

**“SURVIVAL MODE”: ACCESS AND UTILIZATION OF REPRODUCTIVE
HEALTHCARE SERVICES POST-INCARCERATION**

by

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TABLE OF CONTENTS

ABSTRACT.....	vii
Chapter	
1 INTRODUCTION.....	1
2 THEORETICAL FRAMEWORK.....	4
3 LITERATURE REVIEW	6
Gendered Barriers to Reintegration.....	6
Access Barriers to Healthcare	8
Reproductive Health Planning Needs and Intentions.....	10
4 METHODOLOGY.....	14
Contextual Background.....	16
5 ANALYSIS.....	18
Demographics.....	18
Main Themes	18
Intrinsic Barriers	19
Self-Reliance.....	19
Lack of Knowledge	20
Extrinsic Barriers	23
Transportation.....	23
Social Influence.....	25
Parole and Probation Requirements.....	26
Systemic Barriers.....	28
Insensitive Providers and Lack of Cultural Competency.....	28
Inconsistency in Care.....	30
Survival and the Complex Reintegration Process.....	31
CONCLUSION.....	35
REFERENCES.....	39

Appendix

A	IRB APPROVAL LETTERS.....	50
B	DATA COLLECTION MATERIALS.....	52
	Reentering Women Interview Guide.....	50
	Reentry Service Providers Interview Guide.....	53
	Screening Tools.....	55
	Demographic Survey.....	56

ABSTRACT

This research explored the barriers to access and utilization of reproductive healthcare services, among women returning to the community from prison. Previous research suggested that a majority of reintegrating women do not desire pregnancy after incarceration. However, most incarcerated and reintegrating women do not utilize healthcare services, contraception, or health insurance consistently. Extant literature implied that reproductive health norms, lack of transportation, as well as fear and distrust in the medical process deter women from utilizing reproductive healthcare services. This research conducted 15 semi-structured interviews with reintegrating women and reentry service providers from Delaware and two bordering counties in Pennsylvania. Findings suggested that there were intrinsic, extrinsic, and systemic barriers to accessing reproductive healthcare post-release. These include self-reliance, lack of knowledge, lack of transportation, social influence, probation/parole requirements, healthcare inconsistency, insensitivity and lack of cultural competency, and the complex reentry process. The findings from this research provided reentry initiatives, medical personnel, and prison facilities with the data and knowledge needed to better implement and enforce policies that would encourage reintegrating women's utilization of reproductive health services.

Chapter 1

INTRODUCTION

On June 24, 2022, the United States Supreme Court made the decision to overturn the Roe v. Wade decision (Artiga et al., 2022). This historic court ruling once provided a constitutional right to an abortion. However, since the decision to overturn the landmark precedent, states are now in charge of determining the legality of bodily autonomy. For many individuals with uteruses across the United States this controversial court ruling poses threats to accessing healthcare and controlling decisions about mental and physical health (Artiga et al. 2022). People everywhere were impacted by the disapproved decision, but incarcerated and reentering women are at an even higher risk of reduced choice in healthcare access and utilization (Alfonseca, 2022).

According to The Sentencing Project (2020) there are currently 152,584 women incarcerated in local, state, and federal facilities in the United States. This number has inflated over 500 percent since the beginning of 1980. Also, there are approximately 1.2 million women under the supervision of the United States criminal justice system. Often women are imprisoned for shorter amounts of time than men and experience higher rates of reincarceration (Hocking et al., 2002). This leads to women returning to their communities in large influxes, which makes them more vulnerable to the social, financial, physical, and emotional challenges commonly faced post-release (O'Brien, 2001; Richie, 2001; Salisbury & Van Hooris, 2009).

One barrier to women’s successful return to society that is commonly overlooked is their access to health services (Adams et al., 2011). Justice-involved¹ women are more likely to be exposed to childhood and adult physical, emotional, and sexual abuse, as well as illicit substance use compared to male incarcerated individuals and the general population (Clarke et al., 2006a; Clarke et al., 2006b). These factors put women returning citizens at a higher risk for mental, physical, and reproductive health issues such as sexually transmitted infections and unintended pregnancies (Adams et al., 2011; Sutherland et al., 2015). In addition, incarcerated women experience negative health consequences, health disempowerment, and treatment disruption (Ahmed, 2011). Access to trauma-informed and gender-responsive healthcare post-incarceration is needed to guarantee women are receiving the most effective and informed health care (O’Brien, 2001; Salisbury & Van Hooris, 2009; Saxena, Grella, & Messina, 2016). However, little research explores the barriers that may prevent reintegrating women’s access to much needed health services.

The majority of prior reentry research has not acknowledged the reproductive health disparities reintegrating women are experiencing, such as the increased rates of unintended pregnancies, abnormal pap smears, STIs, and the lack of contraception use (Adams et al., 2011; Clarke et al., 2006a; Clarke et al., 2006b). The acknowledgement of the literature gap is important to the lives of women, as well as public health. The goal of this research was to understand the barriers reintegrating women are facing when

¹ I use the terms “justice-involved,” “reentering,” or “reintegrating” to refer to women leaving incarceration and returning to their communities.

accessing reproductive health services and to understand what resources could be helpful to facilitate their access to health services. This research collected data through semi-structured interviews with reintegrating women, as well as reentry service providers. The analysis of the data were guided by a reproductive justice framework. This research was beneficial not only to the lives of reentering women and their families, but also to their community. By understanding how to better implement practices that will encourage reentering women to utilize reproductive health services, policies designed to decrease the rates of unintended pregnancies, STIs, and negative birth outcomes can be more validly informed.

Chapter 2

THEORETICAL FRAMEWORK

This analysis utilized a reproductive justice framework as a lens to examine the obtained data. The reproductive justice framework is an intersectional feminist approach that was cultivated by Black women empowering pro-choice ideologies (Ross, 2017). The framework was implemented to recognize full reproductive and sexual health rights of marginalized women. According to Ross, “reproductive justice theory examines the meaning assigned to reproductive relations and externally imposed policies and practices” (2017:287). Similarly, Roberts (2015) argued that the reproductive health framework embodies the oppression of low-income women and women of color in regard to their ability to make decisions on their reproductive health. Derr defines reproductive justice as, “the human right of every person to: 1) decide if and when she will have a baby and the conditions under which she will give birth; 2) decide if she will not have the baby and her options for preventing or ending a pregnancy; and 3) parent her children with the necessary social supports in safe environments and healthy communities and without fear of violence from individuals or the government” (2017:88).

Chrisler (2014) argued that a women’s reproductive justice should be based on positive rights and a women’s ability to feel as though she is in control of her reproductive health. Since formerly incarcerated women typically report experiencing low levels of self-esteem, empowerment, and self-efficacy, they are less likely to feel in control of their reproductive health when attending physician appointments (O’Brien, 2001; Salisbury & Van Hooris, 2009; Saxena, Grella, & Messina, 2016). Chrisler (2014)

stated, “empowered women, who achieve reproductive justice, experience better well-being and are better able to contribute productively to their own and their family’s future” (2014:208). Thus, utilizing a reproductive justice framework to understand the empowerment and self-efficacy women experience when they have access, as well as positive experiences when utilizing healthcare services, would promote a successful reentry process.

Additionally, Hayes, Sufrin, and Perritt (2020) explained that reproductive justice cannot be achieved without consideration for the social conditions and oppressions that impact an individual’s access and experiences in reproductive life. Therefore, reproductive justice was an important framework to incorporate into the complex process of reintegration to better understand how the marginalized social conditions uniquely contribute to the barriers of reentry. This research analyzed women returning citizen’s access to reproductive health services. Specifically, women’s post-release access to contraception, family planning services, and abortions. This research also expanded on what we know about women’s level of comfort when receiving reproductive health services. The analysis utilized the intersectional feminist reproductive justice approach to expand and fill the literature gap on women returning citizen’s reproductive health. By applying reproductive justice theory to women returning citizens, this research enhanced the literature on the reproductive justice framework to include the reproductive needs of women post-incarceration. This study was also useful to build onto previous literature that applies the reproductive justice theory to women in the criminal justice system.

Chapter 3

LITERATURE REVIEW

Gendered Barriers to Reintegration

Reintegration is defined as the transition from incarceration to living within the community (Muhlhauser, 2017). Many scholars and public officials argue that understanding the process of reentry is important to reduce recidivism, increase public safety, and increase overall wellbeing (Stahler et al., 2013; Mowen & Boman, 2018). Although, justice-involved individuals have varying gender-neutral barriers and concerns in regard to reintegration, justice-involved women have unique barriers that complicate the reintegration process (Chesney-Lind, 1989; Daly, 1992; Garcia-Hallet, 2019; Gilfus, 1993; van Wormer & Kaplan, 2006). For example, justice-involved women commonly have shorter incarceration sentences and commit non-violent crimes compared to their male counterparts (Gilfus, 1993). They also have lower levels of recidivism compared to men but are more likely to experience mental and physical illness, as well recurrent substance use after being released (Maruschak, 2008; Spjeldnes & Goodkind, 2009; van Wormer & Kaplan, 2006). In addition, women tend to reintegrate into disadvantaged communities with less resources because most reentry and correctional programs represent a “one-size fits all” mentality and fail to recognize women have distinct pathways to desistance (Holfreter & Wattanaporn, 2014; Richie, 2001; Salisbury & Van Hooris, 2009). This is detrimental to justice-involved women, the community, and the economy since many of the reentry initiatives in place do not cater to the gender-specific

risks of criminality and desistance (Anderson & Javdani, 2017; Holtfreter & Wattanaporn, 2014).

Many feminist scholars have highlighted the gender-specific risks for women's recidivism and offending (Chesney-Lind, 1997; Gilfus, 1993; O'Brien, 2001; Ramirez, 2016; Richie, 2001; Rettinger & Andrews, 2010). For example, women involved in crime generally have history of abuse, trauma, substance use, as well as economic, relational, and educational deprivations (Arditti & Few, 2006; Chesney-Lind, 1989; Daly, 1992; Gilfus, 1993; O'Brien, 2001; Richie, 2001). Also, nearly two-thirds of justice-involved women are mothers or primary care-takers (Glaze & Maruschak, 2010). Therefore, they need reintegration services that focus on the family connections, financial resources, and trauma informed approaches to mental and physical health needs to increase motivation for desistance (Saxena, Grella, & Messina, 2016). For example, a study conducted in Australia, found that justice-involved women, similar to men, were often young, poorly educated, and unemployed (Sutherland et al., 2015). The intersectionality of these social aspects contributes to a large number of the barriers that justice-involved women face during reintegration. In addition, van Wormer & Bartollas (2021) explained that due to the increased experience of violence and trauma among justice-involved women, they are more likely to have lower perceptions of self-efficacy, trust, and increased need for social support compared to their male counterparts. Tyler and Brockmann (2018) found that racial and socioeconomic health inequities of formerly incarcerated women affect not only themselves, but also their families and communities. Most justice-involved women come from marginal conditions with limited access to healthcare and high levels of

poverty (van Wormer & Kaplan, 2006). Therefore, a large barrier to women's successful return to society is their inability to access proper healthcare services.

Access Barriers to Healthcare

There are many unique challenges that reentering women experience, but there is a paucity of research that has examined the barriers that limit access to their reproductive health (Clarke et al., 2006a; Clarke et al., 2006b; Ramaswamy et al., 2015; Ramaswamy et al., 2018; Oswald et al., 2010). Previous research explains that low-income and medically underserved populations are the most vulnerable to risky, sexual behaviors compared to their affluent counterparts (Macaluso, Cheng, & Akers. 2000; Oswald et al., 2010). The underserved populations that are most effected by unintended pregnancies, negative birth outcomes, high rates of STIs, and failed use of contraception include women of color who are living in poverty (Janevic et al., 2013; Radecki & Bertstein, 1990; Willers et al., 2008). One of the main reproductive health failures among these populations is inaccurate use of short-term contraception methods, such as oral birth control and condoms (Miller et al., 2000).

According to the Center for Disease Control and Prevention (CDC) (2013), racial, socioeconomic, education, and geographic location are all markers for poor health of individuals of the United States. For example, the report states, "Persons with low levels of education and income generally experience increased rates of mortality, morbidity, and risk-taking behaviors and decreased access to and quality of health care. This report confirms that the lowest levels of education and income are most common and persistent among subgroups that systematically exhibit the poorest health" (CDC 2013:15). Since

prior research explains that justice-involved women generally are disproportionately women of color, with low levels of income and education, as well as living in impoverished and underserved neighborhoods, the likelihood of heightened health disparities among justice-involved women are increased (Richie, 2001; Saxena et al., 2016; Spjeldnes & Goodkind, 2009; Tyler & Brockman, 2018).

Extant literature on healthcare barriers suggests that individuals in the general population who are medically underserved experience more than one hurdle to accessing health services (Ahmed et al., 2001). The main deterrents for being able to utilize medical services include lack of information, transportation, and unmet accommodations (Ahmed et al., 2001; Kullgren et al., 2012; Syed, Gerber, and Sharp, 2013). Although financial concerns, such as lack of insurance, do pose as a threat to utilizing healthcare, most individuals report that there are more pressing problems that stop them from accessing medical services (Ahmed et al., 2001; Kullgren et al., 2012; Syed et al., 2013). For example, individuals with financial barriers reported that finding childcare, transportation, and getting time off work were the largest deterrents from accessing medical providers (Kullgren et al., 2012). Therefore, financial barriers stem from social conditions that are common challenges that reintegrating individuals are already struggling with.

Prior research that specifically focuses on formerly incarcerated individual's lack of access to general healthcare services found that barriers stemmed from inconsistencies in social support, finances, and information (Colbert et al., 2013; Marlow, White, & Chesla, 2010; Walsh-Felz et al., 2019). Navigation of the healthcare system post-

incarceration is an impactful challenge to returning citizens. Despite having access to health insurance many returning citizens report that without support from reentry service providers or community supervisors they are unsure of their abilities to utilize care (Colbert et al., 2013; Salem et al., 2018). Also, many reintegrating individuals report distrust in the healthcare system because of experiences they had while incarcerated and out of fear of stigmatization (Colbert et al., 2013; Howerton et al., 2007; Marlow et al., 2010). Similar to the barriers of the general population, formerly incarcerated individuals reported that transportation was a challenge to accessing healthcare and obtaining needed prescriptions, as well (Ahmed et al., 2001; Kullgren et al., 2013; Syed et al., 2012; Walsh-Felz et al., 2019). Transportation is a consistent barrier for many social services returning citizens encounter (Ramaswamy, Unruh, & Comfort, 2018). Without transportation, reintegrating individuals cannot maintain employment, attend required treatment meetings, or access needed healthcare.

Reproductive Health Planning Needs and Intentions

There are only a handful of studies that have followed women post-incarceration to determine their intentions to access and utilize healthcare (Colbert et al., 2013; Fox et al., 2014; Lee et al., 2006; Wang et al., 2008; Walsh-Felz et al., 2019). Some studies that followed both men and women after incarceration found that those with HIV or chronic medical needs were more likely to utilize consistent care (Fox et al., 2014; Lee et al., 2006; Wang et al., 2008). For example, Wang et al. (2008) found that of individuals leaving the San Francisco County jail that were HIV positive and had discharge plans were six time more likely to have a consistent source of healthcare, compared to other

incarcerated individuals. Also, formerly incarcerated individuals from the San Francisco County Jail who were HIV positive and uninsured were 1.3 times more likely to have consistent care than the general uninsured population. Similarly, Fox et al. (2014) reported that 82 percent of their participants with HIV were receiving medical care at six months. However, the authors explained that of their 135 formerly incarcerated participants, fewer than half had regular medical care at six months post-release. These analyses have mixed gendered respondents and do not focus solely on reproductive healthcare. However, participants in all studies with HIV, which is a sexually transmitted infection, did report higher rates of accessing health services. Based on the findings of these prior studies, I argued that this exploratory research would find that women with chronic and urgent reproductive health needs would have better access and utilization of reproductive health services, compared to those without chronic reproductive health needs.

Unfortunately, the analyses that do consider barriers to accessing healthcare for justice-involved women rarely consider their reproductive health beyond STIs, despite reintegrating women being a high-risk population for reproductive health issues. One analysis explained that women leaving New York City jails reported higher rates primary care utilization (PCU) if they were HIV positive or pregnant (Lee et al., 2006). Also, Lee et al. (2006) found that women with health insurance were more likely to report PCU, than uninsured respondents. Since many justice-involved women have low levels of education, they are less aware of the dangers of risky sexual (Sutherland et al., 2015). Although women, post-release, are at high risk for reproductive health issues, nearly 85

percent still report that they plan to be heterosexually active within the first six months of release (Sufrin et al., 2015). Similarly, when sexually active, many women reported engaging in unprotected sex and transactional sex during their initial post-release period (Adams et al., 2011; Oswald et al., 2010). The increased likelihood of risky sex practices For example, only 7.6 percent of justice-involved women reported having access to contraception after six months post-release, despite the majority of the participants reporting not wanting to get pregnant after release (Sutherland et al., 2015). The findings of LaRochelle et al. (2012) support this contention. They found that 60 percent of incarcerated women stated that they wanted to have access to birth control before returning to society to avoid reproductive health barriers they may experience after release. Also, Ramaswamy et al. (2015) reported that 90 percent of their sample described not wanting to get pregnant post incarceration, but less than 50 percent of the participants reported consistently using contraception. These analyses provided quantitative data for broad patterns, but they do not illuminate the reasons why women who do not want to get pregnant do not consistently use birth control.

Understanding the motives for not accessing contraception post-incarceration is important since unintended pregnancies can be costly to not only the mother, but also to the public (Clarke et al. 2006a). Morse et al. (2017) noted that incarcerated women pose a large public health risk due to the lack of healthcare access available to them. Mainly, they are at higher risk for unintended pregnancies, pregnancy complications, mental health disorders, and abnormal pap smears. Similarly, Adams et al. (2011) found that a majority of formerly incarcerated individuals have little education on the risks of the

human immunodeficiency virus (HIV) and hepatitis C virus (HCV). They were also most likely to engage in risky sexual behaviors in the initial days post-release. Consequently, multiple researchers have reported that individuals post-release have trouble accessing healthcare and medications for multiple reasons, such as lack of health insurance and difficulties navigating healthcare providers (Clarke et al., 2006; Adams et al., 2011; Morse et al., 2018; Sufrin, Kolbi-Molinas, & Roth, 2015).

Contraception is commonly not available in incarceration facilities and when returning to society few women have health insurance nor access to contraceptives (Clarke et al. 2006a; Clarke et al. 2006b; Sufrin et al. 2015). Clarke et al. (2006a) study is one of the few to analyze women's post-release access to contraception. They found that merely connecting women to contraceptive providers within their communities only led to a 4.4 percent initiation of birth control. They also found that 80 percent of participants expressed a desire to initiate use of contraceptives, but only 47 percent were successful at doing so. Therefore, recognizing the barriers that limit access to reproductive healthcare and providing reentering women with resources that motivate obtainment of reproductive healthcare is beneficial to women, their families, and public health providers. To my knowledge, there is very limited extant research evaluating the reproductive health disparities of returning citizens. This research sought to explore the disparities in access to reproductive health services among justice-involved women.

Chapter 4

METHODOLOGY

The participants for this research consisted of a convenience sample of reintegrating women and reentry service providers who were interested in discussing their access to reproductive healthcare. Participants were targeted in Delaware and the bordering counties in Pennsylvania, including but not limited to Bucks, Chester, Delaware, and Lancaster County. Criteria for service providers included working or volunteering at a reentry facility with females identifying reentrants in Delaware or Pennsylvania. Criteria for reentering women required being a female identifying reentrant, residing in Delaware and Pennsylvania, and being released from incarceration within two years from the interview date. This research utilized a snowball sampling technique. The data were obtained using qualitative methodology, consisting of semi-structured interviews and demographic surveys. Institutional Review Board (IRB) approval was originally granted in July 2021 to interview reentry service providers. Because there was difficulty recruiting reentering women, approval from the Delaware Department of Correction (DEDOC) was sought to recruit women in work release and under community supervision. IRB and DEDOC Review Board approval was granted to recruit participants through all level one to level four facilities in April 2022. Level one to level four facilities include work release facilities, probation and parole offices, as well as home confinement (DEDOC 2022).

To recruit participants, fliers were distributed via email and in person to reentry services in every county of in Delaware and neighboring counties in Pennsylvania.

Reentry service providers were located using Pennsylvania and Delaware state and county websites that provide resources for returning citizens (see Appendix). A total of 67 service providers were contacted via email and approximately 49 were contacted via phone. In addition, fliers were posted in every parole/probation center in Delaware, as well as distributed via email to the DE, female work release facility, Hazel D. Plant Women's Treatment Facility. The researcher spent a total of 10 days distributing fliers to potential participants in each probation/parole center but was not able to enter the work release facility. However, the majority of service providers in Delaware work primarily with reentering men, so recruiting women through service providers was difficult. Also, multiple probation officers explained to me the lack of trust between the probation office and their clients. Therefore, women recruited from probation centers may not have felt comfortable completing an interview with me. Finally, as discussed in much more detail later in this analysis, reentering women are focusing on survival and have little time to meet their own personal needs. Therefore, women may not have had the time or capability to complete a 45-minute interview with me because of meeting other needs. Due to these difficulties recruiting reentering women, efforts were focused on interviewing reentry service providers.

A total of 15 interviews were completed. Eleven of the interviews were completed with reentry service providers and four were collected with reentering women. Interviews with participants lasted an average of 45 minutes with a ranged from 30 minutes to 90 minutes. Participants were compensated with a \$25 dollar gift card to a gas station, grocery store, or supercenter, such as Walmart, Target, or Amazon, after completion of

the interview. All interviews were transcribed verbatim. Interviews were coded using grounded theory in NVivo, a qualitative interpretation software. Using open-coding, I explored the transcripts for comparisons, concepts, and emerging themes (Charmaz, 2006). Transcripts were first coded in a word processor for the initial line-by-line coding phase; then, I used NVivo for the focused coding process. I used previous literature on reentry barriers and inequalities in accessing healthcare to identify connections in my axial codes. After refining the codes, I identified my main themes and patterns that were present in multiple transcripts. Using a selective coding process, I was able to identify themes of intrinsic, extrinsic, and systemic barriers to healthcare. Pseudonyms were used to maintain confidentiality and keep participants identities anonymous.

The purpose of utilizing semi-structured interviews was to allow participants to share their thoughts, feelings, and beliefs about their access to reproductive healthcare services, as well as to have personal conversations with the participants. The main themes that were addressed in the interviews included current access and attendance to reproductive health services, pre-incarceration utilization of reproductive health services, reasons for not accessing reproductive health services, and ways reentry initiatives can better support accessibility to reproductive health services. In the results that follow, pseudonyms were used to maintain confidentiality and keep participants identities anonymous.

Contextual Background

According to the Sentencing Project (2020) Delaware is ranked 40th in states for the female imprisonment rates (18 per 100,000 female residents). This indicated that

there are low rates of female incarceration in the state of DE. This can be explained by a variety of factors. The majority women under supervision of the criminal justice system in DE are detained for public order offenses, such as drug dealing, motor vehicle offenses, and weapons charges (Huenke, 2020). Another factor that has reduced the number of women involved with the justice system in DE is the COVID-19 pandemic. During the start of 2020, prisons released many incarcerated individuals that were not deemed a threat to society to reduce the spread of COVID-19 (Brennan Center for Justice 2022). Therefore, fewer women are incarcerated in the state of DE.

Chapter 5

ANALYSIS

Demographics

The majority of reentering women identified as Black, and one identified as white. All four women had health insurance and three were employed. The median age of these women was 37 and all four had a GED or high school diploma. Two reentering women used contraception methods and one had a primary health care provider they visited regularly. All women were mothers, with two having 1 child and two having 2 children.

Reentry service providers consisted of a family reunification case manager, five general case managers, a community reentry liaison, a volunteer midwife at a substance use clinic, a medical provider, a health insurance case manager, and a volunteer attorney/reentry advocate working with a reentry coalition in PA. Two reentry service providers worked in a bordering county in PA and the remaining nine worked in DE. Providers had been working for a range of 2 years to 17 years with reentering populations and the majority provided services to both men and women leaving incarceration.

Main Themes from Interviews

Similar to previous research (Copeland 2005; Garg et al. 2020) several barriers to healthcare after reentry were identified. Three main themes related to barriers were identified in this analysis: intrinsic barriers, extrinsic barriers, and systemic barriers that influence access and utilization of healthcare post incarceration. Importantly, these factors were not mutually exclusive of each other and often cooccur to create a web of

barriers in accessing healthcare services. Each type of barrier is discussed in the following sections.

Intrinsic Barriers

Intrinsic barriers were defined as deterrents that are present within an individual, which include such things as perceptions and beliefs (Clarke, 2007; Copeland et al., 2005; Garg et al., 2020). For the purpose of this analysis, two subcategories were defined to organize themes from interviews. They include self-reliance and lack of knowledge

Self-Reliance

Extant literature explained that people from vulnerable backgrounds implement a self-reliant ideology to protect themselves (Jennings et al., 2015; Samuels & Pryce, 2008). As described previously, many individuals leaving incarceration are overrepresented by people of color and individuals with vulnerable backgrounds. Thus, similar to their non-incarcerated counterparts, justice-involved women are more likely to participate in self-reliance, which ultimately acts as a barrier to receiving healthcare. For example, Hazel, a participant that was released from incarceration nearly 14 months prior to our interview stated, “We’re not taught to take care of ourselves in those ways, we’re taught to survive.” Hazel was referring to her upbringing as a Black woman in a predominately Black neighborhood. She explained further that “I want to [find a doctor], I just need to get myself together first.” This ideology of self-reliance and having to take care of oneself without the help of others is a survival mechanism often found in disadvantaged communities, which are overrepresented in the carceral system (Jennings et al., 2015; Samuels & Pryce, 2008). Unfortunately, there are many roadblocks that

hinder a women's ability to be able to rely on themselves post-release because of the inequalities that are present (Cobbina, 2016; Garcia-Hallet 2019; Payne, Brown, & Wright 2019;). Therefore, this trait of self-reliance can be seen as a barrier to accessing healthcare, especially reproductive healthcare post-release because of the difficulties and stress that women experience having to take care of their basic survival needs after leaving incarceration.

Self-reliance was also a common theme discussed among reentry service providers. For example, Hannah explained "At least what I've noticed on my caseload they [women] are more likely to just like go off, do their own thing and handle it themselves. They come get a little bit from me and then they're good." Self-reliance is not only a feature of systemic marginalization, but also a survivalist concept created during the incarceration process. Prison facilities are masculinized institutions (De Viggiani, 2006) that breed a need for survival, lack of trust, and oppressive requirements. Thus, formerly incarcerated women are instilled with internalized reliance on themselves and not others to survive. This reduces the likelihood of utilizing healthcare even when there are available services such as case managers, to help reduce the burden of setting up healthcare appointments, insurance, and provide social support, which is consistent with available literature following people post-incarceration (Wang et al., 2008; Ramaswamy et al., 2018).

Lack of Knowledge

Another intrinsic barrier present during the reentry process was a lack of knowledge about healthcare services. Many women do not have primary care physicians

prior to being incarcerated (Morse et al. 2017). Therefore, after leaving incarceration they are not equipped with the education and experience required to make informed choices about their healthcare. Three out of four reentering women interviewed explained that they did not have stable and consistent healthcare provider prior to entering incarceration. All three explained that they sought medical care when necessary, such as an emergency or pregnancy, but did not attend on a regular basis. The one woman that did attend reproductive healthcare appointments regularly was diagnosed with a sexually transmitted infection (STI) along with Hepatitis C and was working with a doctor on a health plan. She explained that she did not start attending doctors' appointments regularly until her condition became serious. Similarly, Sandra explained, "I don't know what I could have benefitted from. I was not concerned [about healthcare] until after I had a miscarriage."

Unfortunately, Sandra was not alone in not being aware of what was available and needed to maintain reproductive health. None of the women interviewed had received regular pap smears. Also, Talia was recently pregnant with her second child. She was trying to get pregnant after being incarcerated for nearly 7 years. She stated, "I had never been aware of it [family planning services]. This is all new to me." She got pregnant on her own after leaving prison and did not attend a doctor's appointment until she knew she was pregnant. This is consistent with previous literature, which explains people post-release are not likely to follow-up with medical providers, unless there is an emergency, or a case manager helped facilitate the appointments (Burns et al. 2022; Lincoln et al. 2006).

Also, Linda, Taylor, and Alison, all reentry service providers, explained that many incarcerated women do not have access to case managers or reentry liaisons while incarcerated. This makes the process of finding and connecting to healthcare providers after leaving incarceration even more difficult for women without.

Linda stated, “But if they are not connected with a case manager or someone like SL, who is our reentry resource liaison, that’ll help people make the connection, I don’t think a lot of people know how to advocate for themselves and figure out that part out. They need to be connected to some social service to make that connection.”

Similarly, Taylor explained, “Most of them [reentering women] probably do not have primary health care providers. Now the women with my organization, they’re all set up with a primary health care provider while they’re incarcerated. But if you’re not in a setting like that, unlike what you and I would do is have a primary care physician that we would call. They don’t have that.”

Additionally, Alison stated “I didn’t realize before I came into this position, how many grown adults don’t know to flip over the insurance card and find what physicians or what doctors are in their network. Like you have to tell them how to do that and like take them to the website. So, just small things like that. And really, like, a lot of hand holding...I don’t want to call it hand holding but that is sort of what it is. Just really guiding people. And sort of giving them the pieces.”

These narratives represented the interviewees beliefs that there was a lack of knowledge around how to access healthcare services and the disparities among people leaving incarceration trying to utilize healthcare options. Reentering women with access to case managers were exposed to the knowledge and support needed to setup reproductive healthcare appointments after leaving incarceration. However, not all women have access to case management nor do case management facilities have the funds to support every woman leaving incarceration. Therefore, providing more knowledge and education around tasks such as setting up a new healthcare provider,

utilizing insurance benefits, the types of concerns that should be addressed at a physician appointment would empower justice-involved women to make choices about accessing reproductive healthcare.

Extrinsic Barriers

Extrinsic barriers were defined as deterrents that are present outside of an individual's being (Clarke, 2007; Copeland et al., 2005; Garg et al., 2020). For the purpose of this analysis, three subcategories were used to define external barriers. They include transportation, social influence, and probation/parole requirements.

Transportation

Transportation was a common extrinsic barrier that was discussed in all reentry literature (Ahmed et al., 2001; Kullgren et al., 2013; Syed et al., 2012; Walsh-Felz et al., 2019). Importantly, transportation was a key aspect to accessing healthcare that was highlighted during the reentry process. Three of the four reentering women detailed their inability to find stable transportation. One reentering woman stated she owned a car and was able to get to and from doctor's appointments. However, the other three women explained that they did not own a vehicle and relied on friends, family, or the bus to make it to different appointments.

For example, Jade explained "I wish there were closer ones [doctors' offices] instead of being so far apart...it's [transportation] iffy. I don't own my own car. I've taken public recently actually, with my son, and it's horrible. Because I have him in his stroller and they want me to take him out of his stroller... And then they want me to take his stroller apart, and I'm not doing all that."

Jade's narrative portrayed the struggles of trying to find stable transportation to get to and from important doctor's appointment after incarceration. At the time of the

interview Jade was using methadone to help recover from a substance use disorder and was required to attend a healthcare clinic. Therefore, not having stable transportation was putting her at risk of relapsing or violating parole requirements.

Similarly, Ellen explained that having access to transportation was important to helping women find access to healthcare. She highlighted the experiences of other reentering women in her transitional house as, “they're trying to call their friends and ask them, ‘Do you have penicillin?’ They're trying to find the meds that they need because they may have a bacterial infection. They know about it, but they can't get there. And then if they take the bus, it's an all-day process, they have to work. It's not easy.”

Similar to the experiences described by these reentering women, every service provider interviewed said transportation was an extrinsic barrier to accessing healthcare services. All of the service providers described the difficulties including bus routes, failed pick up services, and long distances to doctor’s appointments.

For example, Linda stated “So yeah, you know, it's basically the way the bus routes work like one goes down one pike. One goes down another Pike. One goes down all the different pikes. And that’s it. It doesn’t do much zig zagging. So, it doesn't do much like if someone doesn't have the ability to get to one of those main roads. I mean it's helpful when you're close to it. But for a lot of people... but for people that are living a little bit further it's useless.”

Overall, unstable and inconsistent transportation hindered women from successfully utilizing healthcare services that may be available to them. Not having access to transportations also limits women’s options to types of healthcare and available doctors, which limits the empowerment of having the ability to choose the best healthcare path.

Social Influence

The next extrinsic theme that impacted women's access and utilization of healthcare services was social influence. Previous literature explained that social relationships, networks, and integrations have a large role in shaping help-seeking behaviors and health choices (House, Landis, & Umberson, 1988; Umberson, Crosnoe, & Reczek, 2010). The majority of the reentry service providers explained that they do not discuss reproductive healthcare with their clients unless the client initiated the conversation or expressed a concern related to obstetric or gynecology matters. The majority explained that they were not aware of reproductive healthcare programming available to women after leaving incarceration and suggested that education around this topic would be helpful for both reentering women and providers. All of the general case managers stated they provide condoms to their clients, but that is the extent of contraception, safe sex education, and preventive reproductive health advice provided in their aftercare programs.

Carly explained, "most of our work around medical care is around like crisis. Especially like someone who's having a seizure or someone having a heart condition, and usually we're just kind of piecemealing and finding someone. Especially post-covid, well in the world of Covid, where it's so hard to get an appointment. We're usually just matching up people to providers for specialties because those will take precedent over just general healthcare."

Although reentry service providers are not the only form of social influence justice-involved women have, they do play a large role in the reentry process (Clone & Dehart, 2014; Wohl et al., 2011). Therefore, service providers that do not educate or highlight the importance of preventive reproductive healthcare in combination with other

healthcare services, are failing to provide women with the necessary tools to access services after leaving incarceration. As stated previously, extrinsic, intrinsic and systemic barriers are not mutually exclusive. This was especially true in terms of social influence. Justice-involved women's social influence derives from cultural background, internal perceptions of who to trust, and people that they are required to interact with (Leverentz, 2011). Thus, many reentering women described their social influences as their mothers, friends, and case managers.

Hazel remarked, "I'm not even really sure with this stuff. I always ask my mom to help me I am not going to lie. I don't go to anybody else but my mom." She was referring to only going to her mother with help on reproductive healthcare matters. Therefore, if her mother was not able to provide the necessary knowledge to successfully direct and empower her daughter to make a choice about accessing and utilizing healthcare, Hazel more than likely would not be adequately equipped to make that decision. Thus, providing more educational resources and finances to support reproductive health programming during and after incarceration, as well as culturally competent staff, is extremely important to public health and the agency of choice for justice involved women.

Probation and Parole Requirements

Many participants explained that barriers to reentry were specifically heightened by probation/parole requirements. Ellen, who was released from incarceration approximately six months prior to her interview, discussed the challenges she was facing

to utilizing healthcare. She was sentenced to home confinement and was only able to leave her home for two hours each day. She remarked,

“Yes. I cannot, because of the home confinement monitor, seem to find enough time to... If they order stuff, like they ordered a chest x-ray to check my lungs. They ordered some other tests because I did have a seizure on Sunday. But I've gone there twice now on my free time, which is two hours a day. And usually, by an hour and a half I have to leave. And so, I've been there trying to get these tests done, and I don't have access to be able... And I tell them that. I tell them that I only have an hour to be able to sit here or whatever. And I just have not been able to get it done. I have to go through a whole big approval process to be able to see them, or to get the x-rays and stuff done.”

Reentry service providers shared similar sentiments. Carly shared, “I have a case, a client, with cancer. So, like the probation officer, hasn't been flexible when it comes to reporting, and it's literally like terminal. So, we've had to advocate to be like she doesn't have much longer to live, so coming to report to you is not important right now.”

Similarly, Alison stated, “And they've got so much else to do like they've got a report to probation. They may have tasks, and they have after care. They may have a whole bunch of other stuff, which is court ordered to do that. They're just like, oh, well, I forgot you know... I've got all this other, you know mental health, and some of these treatments, and I've got to go to these places, and you know. I think really like the general health like going for a physical and stuff like that is always put on the back burner because they have to, you know, they don't want to end up violating, so they have to attend probation.”

Coinciding with the multitude of reentry process facets, which are discussed further, probation requirements limit women's time, emotional threshold, and priorities. Even when women's health is at risk, they are not going to take a chance at violating probation requirements due to fear of being sent to prison. Therefore, reproductive healthcare is especially put on hold and other health related concerns are more likely to be prioritized if health is even considered. These findings were consistent with previous

literature that argued probation and parole are not used to help reduce recidivism and improve successful reentry, but rather were used as a mechanism of control and economic gain for the correctional system (Petersilia 2011; Robinson & Miller 2016; Payne & Brown 2021).

Systemic Barriers

Systemic barriers were defined as policies, practices, and procedures that deter equal access and utilization of healthcare services (Rojewski et al. 2018). As described previously, all the barriers discussed were not separate from each other. In fact, many justice-involved women experience incarceration due to intersecting systemic inequalities (Wesely & Dewey, 2018). Thus, all the factors described were intertwined with the systemic barriers to accessing healthcare post-release. For the purpose of this analysis, the following subcategories were used to describe systemic barriers post-release: instability, lack of cultural competency, and the complex process of reentry.

Insensitive Providers and Lack of Cultural Competency

A major systemic barrier to accessing and utilizing healthcare after incarceration was insensitivity and a lack of cultural competency among healthcare providers. All four reentering women explained situations where they were treated negatively by a healthcare provider due to insensitivity to a medical condition, lack of knowledge about prisons, and inability to recognize trauma. For example, Jade explained

“...psychiatric doctors for the most part want to push meds. There's been many times where I've been on 15 meds for psych stuff. Because once they see that drug addiction on my record, they want to... Even right now, I could be so heavily medicated if I wanted to, because they give you the Seroquel and the Zyprexa and the heavy sedative type drugs. I think that my doctor at the [removed] is great, as far as that. But I don't really get a very friendly response when they see my record

at places like family medicines. I just had all my teeth done. They ask very strange questions about, "Why are your teeth like this?" You learn to not trust them because they view you in a certain light. And especially when I walk in with this thing on my ankle. I went to the pharmacy, and I was asking them what could throw a false positive? Are any of these meds I'm on giving me a false positive? And they just write it off as, "Well, if it's positive, then, you're positive." You know what I mean? They can't accept the idea that I wouldn't actually use."

Similarly, Ellen stated "Yeah, I do because... And really, truly the only reason I do [go to an ob-gyn] is because I have herpes. If I did not have herpes, I would not... Because for some reason, I find that the baby doctors and the OBGYNs, for some reason, are the most judgmental in regard to addiction. Also, too, OBGYNs are just not knowledgeable. And you would think they would be more knowledgeable. I was on Depo for years and it made my Hepatitis C worse. When I went to family medicine they were like, "What are you doing on Depo if you have Hep C?" And I'm like, "I don't know." They are knowledgeable about certain things, but I prefer family medicine over OBGYNs any day."

Similar to reentering women's experiences, the majority service providers also described situations where clients were not treated adequately by medical professionals.

Taylor remarked,

"But I would say that stigma of incarceration. And also, I know you're doing a lot of... this is supposed to be post incarceration... But if you can include this anywhere. While incarcerated I think that inmates' health is not necessarily taken seriously. Like, it has to be an extreme emergency. And this is not to discredit our prison or any prison. But just in general. There is a lot of voids. And also, a lot of medical professionals don't know that so it can sometimes be hard. Because they don't know what they need to spring for and what they don't."

All of the narratives illustrated the poor interactions that occur among healthcare providers and justice-involved women. The negative interactions stem from a narrow understanding of institutionalization, lack of interaction with justice-involved individuals, as well as limited education on culture competency and trauma. These multiple factors combine and lead justice-involved women to feel unsafe, a lack of trust, and an overall

discomfort with attending a healthcare service (Colorado Health Institute 2021). This was consistent with previous research, which illustrated that lack of cultural competency was associated with a delay in seeking care and reduce help-seeking behaviors among vulnerable groups such as immigrants, people raised in foster care, Muslims, and people of color (Anderson et al. 2003; Anderson, Wood, & Shelbourne 1997; LaVeist, Nickerson, & Bowie 2000; Lillie-Blaton et al. 2000; Smedley, Stith, & Nelson 2002).

Inconsistency in Care

Inconsistency due to incarceration was a common theme discussed during interviews. All four reentering women explained circumstances that were out of their control and caused by involvement with the system, such as childcare, health insurance, medications, and social service changes. Ellen, along with multiple service providers, explained the difficulties of losing social service benefits while incarcerated and having to get them reinstated upon release.

“Usually if you're there for 90 days or more, you're going to lose your benefits because they report that you're in jail. Luckily, I did not because I was only there for 62 days. So, my benefits were not interrupted. And usually they are, even my food stamps, everything. They were not interrupted, so it was easy to return to the health plan that I have, because I have Hep C.”

Alex, a service provider, explained, It's just like they're not getting the proper care that they need because there's no consistency there. And it's an inconsistency of insurances, of caregivers, location all these different kinds of things.”

In addition to inconsistency in insurance, social services, and medicines, there was also inconsistency in residency, employment, income, social support, and many other factors that are unique to the reentry process (Visher et al. 2004). Thus, inconsistency can cause undue stress on women, which might cause them to forget appointments, be too

overwhelmed to make appointments, or feel uncomfortable accessing reproductive healthcare services because of the instability in what to expect from the care appointment. The inconsistency of shifting medical and pharmaceutical providers due to location, insurance, and health conditions changings could deter women from accessing healthcare.

Another inconsistency that was rarely discussed in extant literature was the challenges of maintaining contraception during and after incarceration. All four reintegrating women expressed that they had been on different forms of contraception throughout their life course, but were forced to switch brands, forms, or stop all together once incarcerated. The Delaware prison system offers long-acting reversible contraception (LARCS) upon release of incarceration and while incarcerated, offers other forms for reasons deemed medically necessary. However, they are not required to maintain previous contraceptive medications or medications for any condition for that matter (Peart & Knittel 2020). This inconsistency in medication use can cause confusion, distrust, and deterioration of overall health (Ahmed et al. 2016; Nam et al., 2011). Ahmed et al. (2016) found that incarcerated women reported many inconsistencies that caused barriers to accessing healthcare during their stay in correctional facility, such as health disempowerment, treatment interruption, and poor health outcomes. These experiences could impact the utilization of healthcare post-release, as well.

Survival and the Complex Reentry Process

The final barrier that hindered women from accessing and utilizing healthcare services was the complex reentry process. As stated previously, none of the barriers discussed thus far were mutually exclusive to one another and many of them were

related. This was especially true in regard to the reentry process. Extant literature explains that the reentry process is filled with barriers to successfully getting housing, employment, childcare, and many other factors that impact an individual's likelihood to survive after leaving incarceration (Arditti & Few, 2006; Chesney-Lind, 1989; Daly, 1992; Gilfus, 1993; O'Brien, 2001; Richie, 2001). This theme was discussed in all 15 interviews. The majority of respondents explained the many hardships and complicated circumstances that were commonly faced after leaving prison. Many interviews also revealed that healthcare was not a priority until health was an emergency or dire. Mainly, employment, housing, getting a driver's license, reuniting with children, and generally retaking control of their lives are top priorities. Then, once these difficult and time-consuming tasks were completed, healthcare and maintaining a healthy lifestyle might be addressed. However, the healthcare sought tended to be related to primary care and not reproductive care. Alex, a service provider that worked in the reentry field for nearly 15 years, explained, "If I finally get a job, they're not gonna give me permission to leave for a 10 am appointment when my shift started at 7 am, which all ultimately goes back to survival and I'm going to put monetary needs in front of my own health."

Many other service providers stated that their clients were more likely to ask for help with areas related to surviving everyday life. Even transportation was often put over healthcare. Adrienne, a reentry case manager, explained,

"Lack of ability to get to there. And, you know, childcare. The work schedules if they're working at lower-level jobs they can't just leave you know. So, do you go to work, or do you keep this appointment? Especially, if they're getting paid on an hourly basis so I think there's just many factors."

Hope also stated,

“I think it, it [probation] becomes so stressful for our clients. Not only are you like back...you're back in the community. It's a total flip and you have someone who could literally just rip that out from under you, so quickly. And so, when they're barking orders and saying what needs to be done, it can bring so much stress to an individual's life. Especially when they're also being told, you need to make this appointment and this appointment, and that could include, you know, like I had mentioned before, any mental health or any medical appointment that needs made. They're so stressed out that, like they panic and feel like, Oh, my gosh! I just got into this house and they're requiring this much money from me, but I just got out and I don't have a job yet. I don't even have my ID or my social security card and like all those things. That's what we're here to help them with but...”

In addition, Hannah expressed,

“I think, especially someone that's like returning to the community has so many different things being thrown at them with probation and community service if needed. If they have task or after care part of probation, they're trying to obtain employment and pay rent like things can get super overwhelming that they might not prioritize that [healthcare].”

These narratives represented the survival approach to overcoming the complex reentry process. A small area of reentry literature highlighted that survival is the top priority after leaving incarceration (Garcia-Hallet 2019; Payne & Brown, 2021). However, this instinct of survival is especially true for justice-involved women, since they are experiencing an intersection of multiple vulnerabilities (Arditti & Few, 2006). Therefore, reproductive healthcare is not able to be accessed because there are many of factors at play that need to be addressed in order to survive. Not surprising, health is not seen as a priority to survival unless someone experiences an emergency or needs medication quickly. Only then will health be prioritized over other aspects to successful reentry. However, the intersection of requirements to maintain desistance does not always put health first. In order to help justice-involved women feel empowered to make choices about their reproductive healthcare, society must provide them with the necessary tools to

overcome all aspects of the complex reentry process. Society must also encourage knowledge and education about the importance of utilizing reproductive healthcare and making informed choices about future reproductive intentions.

CONCLUSION

Hays et al. (2020) argued that reproductive justice cannot be obtained without proper and equal opportunities for marginalized women. Therefore, reentry service providers, and medical providers must consider the social factors that limit reintegrating women's access to reproductive justice. Extant literature explained that reintegrating women are at a high risk for physical and reproductive health conditions, yet little access the proper medical services needed to sustain their health criteria. This research was important to the advancement of reentry literature since it considers the reproductive healthcare barriers, which are commonly overlooked in the extant literature. Also, this research can help educate service and healthcare providers about the reproductive health needs of reentering women. Results indicated that justice-involved women have a wide array of barriers to accessing and utilizing reproductive healthcare services. Participants suggested that more educational programs, easier access to transportation, as well trauma-informed and culturally competent care would empower justice-involved women to make informed choices about their reproductive healthcare. Consistent with extant literature many justice-involved women had low levels of education and were not aware of the dangers of risky sexual practices (Sutherland et al., 2015). Also, education on reproductive health for women while incarcerated and immediately post incarceration has been suggested to increase use of contraception (Oswalt et al., 2010). Therefore, programs during and after incarceration could possibly increase desires to access reproductive healthcare post-release. Because a majority of providers were not familiar

with what reproductive health services are available and desired by reentering women, this should include educational programming for providers working with the population.

These findings inform reentry initiatives, medical personnel, and prison facilities with the data and knowledge needed to better implement and enforce policies that encourage reintegrating women's utilization of reproductive health services. Next, since reintegrating women are at an increased risk of unintended pregnancies and often lack necessary reproductive health education, this research could aid in the reduction of unintended pregnancies and increased informed choice to use contraception, access abortions, and make decisions about their reproductive futures. By providing correctional facility policy makers, reentry initiative organizers, and medical providers with findings that help explain women's experiences with accessing reproductive health services, they are better able to inform, prepare, and equip reintegrating women with the essential programs, services, and products to adequately utilize reproductive services post-incarceration. In addition, extant studies have reported that setting up discharge plans while still incarcerated can increase consistent healthcare post-release (Wang et al., 2008; Ramaswamy et al., 2018).

Many reentry strategies encompass a male focused or gender-neutral programming to assist reintegrating women. These programs often fail to meet the actual needs of reintegrating women (Anderson & Javdani, 2017; Holftreter & Wattanaporn, 2014; Saxena et al., 2016). For example, reentry initiatives lack resources and programming to properly educate and improve women's sexual and reproductive health (Ramaswamy et al., 2018). The findings here were consistent with existing literature. The

majority of reproductive healthcare providers did not have programming to discuss reproductive healthcare, nor did they provide resources to facilitate safe sex practices, promote informed pregnancy decisions, or encourage preventive exams such as pap smears and mammograms. Incorporating programming that encompass these characteristics in prison facilities, as well as in reentry service initiatives, have the potential to increase reintegrating women's knowledge, access, and ultimately use of reproductive health services.

Despite the benefits of this analysis there were limitations. For example, the sample size for this study was small. Future research should expand analyses to examine reintegrating women nationally to better understand their access to reproductive health services. In addition, research should focus on the access and utilization of reproductive health services for justice-involved women in states with strict abortion and contraception laws, as Delaware is a progressive state with women having the support of the law to make choices about their reproductive care. Lastly, future research should consider examining medical service providers experiences working with justice-involved women both during and after incarceration.

Justice-involved women deserve equal access to reproductive healthcare. The consequences of an unintended pregnancy are particularly complicated since the Supreme Court's abolishment of a woman's right to choose. Women reentering society from prison have intersectional vulnerabilities that prevent them from making empowered and informed healthcare choices. Policy makers, correctional facilities, and medical providers

need to be better equipped to provide knowledge, competency, and informed care when working with this population.

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Appendix A

IRB APPROVAL LETTERS



Institutional Review Board
210H Hulihan Hall
Newark, DE 19716
Phone: 302-831-2137
Fax: 302-831-2828

DATE: July 27, 2021

TO: Emalie Rell
FROM: University of Delaware IRB

STUDY TITLE: [1767631-1] Reintegrating Women's Access to Reproductive Health Services
SUBMISSION TYPE: New Project

ACTION: APPROVED
EFFECTIVE DATE: July 27, 2021
NEXT REPORT DUE: July 26, 2022

REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category # (6,7)

Thank you for your New Project submission to the University of Delaware Institutional Review Board (UD IRB). The UD IRB has reviewed and APPROVED the proposed research and submitted documents via Expedited Review in compliance with the pertinent federal regulations.

As the Principal Investigator for this study, you are responsible for, and agree that:

- All research must be conducted in accordance with the protocol and all other study forms as approved in this submission. Any revisions to the approved study procedures or documents must be reviewed and approved by the IRB prior to their implementation. Please use the UD amendment form to request the review of any changes to approved study procedures or documents.
- Informed consent is a process that must allow prospective participants sufficient opportunity to discuss and consider whether to participate. IRB-approved and stamped consent documents must be used when enrolling participants and a written copy shall be given to the person signing the informed consent form.
- Unanticipated problems, serious adverse events involving risk to participants, and all non-compliance issues must be reported to this office in a timely fashion according with the UD requirements for reportable events. All sponsor reporting requirements must also be followed.

The UD IRB REQUIRES the submission of a PROGRESS REPORT DUE ON July 26, 2022. A continuing review/progress report form must be submitted to the UD IRB at least 45 days prior to the due date to allow for the review of that report.

If you have any questions, please contact the UD IRB Office at (302) 831-2137 or via email at hsrb-research@udel.edu. Please include the study title and reference number in all correspondence with this office.

INSTITUTIONAL REVIEW BOARD



Institutional Review Board
210H Hulihan Hall
Newark, DE 19716
Phone: 302-831-2137
Fax: 302-831-2828

DATE: March 4, 2022

TO: Emalie Rell
FROM: University of Delaware IRB

STUDY TITLE: [1767631-3] Reintegrating Women's Access to Reproductive Health Services
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED
EFFECTIVE DATE: March 4, 2022
NEXT REPORT DUE: July 26, 2022

REVIEW TYPE: Full Committee Review

Thank you for your Amendment/Modification submission to the University of Delaware Institutional Review Board (UD IRB). The UD IRB has reviewed and APPROVED the proposed research and submitted documents via Full Committee Review in compliance with the pertinent federal regulations.

As the Principal Investigator for this study, you are responsible for, and agree that:

- All research must be conducted in accordance with the protocol and all other study forms as approved in this submission. Any revisions to the approved study procedures or documents must be reviewed and approved by the IRB prior to their implementation. Please use the UD amendment form to request the review of any changes to approved study procedures or documents.
- Informed consent is a process that must allow prospective participants sufficient opportunity to discuss and consider whether to participate. IRB-approved and stamped consent documents must be used when enrolling participants and a written copy shall be given to the person signing the informed consent form.
- Unanticipated problems, serious adverse events involving risk to participants, and all non-compliance issues must be reported to this office in a timely fashion according with the UD requirements for reportable events. All sponsor reporting requirements must also be followed.

The UD IRB REQUIRES the submission of a PROGRESS REPORT DUE ON July 26, 2022. A continuing review/progress report form must be submitted to the UD IRB at least 45 days prior to the due date to allow for the review of that report.

If you have any questions, please contact the UD IRB Office at (302) 831-2137 or via email at hsrb-research@udel.edu. Please include the study title and reference number in all correspondence with this office.

INSTITUTIONAL REVIEW BOARD

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Appendix B

DATA COLLECTION MATERIALS

Reentering Women Interview Guide

How are you doing today?

Tell me a little about the day you were released from your last incarceration?

I'd like to understand the experiences of women who were previously incarcerated, with a focus on their access to reproductive healthcare. I am going to start by asking you a series of questions regarding your access and utilization of health services prior to incarceration, during your incarceration, and after release. Remember you are the expert on the services that could help you in your everyday lives. The information you provide can help inform policies and attempt to fill gaps in existing research.

Prior to incarceration: All of the next questions refer to the period before your last incarceration.

1. What was your daily life like prior to your last incarceration?
2. Describe to me the health services you received prior to incarceration?
 - a. What kind?
 - b. Where?
 - c. How often did you attend?
3. Did you have health insurance prior to your last incarceration?
4. Did you want to have children prior to being incarcerated?
 - a. Why/not?
 - b. How would you go about becoming pregnant?
5. Did you already have any pregnancies prior to incarceration?
 - a. Were they desired?

During your last incarceration: All of the next questions refer to the period during your last incarceration.

6. Did you receive reproductive health counseling and family planning care during your time incarcerated?
 - a. If no, why not?
 - i. Do you feel you would have benefitted from receiving them?
 - b. If yes, what services?
 - i. Do you feel you benefitted from these services? Why/why not?
7. To what extent and how satisfied were you with your medical care prior to/during?
 - a. Describe to me the most positive aspects of that care.
 - b. The most negative aspects...

After release: All of the next questions refer to the period after your last incarceration.

8. When you left incarceration, to what extent were you concerned about healthcare, specifically your reproductive health?
9. Did you want to have children after being incarcerated?
 - a. If so, why?
 - i. Certain time frame in mind as to when you would like to have them?
 1. Would you mind becoming pregnant now?
 - b. To what extent would you go about and try becoming pregnant?
10. When you left incarceration did you have a familiar primary healthcare provider to visit?
11. Did you have access to health insurance initially after leaving incarceration?
 - a. If yes, how did you establish it?
12. Describe to me the reproductive health services you have received since being released? What were the positive aspects of the services? Negative aspects?
 - a. How did you find these services?
 - b. How long did after being released did it take to utilize these services?
13. If you did go to a family planning clinic visit after initial release from incarceration, what made it accessible?
 - a. Was there anything that made your experience less accessible?
 - b. If you did not go, describe to me what prevented you from accessing these services?
14. Have you had any pregnancies since reintegrating?
 - a. Were they desired?
 - b. Other sexual health issues?
15. To what extent do your friends and family support your desires around pregnancy?
16. Describe to me in as much detail as possible if any people in your life who have made it easier to take care of your reproductive health. For example, getting birth control, condoms, or being tested for STDs?
17. Describe to me in as much detail as possible if any people in your life who have made it harder to take care of your reproductive health.

Lastly, I would like to discuss what could have helped or deterred you in your reproductive health care process.

1. To what extent have you felt supported while receiving reproductive health service? Describe to what has helped you during your reproductive health care process.
2. How have you learned about healthcare providers? What role has a case manager/PO played?
3. To what extent have you felt deterred from receiving reproductive health service? Describe to what has prevented you from fully accessing reproductive health care services.

4. How do your loved ones support your desire to have more children(or children, or not have children whatever the case may be for respondent)?
5. What things or services could help you in getting access to reproductive healthcare services?
6. What reproductive services do you think you might benefit from?

Reentry Service Provider Interview Guide

First, I am going to ask you a few questions about the individuals you work with access to reproductive health services.

1. How long have you been working with justice-involved women?
2. How would you explain the overall health of the women you have worked with?
3. How would you explain the access to healthcare for these women?
4. Do you think the reentry service providers provide adequate services that aid in physical health issues reintegrating women might face? (Why/why not?)
 - a. More specifically for reproductive health services?
5. What are the best resources for reintegrating women to utilize to access affordable healthcare?
 - a. How do they find these resources?
6. What are your experiences with the reproductive health care needs that reintegrating women face?
 - a. Can you explain these more in-depth?
7. Do you think access to reproductive health services is a barrier for reintegrating women?
 - a. What about overall physical health services?
 - i. What are other barriers to reintegrating women utilizing reproductive healthcare?
8. Do you think that reintegrating women would benefit from access to reproductive health services? (Why/why not?)
 - a. How might these services be beneficial?
9. How might reentry service providers better provide information and help aid reintegrating women with their physical health?
 - a. What about their reproductive health?
10. What do you think deters women's access physical or reproductive health services?
 - a. What about encourages their utilization?

Next, I am going to ask you about your perceptions of reproductive health needs of reintegrating women.

1. How would you explain the pregnancy intentions of the women you work with after incarceration?
2. How would you explain the reproductive health care intentions of women you work with after incarceration?
3. How would you explain the sexual health of reintegrating women that you work with?
 - a. Do women often share this information with you?

4. Do you think reintegrating women that you work with, feel supported in regard to their reproductive health intentions?
5. Do the women that you work with tend to have primary healthcare providers or do they tend to seek out other forms of healthcare?

Lastly, are there any final thoughts you have about reintegrating women's access and utilization of reproductive health care?

1. Are there are any questions that you would've liked me to ask?

Screening Tool

Reentering Women

Do you currently reside in PA or DE?

Have you been released from State prison or County jail in the last two years?

Do you identify as female?

Contact information:

Service Providers

Do you currently work or volunteer as a reentry service provider in PA or DE?

Do you work with female reentrants?

Contact Information:

Demographic Survey

AGE:

RACE/ETHNICITY:

- White, non-Hispanic
- Black or African-American
- Hispanic
- Other: _____

MARITAL STATUS:

- Married
- Domestic Partner
- Widowed
- Divorced
- Separated
- Never Married

EMPLOYMENT STATUS:

- Not currently employed
- Full-time
- Part-time

If employed, what is your OCCUPATION:

PARTNER'S EMPLOYMENT STATUS (if married or cohabiting):

- Not currently employed
- Full-time
- Part-time

If partner employed, what is his/her OCCUPATION:

—

EDUCATION (highest level completed):

- Less than high school
- High School graduate or GED
- Some College
- Bachelors degree or higher

PARENT'S EDUCATION (highest level completed)—
specify mother or father:

- Less than high school
- High School graduate or GED
- Some College
- Bachelors degree or higher

CURRENT NUMBER LIVING IN HOUSEHOLD:

NUMBER OF CHILDREN:

HEALTH INSURANCE STATUS:

- Not covered by insurance
- Employer-based insurance plan
- Self-pay
- Medicaid
- Medicare
- Other: _____
- Don't know

ANNUAL HOUSEHOLD INCOME:

- Under \$10,000
- \$10,000-\$19,999
- \$20,000-\$29,999
- \$30,000-\$39,999
- \$40,000-\$49,999
- \$50,000-\$59,999
- \$60,000-\$69,999
- \$70,000-\$79,999
- \$80,000-\$89,999
- \$90,000-\$99,999
- \$100,000-\$124,999
- \$125,000-\$149,999
- \$150,000-\$199,999
- Over \$200,000
- Don't Know

How adequate is your household income in meeting your monthly needs?

- Very adequate
- Adequate
- Less than adequate
- Not at all adequate

Primary form of CONTRACEPTION:

- None; don't use
- Condom (male ___; female ___)
- Oral contraceptive (the pill)
- Injectable (Depo-Provera)
- Vaginal Ring (~~Nuvaring~~)
- IUD (if so, which type: _____)
- Implants (rods)
- Emergency contraception (Plan B)
- Natural Family Planning
- Withdrawal
- Other barrier methods (diaphragm, cervical cap, sponge)
- Other: _____

