A BRIEFING FOR THE NATIONAL REINTEGRATION GATHERING

CANADIAN ASSOCIATION OF ELIZABETH FRY SOCIETIES

Health and Reintegration

The health of federally sentenced women and gender-diverse people, and the conditions that support a successful return to community

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Women and gender-diverse people in federal prisons

Summary

Federally sentenced women and gender-diverse people enter federal prisons with high rates of trauma, mental illness and chronic physical illness, and many leave in poorer health than when they arrived. On average, 798 women were in custody in Correctional Service of Canada (CSC) institutions in 2024–25 [1]. CSC research found that 79.2% of women in federal custody met the criteria for a current mental disorder, and that 86% of federally sentenced women reported physical abuse in their lifetime [2,3]. The population is also older than it was a decade ago: the number of women aged 50 and over in federal custody rose from 56 in 2007–08 to 102 in 2017–18 [4].

Incarceration shortens lives. People in federal penitentiaries have the health problems of people 10 to 15 years older in the community, and their life expectancy is around 62 years, compared with the Canadian average of 82 [5]. Conditions inside penitentiaries designated for women add to this burden. People live with food scarcity and nutritional deficits, face extraordinary barriers to obtaining health supplements, and receive mental health care that often responds only at the point of crisis. Since 2025, CAEFS Regional Advocates have also documented indoor temperatures of 35°C to 42°C and forced changes to opioid agonist therapy [6,7,8,9].

Health is part of reintegration. A person who is hungry, in pain, untreated for trauma or restricted in therapeutic interventions is less able to thrive, which adds significant barriers to reintegration. This briefing summarizes the evidence and sets out recommendations for health in custody and in the community.

79.2%
of women in federal custody met the criteria for a current mental disorder (95.6% of Indigenous women) [2]

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of federally sentenced women reported physical abuse in their lifetime, and 68% reported sexual abuse [3]

62 years
is the life expectancy of people in federal penitentiaries, compared with the Canadian average of 82 [5]

About half
of women in federal prisons are Indigenous; 75% of women in maximum security are Indigenous [10]

I The issues

Five connected issues shape the health of federally sentenced women and gender-diverse people, from admission through release.

Trauma and mental illness

Most federally sentenced women have survived violence before they reach prison. In CSC's 2010 survey of federally sentenced women, 86% reported physical abuse and 68% reported sexual abuse in their lifetime [3]. CSC's 2018 national prevalence study found that 79.2% of women in federal custody met the criteria for a current mental disorder, including anxiety disorders (54.2%) and borderline personality disorder (33.3%); 76.0% met the criteria for a lifetime alcohol or substance use disorder [2]. Nearly one in three women (33%) met the criteria for post-traumatic stress disorder [11].

Care inside penitentiaries designated for women does not match this level of need. At Fraser Valley Institution in 2026, people told CAEFS that they "must reach a point of crisis or engage in self-injury" before their mental health needs are treated as urgent [8]. At Edmonton Institution for Women, people described "a triage-based system where supports are often only available when a person's condition becomes acute" [12]. CAEFS's national review of 35 advocacy letters found that mental health services in maximum security are especially limited and that restrictive conditions worsen symptoms [13].

> *"People described feeling that they must reach a point of crisis or engage in self-injury before their mental health needs are recognized as sufficiently urgent to receive care."*
>
> CAEFS, Fraser Valley Institution management letter, June 2026 [8]

Chronic physical illness, aging and shortened lives

Women arrive in federal custody with a high burden of physical illness. Among women admitted to federal custody in 2012–13, 26% reported back pain, 23% a history of head injury and 19% hepatitis C, compared with 1% of women in the general population; 47% of women over 50 reported a cardiovascular condition [14]. In a CSC study of federally sentenced women aged 50 and over, 96% reported two or more physical health problems, and menopause, cancer and osteoporosis were named as common concerns [15].

Government research has recognized for years that people age faster in prison. CSC's 2010 profile of older women in federal custody noted that a 50-year-old in a federal institution is comparable to a 60-year-old in the general population [16]. The Office of the Correctional Investigator (OCI) and the Canadian Human Rights Commission found in 2019 that the health of people in federal custody "mirrors the health conditions

of individuals that may be up to ten years older," and that people aged 50 and over made up 25% of the federal custodial population [4]. Adelina Iftene's research on aging in Canadian penitentiaries describes accelerated aging of 10 to 15 years and a life expectancy of around 62 years in federal custody, compared with 82 years for Canadians generally [5]. CSC's own review of deaths in federal custody from 2017–18 to 2019–20 found that people who died of natural causes, nearly all of them men, were on average 63.9 years old [17].

Heat adds risk for older and ill people. At Grand Valley Institution for Women in 2026, indoor temperatures reached between 35°C and 42°C, and people with COPD, seizure disorders and cardiac and respiratory conditions reported worsening symptoms [7]. At Fraser Valley Institution, one person reportedly experienced heatstroke [8]. In 2026, CAEFS won a Federal Court decision on dangerous heat in the Secure Unit at Edmonton Institution for Women [18].

62 years

life expectancy in federal custody, compared with 82 years for Canadians generally [5]

Food scarcity and nutritional deficits

People in penitentiaries designated for women live with food scarcity and nutritional deficits, and the way food is provided depends on security level. In maximum security, people receive prepared meals. In medium and minimum security, people live in units where they cook for themselves from grocery orders paid from a daily food allowance. Recently, CSC reduced grocery budgets in penitentiaries designated for women while increasing them in penitentiaries designated for men, on the rationale that women require fewer calories, although federal nutrition guidelines do not distinguish recommended calorie intake by sex or gender [6].

In maximum security, the meals are consistently reported as not enough. People in maximum security units consistently tell CAEFS they are "always hungry," and portion sizes depend on which cook is on duty [20]. At Grand Valley Institution, for example people in maximum security report receiving half a bagel or English muffin, and people buy high-sugar and high-salt canteen food to make up for poor food quality and low protein [21,7].

In medium and minimum security, the allowance comes with no preparation. Women receive a grocery budget but no course in cooking, meal planning or budgeting. This leaves people in penitentiaries designated for women, many of whom may not have had strong cooking or budgeting skills prior to incarceration, left to fend for themselves, and the outcome is an unbalanced diet high in refined sugars and carbohydrates. Sharing food is criminalized in many of the penitentiaries designated for women with

people in different living units, and people often do not have a choice where they live. This practice cuts off opportunity for healthy meal planning and sharing between positive contacts, leaving individuals in units where they may feel isolated or conflict with their peers, making accessing the kitchen to cook at all a stressful process. Many people per unit are left share aging kitchens, and cookware is often hazardous, including scratched non-stick (Teflon) pans that should be replaced. CAEFS has documented produce that is "often rotting when it is issued" and one person whose grocery order delivered only a can of tomatoes [21,22].

Health supplements are extraordinarily difficult to obtain in penitentiaries designated for women, and CAEFS has documented the limited affordability and inconsistent availability of over-the-counter health items [13]. CSC policy requires that meals "meet the minimum nutritional standards for Canadians as outlined in" Canada's Food Guide [23], yet CSC's own 2019 audit found that the national menu fell short of the Food Guide on six of the 28 days of the menu cycle [24]. The only published nutritional analysis of the federal menu was assessed against men's dietary reference values and includes no findings specific to women [25].

> *"We are always hungry up here."*
>
> Person in maximum security, Nova Institution for Women, reported in CAEFS advocacy letter, May 2025 [20]

Reproductive and women's health

Women's health needs are specific, and CSC policy says little about them. CSC's health services directive requires health services to be sensitive to the needs of Indigenous people and women, but it contains no provisions on menopause, cervical screening or reproductive health education [26]. CSC publishes no data on menopause care or cancer screening in penitentiaries designated for women. A 2021 CAEFS report based on consultations with 200 people found that reproductive health "is threatened by the very nature of their incarceration" [27].

Education is part of this care. Endometriosis affects about 10% of women and girls of reproductive age worldwide, causes severe pain and is often diagnosed only after years of delay [28]. Women in prison need education to recognize its symptoms and access to assessment. Human papillomavirus (HPV) causes about 95% of cervical cancers, and the disease is preventable through vaccination and screening [29]. Federally sentenced women need education on HPV, access to HPV vaccination and testing, and regular cervical screening, as the United Nations Bangkok Rules require [30].

While some menstrual products are offered, menstrual products that fit the needs of different bodies and period types are consistently reported as lacking. In many of the penitentiaries, this has been supplemented on canteen, leaving individuals able to buy additional options with a health and hygiene

credit of $7 per pay period [31]. However, this limited resource allocation leaves people in a series of forced choices in prison, with what health resource to prioritize. The Bangkok Rules require sanitary products "provided free of charge" [30]. CAEFS has documented the limited affordability and availability of not just menstrual products, but additional essentials such as sunscreen and over-the-counter medication across penitentiaries designated for women [13].

Disrupted care in custody

Health care in federal prisons is frequently interrupted. CAEFS has documented countless instances of disrupted access to medication, including but not limited to lost prescriptions for heart and thyroid medication, and long waits for physicians and dentists [7,13]. Since October 2025, a CSC policy change has forced people to switch opioid agonist therapy medications, which many community health practitioners describe as "inconsistent with patient-centered care" [9,32].

2 Why sex and gender shape these outcomes

Research on sex and gender differences in the stress response helps explain why trauma and incarceration affect women's health in specific ways. The differences are averages: the ranges for women and men overlap, and social conditions such as exposure to violence, poverty and social support contribute to them. Much of the evidence on biological mechanisms comes from animal research and describes likely mechanisms rather than settled findings in people.

Women develop post-traumatic stress disorder (PTSD) at about twice the rate of men.

Lifetime prevalence is about 10–12% in women and 5–6% in men, and women have a two to three times higher risk [33]. A review of 290 studies found that women were more likely to meet the criteria for PTSD even though they were less likely to experience potentially traumatic events, and that differences in exposure only partly account for the gap [34].

The female stress-response system appears more reactive.

Reviews describe sex differences in the hypothalamic–pituitary–adrenal (HPA) axis, the body's central stress-response system, that increase endocrine, emotional and arousal responses to stress in females [35,33]. These findings come largely from animal studies.

Women in prison carry a higher burden of trauma-related illness.

Across 56 samples of 21,099 people in prison in 20 countries, PTSD affected 21.1% of women and 6.2% of men [36]. Depression is also about twice as common in women: across more than 3.5 million people in over 90 countries, the odds of a major depression diagnosis were 1.95 times higher for women [37].

Trauma is linked to chronic physical illness.

Adults with four or more categories of childhood adversity had 2.2 times the odds of ischemic heart disease and 3.9 times the odds of chronic bronchitis or emphysema [38]. Chronic stress places a cumulative physiological burden on the body, described as allostatic load [39]. People with stress-related disorders, including PTSD, have a higher risk of later autoimmune disease [40]. Autoimmune disorders affect 13.1% of women and 7.4% of men [41], and a clear majority of people with chronic pain are women [42].

Relationships and community protect health.

Social support is the most consistent predictor of a good outcome after trauma [33]. Research on women's responses to stress describes a pattern of tending and befriending, in which women under stress seek out, protect and rely on relationships, alongside the fight-or-flight response [43]. Research on gender-responsive practice with criminalized women makes healthy connections to children, family, significant

others and community a guiding principle for women's programs [44]. For women in federal custody, separation from family and community therefore affects health as well as wellbeing.

Hormonal transitions add periods of risk.

Women were two to four times more likely to experience a major depressive episode during and after the menopausal transition than before it [45]. This bears directly on the growing number of older women in federal custody [4].

> *For women and gender-diverse people in federal prisons, this evidence points to practical needs: trauma therapy, adequate nutrition and supplements, care and education that address reproductive and menopausal health, and sustained connection to family and community.*

3 Health and reintegration

Health shapes every step toward release. Release decisions depend on progress in correctional programs, stable behaviour and a credible release plan, and each of these depends on health and general wellness. A person in untreated pain or withdrawal, or living with untreated trauma, is less able to attend programs and to show the stability the Parole Board of Canada looks for. CAEFS has told CSC that access to trauma-informed health care is essential "to support meaningful engagement in correctional plans and successful reintegration" [7].

Leaving custody

Release is the point at which health care is most often interrupted. CSC's health services directive requires discharge planning only for people with "complex health needs" or major mental disorders [26]. The OCI reported in 2025 that many people leaving federal custody "lose access to care abruptly upon release," and named disruption of medication, lack of identification and unstable housing as barriers [46]. Women often leave federal custody without a family physician, without a copy of their health records and without an appointment with any community provider. No study has measured death or illness after release from federal prisons; research on people leaving provincial custody in Ontario, who complete much shorter sentences, found the highest risk of death in the first two weeks after release [47].

Family contact after release

The release process also adds significant trauma, and often emotional suffering is increased post-release, as women learn they will not be able to easily reunite with their families in the community. Women work for years to meet the expectations of their correctional plans and earn release, told that family and community

networks are essential in programming, and many then find that the conditions of their release and the travel permit process keep them from their families. Travel to see family outside the area of supervision currently requires a permit, and permits can be refused, delayed or cancelled. This process treats family contact as an unstable privilege, and it keeps women in pain in the community: separated from children, parents, partners and the people most likely to help them stay well.

Research with people on parole in Canada has documented how travel permit requirements restrict movement and family contact [48]. Because social support is the most consistent predictor of recovery after trauma [33], restrictions on family contact work against both health and reintegration. Where there is no risk related to family, family contact should be broadly supported.

Health also determines whether release lasts. The soft skills women need in the community, including cooking, budgeting and managing a household, are the same skills a federal sentence rarely teaches. When the conditions of incarceration force people in penitentiaries designated for women into environments of enforced poverty and nutritional and wellness deprivation, we are normalizing these experiences. People, upon release, don't understand the importance of an anti-inflammatory diet on women's health. People are ill equipped to understand their bodies, leading to and adding to chronic illness post release. The Bangkok Rules require additional support after release for women who need "psychological, medical, legal and practical help to ensure their successful social reintegration" [30]. Elizabeth Fry Societies work hard to provide much of this support in the community, often under-resourced in doing so without dedicated health funding. More can be learned about family and reintegration in the companion CAEFS document, *Family Contact and Reintegration*.

What Creating Choices established

Creating Choices, the 1990 report of the Task Force on Federally Sentenced Women that CAEFS co-chaired, set five principles for women's corrections in Canada: empowerment; meaningful and responsible choices; respect and dignity; a supportive environment; and shared responsibility [49]. The Task Force described a supportive environment as one that promotes physical and mental health, and it assigned responsibility for reintegration to every level of government, to corrections and to the community [49]. In the Task Force's interviews with federally sentenced women in the community, "the women's expressed needs for respect, for support and for the chance to take responsibility for their lives were paramount" [50]. The health conditions described in this briefing fall short of each of these principles.

> *"All levels of government, corrections, volunteer organizations, businesses, private sector services, and the community have a role to play in developing support systems and ensuring continuity of services for women to help them successfully reintegrate our communities."*

Creating Choices, principle of shared responsibility [49]

4 Recommendations in custody

CAEFS recommends that the Correctional Service of Canada, working with provincial health authorities, Indigenous communities and Elizabeth Fry Societies, take the following steps.

1 Increase the food per diem, and teach cooking and budgeting

Increase the daily food allowance in medium and minimum security so that it meets nutritional need and keeps pace with grocery prices, and restore it to at least the level provided in penitentiaries designated for men. Increase portions and protein in maximum-security meals. Provide cooking, nutrition and budgeting courses at the start of every sentence. Replace damaged cookware, including scratched non-stick pans, and renovate aging shared kitchens. Ensure every grocery list and menu meets Canada's Food Guide, as CSC policy already requires, and commission an independent nutrition review specific to penitentiaries designated for women [23,24,51].

2 Remove the barriers to health supplements

Provide vitamin D, calcium, iron, folic acid and multivitamins at no cost where clinically indicated, consistent with Health Canada's advice on vitamin and mineral supplementation [52]. Screen for iron and vitamin D deficiency at admission and at regular intervals, and stock supplements in canteen at cost.

3 Provide trauma therapy on request, not only in crisis

Offer every person individualized, trauma-informed therapy with a qualified clinician, as Bangkok Rule 12 requires, without requiring a crisis or self-injury first [30]. Include Elders and Indigenous healing practices, and allow continuity with community therapists. End the use of Structured Intervention Units and observation cells as a response to mental distress.

4 Provide reproductive and women's health education and care

Deliver regular education on menstrual, sexual and reproductive health, endometriosis, HPV, perimenopause and menopause, bone health and preventive care, as Bangkok Rule 17 requires [30]. Offer HPV vaccination and testing, and cervical and breast cancer screening on an equal basis with women in the community (Rule 18). Provide endometriosis and menopause assessment and treatment, and menstrual products free of charge (Rule 5).

5 **Protect people who are aging or seriously ill**

Install air conditioning in all living units in penitentiaries designated for women, consistent with the Federal Court's 2026 decision [18]. Provide pathways out of prison where people are aging or seriously ill, making full use of existing release mechanisms, including parole by exception under section 121 of the *Corrections and Conditional Release Act* for people who are terminally ill.

6 **Publish current health data**

Publish current data on the physical and mental health of federally sentenced women and gender-diverse people, including nutrition, supplements, menopause care, cancer screening and health after release from federal custody. The most recent CSC data on abuse histories date from 2010, and on physical health from 2014 [3,14]. No published data describe the health of gender-diverse people in federal custody.

5 Recommendations in community

CAEFS recommends that the Correctional Service of Canada, working with provincial health systems, Indigenous health services and Elizabeth Fry Societies, take the following steps to support health after release.

1 **Connect every person to a health clinic before release**

Make a confirmed connection to a community health clinic, community health centre or Indigenous health service near the release destination part of every release plan, not only for people with complex needs. Support Elizabeth Fry Societies to make and follow up these referrals.

2 **Support individuals to join physician waiting lists before release**

Allow women to register with provincial and local waiting lists for a family physician or nurse practitioner before release, using their release destination, so that the waiting period runs while they are still in custody.

3 **Give every person their health file before release**

Establish a routine process to give every person a copy of their CSC health record before release, including diagnoses, prescriptions, test results, immunizations and screening history, so that community providers can continue the individual's care without delay.

4

Secure coverage, identification and medication

Ensure every person leaves with a provincial health card and identification, a supply of medication that lasts until their first community appointment, continuity of opioid agonist therapy and naloxone, as the Bangkok Rules require in calling for additional medical support after release [30,46].

5

Support family contact as an essential part of women's health

Where there is no criminogenic risk related to family, do not restrict access, and support contact with family broadly and reliably, including standing permission for regular family visits, and treat family contact as a support for health and reintegration in release decisions and conditions.

6

Fund health navigation in the community

Fund Elizabeth Fry Societies to provide health navigation in the first weeks after release, when women are establishing care, coverage and housing at the same time.

Sources

1. Correctional Service of Canada. Statistics and research on women offenders. 2025. https://www.canada.ca/en/correctional-service/programs/offenders/women/statistics-research-women-offenders.html
2. Brown G, Barker J, McMillan K, et al. National prevalence of mental disorders among federally sentenced women offenders: In custody sample. CSC Research Report R-406, 2018. https://www.canada.ca/en/correctional-service/corporate/library/research/glance/406.html
3. Barrett MR, Allenby K, Taylor K. Twenty years later: Revisiting the Task Force on Federally Sentenced Women. CSC Research Report R-222, 2010 (summary R-222b, 2011). https://www.canada.ca/en/correctional-service/corporate/library/research/glance/222b.html
4. Office of the Correctional Investigator and Canadian Human Rights Commission. Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody. 2019. https://oci-bec.gc.ca/sites/default/files/2024-03/oth-aut20190228-corrected_eng.pdf
5. Iftene A. Life and death in Canadian penitentiaries. Canadian Family Physician. 2020;66(10):759. See also Iftene A. Punished for Aging: Vulnerability, Rights, and Access to Justice in Canadian Penitentiaries. University of Toronto Press, 2019. https://pmc.ncbi.nlm.nih.gov/articles/PMC7571640
6. CAEFS. Advocacy in prisons designated for women (food update, April 2025). https://caefs.ca/advocacy-in-prisons-designated-for-women/
7. CAEFS. Advocacy letter to Grand Valley Institution for Women, July 2026 visit (September 1, 2026). https://caefs.ca/wp-content/uploads/2026/09/GVI2026-July-advocacy-letter-.pdf
8. CAEFS. Fraser Valley Institution management letter, June 2026 (July 13, 2026). https://caefs.ca/wp-content/uploads/2026/07/CAEFS-FVI-Institutional-Management-Letter-June-2026.pdf
9. CAEFS, Canadian Civil Liberties Association, HIV Legal Network, Prisoners' Legal Services, et al. Letter re: October 1, 2025 CSC Health Services OAT policy changes. February 12, 2026. https://caefs.ca/wp-content/uploads/2026/04/CSC-Health-Services-OAT-Policy-Changes.pdf
10. Office of the Correctional Investigator. Annual Report 2023–2024. https://oci-bec.gc.ca/en/content/office-correctional-investigator-annual-report-2023-24
11. Derkzen D, Barker J, McMillan K, Stewart L. Rates of current mental disorders among women offenders in custody in CSC. CSC Emerging Research Results, 2017. https://www.canada.ca/en/correctional-service/corporate/library/research/emerging-results/16-03.html
12. CAEFS. Advocacy letter to Edmonton Institution for Women, July 2025 visit (August 18, 2025). https://caefs.ca/wp-content/uploads/2025/09/2025_08_18_July-2025-Advocacy-Letter-EIFW.pdf
13. CAEFS. 2024/2025 Regional Advocacy Report. 2026. https://caefs.ca/wp-content/uploads/2026/01/CAEFS-Regional-Advocacy-1.pdf
14. Nolan A, Stewart L. Self-reported physical health status of incoming federally-sentenced women offenders. CSC Research Report R-332, 2014. https://www.canada.ca/en/correctional-service/corporate/library/research/report/332.html
15. Michel S, Gobeil R, McConnell A. Older incarcerated women offenders: Social support and health needs. CSC Research Report R-275, 2012. https://www.canada.ca/en/correctional-service/corporate/library/research/report/275.html
16. Greiner L, Allenby K. A descriptive profile of older women offenders. CSC Research Report R-229, 2010. https://www.canada.ca/en/correctional-service/corporate/library/research/report/229-full-report.html
17. Correctional Service of Canada. Annual Report on Deaths in Custody 2017/2018 to 2019/2020. Special Report SR-23-01, 2024. https://www.canada.ca/en/correctional-service/corporate/library/research/special-reports/23-01.html
18. Federal Court of Canada. 2026 FC 958 (heat conditions in the Secure Unit, Edmonton Institution for Women).
19. CAEFS. Advocacy letter to Nova Institution for Women, April 2026 (May 8, 2026). https://caefs.ca/wp-content/uploads/2026/05/CAEFS-ADVOCACY-LETTER-APRIL-2026.pdf

20. CAEFS. Regional Advocacy visit letter, Nova Institution for Women, March and April 2025 (May 5, 2025). https://caefs.ca/wp-content/uploads/2025/05/CAEFS-ADVOCACY-LETTER-MARCH-APRIL-2025.pdf

21. CAEFS. Advocacy letter to Grand Valley Institution, February 2025 (March 24, 2025). https://caefs.ca/wp-content/uploads/2025/03/2025_03_24_February-GVI-Advocacy-Letter.pdf

22. CAEFS. Advocacy letter to Grand Valley Institution, March 2025 (April 15, 2025). https://caefs.ca/wp-content/uploads/2025/04/2025-04-15-March-2025-Advocacy-Letter-GVI.pdf

23. Correctional Service of Canada. Commissioner's Directive 880: Food Services. https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/880.html

24. Correctional Service of Canada, Internal Audit Sector. Audit of Food Services. 2019. https://www.canada.ca/en/correctional-service/corporate/transparency/audits-evaluations/food-services.html

25. Johnson C, Labbé C, Lachance A, LeBlanc C. The menu served in Canadian penitentiaries: A nutritional analysis. Nutrients. 2022;14(16):3400. https://doi.org/10.3390/nu14163400

26. Correctional Service of Canada. Commissioner's Directive 800: Health Services. https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/800.html

27. CAEFS. Reproductive (In)Justice in Canadian Federal Prisons for Women (press release on report by Martha Paynter). February 8, 2021. https://caefs.ca/wp-content/uploads/2022/04/2021-02-08-RJ-PR-New-Report-Reproductive-InJustice-in-Canadian-Federal-Prisons-for-Women.pdf

28. World Health Organization. Endometriosis (fact sheet). https://www.who.int/news-room/fact-sheets/detail/endometriosis

29. World Health Organization. Cervical cancer (fact sheet). https://www.who.int/news-room/fact-sheets/detail/cervical-cancer

30. United Nations. Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules). General Assembly resolution 65/229, 2010. https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf

31. Correctional Service of Canada. Commissioner's Directive 890: Inmate-Owned Canteens. https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/890.html

32. CAEFS. Advocacy letter to Edmonton Institution for Women, August 2026 visit (October 8, 2026). https://caefs.ca/wp-content/uploads/2026/10/2026_10_08-August-Advocacy-Letter-EIFW.pdf

33. Olff M. Sex and gender differences in post-traumatic stress disorder: an update. European Journal of Psychotraumatology. 2017;8(sup4):1351204. https://doi.org/10.1080/20008198.2017.1351204

34. Tolin DF, Foa EB. Sex differences in trauma and posttraumatic stress disorder: a quantitative review of 25 years of research. Psychological Bulletin. 2006;132(6):959–992. https://doi.org/10.1037/0033-2909.132.6.959

35. Bangasser DA, Valentino RJ. Sex differences in stress-related psychiatric disorders: neurobiological perspectives. Frontiers in Neuroendocrinology. 2014;35(3):303–319. https://doi.org/10.1016/j.yfrne.2014.03.008

36. Baranyi G, Cassidy M, Fazel S, Priebe S, Mundt AP. Prevalence of posttraumatic stress disorder in prisoners. Epidemiologic Reviews. 2018;40(1):134–145. https://doi.org/10.1093/epirev/mxx015

37. Salk RH, Hyde JS, Abramson LY. Gender differences in depression in representative national samples: meta-analyses of diagnoses and symptoms. Psychological Bulletin. 2017;143(8):783–822. https://doi.org/10.1037/bul0000102

38. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998;14(4):245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

39. McEwen BS. Protective and damaging effects of stress mediators. New England Journal of Medicine. 1998;338(3):171–179. https://doi.org/10.1056/NEJM199801153380307

40. Song H, Fang F, Tomasson G, et al. Association of stress-related disorders with subsequent autoimmune disease. JAMA. 2018;319(23):2388–2400. https://doi.org/10.1001/jama.2018.7028

41. Conrad N, Misra S, Verbakel JY, et al. Incidence, prevalence, and co-occurrence of autoimmune disorders over time and by age, sex, and socioeconomic status: a population-based cohort study of 22 million individuals in the UK. The Lancet. 2023;401(10391):1878–1890. https://doi.org/10.1016/S0140-6736(23)00457-9

42. Mogil JS. Sex differences in pain and pain inhibition: multiple explanations of a controversial phenomenon. Nature Reviews Neuroscience. 2012;13(12):859–866. https://doi.org/10.1038/nrn3360

43. Taylor SE, Klein LC, Lewis BP, Gruenewald TL, Gurung RAR, Updegraff JA. Biobehavioral responses to stress in females: tend-and-befriend, not fight-or-flight. Psychological Review. 2000;107(3):411–429. https://doi.org/10.1037/0033-295X.107.3.411

44. Bloom B, Owen B, Covington S. Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders. National Institute of Corrections, 2003. https://ccj.asu.edu/sites/default/files/2024-08/NIC%20Gender%20Responsive%20Strategies.pdf

45. Bromberger JT, Kravitz HM, Chang YF, et al. Major depression during and after the menopausal transition: Study of Women's Health Across the Nation (SWAN). Psychological Medicine. 2011;41(9):1879–1888. https://doi.org/10.1017/S003329171100016X

46. Office of the Correctional Investigator. Correctional Investigator's 2024–25 Annual Report calls for significant reform in mental health. 2025. https://oci-bec.gc.ca/en/content/correctional-investigator-s-2024-25-annual-report-calls-significant-reform-mental-health

47. Kouyoumdjian FG, Kiefer L, Wobeser W, Gonzalez A, Hwang SW. Mortality over 12 years of follow-up in people admitted to provincial custody in Ontario: a retrospective cohort study. CMAJ Open. 2016;4(2):E153–E161. https://cmajopen.ca/content/4/2/E153

48. Kish N. Parole for Life. MA thesis, University of Victoria, 2024.

49. Correctional Service of Canada. Creating Choices: The report of the Task Force on Federally Sentenced Women (summary and principles). https://www.canada.ca/en/correctional-service/programs/offenders/women/creating-choices.html

50. Task Force on Federally Sentenced Women. Creating Choices: The Report of the Task Force on Federally Sentenced Women. 1990. Chapter V. https://www.canada.ca/en/correctional-service/programs/offenders/women/creating-choices/report.html

51. Office of the Correctional Investigator. Annual Report 2016–2017 (Prison Food). https://oci-bec.gc.ca/en/content/annual-report-office-correctional-investigator-2016-2017

52. Health Canada. Canada's food guide: Advice on vitamin and mineral supplementation. https://www.canada.ca/en/health-canada/services/food-guide/explore/dietary-guidelines/applying/advice-vitamin-mineral-supplementation.html

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