than adults in custody. For example, in Ontario, the Ministry of the Solicitor General is responsible for the custody and supervision of adults (18 and over years of age) who are serving a sentence of up to two years less a day or who are awaiting criminal proceedings, while the Ministry of Children, Community and Social Services (MCCSS) is responsible for youth in custody (12 to 17 years of age).

The process of conducting the scan demonstrated that women are an invisible population in the corrections landscape. Many facilities do not disclose their specific capacity for women. A very small unit for women may be connected to larger facilities for men, as in the Cape Breton Correctional Facility, which houses 96 men and "also operates, as needed, a four-bed dorm for adult women and a six-bed temporary detention facility for youth" (Nova Scotia, 2013). The Calgary Youth Centre is attached to the Adult Female Annex.

Table 1 Correctional facilities for women, proximity to maternity services, and presence of mother child program

Co-located with men?	*Total capacity*	*Capacity for women*	*Who provides health services?*	*Distance to maternity services hospital (km)*
No	99	99	Correctional Services Canada	1.5
No	132	132	Correctional Services Canada	4.7
No	215	215	Correctional Services Canada	7.3
No	60	60	Correctional Services Canada	132
No	167	167	Correctional Services Canada	6.4
No	28	28	Correctional Services Canada, Native Counselling Services of Alberta	No address
No	112	112	Correctional Services Canada	3
Yes	109	Not specific	Canadian Border Services Agency	14.9
Yes	125	Not specific	Canadian Border Services Agency- third party service vendor	2.9
Yes	24	Not specific	Canadian Border Services Agency	5.2
yes		Not specific	Correctional Services Canada	12.2
Yes	204	Not specific	Correctional Services Canada	6.5
No	26	26	Department of Justice and Public Safety- Corrections Community Services	0.65
Yes	145		Department of Justice and Public Safety- Corrections Community Services	4.4
Yes	370	48	Nova Scotia Health Authority	12.9
Yes	96	6	Nova Scotia Health Authority	11.5
Yes	124	Not specific	Community and Correctional Services	12
No	56	56	Horizon Health Services	8.4
No	50	Not specific	Integrated Health and Social Services Centres, Integrated University Health and Social Services Centres	11.8
	250	Not specific	Integrated Health and Social Services Centres, Integrated University Health and Social Services Centres	14
Yes	104	21	Correctional Services Division of the Ministry of the Solicitor General	1.2
No	124	124	Correctional Services Division of the Ministry of the Solicitor General	5.1
Yes	1,184	49	Correctional Services Division of the Ministry of the Solicitor General	5.1
Yes	232	16	Correctional Services Division of the Ministry of the Solicitor General	61.4
Yes	450	42	Correctional Services Division of the Ministry of the Solicitor General	14.2
Yes	585	56	Correctional Services Division of the Ministry of the Solicitor General	7.2
Yes	228	43	Correctional Services Division of the Ministry of the Solicitor General	38.5
Yes	132	28	Correctional Services Division of the Ministry of the Solicitor General	17.1
Yes	560	52	Correctional Services Division of the Ministry of the Solicitor General	8.1
Yes	315	42	Correctional Services Division of the Ministry of the Solicitor General	9.2
Yes	23	4	Correctional Services Division of the Ministry of the Solicitor General	0.5
Yes	105	30	Correctional Services Division of the Ministry of the Solicitor General	4
Yes	121	8	Correctional Services Division of the Ministry of the Solicitor General	6.4
Yes	101	8	Correctional Services Division of the Ministry of the Solicitor General	1.8
Yes	185	17	Correctional Services Division of the Ministry of the Solicitor General	4.3
Yes	252	8	Manitoba Justice Corrections Division	3.4
Yes	114	4	Manitoba Justice Corrections Division	1.9
Yes	289	8	Manitoba Justice Corrections Division	2.8

(*continued*)

Table 1

Co-located with men?	*Total capacity*	*Capacity for women*	*Who provides health services?*	*Distance to maternity services hospital (km)*
No	196	196	Manitoba Justice Corrections Division	18.9
No	16	16	Ministry of Corrections and Policing	13.7
No	320	320	Ministry of Corrections and Policing	6.5
Yes	427	Not specific	Alberta Health Services	17.9
No	Not specific	Not specific	Alberta Health Services	17.7
Yes	546	Not specific	Alberta Health Services	1.7
Yes	395	Not specific	Alberta Health Services	6.8
Yes	249	Not specific	Alberta Health Services	15.2
Yes	684	Not specific	Alberta Health Services	18.1
Yes	1952	Not specific	Alberta Health Services	13.4
Yes	103	Not specific	Alberta Health Services	3
Yes	146	Not specific	Alberta Health Services	2.4
No	315	315	BC Provincial Health Services Association	11.1
Yes		15	BC Provincial Health Services	34.4
Yes		25	BC Provincial Health Services	5
No	8	8	Nunavut Department of Health	2.3
Yes			Health and Social Services- Government of Northwest Territories	Midwifery care only in Fort Smith
Yes	190	33	Yukon Department of Justice	6.1
Yes		Not specific	Department of Justice and Public Safety- Corrections Community Services	91.9
Yes	60	Not specific	IWK Health Services	16.7
Yes	16	Not specific	Health PEI	3.4
Yes		Not specific	Horizon Health Services	8.4
Yes		Not specific	Unspecified	14
Yes	192	Not specific	Ministry of Children, Community and Social Services- Youth Justice Service Division	12.5
No		Not specific	Ministry of Children, Community and Social Services- Youth Justice Service Division	4.4
Yes	150	45	Manitoba Justice Corrections Division	7.1
Yes	45	22	Ministry of Corrections and Policing	3.6
Yes	Not specific	Not specific	Alberta Health Services	17.7
Yes			Alberta Health Services	11.8
Yes		Not specific	BC Provincial Health Services	15.4
Yes		Not specific	BC Provincial Health Services	10.9
Yes	16	Not specific	Nunavut Department of Health	2.3
Yes		Not specific	Not specific	1.4
Yes	14	Not specific	Yukon Health and Social Services	1.7

In some provinces, no list of facilities for women was available. In the case of Ontario, it was necessary to contact the Ministry of the Solicitor General to receive a complete list. In the case of Newfoundland and Labrador, repeated attempts at contacting government officials failed. We learned from the Elizabeth Fry Society of Newfoundland and Labrador that women are being incarcerated in Her Majesty's Penitentiary, a provincial corrections facility for men, due to lack of space in the women's facility, the Newfoundland and Labrador Correctional Centre for Women. This was also reported in the news several years ago (The Canadian Press, 2016).

Mother child programmes

Each of the federal prisons for women reportedly has a mother-child programme, however, it was not clear how many children participate. There is a programme in only one provincial/territorial facility, the Alouette Correctional Centre in BC. Two provinces responded to our questions about mother-child programmes. Manitoba Justice reported the Province's Women's Correctional Centre had instituted a mother-child programme in the past, but it was cancelled before any child participated, due to lack of referrals. They did not clarify how referrals are made or eligibility criteria. A representative of the Nunavut Department of Justice stated there was no mother-child programme at Nunavut Women's Correctional Centre because they "[. . .] have yet to see a need for it" (J. Deroy, personal communication, March 26, 2019).

Health services

Responsibility for providing health care to people in prison varies across jurisdictions. CSC is responsible for providing health care to people experiencing federal incarceration (CSC, 2020a). In Nova Scotia (Nova Scotia, 2020), New Brunswick (Personal communication, R. Ritchie, Superintendent of the New Brunswick Women's Correctional Centre, October 10, 2019), British Columbia (British Columbia, 2017) and Alberta (Personal communication, T. Grzech, Alberta Corrections, April, 2019), the provincial health authority uses the health-care providers who care for people in provincial prisons. In some cases, the shift of responsibility to the health authority is recent and in response to concerns about the quality of care (Metcalfe, 2018). Newfoundland is amid a shift in responsibility (Personal communication, S. Michellin, Assistant Superintendent, NL Correctional Centre for Women, July 4, 2019). In Prince Edward Island health-care providers collaborate with Health PEI, the health authority, but are used by Community and Correctional Services (Personal communication, S. Ellis, Manager, October 7, 2019). In Ontario, health staff is used by the Ministry for Community Safety and Correctional Services (personal communications, Ministry of the Solicitor General, April 8, 2019). Manitoba Corrections uses a health-care staff for its facilities (Personal communication, E. Klassen, Director of Operations, April 1, 2019). The Department of Justice is responsible for the provision of health services in facilities in the Yukon (Personal communication, T. Murray, Deputy Superintendent, Whitehorse Correctional Centre, April 1, 2019). Health care for youth may be different still: in Nova Scotia, the health services for provincially incarcerated adults are provided by the provincial health authority, while health services at the Youth Centre are provided by the IWK Health Centre, a different authority specific to pediatric and maternity services (IWK Health Centre, 2020).

The distance between the facilities and the nearest hospital with maternity services varied considerably. For example, it is only 1.5 km from the Nova Institution for Women federal prison to the Colchester East Hants Hospital in Truro, Nova Scotia, while it is over 132 km from the Okimaw Ochi Healing Lodge in Maple Creek, Saskatchewan to the nearest maternity hospital, located in Medicine Hat, Alberta.

Discussion

Where the women are: invisibility and co-location

In most provincial institutions, women are co-located with men. In some cases, the capacity for women in these facilities is quite small. For instance, two Ontario jails have the capacity to house eight women each, with a total population of over 100. Being one of a small number of women in a large facility imprisoning a larger men's population can be isolating and may result in inadequate access to women's health services (Braithwaite, Treadwell and Arriola, 2005). Co-locating a small women's population with a larger men's provincial facility may create unique problems. Health-care staff may lack specialization in women's health matters (Besney *et al.*, 2018). Even with awareness of women's needs and histories of trauma, attempts to adjust prison spaces to address them may be futile due to the overarching hostility of the environment (Jewkes *et al.*, 2019). A comprehensive list of facilities designated for women may allow researchers and advocates to further investigate the influence of these types of concerns.

Despite increasing attention to immigration detention in the USA (Cho *et al.,* 2020; Von Werthern *et al.*, 2018) the policies and practices in Canada are poorly understood. Immigration is one of the most complex areas with respect to governance and health oversight, making health research with this population challenging. We were unable to find sex or gender-disaggregated data about populations kept in immigration facilities, nor their predominant health concerns and maternity care needs.

Youth is a very small population of incarcerated people in Canada and girls makeup only 24% of girls experiencing incarceration (Malakieh, 2019). There are facilities that incarcerate girls in each province and territory, however, only one, the Manitoba Youth Centre, specified the percentage of its capacity dedicated to girls: 30%. Manitoba is a troubling outlier with respect to the incarceration of youth. Despite only 4% of the population of children 15–19 years of age living in Manitoba (Statistics Canada, 2016a, 2016b), the province has 24% of the youth experiencing incarceration in the country (Malakieh, 2019). While nationally 35% of incarcerated youth identify as Indigenous (Department of Justice, 2018), in Manitoba, that number is 80% (Grabish and Monkman, 2018). Incarceration of youth has lifelong consequences: incarceration as a youth is associated with mental health issues as an adult (Barnert *et al.,* 2017) and many youth who experience convictions are at risk of experiencing conviction again as an adult. Therefore, the disproportionate criminalization of Indigenous youth is a harmful practice that requires urgent attention.

There are no reliable statistics on pregnancy rates among incarcerated youth in Canada. A recent study in Georgia in the USA found 25.5% of girls experiencing incarceration had ever been pregnant (Gray *et al.*, 2016). In Canada, the rate of adolescent pregnancy is approximately 14 per 1,000 or 1.4% (Fleming *et al.,* 2015). While unfortunately not disaggregated by sex or gender, a 2013 study found 35% of youth experiencing incarceration in British Columbia had "been pregnant or caused a pregnancy" (McCreary Centre Society, 2014, p. 29). Of youth in the study who reported being sexually active, 67% had more than 6 partners. More than 65% had never used a condom during sexual intercourse. Clearly, girls experiencing incarceration face far greater sexual health risks and risk of unplanned pregnancy than the general population. It is critical that researchers examine the health needs of girls experiencing incarceration, and that they receive sexual and reproductive health-care that not only meets professional standards of acceptability but is culturally safe.

Mother child programmes

As we expected, we found only one provincial prison that operates a mother-child programme, at Alouette. In Inglis v BC (2013), Madam Justice Ross ruled the decision to close that programme in 2008 violated the women's *and their children's* constitutional rights

to equality and liberty. The ruling also recognizes that separation from their incarcerated mother is not in the *Best Interests of the Child* [United Nations General Assembly (UNGA), 1989]. The reinstatement of the mother-child programme at Alouette did not result in the creation of programmes in other provinces/territories. Reinstating a programme is a different hurdle than creating a new one; Justice Ross' decision was based on the unfairness of the decision to close the programme, not the unfairness of a general practice in women's prisons to separate mothers and children. Despite its reinstatement, the Alouette programme is infrequently used. As in the federal programme, strict eligibility criteria and increased surveillance required of participants are disincentives to participate (Miller, 2013).

Prisons in Canada do not routinely collect information about women's children; it is not known how many incarcerated women have pre-school age children that could participate in the mother-child programme, how many pregnant incarcerated women give birth and lose access to their children or how many of these children end up in foster care. The incarceration of women in Canada is a continuation of colonial, racist attitudes towards Indigenous mothers and of systemic state interference in their families and communities (National Inquiry into Murdered and Missing Women and Girls, 2019). Rather than advance mother-child programmes, the risks of maternal incarceration to child well-being should prompt exploration of alternatives to prisons.

Responsibility for health services

At the federal and provincial/territorial levels, legislation stipulates that governments are responsible for the health of people in prison. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Mandela Rules") (UNGA, 2015) and Bangkok Rules both require governments to provide people in prison with health-care equal to those found in the community. Oftentimes, to advocate for a type of care in a facility it is necessary to demonstrate it is available elsewhere. For example, advocacy for curative Hepatitis C virus treatment in provincial facilities argues that the federal service provides this care (Kronfli *et al.*, 2019). Understanding what health services are available and where is limited by the heterogenous responsibility for health in prisons across Canada.

People experiencing incarceration are indisputably a population with high health-care needs, experiencing backgrounds and histories of deprivation, abuse, poverty, trauma, homelessness, substance use and mental and physical illness (Kouyoumdjian *et al.*, 2016). Poor prisoner health has negative repercussions for the health of the community at large (Restum, 2005). While health services are a minor determinant of health, varying access and policies across jurisdictions impede understanding of health services and experiences.

There is no evidence that health service provision under Justice versus Health departments (or vice versa) ameliorates outcomes, nor has there been much research to measure any differences in health outcomes based on Ministry responsible. Reportedly, complaints have fallen in British Columbia's provincial jails, as the health services were transferred from a private contractor to the province's health authority in 2017 (Metcalfe, 2018). As services shift from one department to another such as is currently underway in Newfoundland, measuring changes in outcomes, even as basic as complaints, may be illustrative.

Maternity services

Our review finds that people incarcerated in prisons for women in Canada face distances of up to 132 km to a hospital with maternity services, putting these women and their infants at elevated risk of negative outcomes. The studies by Carter Ramirez *et al.* (2020a) and Carter Ramirez *et al.* (2020b) provide the first quantitative evidence in Canada of the harm of incarceration to perinatal and neonatal health. There are no known guidelines for the perinatal care of incarcerated women in Canada (Alirezaei and Roudsari, 2020). The

inventory we created here can be used to support data collection and guidelines development across jurisdictions and enhance our understanding of sexual and reproductive health experiences and care for populations experiencing incarceration.

Inconsistency and opacity

This scan demonstrates inconsistency across the institutions or their governing departments with respect to access to basic information. As public institutions, there must be greater accountability from prisons to inquiries about this information. Incarcerated people are members of the public and must be part of our efforts to monitor and address public health.

Limitations

This inventory is a starting point and has several limitations. Several times during the compilation of the institution inventory we stepped back and evaluated the kinds of institutions to include. Our goal was to build a picture of where and under what conditions women and girls are being incarcerated in Canada. We found that it was necessary to broaden our scope to include many different types of institutions, including immigration detention centres and youth correctional facilities. However, we did not include police lock-up, courthouse cells or involuntary psychiatric units. We are not able to track to what extent women may be held unofficially in prisons designated for men such as is the case at Her Majesty's in Newfoundland. Although non-citizens may be held in provincial facilities (Bensadoun, 2019; Global Detention Project, 2018a, 2018b), we do not know their numbers by sex or gender.

Although we attempted to include all facilities designated for women, there is no statistical reporting available regarding trans and nonbinary people in these sites. We did not include the facilities designated for men in which trans and non-binary persons are held. Trans and nonbinary populations experience layers of social oppression, including the potential harm of incarceration in an institution that is not gender-affirming. Their needs for inclusive health-care are inadequately addressed in Canada, and no information is available regarding their health experiences in Canadian correctional facilities. There is a need for additional research and improved reporting for these populations.

The lack of clarity regarding where and how women are incarcerated across the country limits researchers and advocates the ability to systematically survey or assess women's health or any other aspect of women's experience of incarceration. We may be missing something because of the lack of a database with which to compare. There are urgent questions we failed to ask: how many segregation cells or "secure intervention units" are in each facility? How does each facility allocate maximum, medium and minimum-security levels? To what extent does overflow occur or the practice of "double-bunking"? What are the sex and gender differences in rates of remand/pretrial custody in provincial facilities?

As this project was conceived as an environmental scan to gather basic information to support future research, ethics approval was not sought. Future research could involve surveys and interviews with facility representatives and women experiencing incarceration, with ethics approval.

Because of the complexity of the issue and its multi-jurisdictional and multi-departmental nature, no one had created such an inventory before and it is unclear who is optimally suited to maintain it. It is likely to shift regularly. New jails are already being built: Prince Edward Island is constructing a women's facility and the Government of Nova Scotia plans for a new jail on Cape Breton Island.

Conclusion

The objective of this environmental scan was to create a comprehensive inventory to fill a practical gap in knowledge of where women were incarcerated in Canada, who was responsible for their health services and where they could seek maternity services. Our intention is for the inventory to power advocacy, research and policy efforts. Although this scan is an important first step towards this objective, the data we have collected, particularly on co-location and capacity, must be enhanced.

With increasing numbers of incarcerated women, it is also important to examine how women experiencing incarceration access health services. This inventory is a first step to collect sex and gender-disaggregated information related to the health of people in prison across jurisdictions. Further research is needed on the health team composition in each site such as the inclusion of doulas, midwives, nurse practitioners and other providers with sexual and reproductive health specializations; access to culturally safe and traditional care; and policies and procedures governing transport and personal searches of people in prisons to health-care services.

The invisibility of women in prisons across Canada at all levels of government impedes women's equal access to health and other services. This invisibility also limits researchers, health professionals and advocates' ability to understand and assess the experiences of women in prisons in Canada. Identifying where women are and what they do or do not have access to is but a bare minimum step to exploring inequities and solutions such as community-based alternatives to incarceration.

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