



Salience and context of incarceration history disclosure in sexual and reproductive health service delivery

Erin J. McCauley^{a,b,*} , Erin R. Johnson^c

^a Sociology Program, Department of Social and Behavioral Sciences, University of California, San Francisco, San Francisco, CA, USA

^b Philip R. Lee Institute for Health Policy Studies (Affiliated Faculty) School of Medicine University of California, San Francisco, San Francisco, CA, USA

^c Department of Sociology, University of Southern Indiana, Evansville, IN, USA

ARTICLE INFO

Keywords:

Incarceration
Providers
Sexual and reproductive health services
Stigma

ABSTRACT

Incarceration is a stigmatized event with profound health consequences, yet little is known about how its disclosure is experienced and managed within clinical encounters. Sexual and reproductive health (SRH) settings, where stigma and trust are particularly salient, provide a critical context for examining disclosures. We explore the context in which providers come to know patients' incarceration histories in SRH service delivery, and the salience of disclosures. Drawing upon qualitative interviews ($n = 49$) with SRH providers who had treated patients with a history of incarceration ($n = 7$) and formerly incarcerated individuals who had sought or received SRH care ($n = 42$) between 2022 and 2023, we used a general inductive approach where we developed codes from provider interviews and applied them to both provider and patient interviews, with the latter complementing and triangulating the provider-derived findings. Providers reported learning of incarceration histories through direct patient disclosure, patient charts, transfers from correctional facilities, or referrals from reentry programs. While many emphasized offering the same care to all patients, providers and formerly incarcerated individuals nonetheless described how incarceration history informed treatment considerations and provider perceptions. Providers also described variation in care across correctional system involvements but noted they lacked training on the health consequences of criminal legal involvement and the intricacies of the system. Participants emphasized the importance of trauma-informed care and reported that family incarceration was also disclosed and shaped SRH. Findings highlight the salience of incarceration history in SRH services and underscore the need for provider training.

1. Introduction

Incarceration is a profound sociostructural determinant of health in the United States (U.S.) (Nowotny & Kuptsevyich-Timmer, 2018; Wildeman & Wang, 2017). With more than two million people currently incarcerated and many more cycling through jails, prisons, and detention facilities each year, the U.S. maintains the highest incarceration rate in the world (Sawyer and Wagner, 2020). The experience of incarceration shapes health across the life course, contributing to the development and persistence of health disparities. Research has documented that incarceration is associated with heightened risk of infectious disease, chronic illness, and poor mental health outcomes (Fazel & Bailargeon, 2011; Massoglia et al., 2014; Schnittker & John, 2007). These effects are particularly pronounced in sexual and reproductive health (SRH), where incarceration disrupts continuity of care, exposes

individuals to sexually transmitted infections, effects pregnancy and childbirth (Paynter et al., 2025a; Sufrin, 2017; Sufrin et al., 2020), and increases vulnerability to sexual violence (Belknap & Wilson, 2025; Buehler & Kottke-Weaver, 2024, p. 52; Macalino et al., 2005; Norris et al., 2022; Nowotny et al., 2020; Puglisi et al., 2021; Ramaswamy et al., 2024; Sufrin, 2017; Wang et al., 2013; Wiehe et al., 2015; Wolff et al., 2006).

The U.S. criminal legal system operates through a complex and expansive system that includes federal and state prisons (generally serving individuals convicted of felonies with sentences longer than one year), local jails (which detain individuals pretrial and those serving shorter sentences), and community corrections (such as probation and parole). Contact with the criminal legal system often entails ongoing surveillance, movement restrictions, electronic monitoring, court fees, and the constant threat of re-incarceration (Miller, 2021). Incarceration

* Corresponding author. Sociology Program, Department of Social and Behavioral Sciences, University of California, San Francisco, San Francisco, CA, USA.

E-mail address: Erin.McCauley@ucsf.edu (E.J. McCauley).

<https://doi.org/10.1016/j.ssmqr.2026.100784>

Received 28 January 2026; Received in revised form 19 March 2026; Accepted 1 May 2026

Available online 2 May 2026

2667-3215/© 2026 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

is not a discrete event but a prolonged condition of constrained autonomy that continues to structure daily life, family relationships, employment, housing, and healthcare access long after release (Comfort, 2007; Miller, 2021; Wildeman & Wang, 2017). The U.S. carceral system is also profoundly racialized (Pettit & Western, 2004). Decades of policy decisions have produced stark racial inequities, with Black, Indigenous, and other minoritized communities disproportionately entangled in the criminal legal system (Alexander, 2010). These inequities intersect with gender, poverty, and substance use criminalization, shaping who is most likely to experience incarceration and how its consequences accumulate across the life course (Massoglia, 2008; Massoglia & Pridemore, 2015; Schnittker & John, 2007).

Incarceration and incarceration histories are particularly consequential in pregnancy and SRH. People who are incarcerated while pregnant often face delayed prenatal care, limited access to abortion and contraception, barriers to informed consent, and carceral policies that constrain reproductive autonomy (Paynter et al., 2025a, 2025b; Sufirin et al., 2023). Recent qualitative research documents how family planning providers navigate institutional restrictions, security protocols, and ethical tensions when caring for incarcerated patients, often within systems that limit timely access to abortion and contraceptive services (Paynter et al., 2025a, 2025b). In addition, Sufirin and colleagues demonstrate how incarceration shapes abortion decision-making itself, precluding access through logistical barriers, coercive dynamics, and the compression of decision timelines under conditions of custody (Sufirin, 2017; Sufirin et al., 2023). Even after release incarceration history shapes care by disrupting insurance coverage and fragmenting medical records (Wang et al., 2008) and exposing individuals to trauma and stigma (Clarke et al., 2006; Schnittker & John, 2007). Thus, incarceration history is not merely background context in SRH health services; both incarceration history and how it is disclosed may constrain reproductive choice and shape SRH service needs and experiences.

Although incarceration has been widely studied as a social determinant of health, less is known about how it shapes the clinical encounter itself. A growing body of scholarship demonstrates how stigma and bias shape healthcare interactions along lines of gender (Alcalde-Rubio et al., 2020; Guzikovits et al., 2024; Zhang et al., 2021), race (Goyal et al., 2015; Hoffman et al., 2016; Johnson et al., 2004; Shen et al., 2018; Todd et al., 1993), socioeconomic status (Scott et al., 1996; van Ryn & Burke, 2000; Willems et al., 2005), and substance use disorders (Cazalis et al., 2023; Muncan et al., 2020; Parish et al., 2025). Patients with stigmatized identities or experiences often receive differential treatment, face skepticism about their symptoms, and encounter barriers to accessing appropriate care. Incarceration, too, is a stigmatized experience (Devah Pager, 2003; Frank et al., 2014; Keene et al., 2018; McCauley, 2025; Pager, Western, & Sugie, 2009; Stewart & Uggen, 2020). Yet, while prior research has shown that incarceration affects employment, housing, and education opportunities, much less is known about whether and how this history enters the healthcare domain, particularly in SRH service delivery where issues of trust and stigma are particularly salient.

One crucial but underexplored mechanism through which incarceration history may influence provider perceptions and treatment decisions is disclosure—yet it remains unknown if and how providers come to learn of incarceration history during clinical interactions. While recent research has recommended screening for incarceration history (MacKenzie et al., 2021), there is a paucity of research on how providers currently come to learn about incarceration history. Further, what research does exist suggests that providers are ill-prepared to ask (Patil et al., 2025). We hypothesize that providers may learn about patients' incarceration histories through multiple pathways (such as documentation in medical charts or direct disclosure by patients). Importantly, pathways for disclosure may also carry potential consequences. For example, learning about incarceration through official records may frame providers' perceptions before an encounter even begins, while patient self-disclosure may reflect a deliberate attempt to contextualize

health concerns or explain gaps in care. Disclosure can shape not only the tone and content of clinical interactions, but also the therapeutic relationship, communication strategies, and treatment planning. At the same time, disclosure moments can be fraught for patients who fear stigma and discrimination (Martin et al., 2020). To date, however, little empirical work has examined how incarceration histories are disclosed in healthcare, and what these disclosures could mean for clinical practice and patient experience.

The SRH context makes this question especially urgent. SRH services often involve intimate examinations, sensitive discussions, and ongoing trust between providers and patients (Dehlendorf et al., 2025; Dehlendorf & Rinehart, 2010; Newton-Levinson et al., 2024; Shankar et al., 2025; Stacey & Dempsey, 2014). Providers must navigate histories of trauma, high rates of sexually transmitted infections, and reproductive health disparities, all of which are disproportionately borne by people with incarceration experience (Nowotny et al., 2020; Ojikutu et al., 2018; Scott et al., 2016; Spaulding et al., 2009). Incarceration may therefore be a critical piece of information in SRH encounters, shaping not only risk assessment and screening practices but also communication strategies and providers' perceptions of patients' capacity to engage in care. Yet, without systematic training in the criminal legal system or its health consequences, many providers are ill-equipped to respond to incarceration disclosures in ways that are both clinically appropriate and ethically sound.

This study addresses these gaps by considering the context and salience of incarceration history disclosures in SRH service delivery through qualitative interviews. Drawing on semi-structured interviews with sexual and reproductive health providers ($n = 7$) in the San Francisco Bay Area and interviews with individuals with a history of incarceration who sought or received SRH services ($n = 42$) in Nashville, Tennessee, we ask three interrelated questions. First, how do providers learn about patients' incarceration histories? Second, how do providers interpret this information, and how does it shape their clinical practice? Third, how do patients describe disclosure moments, and what do these disclosures mean for their experiences of care? By situating provider accounts alongside patient narratives, we highlight the clinical, ethical, and structural dimensions of incarceration disclosures in SRH care. In doing so, we extend literatures on stigma in healthcare, trauma-informed practice, and the social determinants of health, and identify concrete points of intervention for training, policy, and practice.

2. Methods

In the present manuscript we employ qualitative interviews to understand the context and salience of incarceration history disclosures in clinical encounters. We used purposive, criterion-based sampling to recruit two participant groups: SRH service providers and individuals with a history of incarceration. Sampling was designed to include participants with direct experience of incarceration history disclosure in clinical contexts.

2.1. Data collection

We conducted 60-min semi-structured interviews with (a) SRH service providers in the San Francisco Bay Area, California ($n = 7$) and (b) individuals with a history of incarceration who had sought or received SRH services in Nashville, Tennessee ($n = 42$) between 2022 and 2023. All interviews were conducted remotely via Zoom or telephone by one of two members of the research team trained in qualitative interviewing. Provider interviews were focused specifically on the context and salience of incarceration history disclosures in clinical encounters. The research team recruited providers through a large public university medical system through distributing flyers in provider lounge areas, through email listservs, and through email invitation. Providers were considered eligible to participate if they had ever treated a patient with a history of incarceration and self-identified as a SRH service provider.

Interviews were conducted with both physicians and nurse practitioners. Participants practiced across multiple affiliated settings, including community health clinics, outpatient specialty and primary care clinics, and a county-owned safety-net hospital that serves as the primary teaching hospital of the university. This hospital provides care to the general public and, as the region's safety-net hospital, also receives individuals in custody when higher-acuity care is required. Thus, participants' experiences reflect care delivered across diverse academic and community-based environments rather than a single health service setting. Our interview guide focused on disclosure of incarceration history; however, several providers also described caring for individuals who were currently incarcerated. Although this was not systematically probed, these narratives were retained because they contextualize how providers identify and experience patients' carceral system contact, and because some providers did not explicitly distinguish between currently and formerly incarcerated patients in their accounts.

The provider data formed the basis of the analysis and were complemented by interviews with individuals with a history of incarceration who had sought or received SRH services. These interviews were drawn from a study by the research team exploring how a history of incarceration shapes SRH. To recruit individuals with a history of incarceration, we partnered with a community-based organization that works in reentry services that the research team has had a relationship with since 2014. This organization posted flyers in their office and included the opportunity to participate in periodic announcements. Participants were considered eligible if they were over 18 years old, had spent at least one night in prison or jail, and sought or received SRH services since their incarceration. Nashville is a metropolitan area where correctional facilities are operated at both the county and state levels. Healthcare for incarcerated individuals is provided within correctional facilities through contracted correctional health services, while individuals requiring higher-acuity or specialty care may be transported to community hospitals.

We did not systematically collect demographic data (e.g., race, ethnicity, gender identity) from participants as part of the structured interview protocol. However, based on voluntary self-description during interviews and interviewer observation, most providers in our sample identified as women and were non-Hispanic White, while most participants with a history of incarceration identified as women and were non-Hispanic Black. For both interview populations, participants viewed or received flyers and contacted the research team to participate. We received a waiver of written consent and obtained verbal consent. All participants received a copy of the consent form via email at least 24 h prior to interview. The project was approved by the University of California, San Francisco Institutional Review Board. Interview recordings were transcribed and anonymized. Participants received a \$100 gift card to Amazon for participating in the interview.

We conducted seven provider interviews focused specifically on the context and salience of incarceration history disclosures during clinical interactions. While the sample is modest, qualitative research emphasizes analytic depth rather than numerical size. Following Malterud et al.'s concept of "information power," smaller samples are sufficient when the research question is narrow, participants have direct experience with the phenomenon of interest, and interviews generate rich data (Malterud et al., 2016). In this study, themes in the provider data began to recur immediately, and we judged that thematic saturation was reached within the sample (Vasileiou et al., 2018). As such, the number of interviews was adequate to address the focused aim of understanding how providers learn about incarceration histories in sexual and reproductive health care.

In contrast, the interviews with formerly incarcerated participants were designed with a broader orientation, exploring multiple aspects of SRH care experiences following incarceration and capturing personal narratives for the larger project exploring the lived experience of SRH service delivery following incarceration. These interviews yielded considerably more varied content and themes, which justified a larger

sample. This larger group allowed us to capture a diversity of perspectives and ensure that the broader thematic terrain could be adequately represented. Our analytic approach prioritized capturing this thematic range and variation in experiences, not quantifying prevalence or assessing representativeness.

2.2. Data analysis

We analyzed transcripts using a general inductive approach, starting with the provider transcripts. Each transcript was read closely and coded line by line to capture meaningful segments of text. Open codes were developed directly from the data and refined through iterative reading, with attention to the contexts in which incarceration history was disclosed and the ways providers described its salience in SRH care. Codes were then distilled into broader categories and themes that captured shared patterns across interviews while allowing for divergent perspectives. Once a codebook was developed using the provider transcripts, these codes were deductively applied to the transcripts of individuals with a history of incarceration.

Both sets of transcripts were coded by a single researcher. To enhance analytic rigor, the coder maintained detailed analytic memos and an audit trail to document coding decisions and theme development while coding all transcripts. Reflexive notes were kept throughout to account for the researcher's positionality and assumptions. Credibility was further supported through peer debriefing with another member of the research team. This yielded a fully coded dataset. The provider interviews anchor this analysis, and the interviews with patients with a history of incarceration are used to triangulate and complement the provider findings. Drawing on both data sources allowed us to situate provider perspectives within the lived experiences of formerly incarcerated individuals and enhance the robustness of our interpretations.

Given the distinct political, healthcare, and criminal legal contexts of the San Francisco Bay Area and Nashville, Tennessee, we examined whether themes varied systematically by site during analysis. While participants referenced broader regional differences in carceral policy climates and social attitudes, patterns related specifically to disclosure pathways and how incarceration history shaped clinical interactions were largely consistent across sites. Providers had also trained or practiced in multiple regions of the U.S. Because the mechanisms of disclosure and their influence on care were not site-specific, we present results thematically rather than stratified by region.

3. results

Of the seven providers, all reported that they consistently knew when patients had a history of incarceration. Of the 42 individuals with a history of incarceration, all but one individual reported an incarceration history disclosure during a health services interaction. Providers outlined the context of incarceration history disclosure, discussed the salience of incarceration history for care, and emphasized the need to include information about the criminal legal system in health services training to better prepare providers. While the interview guide focused on incarceration history, some providers described providing care to both currently and formerly incarcerated individuals.

3.1. Context of disclosure

The providers reported three main pathways through which they learned of patients' incarceration histories. First, information was often available in the medical chart, either as explicit notes or through integrated system records documenting prior care in a correctional facility. Second, incarceration history was apparent through observation, such as when patients were transferred directly from correctional institutions or referred by programs serving formerly incarcerated individuals. While treating currently incarcerated patients was not the focus of these interviews, the experience was noted by providers, and some providers

remembered these patients in future visits after release. Finally, patients directly disclosed incarceration histories themselves, often to explain care gaps, while providers were taking a social history, or to provide context for health concerns. For social histories, providers did not specifically ask about incarceration history, but it was disclosed by patients in relationship to another aspect of their social history (such as housing or prior substance use treatment). As one provider explained, “*some of our pregnant patients are being brought in from juvenile justice centers that don't provide prevention or care. So okay, so that's an obvious situation where you know upfront, but otherwise I would say the vast majority is self-disclosure*” (P101).

Similarly, individuals with a history of incarceration we interviewed frequently disclosed their incarceration history during clinical encounters. Most patients reported actively disclosing, saying things like “*I don't have no problem telling nobody*” (P203), “*I've never had an issue telling nobody about my story*” (P201), or “*I always tell them*” (P226). Other patients disclosed when pressed, for example one patient said “*I was trying not to disclose that information with them at all. But that was a specific question they asked* (P207)”. Whether actively disclosed or disclosed when confronted with a question, either specifically about incarceration history or related to other indicators (such as gaps in care), patients described frequently disclosure incarceration histories. The only individual with lived experience who did not report disclosing her or his history during a clinical encounter made the decision not to do so after a family member reported a negative experience of disclosure.

3.2. Salience of disclosure

Providers and patients with a history of incarceration often described incarceration history disclosures as shaping care. While providers frequently first emphasized that they provided the “*same*” care (P102) for patients with a history of incarceration, they also described the knowledge being salient to care and shaping their considerations in several ways.

3.2.1. Indicator of trauma

Providers consistently described incarceration history as a marker of trauma. One reflected, “*I definitely switch to trauma informed care. There is usually a huge PTSD ... and I'm sure that what they don't share is probably more than what they have shared*” (P104). Awareness of incarceration histories shaped how clinicians approached SRH care, prompting them to adjust their communication, exam techniques, and counseling practices to prioritize safety and trust. Patients also noted that some providers switched to trauma informed care after disclosures. Some referenced trauma informed care by name, while most described care approaches that the research team identified as trauma informed care approaches (such as explaining each step during a procedure with repeated consent or allowing patients to collect specimens themselves when possible). For example, one patient said, “*I mean, he coached me all the way through it*” (P202). Unfortunately, while trauma informed care was frequently mentioned by patients when describing ideal or best health service experiences, many patients reported that this was not the norm for their care.

3.2.2. Unique health concerns

Clinicians emphasized distinct health risks associated with incarceration. These often included infectious disease, chronic conditions, and mental health challenges. One explained that once they know a patient has been incarcerated they are on the lookout for “*bloodborne infections, tuberculosis, and mental health things like PTSD, depression, anxiety, and substance use*” (P107). SRH encounters often entailed heightened vigilance for sexually transmitted infections: “*Frequent STI screening, safe sex talk over and over again*” (P103). Patients also reported knowing they were at risk of specific health concerns. They also stressed the need for care external to the criminal legal system, especially when health concerns were related to incarceration. For example, one patient

said “*I guess why I felt I needed to seek - check for STDs or get another as soon as I got released, because I said I got one [test] when I was in jail, because they were so horrible about going through it in jail that I didn't trust it. I didn't trust the results. I didn't trust them, and I wanted to get checked immediately*” (P207). Another said they sought care immediately after release because “*[in jail] I hadn't had my health care taken care of properly*” (P223). Even though patients reported stigma in their SRH services in the community, patients who compared community care to care in custody consistently preferred community care.

3.2.3. Perceptions of patients

Providers generally emphasized that they provided the same care to patients with and without a history of incarceration. However, they also outlined specific concerns about this population which shaped their care. Incarceration history informed providers' perceptions of patients' ability to engage with care. Some worried about continuity and adherence to treatment, for example stating “*I would not be surprised if they were more at risk for not being able to follow through*” (P102). Others acknowledged how structural disadvantage shaped care engagement. For example, one provider said, “*so often people who have a history of incarceration have had complicated lives and for people with complicated lives convenience can also be appreciated*” (P107). At the same time, this provider reflected on stigma in clinical settings with other providers, stating bluntly, “*Unfortunately, you know, I think stigma is alive*” (P107).

Patients similarly reported experiences of stigma, stating “*They don't treat you like you're a human ... shall I say. They treat you like you still incarcerated*” (P239). Another patient emphasized “*I'm looked at differently*” (P210). While providers perceived that they were providing the same level of care, the concerns they expressed about stigma among other clinicians were strongly echoed by patients' narratives of discrimination and differential treatment. The patient data would suggest that while providers may perceive that they are not reinforcing stigma or harm, they may be doing so unintentionally. One patient described a harrowing care experience during birth, which she believed was not properly treated due to perceptions about her based on her incarceration history. “*They told me that the reason why I almost died is because I was on drugs which I wasn't. And my drug labs came back negative, you know, but they didn't know this, and it was because of my [incarceration] history. I'd gone to jail between the two kids and all that*” (P207). Of particular note, is that negative disclosure experiences and experiences of stigma related to incarceration history shaped patients' willingness to disclosure to new providers.

3.2.4. Complexity of care

Some providers highlighted the layered complexity of delivering SRH care to formerly incarcerated patients. Some providers discussed disruptions in care for chronic conditions complicating care, and that prior experiences with correctional healthcare may shape perceptions of consent with providers after release. Other providers went on to note that providing care to currently incarcerated patients generates even more complexity when carceral procedures shaped the encounter. One provider described examining women who arrived in handcuffs: “*There was a trigger right there ... my first rule in my medical practice is to do no harm, and this is harmful. This is not how she wants to see me ... but this is the rules. This is what you get, so I examined patients with cuffs on them*” (P103). Such experiences underscored ethical tensions between correctional requirements and clinical care, and underscore how past medical experiences while incarcerated may continue to shape future clinical interactions.

Finally, providers noted that disclosures often extended beyond individual patients. Partner and child incarceration also frequently arose in SRH encounters, shaping conversations about stress, safety, fertility, and family planning. These disclosures underscored that the impact of incarceration on SRH and complexity of care is not limited to the individual patient, but can reverberate through families and relationships. While patients mentioned the incarceration of close social contacts, for

example saying “my husband is currently in jail” (P220), we did not ask about and few discussed disclosing their partner’s incarceration to health service interactions. One exception was a woman whose partner has chronic health condition. She emphasized that when she visited the emergency room with her boyfriend “we try not to let it out that he’s been incarcerated” because she doesn’t want him “on the back burner” (P207). Some providers also mentioned the potential importance of partner incarceration in the context of pregnancy saying, they prioritize STI screening “if someone discloses that, or if they say that their partner is currently incarcerated, or about to get out or just got out” (P101). Another said that they did not collect information about partner incarceration, but “I feel like it would be relevant if someone’s partner is incarcerated” (P105).

3.3. Training needs

Across interviews, providers stressed their lack of formal training regarding the criminal legal system and its health consequences. They highlighted the need to understand the scope and workings of the system, the conditions of confinement, and the ways incarceration functions as a socio-structural determinant of health. Without this knowledge, they felt ill-equipped to fully meet the needs of patients with incarceration histories. Providers largely expressed that they were not sure what this training should include, emphasizing that they did not know what they did not know, but that training should occur during medical training and as continuing education. When discussing the importance of such a training, one provider said, “when I look at the history of incarceration, and how we capitalize the prison system. When I read that, and I’m like ... And that’s in my lifetime, and I didn’t know nothing about it, you know, like, for people who really try to do good, this is a contribution to burnout” (P104). Another provider emphasized the need for education that links individual experiences to “patterns of abuse in these larger systems” (P105). Some providers had informal experiences providing care in correctional settings or to formally incarcerated individuals during their training, stressing these experiences stemmed from where the providers they trained under provided care. For example, one participant said, “that’s why we also did some time at like the adult jail or prison, because someone was doing that. And so that was part of our experience. We never had like formal training” (P106). Providers stressed the importance of including the criminal legal system in medical training, with one saying “incarceration is really being used as a tool to, you know, to continue the legacy of slavery. And we might be part of that tool if we’re not aware” (P101).

4. discussion

This study examined how incarceration histories are disclosed and interpreted in sexual and reproductive health (SRH) service delivery. We found that providers learned of patients’ incarceration histories through three main pathways: documentation in medical charts, observation of transfers from correctional facilities or programs, and patient direct self-disclosure. Once disclosed, incarceration history was consistently salient to providers, despite claims that they offered the same care to formerly incarcerated individuals. Providers described disclosures as influencing their use of trauma-informed practices, perceptions of patients, and treatment planning. Patients with a history of incarceration echoed the salience of incarceration history in their care, emphasizing differential treatment and how stigma shaped care. Providers also highlighted the unique health concerns associated with incarceration, as well as the complexity of care when clinical encounters are shaped by correctional rules. The disconnect between providers’ assertions of equitable care and patients’ experiences of stigma is not merely contradictory but analytically revealing. Providers frequently located stigma in “other” clinicians, while patients described differential treatment in ways that suggest bias may be more diffuse and less readily recognized in one’s own practice. This pattern is consistent with prior research on implicit

bias and professional identity, in which clinicians may be trying to maintain commitments to equity while underrecognizing how structural stigma manifests in routine care (Gopal et al., 2021; Vela et al., 2022).

Importantly, providers reported a lack of training on the criminal legal system and its health implications. Although providers were often unable to identify specific training components and expressed uncertainty about gaps in their own knowledge, they consistently called for expanded education during medical training and continuing professional development. They emphasized that such training should center the voices of individuals directly impacted by incarceration, highlighting a recognition that lived experience is essential to addressing stigma and improving care for this population. Providers further suggested that this type of training would not only enhance their ability to better serve patients but also help mitigate uncertainty and strain in clinical encounters, with potential to reduce provider burnout. In addition, family incarceration was also disclosed, underscoring the broader impact of the criminal legal system on SRH encounters. This work builds on research emphasizing how current incarceration shapes access to and experience with SRH service delivery (e.g., Paynter et al., 2025a; Paynter et al., 2025b; Schlafer et al., 2021; Sufrin, 2017; Sufrin et al., 2023), turning to how disclosures of incarceration histories occur during the enduring period of post-incarceration and beginning to consider the salience of these disclosures in SRH service delivery.

Our findings contribute to a growing body of research on the stigma of incarceration and its impact on health. Prior work has documented how contact with the criminal legal system is stigmatized in employment, housing, education and social relationships (Augustine & Kushel, 2022; Brew et al., 2021; Devah, 2003; Keene et al., 2018; McCauley, 2025; Pager, 2007; Pager, Bonikowski, & Western, 2009; Pager & Quillian, 2005); our results suggest that disclosure of incarceration history also plays a role in shaping healthcare encounters. This echoes broader literature on stigma in healthcare, such as the role of race, socioeconomic status, and substance use in shaping treatment experiences (Angerer et al., 2019; Green et al., 2007; McGinty et al., 2015; Nong et al., 2020; Pérez-Stable & Webb Hooper, 2023; Sabin & Greenwald, 2012; Schulman Kevin et al.; Williams & Mohammed, 2009; Wisniewski & Walker, 2020). Importantly, providers’ emphasis on trauma-informed approaches aligns with evidence demonstrating the high burden of trauma among incarcerated populations (McGinty et al., 2015; Scott et al., 2016). Our findings add to this literature by showing how incarceration histories act as a cue for providers to engage with trauma-informed care, while also revealing gaps in training that leave providers uncertain about how best to meet these patients’ needs.

These findings have clear implications for clinical practice. Providers consistently expressed a need for more training on the criminal legal system, including its scope, the structure of the system, conditions of confinement, and health consequences. Although our interview guide centered on disclosure of prior incarceration, providers described experiences caring for currently incarcerated patients and did not consistently differentiate forms of criminal legal system contact. This conceptual flattening may indicate limited clarity about the boundaries of the carceral system and the distinct structural constraints attached to each form of surveillance and control, with implications for how providers interpret patients’ autonomy, risk, and care engagement. Training that integrates trauma-informed and stigma-reduction practices could support providers in offering equitable and responsive care to patients with incarceration histories. Attention to family incarceration disclosures is also warranted, as these dynamics affect patient well-being and decision-making in SRH contexts. Moreover, providers’ accounts of patients examined in handcuffs highlight the broader bioethical tensions between correctional procedures and medical practice (Comer, 2025; Esposito et al., 2024; James, 2023), pointing to the need for institutional policies that uphold ethical principles.

Conceptualizing incarceration as a structural determinant of health requires moving beyond treating incarceration history as an individual risk factor and instead understanding it as a system level exposure that

shapes health (Wildeman & Wang, 2017). In SRH contexts in particular, this also includes constrained autonomy and consent, exposure to trauma, and barriers to accessing services following release. Our findings suggest that while incarceration history becomes salient in clinical interactions, providers often lack the frameworks needed to understand and respond to these structural dynamics. Notably, providers described uncertainty about gaps in their own knowledge and emphasized the need for training that incorporates the perspectives of individuals with lived experience of incarceration. This points to an important potential shift in clinical education: rather than solely expanding provider knowledge, integrating incarceration as a structural determinant may require rethinking whose expertise is centered, elevating lived experience as a critical source of insight for addressing stigma and improving care (Metzl & Hansen, 2014; Sharma et al., 2018).

This study also highlights opportunities for future research. Larger and more diverse samples of providers could help clarify how disclosure processes and their salience vary across geographic and institutional contexts. Research should investigate whether disclosure leads to implicit or explicit bias in treatment decisions, and how patients perceive the act of disclosing incarceration histories. Additionally, the role of family incarceration in shaping SRH encounters warrants further study, as it is common (Enns et al., 2019) and remains underexplored in both healthcare and criminology research. Finally, longitudinal designs could examine how disclosure affects care trajectories over time.

4.1. Limitations

Several limitations should be noted. The provider sample was modest and geographically limited ($n = 7$), which limits transferability, although saturation was reached for the focused research aim of understanding if and how providers know of incarceration history. The provider and patient samples were drawn from different regions and were each drawn from a sole metropolitan area, which may limit generalizability. Coding was conducted by a single researcher, though this was somewhat mitigated by memoing, an audit trail, and peer debriefing. Nonetheless, it is possible that additional coders may have identified alternative interpretations or emphasized different themes. Our cross-sectional design cannot capture how disclosure processes unfold across longitudinal care experiences. Because demographic characteristics were not systematically collected, we are unable to provide precise breakdowns by race or gender identity. Given well-documented racial and gender inequities in the criminal legal system (Carson & Kluckow, 2023) and in healthcare (Williams & Mohammed, 2013), this represents an important limitation of the study. Finally, future research should consider interviewing dyads of patients and providers about specific clinical interactions and/or relationships over time or conducting observations of patient and provider interactions. This deeply situated approach would allow for interesting comparisons in how providers and patients view the same interactions and how these discrepancies or agreements in perceptions shape care over time. Direct observations would move beyond self-reported behaviors and perceptions, allowing an additional perspective on interactions.

5. Conclusion

Incarceration history is routinely disclosed in SRH care and both providers and patients with a history of incarceration describe incarceration history playing a meaningful role in shaping provider perspectives and practices. These disclosures act as cues for trauma-informed care, highlight gaps in provider training, and raise concerns about the influence of stigma on treatment decisions. Recognizing incarceration as a structural determinant of health and integrating related training into medical education is critical to advancing health equity. By situating disclosures and provider responses as a key point where stigma can influence care, this study identifies new directions for practice, policy, and research aimed at improving the healthcare

experiences of formerly incarcerated individuals and their families.

CRedit authorship contribution statement

Erin J. McCauley: Writing – original draft, Supervision, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Erin R. Johnson:** Writing – review & editing, Project administration, Investigation, Conceptualization.

Funding

The University of California, San Francisco School of Nursing provided funding for the research activities of this project. EM received support from The Lifespan/Brown Criminal Justice Research Training Program on Substance Use and HIV (R25DA037190). The findings and conclusions represent the perspectives of authors only.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgments

Thank you to the participants for this study, who were so generous with their time and thoughts.

References

- Alcalde-Rubio, L., Hernández-Aguado, I., Parker, L. A., Bueno-Vergara, E., & Chilet-Rosell, E. (2020). Gender disparities in clinical practice: Are there any solutions? Scoping review of interventions to overcome or reduce gender bias in clinical practice. *International Journal for Equity in Health*, 19(1), 166. <https://doi.org/10.1186/s12939-020-01283-4>
- Alexander, M. (2010). *The new jim Crow: Mass incarceration in the age of colorblindness*. New Press.
- Angerer, S., Waibel, C., & Stummer, H. (2019). Discrimination in health care: A field experiment on the impact of patients' socioeconomic status on access to care. *American Journal of Health Economics*, 5(4), 407–427. https://doi.org/10.1162/ajhe_a.00124
- Augustine, D., & Kushel, M. (2022). Community supervision, housing insecurity, & Homelessness. *Ann Am Acad Pol Soc Sci*, 701(1), 152–171. <https://doi.org/10.1177/00027162221113983>
- Belknap, J., & Wilson, C. M. (2025). The extreme sexual victimization histories of women in prison and the significance of race. *Criminal Justice and Behavior*, 52(3), 410–428. <https://doi.org/10.1177/00938548241310365>
- Brew, B., Alani, F., Li, A., & Wildeman, C. (2021). Sticky stigma: The impact of incarceration on perceptions of personality traits and deservingness. *Social Forces*, 100(4), 1910–1934. <https://doi.org/10.1093/sf/soab091>
- Buehler, E., & Kottke-Weaver, S. (2024). *Sexual victimization reported by adult correctional authorities, 2019–2020—Statistical tables*. Washington DC: US Department of Justice (US).
- Carson, E. A., & Kluckow, R. (2023). *Prisoners in 2022—Statistical tables (Ncj, Issue. <https://bjs.ojp.gov/document/p22st.pdf>*
- Cazalis, A., Lambert, L., & Auriacombe, M. (2023). Stigmatization of people with addiction by health professionals: Current knowledge. A scoping review. *Drug and Alcohol Dependence Reports*, 9, Article 100196. <https://doi.org/10.1016/j.dadr.2023.100196>
- Clarke, J. G., Hebert, M. R., Rosengard, C., Rose, J. S., DaSilva, K. M., & Stein, M. D. (2006). Reproductive health care and family planning needs among incarcerated women. *Am J Public Health*, 96(5), 834–839. <https://doi.org/10.2105/ajph.2004.060236>
- Comer, A. R. (2025). Care of patients who are incarcerated. *AMA Journal of Ethics*, 27(4), 277–282.
- Comfort, M. (2007). Punishment beyond the legal offender. *Annual Review of Law and Social Science*, 3, 271–296. <https://doi.org/10.1146/annurev.lawsocsci.3.081806.112829> (Volume 3, 2007).
- Dehlendorf, C., Desai, S., Danaux, J., Green, C., Sarnaik, S., Crear-Perry, J., & Hart, J. (2025). Advancing a measure of sexual and reproductive well-being aligned with core values of reproductive justice and human rights. *American Journal of Public Health*, 115(9), 1463–1471. <https://doi.org/10.2105/AJPH.2025.308119>
- Dehlendorf, C., & Rinehart, W. (2010). Communication in reproductive health: Intimate topics and challenging conversations. *Patient Educ Couns*, 81(3), 321–323. <https://doi.org/10.1016/j.pec.2010.11.001>
- Devah, P. (2003). The mark of a criminal record. *American Journal of Sociology*, 108(5), 937–975. <https://doi.org/10.1086/374403>

- Enns, P., Yi, Y., Comfort, M., Goldman, A., Lee, H., Muller, C., Wakefield, S., Wang, E., & Wildeman, C. (2019). What percentage of Americans have ever had a family member incarcerated?: Evidence from the Family History of Incarceration Survey (FamHIS). *Socius*, 5, 1–45. <https://doi.org/10.1177/2378023119829332>
- Esposito, M., Szocik, K., Capasso, E., Chisari, M., Sessa, F., & Salerno, M. (2024). Respect for bioethical principles and human rights in prisons: A systematic review on the state of the art. *BMC Medical Ethics*, 25(1), 62. <https://doi.org/10.1186/s12910-024-01049-5>
- Fazel, S., & Baillargeon, J. (2011). The health of prisoners. *The Lancet*, 377(9769), 956–965. [https://doi.org/10.1016/S0140-6736\(10\)61053-7](https://doi.org/10.1016/S0140-6736(10)61053-7)
- Frank, J. W., Wang, E. A., Nunez-Smith, M., Lee, H., & Comfort, M. (2014). Discrimination based on criminal record and healthcare utilization among men recently released from prison: A descriptive study. *Health & Justice*, 2(1), 6. <https://doi.org/10.1186/2194-7899-2-6>
- Gopal, D. P., Chetty, U., O'Donnell, P., Gajria, C., & Blackadder-Weinstein, J. (2021). Implicit bias in healthcare: Clinical practice, research and decision making. *Future Healthcare Journal*, 8(1), 40–48. <https://doi.org/10.7861/fhj.2020-0233>
- Goyal, M. K., Kuppermann, N., Cleary, S. D., Teach, S. J., & Chamberlain, J. M. (2015). Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatrics*, 169(11), 996–1002. <https://doi.org/10.1001/jamapediatrics.2015.1915>
- Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine*, 22(9), 1231–1238. <https://doi.org/10.1007/s11606-007-0258-5>
- Guzikevits, M., Gordon-Hecker, T., Rektman, D., Salameh, S., Israel, S., Shayo, M., Gozal, D., Perry, A., Gileles-Hillel, A., & Choshen-Hillel, S. (2024). Sex bias in pain management decisions. *Proceedings of the National Academy of Sciences*, 121(33), Article e2401331121. <https://doi.org/10.1073/pnas.2401331121>
- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, 113(16), 4296–4301. <https://doi.org/10.1073/pnas.1516047113>
- James, J. E. (2023). The problem is not (Merely) mass incarceration: Incarceration as a bioethical crisis and abolition as a moral obligation. *Hastings Center Report*, 53(6), 35–37.
- Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient Race/Ethnicity and quality of patient–physician communication during medical visits. *American Journal of Public Health*, 94(12), 2084–2090. <https://doi.org/10.2105/AJPH.94.12.2084>
- Keene, D. E., Smoyer, A. B., & Blankenship, K. M. (2018). Stigma, housing and identity after prison. *Sociol Rev*, 66(4), 799–815. <https://doi.org/10.1177/0038026118777447>
- Macalino, G. E., Dhawan, D., & Rich, J. D. (2005). A missed opportunity: Hepatitis C screening of prisoners. *American Journal of Public Health*, 95(10), 1739–1740. <https://doi.org/10.2105/AJPH.2004.056291>
- MacKenzie, O., Goldman, J., Chin, M., Duffy, B., Martino, S., Ramsey, S., Jiménez, M. C., & Vanjani, R. (2021). Association of individual and familial history of correctional control with health outcomes of patients in a primary care Center. *JAMA Network Open*, 4(11), Article e2133384. <https://doi.org/10.1001/jamanetworkopen.2021.33384>
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753–1760. <https://doi.org/10.1177/1049732315617444>
- Martin, K., Taylor, A., Howell, B., & Fox, A. (2020). Does criminal justice stigma affect health and health care utilization? A systematic review of public health and medical literature. *International Journal of Prisoner Health*, 16(3), 263–279. <https://doi.org/10.1108/ijph-01-2020-0005>
- Massoglia, M. (2008). Incarceration, health, and racial disparities in health. *Law & Society Review*, 42(2), 275–306.
- Massoglia, M., Pare, P.-P., Schnittker, J., & Gagnon, A. (2014). The relationship between incarceration and premature adult mortality: Gender specific evidence. *Social Science Research*, 46, 142–154. <https://doi.org/10.1016/j.ssresearch.2014.03.002>
- Massoglia, M., & Pridemore, W. A. (2015). Incarceration and health. *Annual Review of Sociology*, 42, 291–310. <https://doi.org/10.1146/annurev-soc-073014-112326>
- McCauley, E. J. (2025). The leniency of low expectations: Parental incarceration, race, and teachers' evaluations of student writing. *American Journal of Sociology*. <https://doi.org/10.1086/738516>
- McGinty, E. E., Goldman, H. H., Pescosolido, B., & Barry, C. L. (2015). Portraying mental illness and drug addiction as treatable health conditions: Effects of a randomized experiment on stigma and discrimination. *Social Science & Medicine*, 126, 73–85. <https://doi.org/10.1016/j.socscimed.2014.12.010>
- Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, 103, 126–133. <https://doi.org/10.1016/j.socscimed.2013.06.032>
- Miller, R. J. (2021). *Halfway home: Race, punishment, and the afterlife of mass incarceration*. Brown: Little.
- Muncan, B., Walters, S. M., Ezell, J., & Ompad, D. C. (2020). “They look at us like junkies”: Influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City. *Harm Reduction Journal*, 17(1), 53. <https://doi.org/10.1186/s12954-020-00399-8>
- Newton-Levinson, A., Blake, S. C., Swartzendruber, A., Kramer, M. R., & Sales, J. M. (2024). “So that I can trust them with my body:” how people with low incomes who may become pregnant define and prioritize quality reproductive health care. *Contraception*, 138, Article 110517. <https://doi.org/10.1016/j.contraception.2024.110517>
- Nong, P., Raj, M., Creary, M., Kardia, S. L. R., & Platt, J. E. (2020). Patient-Reported experiences of discrimination in the US health care System. *JAMA Network Open*, 3(12), Article e2029650. <https://doi.org/10.1001/jamanetworkopen.2020.29650>
- Norris, W. K., Allison, M. K., Fradley, M. F., & Zielinski, M. J. (2022). ‘You’re setting a lot of people up for failure’: What formerly incarcerated women would tell healthcare decision makers. *Health & Justice*, 10(1), 4. <https://doi.org/10.1186/s40352-022-00166-w>
- Nowotny, K. M., & Kuptsevykh-Timmer, A. (2018). Health and Justice: Framing incarceration as a social determinant of health for Black men in the United States. *Sociology Compass*, 12(3), Article e12566. <https://doi.org/10.1111/soc4.12566>
- Nowotny, K. M., Omori, M., McKenna, M., & Kleinman, J. (2020). Incarceration rates and incidence of sexually transmitted infections in US counties, 2011–2016. *American Journal of Public Health*, 110(S1), S130–S136. <https://doi.org/10.2105/ajph.2019.305425>
- Ojikutu, B. O., Srinivasan, S., Bogart, L. M., Subramanian, S. V., & Mayer, K. H. (2018). Mass incarceration and the impact of prison release on HIV diagnoses in the US South. *PLoS One*, 13(6), Article e0198258. <https://doi.org/10.1371/journal.pone.0198258>
- Pager, D. (2007). *Marked: Race, crime, and finding work in an era of mass incarceration*. University of Chicago Press.
- Pager, D., Bonikowski, B., & Western, B. (2009a). Discrimination in a low-wage labor market: A field experiment. *American Sociological Review*, 74(5), 777–799. <https://doi.org/10.1177/000312240907400505>
- Pager, D., & Quillian, L. (2005). Walking the talk? What employers say versus what they do. *American Sociological Review*, 70(3), 355–380. <https://doi.org/10.1177/000312240507000301>
- Pager, D., Western, B., & Sugie, N. (2009b). Sequencing disadvantage: Barriers to employment facing young Black and white men with criminal records. *The Annals of the American Academy of Political and Social Science*, 623(1), 195–213. <https://doi.org/10.1177/0002716208330793>
- Parish, C. L., Feaster, D. J., Pollack, H. A., Horigian, V. E., Wang, X., Jacobs, P., Pereyra, M. R., Drymon, C., Allen, E., Gooden, L. K., Del Rio, C., & Metsch, L. R. (2025). Healthcare provider stigma toward patients with substance use disorders. *Addiction*, 120(10), 2005–2019. <https://doi.org/10.1111/add.70122>
- Patil, A., Hutchins, G. J., Dabbara, H., Handunge, V. L., Lewis-O'Connor, A., Vanjani, R., & Botero, M. C. (2025). Talking about incarceration history: Engaging patients and healthcare providers in communication. *Journal of General Internal Medicine*, 40(3), 603–610. <https://doi.org/10.1007/s11606-024-09149-z>
- Paynter, M., Heggie, C., McLeod, A., & Norman, W. V. (2025a). The experiences of family planning health professionals providing care to incarcerated patients: A qualitative study. *BMC Pregnancy and Childbirth*, 25(1), 856. <https://doi.org/10.1186/s12884-025-07913-5>
- Paynter, M. J., Heggie, C., McLeod, A., & Norman, W. V. (2025b). Abortion and contraception within prison health care: A qualitative study. *BMC Women's Health*, 25(1), 34. <https://doi.org/10.1186/s12905-024-03523-z>
- Pérez-Stable, E. J., & Webb Hooper, M. (2023). The pillars of health disparities Science—Race, ethnicity, and socioeconomic status. *JAMA Health Forum*, 4(12), Article e234463. <https://doi.org/10.1001/jamahealthforum.2023.4463>
- Pettit, B., & Western, B. (2004). Mass imprisonment and the life-course: Race and class inequality in U.S. incarceration. *American Sociological Review*, 69(2), 151–169.
- Puglisi, L., Halberstam, A. A., Aminawung, J., Gallagher, C., Gonsalves, L., Schulman-Green, D., Lin, H. J., Metha, R., Mun, S., Oladeru, O. T., Gross, C., & Wang, E. A. (2021). Incarceration and Cancer-Related Outcomes (ICRO) study protocol: Using a mixed-methods approach to investigate the role of incarceration on cancer incidence, mortality and quality of care. *BMJ Open*, 11(5), Article e048863. <https://doi.org/10.1136/bmjopen-2021-048863>
- Ramaswamy, M., Hall, B., Cejtin, H., Sufirin, C., Moore, S., Nattell, N., Jodry, D., & Flowers, L. (2024). Cervical cancer prevention in individuals with criminal legal System involvement. *Journal of Lower Genital Tract Disease*, 28(4).
- Sabin, J. A., & Greenwald, A. G. (2012). The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: Pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma. *American Journal of Public Health*, 102(5), 988–995. <https://doi.org/10.2105/AJPH.2011.300621>
- Sawyer, W., & Wagner, P. (2020). Mass incarceration: The whole pie. https://www.priso-npolicy.org/reports/pie2020.html?c=pie&gclid=Cj0KCQiAlMCOBhCZARIsANlid6bM4AJNokkv0xXQILZkf0OC9IP1uFxFKFWZfSAphE7bCBkrBVqVqWLVsaAoxBEALw_wcB
- Schnittker, J., & John, A. (2007). Enduring stigma: The long-term effects of incarceration on health. *Journal of Health and Social Behavior*, 48(2), 115–130.
- Schulman Kevin, A., Berlin Jesse, A., Harless, W., Kerner Jon, F., Sistrunk, S., Gersh Bernard, J., Dubé, R., Taleghani Christopher, K., Burke Jennifer, E., Williams, S., Eisenberg John, M., Ayers, W., & Escarce José, J. The effect of race and sex on physicians' recommendations for cardiac catheterization. *New England Journal of Medicine*, 340(8), 618–626. <https://doi.org/10.1056/NEJM199902253400806>
- Scott, C. K., Lurigio, A. J., Dennis, M. L., & Funk, R. R. (2016). Trauma and morbidities among female detainees in a large urban jail. *The Prison Journal*, 96(1), 102–125. <https://doi.org/10.1177/0032885515605490>
- Scott, A., Shiell, A., & King, M. (1996). Is general practitioner decision making associated with patient socio-economic status? *Social Science & Medicine*, 42(1), 35–46. [https://doi.org/10.1016/0277-9536\(95\)00063-1](https://doi.org/10.1016/0277-9536(95)00063-1)
- Shankar, M., Loeliger, K. B., Ager, E., Arnal, M., Johnson, S., Matticks, Z., Nakamura, E., Begna, H., & Schwarz, E. B. (2025). Trauma inquiry and response in sexual and reproductive health settings: Collaborative learning among clinicians. *Reproductive Health*, 22(1), 164. <https://doi.org/10.1186/s12978-025-02135-6>

- Sharma, M., Pinto, A. D., & Kumagai, A. K. (2018). Teaching the social determinants of health: A path to equity or a road to nowhere? *Academic Medicine*, 93(1), 25–30. <https://doi.org/10.1097/acm.0000000000001689>
- Shen, M. J., Peterson, E. B., Costas-Muñiz, R., Hernandez, M. H., Jewell, S. T., Matsoukas, K., & Bylund, C. L. (2018). The effects of race and racial concordance on patient-physician communication: A systematic review of the literature. *Journal of Racial and Ethnic Health Disparities*, 5(1), 117–140. <https://doi.org/10.1007/s40615-017-0350-4>
- Shlafer, R., Saunders, J. B., Boraas, C. M., Kozhimannil, K. B., Mazumder, N., & Freese, R. (2021). Maternal and neonatal outcomes among incarcerated women who gave birth in custody. *Birth*, 48(1), 122–131. <https://doi.org/10.1111/birt.12524>
- Spaulding, A. C., Seals, R. M., Page, M. J., Brzozowski, A. K., Rhodes, W., & Hammett, T. M. (2009). HIV/AIDS among inmates of and releasees from US correctional facilities, 2006: Declining share of epidemic but persistent public health opportunity. *PLoS One*, 4(11), Article e7558. <https://doi.org/10.1371/journal.pone.0007558>
- Stacey, R. E., & Dempsey, A. R. (2014). The influence of trust in health care systems on postabortion contraceptive choice. *Obstetrics & Gynecology*, 123.
- Stewart, R., & Uggen, C. (2020). Criminal records and college admissions: A modified experimental audit. *Criminology*, 58(1), 156–188. <https://doi.org/10.1111/1745-9125.12229>
- Sufrin, C. (2017). *Jailcare: Finding the safety net for women behind bars*. Univ of California Press.
- Sufrin, C. B., Devon-Williamston, A., Beal, L., Hayes, C. M., & Kramer, C. (2023). “I mean, I didn’t really have a choice of anything:” how incarceration influences abortion decision-making and precludes access in the United States. *Perspectives on Sexual and Reproductive Health*, 55(3), 165–177. <https://doi.org/10.1363/psrh.12235>
- Sufrin, C., Jones, R. K., Mosher, W. D., & Beal, L. (2020). Pregnancy prevalence and outcomes in U.S. jails. *Obstetrics & Gynecology*, 135(5).
- Todd, K. H., Samaroo, N., & Hoffman, J. R. (1993). Ethnicity as a risk factor for inadequate emergency department analgesia. *JAMA*, 269(12), 1537–1539.
- van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians’ perceptions of patients. *Social Science & Medicine*, 50(6), 813–828. [https://doi.org/10.1016/s0277-9536\(99\)00338-x](https://doi.org/10.1016/s0277-9536(99)00338-x)
- Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, 18(1), 148. <https://doi.org/10.1186/s12874-018-0594-7>
- Vela, M. B., Erondy, A. I., Smith, N. A., Peek, M. E., Woodruff, J. N., & Chin, M. H. (2022). Eliminating explicit and implicit biases in health care: Evidence and research needs. *Annu Rev Public Health*, 43, 477–501. <https://doi.org/10.1146/annurev-publhealth-052620-103528>
- Wang, E. A., Wang, Y., & Krumholz, H. M. (2013). A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: A retrospective matched cohort study, 2002 to 2010. *JAMA Internal Medicine*, 173(17), 1621–1628.
- Wang, E. A., White, M. C., Jamison, R., Goldenson, J., Estes, M., & Tulskey, J. P. (2008). Discharge planning and continuity of health care: Findings from the San Francisco County Jail. *Am J Public Health*, 98(12), 2182–2184. <https://doi.org/10.2105/ajph.2007.119669>
- Wiehe, S. E., Rosenman, M. B., Aalsma, M. C., Scanlon, M. L., & Fortenberry, J. D. (2015). Epidemiology of sexually transmitted infections among offenders following arrest or incarceration. *American Journal of Public Health*, 105(12), e26–e32. <https://doi.org/10.2105/AJPH.2015.302852>
- Wildeman, C., & Wang, E. A. (2017). Mass incarceration, public health, and widening inequality in the USA. *The Lancet*, 389(10077), 1464–1474.
- Willems, S., De Maesschalck, S., Deveugele, M., Derese, A., & De Maeseneer, J. (2005). Socio-economic status of the patient and doctor-patient communication: Does it make a difference? *Patient Educ Couns*, 56(2), 139–146. <https://doi.org/10.1016/j.pec.2004.02.011>
- Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, 32(1), 20–47. <https://doi.org/10.1007/s10865-008-9185-0>
- Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist*, 57(8), 1152–1173. <https://doi.org/10.1177/0002764213487340>
- Wisniewski, J. M., & Walker, B. (2020). Association of simulated patient Race/Ethnicity with scheduling of primary care appointments. *JAMA Network Open*, 3(1), Article e1920010. <https://doi.org/10.1001/jamanetworkopen.2019.20010>
- Wolff, N., Blitz, C. L., Shi, J., Bachman, R., & Siegel, J. A. (2006). Sexual violence inside prisons: Rates of victimization. *Journal of Urban Health*, 83(5), 835–848. <https://doi.org/10.1007/s11524-006-9065-2>
- Zhang, L., Losin, E. A. R., Ashar, Y. K., Koban, L., & Wager, T. D. (2021). Gender biases in estimation of others’ pain. *The Journal of Pain*, 22(9), 1048–1059. <https://doi.org/10.1016/j.jpain.2021.03.001>