



# **WHO Conference on Women's health in Prison**

***Correcting gender inequities in prison health***

**Consultative document for discussion at the WHO International  
Conference on Prison Health - Kyiv, Ukraine 13 November 2008**



## ABSTRACT

The WHO Regional Office for Europe in 1995 launched the Health in Prisons Project (HIPP), supported by the WHO Collaborating Centre for Health and Prisons in the Department of Health, London. HIPP works within a network of countries committed to reducing the public health hazards associated with prisons and with protecting and promoting health in prisons. Representatives of some 36 Member States in Europe send representatives, from Ministries responsible for health in prisons and the Ministries of Health, to attend the annual conference and network meeting of HIPP. The network combines shared experience with expert advice to produce guidance for countries wishing to improve health care and circumstances in their prisons, and in particular to develop their role in preventing the spread of disease, and to maximize an important opportunity for promoting health in a marginalized group and contributing to general public health in their communities.

At the request of the Member States involved, the WHO Health in Prisons Project has together with partner organizations and experts, and with the support of the United Nations Office on Drugs and Crime (UNODC), the Quaker Council for European Affairs in Brussels, the Quaker United Nations Office in Geneva, the Sainsbury Centre for Mental Health (SCMH), the AIDS Foundation East-West (AFEW) and the European Monitoring Centre for Drugs and Drug Addiction reviewed all issues affecting women's health in the criminal justice system and has especially considered the gross inequities as regards to women's health in prisons. HIPP has adopted the following declaration and background paper as evidence fully justifying the recommendations and call for action in its conclusion.

### Keywords

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# Foreword

## *Focusing on women's health in prison*

Prison policies often overlook the special needs of women and their health. Frequently, women in prison suffer high levels of mental illness and drug or alcohol dependency, as well as sexual and physical abuse and violence. Issues arising from gender-specific health care needs and family responsibilities are also frequently neglected. Although women represent a small percentage of the total prison population their numbers are increasing, and the rate of increase is much greater than that of men.

The rise and rapid spread of HIV infection and AIDS, the resurgence of other serious communicable diseases such as tuberculosis and hepatitis and the increasing recognition that prisons are inappropriate receptacles for people with dependence and mental health problems, have thrust prison health high on the public health agenda. As we have stressed before, any national health strategy must include prison policies that address these serious health problems.

Health is a fundamental human right, especially for individuals held in the custody of the state. Although women should be entitled to the same rights as men, prison systems were primarily designed for men and many prisons do not have adequate facilities to protect women's rights or to promote their health. Compounding the difficulty of addressing this problem is the lack of data and research about women's health status while in prison. Health systems must include penitentiary health policies that integrate women's health needs in all phases of planning and implementation.

Since 1995 the WHO Regional Office for Europe has been committed to reducing the public health hazards associated with prisons and protecting and promoting health in prisons. Regional Office reports such as the *2007 Health in prisons, a WHO guide to the essentials in prison health* have combined the latest research and analysis from experts in the field and have raised the profile of the prison health issues. Building on the World Health Assembly Gender Policy, we have supported research to develop evidence-based guidance on the major aspects of women's health in connection with prisons and the criminal justice system as a whole.

The principles and recommendations of the Kyiv Declaration are an important step towards improving our health systems and addressing the health needs of women involved in the criminal justice system. I hope that this report and our discussions at the conference will convince all Member States to adopt and implement the Kyiv Declaration in fulfillment of their commitment to human rights and health promotion for all.

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# The Kyiv Declaration on Women's Health in Prison

1. We, the government recognized representatives of Ministries concerned with health in prisons, the WHO Collaborating Centre in the Department of Health, London, representatives of the United Nations Office on Drugs and Crime, the Quaker Council for European Affairs in Brussels, the Quaker United Nations Office in Geneva, the Sainsbury Centre for Mental Health, the AIDS Foundation East-West, the European Monitoring Centre for Drugs and Drug Addiction and other international organizations with expert knowledge of health in prisons throughout Europe and in the USA, **note with concern** that current arrangements in criminal justice systems for dealing with women offenders are often failing to meet their basic and health needs and are therefore far short of what is required by human rights, by accepted international recommendations and by social justice.
  
2. **We have been made aware** that the facts concerning women in prison are complex and challenging, and can make addressing their health needs very difficult:
  - While women constitute a very small proportion of the general prison population (the median level in Europe is 4.9%, with high variations between countries) the recent rate of increase in the number of women in prison is greater than that for men. In Europe, there are about 100.000 women in prison every day.
  - The majority of offences for which women are imprisoned are non-violent, property or drug-related and many women serve a short sentence, which means that the turnover rate is high.
  - The overall security requirements in prisons are usually designed for the male prison population, and has been found discriminating against women in prison, who are mostly imprisoned for non-violent offences and do not need a high security level.
  - The number of women held in pre-trial detention in many countries is equivalent to or even larger than the number of convicted female prisoners. Pre-trial detainees may have limited contact with other prisoners, fewer opportunities for medical treatment and vocational or job programmes, and restrictions on family contact, including visits, which impacts disproportionately on women with children as well as on the children themselves.
  - The prevalence of mental health problems is high among women in prison and is infrequently addressed adequately. High rates of post traumatic stress disorder (PTSD) and substance use disorder affect the majority of female prisoners. Women in prison are more likely to self-harm and commit suicide than male prisoners.
  - A large proportion of women in prison have experienced a lifetime of victimization including child abuse, neglect and domestic violence. There is a close link to the woman's criminogenic pathway and her mental and physical illness.

- Since foreign national women, girls and older women in prison are a minority group within a minority of the prison population, their needs are easily overlooked.
- Due the small numbers of women in prison, countries generally only have a few number of prison facilities for women. Women are therefore often placed far from home, which puts a further strain on family ties.
- Many women in prison are mothers and usually the primary or sole carer for their children. It is estimated that in Europe around 10.000 babies and children under two are affected by their mother's imprisonment. When considering all children aged under 18 years old, the number affected by their mother's imprisonment is much higher, counting into hundreds of thousands.
- When women give birth or have care of a baby while in prison, it is important to have a regime which allows the mother to nurture and bond with her child. The age until which children can stay with their mothers in prison varies widely across Europe. Three years is the most common age limit.
- The prevalence of HIV and other sexually transmitted infections among women prisoners is often higher than among male prisoners.

3. **We accept** that the evidence clearly shows unacceptable gaps and deficiencies in many parts of Europe:

- The prison environment does not always take into account the specific needs of women. This includes the need for adequate nutrition, health and exercise for pregnant women and greater hygiene requirements due to menstruation such as the availability of regular showers and sanitary items which are free of charge and may be disposed of property.
- Mental illnesses including drug problems, and traumatization are infrequently addressed. There are shortcoming in recognized standards of evidence based treatment such as substitution therapy, psychotherapy, counseling, training, peer support and harm reduction measures.
- The safety and privacy of women in prison can be undermined by the use of male officers in certain positions or roles, which may lead to inappropriately powerful relationships over the women in prison under their charge. Examples of this include allowing male officers to perform intimate tasks (e.g. pat searching) or allowing them access to washing areas.
- There are often deficiencies in the provision of training provided to prison staff. Gender-sensitivity training and training on specific health needs of women in prison should be widely available in all systems.

- There is a challenge in many prison systems to balance respect and dignity of the woman in prison with the surveillance and security in the prison, while providing care and treatment.
- It is not uncommon for women in prison to discover at the same time that they are pregnant and also HIV infected. The psychological burden of being in prison, having a new pregnancy and discovering HIV infection can be devastating for the woman and this is seldom adequately addressed in custodial environments.
- The provision of an effective system of prison inspection and oversight done by an independent body and with a confidential complaint system is essential in preventing violence and abuse within the prison. Such systems are often lacking.
- Prison policies and programmes are seldom specifically tailored to the needs of women, especially in the vital area of pre-release programmes and resettlement.
- Pre-release interventions, including interventions specifically aimed to reduce the acute risk of drug-related death among women prisoners in the first weeks after their release, are very important, but do often not take place.
- Continuity of care (through care) upon release is of utmost importance and should be the responsibility of prison staff, health care staff and social care authorities in the community together, but this continuity of care is often not guaranteed.

4. **We fully support this Kyiv Declaration and undertake through our various channels to draw the attention of governments and policy makers to the key recommendations which follow.**

**Member States at government and policy-making level** should urgently review their current policies and services for meeting basic and health (care) needs of women in all stages of the criminal justice systems and where necessary introduce changes to meet the following:

4.1 **The underlying importance of human rights** should underpin all thinking and all policy development for all those in compulsory detention.

4.2 The **important principles** which should be followed in deciding what should be done to improve current practice should include:

- **Imprisonment of women should be considered only as a last resort**, when all other alternatives are found to be unavailable or are unsuitable.
- Health service provision and programming should specifically address mental illness, in particular substance use disorders and post traumatic stress disorder. This is essential to any prison health care system.

- If children are involved, **the needs of the children must be the main and determining factor** in decisions regarding women's imprisonment, including putting the needs of the child first when considering whether and for how long the child should stay with their mother in prison.
- All policies affecting women in the criminal; justice system must **recognize the significant variations in need** which can exist between different groups of women.
- Health service provision for women's needs in prison must be individualized, framed and delivered in a **holistic and humane manner**.

#### 4.3 Key services to be provided should include:

- A **comprehensive and detailed screening** when first admitted to prison and regularly throughout their stay; this should cover socio-economic and educational background, health and trauma histories, current health status and an assessment of skills held or required
- An **individualized care, treatment and development** plan, to be prepared by joint effort between different health care providers and all other staff likely to be involved in a woman's care and custody in consultation with the women themselves.
- A **primary health care** service provided in the prison, which is outlined to the woman during the important induction period; her rights to access including emergency access, to confidentiality, to privacy and to health information and promotion activities should be made clear, preferably by means of an easily understandable written pamphlet.
- **Specialist health care** which is readily provided and adjusted so as to meet the needs of women such as for mental health including help with a legacy of abuse and post traumatic stress disorder; chronic health conditions, HIV/AIDS including counseling and support, hepatitis, tuberculosis and other infectious diseases; drugs and alcohol dependencies; learning disabilities; and reproductive health. Access to specialist health care is explained to the woman in prison when discussing her individual care plan.
- **Pre-release preparations which are adequately planned and help provided in order to ensure continuity of care and access to health and other services after release.** Health and social care cannot be provided in isolation from community services; just as health and nursing staff must maintain professional contacts with their peer groups, so must all service within prisons have good links to the equivalent services in the community.

4.4 The above services and approaches are likely to succeed only if the **role of governments, policy makers and senior management** is understood, accepted and applied. In broad terms, this requires:

- That the criminal justice system is seen to be serving the interests of women in their care, so that gender-specific health and other needs are readily met and easily accessed;

- That every prison which is required to house women prisoners must have a written policy showing that the practices in that prison are sensitive to the special needs of women and that the staff have undergone gender sensitivity training;
  - That where and whenever children are involved, their needs and best interests are clearly seen as the first and main consideration in what is provided for them.
5. **We have agreed** to collaborate with the WHO Health in Prisons Project and its partners so that **over the next three years** guidance on the implementation of this Declaration will be produced from the experiences gained from the initiatives and good practices already under way in different parts of the Region and made available to all countries of Europe. We will consider how we can assist all countries in monitoring progress towards better, fairer and more gender sensitive services, made available for women in all parts of the criminal justice system.

# Introduction

## ***Need for a Declaration on women's health in prison***

*'As prison sentences have been designed for men and by men, women are always an exception. It is a challenge to find special solutions to meet the needs of imprisoned women'*<sup>1</sup>

Women constitute a special group within prisons, due to their gender. Although their characteristics and corresponding needs can vary considerably between different countries, a number of factors are common to most. These include a high level of mental illnesses, a high level of drug or alcohol dependency, the experience by many women of sexual and physical abuse and violence before or in prison, the neglect of gender-specific health care needs and additional issues related to the women's responsibility for children and families. Many women in prison have young children, for whom they were often the primary or sole carer before they entered prison.

Women's rights while in prison are the same as men's rights, but women seldom have equal access to these rights. As prison systems have been primarily designed for men, who make up over 95% of most national prison populations, women's health needs are often not addressed by prison policies and procedures. Data on the health of women in prison and the health care provided for them are rare, because most prison data are not gender specific.

The health status of prisoners is generally much poorer than that of the general population and women's health needs can be seriously neglected in a male-dominated prison system. Many women in prison have a background of physical and sexual abuse and of alcohol and drug dependency. It is common for them not to have received adequate health care prior to their incarceration. Women in prison *generally* have a higher level of mental health problems than women in the general population. This frequently stems from prior victimization. Mental illness is often both a cause and a consequence of imprisonment and the rates of self harm and suicide are noticeably higher among female than among male prisoners. Both rates are higher than in the outside community.

It is often *ignored* that imprisoning women has greater social cost to family and community than is the case with most men prisoners. Family breakdown, long term problems in children taken into care, and a loss of community spirit and cohesion, can push the social costs of women's imprisonment to considerably higher level than for men's imprisonment.

This paper is a background paper for the WHO Declaration on Women's Health in Prison, which will be discussed during the Annual Conference 2008 of the WHO Health in Prisons Project.

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<sup>1</sup> Sonja Kurten-Vartio, 2007: *Women in Prison. Social, Economical and Cultural Rights of Female Prisoners. European Parliament, Hearings 2007.*  
[http://www.europarl.europa.eu/hearings/20070626/femm/kurten\\_vartio\\_en.pdf](http://www.europarl.europa.eu/hearings/20070626/femm/kurten_vartio_en.pdf)

The paper reflects the evidence from literature research and the best evidence given by the expert group and other key contributors on Women's Health in Prison, whose members are listed at the end of the paper under acknowledgements.

## ***Objectives of a WHO Declaration***

The objectives of a Declaration on Women's Health in Prison are:

1. To raise awareness among the countries within the WHO European Region of the current situation regarding the health of and health care provided for women in European prisons;
2. To call for marked improvements in the current situation by the implementation of WHO recommendations for:
  - a general approach that creates a more acceptable and gender sensitive criminal justice system, with special attention to the rights of any women and children involved;
  - the amount and quality of health care to be provided within prisons, which should be at least broadly equivalent to the health care provided in the community; and
  - the establishment of satisfactory methods for ensuring continuity of care.

## ***Definitions***

Regarding this paper, the following definitions apply:

**Europe:** The European Region of the World Health Organization.

**Foreign national prisoner:** A person who is neither a legal citizen nor a permanent resident of the country where he or she is being held in prison.

**Girl:** A female person under the age of 18.

**Older woman:** A female person of the age of 50 or older.

**Prison:** A place of compulsory detention where persons are confined while on remand awaiting trial, on trial or for punishment, *following conviction for a criminal offence* because they have been convicted of a crime (not including police cells).

**Prisoner:** A person held in prison, awaiting trial or serving a prison sentence.

**Woman in prison:** A female person of at least 18 years old, held in prison, awaiting trial or serving a prison sentence.

**Women's health:** a state of 'complete mental, physical, spiritual and social well-being' for all female infants, girls and women regardless of age, socio-economic class, race, ethnicity and geographic location.

## Women, prison and society

*The following section contains some of the best scientific evidence and recommendations by international health agencies, scholars and other experts on the health of women in prison.*

### **Facts and figures**

1. Over half a million women and girls are held in prisons throughout the world, either as remand or sentenced prisoners. In Europe, there are about 100.000 women and girls in prison (UNODC, 2007). Women constitute a very small proportion of the general prison population worldwide, usually between 2 and 9 percent of a country's prison population. Only 12 prison systems worldwide report a higher percentage than that. The median level in Europe is 4.4%. In Europe, the highest percentage of women in prison is found in Spain (almost 8%) and the lowest in Azerbaijan (under 1.5%) (Walmsley, 2006)<sup>2</sup>.
2. Although women are a minority in national prison populations all over the world, the female prison population is nevertheless increasing. This increase in women's imprisonment is part of a global trend towards the increasing popularity and use of imprisonment and a corresponding under-use of constructive alternative, non-custodial sanctions. This is particularly the case in relation to drug offences and non-violent theft (Penal Reform International, 2007). Most female drug offenders could be dealt with more effectively by alternatives to imprisonment targeted specifically at the drug problem, rather than through imprisonment (UNODC, 2007).  
Furthermore, the *rate* of increase in the number of women in prison is much greater than that for men (Bastick, 2005). For instance in England and Wales, the number of women in prison has increased by over 200% in the past 10 years, compared with a 50% increase in the number of men prisoners during the same period (Prison Reform Trust, 2006).  
Some of the increase is the result of global displacement of women due to war, social unrest, economic crises and gender-insensitive criminal justice systems.
3. Many women in prison serve a short sentence, which means that the turnover rate is high. The majority of offences for which women are imprisoned are non-violent, property or drug-related (QCEA, 2007). Worldwide, women are more often imprisoned for drug offences than for any other crime (Taylor, 2004). Women, often from poor countries, are frequently used by drug couriers to smuggle drugs across borders for a small amount of money (UNODC, 2007).
4. In many countries the number of women held in pre-trial detention is equivalent to or even larger than the number of convicted female prisoners (UNODC, 2007). Pre-trial detainees may have limited contact with other prisoners, fewer opportunities for medical treatment and vocational or job programmes, and restrictions on family contact, including visits, which impacts disproportionately on women with children as well as on the children (Penal Reform International, 2007).

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<sup>2</sup> See also: Prison Health Database (WHO Health in Prisons Project): <http://data.euro.who.int/HIP/>

5. Women in prison frequently come from deprived backgrounds, have often experienced physical and sexual abuse, alcohol and drug dependency, and inadequate health care prior to their imprisonment. (Penal Reform International, 2007). Furthermore, women entering prison are more likely than men to suffer from mental ill-health, often associated with domestic violence, physical and sexual abuse (UNODC, 2007).
6. Because of the small numbers of women prisons, women convicted of a wide range of offences are often housed together. The overall regime is then determined by maximum security requirements of a very few high risk women prisoners. Overall security requirements are designed for the male prison population and as such discriminate against women in prison, who are mostly imprisoned for non-violent offences and do not need a high security level (Penal Reform International, 2007).

### ***Human rights standards and international conventions***

*‘The concept of equality means much more than treating all persons in the same way. Equal treatment of persons in unequal situations will operate to perpetuate rather than eradicate injustice’<sup>3</sup>*

7. Women who are imprisoned are still covered by human rights legislation. As stated in the *Universal Declaration of Human Rights*<sup>4</sup>, the State may only limit the exercise of a person’s rights and freedoms - including the rights and freedoms of a person who is a prisoner - “for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society”.
8. The main UN standard relating to the human rights of women, providing the basis for realizing equality between women and men, is the *Convention on the Elimination of All Forms of Discrimination against Women*<sup>5</sup>. In article 2, the States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:
  - (a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;
  - (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;

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<sup>3</sup> Office of the UN High Commissioner for Human Rights, Fact Sheet No. 22, Discrimination against Women: The Convention and the Committee, Geneva, undated.

<sup>4</sup> Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948.

<sup>5</sup> On 18 December 1979, the Convention on the Elimination of All Forms of Discrimination against Women was adopted by the United Nations General Assembly.

- (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
  - (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
  - (e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;
  - (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;
  - (g) To repeal all national penal provisions which constitute discrimination against women.
9. The main international standards relating to the protection of the human rights of prisoners and to ensure that prisoners' treatment aims to facilitate their social reintegration are (without being exclusive):
- The UN Standard Minimum Rules for the Treatment of Prisoners<sup>6</sup>
  - The Basic Principles for the Treatment of Prisoners<sup>7</sup>
  - The 2006 European Prison Rules<sup>8</sup>
  - The 2008 European Parliament resolution on the particular situation of women in prison and the impact of the imprisonment of parents on social and family life<sup>9</sup>
  - The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment<sup>10</sup>
  - The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment – The CPT Standards<sup>11</sup>.

These standards constitute the fundamental principles, which are valid in all systems and prisons worldwide and apply to all prisoners, without discrimination.

The standards agree that there shall be '*no discrimination on grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status*'.

The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment states in its Principle 5 (2):

*'Measures applied under the law and designed solely to protect the rights and special status of women, especially pregnant women and nursing mothers, children and juveniles, aged, sick or handicapped persons shall not be deemed to be discriminatory. The need for, and the*

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<sup>6</sup> Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

<sup>7</sup> Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990.

<sup>8</sup> On 11 January 2006 the Committee of Ministers of the Council of Europe adopted this new version of the European Prison Rules.

<sup>9</sup> Adopted by the European Parliament on 13 March 2008, Strasbourg.

<sup>10</sup> Adopted by General Assembly resolution 43/173 of 9 December 1988.

<sup>11</sup> By European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Council of Europe, Strasbourg, CPT/inf/E (2002) 1 – Rev. 2004

*application of, such measures shall always be subject to review by a judicial or other authority'*

This makes clear that special measures to address the particular needs of women in prison are not discriminatory in themselves.

## ***Women in prison and society***

### **Relationships**

10. When women enter prison, they are dislocated from their families and their social support network. One of the challenges for people when they return to the community after release from prison is to get those relationships operating again. Facilitating visits is a very important part of that (Penal Reform International, 2007).
11. Because of the small numbers of women in prison, there are fewer prisons for women. Consequently, women are often imprisoned far away from their homes and families, causing serious problems in the attempt to preserve strong family ties (Quaker, 2007). The distance and costs involved in visiting women imprisoned far from home pose a major obstacle in having regular visits (UNODC, 2007). Their imprisonment far away from home has also serious difficulties for the women's resettlement after release.

### **Girls in prison**

12. Since girls in the juvenile justice system may be easily overlooked because they represent only a small group, special attention must be devoted to the particular needs of the girl.
13. The number of girls in the juvenile justice system has increased dramatically over the last years. In the USA for instance, girls currently make up approximately 25% of the total population in juvenile justice facilities (Kelly, 2007). However, the number of girls in prison within the total women prison population is low (Quaker, 2007).
14. Girls, because of their small numbers, are sometimes accommodated in the same sections as adult women in prison. International standards state that girls and adult women in prison should be imprisoned separately. However, if this would lead to fewer opportunities for education than if they are imprisoned together, safeguards should be put in place so that girls do not mix with women with serious long-term criminal histories. It is important to realize that girls in prison might have the same problems and often have the same backgrounds as adult women in prison. For instance, at least some of the girls in prison are mothers and maybe the primary or sole carers of their children.
15. Little is known about the health needs of imprisoned girls, but there is emerging concern regarding substance misuse, mental health problems, poor sexual health and poorer general physical health on a range of indicators (Douglas, 2008). For instance, girls are increasingly at risk of HIV infection and they also may be mothers.

## Older women in prison

16. Older women in prison (over the age of 50) represent only a small proportion of the overall female prison population. However, their imprisonment brings along particular issues, such as the possibility of compassionate release, retirement and special (health) requirements.
17. As a minority within a minority, the special needs of older women in prison are rarely considered separately. However, older prisoners may be in need for greater and often more specific health care compared to younger prisoners. For some older women, the effects of the menopause may particularly impact on their health care needs and they may have different hygiene needs as well (QCEA, 2007). Also, they might be in need of special requirements regarding physical problems and limitations.

## Foreign national women in prison

18. Foreigners are vastly overrepresented in the criminal justice system of most countries in Europe. A large proportion of foreign national women have been convicted of drug offences (UNODC, 2007). On average, more than 30% of the women in prison who are foreign nationals are imprisoned for drug offences (QCEA, 2007). Another common reason for imprisonment of foreign national women is because of their illegal status in the country. It is important to realize that foreign national women may have dependent children in the country of arrest or in the home country and their parental status should always be taken into account by police, prosecutors and courts (UNODC, 2007).

## Children of women in prison

19. Concern about women in prison must be broadened to include the children of women in prison. The General Assembly's 2003 resolution on Human rights in the administration of justice invited '*governments, relevant international and regional bodies, national human rights institutions and non-governmental organizations to devote increased attention to the issue of women in prison, including the children of women in prison, with a view to identifying the key problems and ways in which they can be addressed...*'<sup>12</sup>
20. The majority of women in prison are mothers and usually the primary or sole carer for their children. Research from many countries has shown that when fathers are imprisoned, generally the mother continues to care for the children. However, when a mother is imprisoned, the family will often break up, resulting in large numbers of children being institutionalized (UNODC, 2007). For instance in the United Kingdom, for every mother being imprisoned, in 80% of the cases the father does not look after the child<sup>13</sup>. Family break up can also occur if women are held in remand awaiting trial and if sentences are for short periods of time.  
It has been estimated by the Howard League for Penal Reform, a non-governmental organization in the United Kingdom, that in Europe there are some 10.000 babies and children aged under two affected by their mother's imprisonment<sup>14</sup>. When considering all

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<sup>12</sup> A/RES/58/183, adopted 22 December 2003, para. 15.

<sup>13</sup> Statistic given by Ms Anne Owers in Salter lecture at Britain Yearly Meeting, 23 May 2008.

<sup>14</sup> In: Council of Europe, Parliamentary Assembly Recommendation 1469 (2000), adopted on 30 June 2000.

children aged under 18 years old, the number affected is much higher, counting into hundreds of thousands.

21. In many countries, babies born to women in prison stay in prison with their mother and very young children may accompany their mothers into prison. Facilities vary widely between and within countries. Some countries have 'Mother and Baby Units', with special facilities to support the mother and the child's development. In others, babies live in the prisons without their presence being officially noted or monitored by the State, and without any special provision being made for them. In prison, facilities to ensure the safety, health and development of a child are often lacking or inadequate. On the other hand, studies have shown that young children who are forcibly separated from their mothers suffer long-term developmental and emotional damage.

On separation of mothers and their children, mothers may not see their children again or may lose track of them. Sometimes this is due to the costs involved in arranging their visits to the prison. Other times it is due to the rejection of the mother by the relatives taking care of the children or because the mother has lost the custody of the child (UNODC, 2007). These psychological and developmental problems tend to stay with children throughout their whole lives.

Both allowing babies to live in prison and separating babies from their mothers are full of difficult problems and dilemmas. In all decisions made concerning a child of a woman in prison, the best interests of the child must be the primary consideration (Bastick, 2005).

Their preferences should always be considered and prison policies should promote and facilitate the participation of children in the decision-making, taking due consideration of their age (Alejos, 2005).

The South African Constitutional Court ruled in 2007 that that '[a] child's best interests are of paramount importance in every matter concerning the child', applies when sentencing a child's primary caregiver. Furthermore, it issued guidelines to 'promote uniformity of principle, consistency of treatment and individualization of outcome':

22. The age until which children can stay in prison with their mothers varies considerably across Europe. Three years is the most common age limit for children to stay with their mother in a prison, with Hungary and The Netherlands having the lowest age limit at six months in prisons and Turkey the highest at six years in prisons. Norway is the only European country that totally prohibits children from staying with their mother in prison (Quaker, 2007). There could be a relationship between the category of prison and the average length of sentence on the policy regarding children staying with their mothers in prison. For instance, the age until which children can stay with their mothers in an open prison is often higher, and the surroundings and facilities can be more suitable for children.
23. Contact between mothers inside prison and their children outside prison may be severely and/or inappropriately restricted. In some countries temporary separation (e.g. by stopping visits) from their children is used as a punishment on the mother (Robertson, 2008). Children are a life-sustaining force for many prisoners and breaking up the bond between the mother and child is often punishment of the worst kind for the mother (UNODC, 2007) and has a

considerable impact on her physical and mental health. At the same time it punishes the child who has done nothing wrong.

24. Being imprisoned far away from their homes is a particular hardship for women with children. Research has shown that if the ties with children are maintained, the chances of a women prisoner's re-offending upon release are lowered (QCEA, 2007).
25. Children of prisoners have committed no crime and therefore should not suffer as though they had. Those children who live in prison should lead lives at least as good as the ones they would have lived outside prison. Facilities should always include good nutrition, decent playing areas and where appropriate kindergarten facilities. The best interests of the children should at all times be the primary consideration (Robertson, 2008). Arrangements for children residing in prisons to leave the prisons at any time should be made if it is considered to be in the best interests of the child (Alejos, 2005).
26. Children outside prison who have a parent imprisoned may experience a range of psychosocial problems during the imprisonment of a parent, including: depression, hyperactivity, aggressive behavior, withdrawal, regression, clinging behavior, sleep problems, eating problems, running away, truancy, poor school grades and delinquency. Furthermore, parental separation can be experienced as desertion or abandonment, which can worsen the distress for the children (QCEA, 2007).

# Women's Health and Prison

## *Need for gender-specific health care*

27. Women in prison often have more health problems than male prisoners. As indicated before, many suffer from chronic and complex health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition and poor health care (WHO/Europe (a), 2007; Canadian HIV/AIDS Legal Network, 2006). Drug-dependent women offenders have a higher prevalence than male offenders of tuberculosis, hepatitis, toxemia, anemia, hypertension, diabetes and obesity (Covington, 2007). Mental illness is overrepresented among women in prison as 80% have an identifiable mental illness. Two-thirds suffer from post traumatic stress disorder (Zlotnick, 1997) and two-thirds suffer from a substance-related disorder<sup>15</sup>. The frequency of co-morbidity is substantial. Mental illness is often correlated with prior victimization (Zlotnick, 1997). Women's prisons require a gender-specific framework for health care which pays special attention for reproductive health, mental illness, substance use problems and physical and sexual abuse. Timely access to all services available for women outside prison, should be available for women inside prison. As with all prisoners, confidentiality of medical records should always be guaranteed.
28. Women in prison in Western Europe tend to place a greater demand on medical services than men. For instance in Italy, approximately twice as many women in prison are asking to see a doctor or nurse each day than men in prison (Zoia, 2005). In other Western European countries this rate might be even higher. Among the reasons for their higher demand on medical services are their higher needs for care related to a history of violence and abuse, drug use problems and reproductive needs.
29. It is important to deal with some of the specific needs of women in prison by taking advantage of the time they are in prison to provide education about preventing illness and maintaining good health, and in particular on HIV/AIDS and other sexually transmitted diseases. Besides, it is important that vocational and job training programmes are being offered.

As a result of the chaotic lifestyles of many of the women that enter prison, their time in prison may be the first time in their life, where they have access to health care, social support and counseling. Information, prevention and screening programmes for women in prison are therefore essential and particular attention should be given to the different groups of women and their specific needs (Zoia, 2005). An even better option would be to screen the women upon entry in prison and if appropriate, send them out to special programmes offered in the community.

30. Women's specific health care needs are often unmet in prison. The prison environment does not always take into account the specific needs of women, such as the accessibility to regular showers, the greater need for hygiene and hygiene products due to menstruation, the need to make sanitary napkins available free of charge and to dispose of them properly and adequate

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<sup>15</sup> In: fact sheet on prisons and mental health, retrieved from [http://www.euro.who.int/prisons/topics/20071010\\_1](http://www.euro.who.int/prisons/topics/20071010_1)

nutrition for pregnant women as well as for women who are infected with diseases like HIV/AIDS. Women's normal human functions, such as menstruation, reproduction and the need for exercise, are too often being medicalized. For example, access to sanitary napkins or exercise for healthy women does not need to be approved or managed by health care personnel.

### ***Organization of health care services for women in prison***

31. All prison officers working with women in prison should have attended a gender-sensitivity training and training on specific health needs of women in prison. The safety and privacy of women in prison should not be impaired by the use of male officers in certain positions or by allowing male officers to perform certain tasks (e.g. pat searching) (Weinstein, 2005). Concern for the safety and privacy of women also apply to transport arrangements between prisons and between prisons and hospitals.

In the criminal justice system as a whole, court staff, advocates and judges need to be educated about existing health care in prisons and the specific health needs of women, and be able to take this into account when sentencing and defending women in the trial process.

32. Women in prison need free access to a full range of medical and dental services, as outlined in the WHO guide to the essentials in prison health (WHO/Europe (a), 2007)

### ***HIV, Hepatitis C and other infectious diseases***

33. Women in prison often have marginalized and socially deprived backgrounds which are high-risk for HIV. Many of them may already be infected with HIV upon entry in prison (Reyes, 2000). Women are at greater risk than men of entering prison with sexually transmitted diseases like chlamydia, gonorrhea and syphilis and also with HIV/AIDS. This as a result of high risk behavior, including participation in prostitution and the likelihood of being a victim of sexual abuse (Covington, 2007).
34. Women are at a considerably greater risk of contracting HIV and Hepatitis C from sexual activity than men. Those women who engage in injecting drug use have a particularly high risk, through sharing syringes and needles. They might have had unprotected sex with their drug partners or have been engaged in sex for money. Women's cultural and societal conditions might be such that they are not in a position to control their own sexual lives (Reyes, 2000; Bastick, 2005; WHO/Europe (a), 2007)
35. Women in prison should always have access to condoms as well as dental dams, in the light of the possibility of sexual relationships within prisons. As a basic rule however, sexual relationships involving staff and prisoners should be prohibited.
36. Sexually transmitted infections other than HIV (such as chlamydia, gonorrhea and syphilis), quite common in women in prison and often undetected, are a major factor in the spread of HIV, as they enhance transmission as well as diminishing the general resistance in the patient (Reyes, 2000).

37. Prison systems should ensure that HIV-infected prisoners receive care, treatment and support equivalent to that available to people living with HIV in the community, including Anti Retroviral Therapy (WHO (b), 2007). Clean needles and syringes should be provided in order to prevent women from sharing them and so preventing the spread of HIV and other infectious diseases. There is evidence that HIV infections in prison are being reduced when needles and syringes are provided (WHO (d), 2007). Wherever needles and syringes are not allowed in prison, other harm reduction measures should be accessible. Harm reduction measures should also apply to tattooing and piercing practices.
38. The WHO guidelines on HIV infection and AIDS in prisons, first issued in 1993, contain the following recommendations specific to women in prison:
- a) Special attention should be given to the needs of women in prison. Staff dealing with detained women should be trained to deal with the psychosocial and medical problems associated with HIV infection in women;
  - b) Women in prison, including those who are HIV-infected, should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to child, or through sexual contact. Since women in prison may engage in sexual contacts during imprisonment or release on parole, they should be enabled to protect themselves from HIV infection, e.g. through the provision of condoms and skills in negotiating safer sex, Counseling on family planning should also be made available, if national legislation so provides. However, no pressure should be placed on women in prison to terminate their pregnancies. Women should be able to care for their young children while in prison regardless of their HIV status;
  - c) The following should be available in all prisons holding women:
    - gynecological consultations at regular intervals, with particular attention paid to the diagnosis and treatment of STDs
    - family planning counseling services oriented to women's needs
    - care during pregnancy in appropriate accommodation
    - care for children, including those born to HIV-infected mothers
    - condoms and other contraceptives during detention and prior to parole periods or release.
39. Regarding tuberculosis control among women in prison, the same minimum standards and guidelines as for male prisoners should apply. The WHO minimum standards regarding Tuberculosis control programmes are reflected in the WHO Status Paper on Tuberculosis (WHO (e), 2007), among which complete access to tuberculosis diagnosis and treatment for all prisoners entering the prison system is mentioned<sup>16</sup>.

## ***Substance use***

40. Drug offences are one of the most common crimes committed by women in Europe and drugs hold an important key to women's offending. Drug offences can be categorized as:

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<sup>16</sup> In the second half of 2008, KNCV Tuberculosis Funds is publishing its 'Guidelines for control of Tuberculosis in Prisons', which apply to male as well as female prisoners.

1. offences in order to obtain drugs; 2. offences committed under influence of drugs; and 3. offences regarding drugs, unrelated to a drug dependency.

A study in 1999 by the US Bureau of Justice Statistics reported that almost one in three women in prison admitted to committing the offence in order to obtain money to support their need for drugs (Wolf, 2007). Furthermore, a high percentage of women in prison have a drug problem and research has shown that problematic drug use rates are higher among women than men. (QCEA, 2007). Female prisoners in the European Union are more likely to inject drugs than male prisoners (EMCDDA, 2004). It is estimated that at least 75% of women arriving in prison have some sort of drug-related problem at the time of arrest (WHO/Europe (a), 2007) and another estimation states that 75% of women entering European prisons are problematic drug and alcohol users<sup>17</sup>. In many countries, not enough is known about women in prison with substance use problems, including their treatment experiences, effective treatment models and interventions. Relatively few international, national or local studies exist on the prevalence of substance use and associated problems addressing gender issues. (UNODC, 2004).

41. A study in England and Wales showed that:

- over 85% of women smoked tobacco before they entered prison, compared to a national average for women of 24%;
- 42% of women in prison drank alcohol in excess of Government guidelines prior to imprisonment, compared to 22% of the general adult female population;
- 75% of women in prison had taken an illicit drug in the 6 months prior to imprisonment while only 12% of the general population had taken an illicit drug in the last 12 months (Plugge, 2006).

42. Generally, women with substance use problems:

- have fewer resources (education, employment, income) than men;
- are more likely to be living with a partner with a substance use problem;
- have care of children;
- have more severe problems at the beginning of treatment for substance use;
- have higher rates than men of trauma related to physical and sexual abuse and concurrent psychiatric disorders, particularly post-traumatic stress disorder and other mood and anxiety disorders (UNODC, 2004).

43. A major concern is that women in prison are frequently not gaining access to drug treatment programmes and that in any case the programmes are not designed for women. Treatment programmes for women may help women to feel safe and supported and make it easier to pay attention to gender specific issues (QCEA, 2007). A gender sensitive approach to women's health care should therefore take into account the need to provide specialized addiction treatment programmes for women in prison (UNODC, 2007).

In most countries women experience social, cultural and personal barriers to treatment entry in the community and therefore prisons may provide a very good opportunity to address the addiction treatment needs of these women in a safe environment, away from the negative

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<sup>17</sup> In: 'Health Care Needs of Women in Prison: The Gap between Policy and Implementation'. M. MacDonald, presentation given at 'What Works with Women Offenders: Lessons from Other Countries on Dealing with Drug Related Offenders', Prato, Italy, 20-22 June 2005: <http://www.uce.ac.uk/crq/moragpubs.htm>

thoughts and consequences associated with undertaking such treatment in the community (UNODC, 2007). Unfortunately though, a large number of imprisoned women return to the community without receiving any treatment while in prison (Zurhold, 2005). For instance in California, 70% of the women in prison are in need of drug treatment, but only 14% actually receive treatment while in prison (Weinstein, 2005). Of course, the lack of drug treatment facilities in the community should not be a reason for imprisonment of women.

44. The evidence that substitution treatment for prisoners with substance use problems works and is cost-effective is overwhelming. Substitution treatment should be available for all women in prison with substance use problems. Attention should be paid towards progress in the implementation and in developing whatever support for staff is required, including the development of clear guidelines (WHO/Europe (b), 2007). Furthermore, continuity of treatment should be guaranteed when a woman is moved to another prison. Because of the frequency of transfer of female prisoners and herewith the interruption in treatment, it is difficult for individual prisons to monitor success rates and on the other hand it is difficult for a woman to complete her treatment before release.
45. Drugs are one of the main causes of prison security measures such as internal body searching, restrictions of visits and restrictions of home leave. These measures can be particularly punitive for women. A balance has to be found between humane treatment and making efforts to ensure prisons are free from illicit drugs (QCEA, 2007). The main focus should always be on the prisoner, and not on the staff or administration. It is always a challenge of balancing respect and dignity of the woman in prison and the surveillance and security in the prison, while providing care and treatment. In achieving this balance, prison staff should consult the prisoners.
46. It is important that anti-drug measures, as well as treatment programmes, acknowledge the presence of illicit drugs in prison. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) states that:  
*'...some prisoners continue their pattern of drug use and others start using drugs in prison. Studies that are available show that between 8% and 60% of inmates report having drugs while in prison and 10-36% report regular drug use...'*<sup>18</sup>

### **Mental health and mental ill-health**

47. In addition to substance use disorders, women in prison suffer from mental health problems such as post traumatic stress disorder, depression, anxiety, phobias, neuroses, self-mutilation and suicide at alarmingly high rates. This is frequently a result of lifetime abuse and victimization. Research indicates that women in prison suffer from mental health problems to a much higher degree than both the general population and the male prison population (Bastick, 2005). For instance, a study conducted by the Bureau of Justice Statistics showed that 73% of the women in USA state prisons and 75% of women in USA local prisons have symptoms of mental disorders, compared with 12% of women in the general population (Covington, 2007). In England and Wales a total of 90% of women in prison have a

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<sup>18</sup> Annual Report 2004, The state of the drug problems in the European Union and Norway, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA): <http://ar2004.emcdda.europa.eu/en/page096-en.html>

diagnosable mental disorder, substance use or both and nine out of ten women in prison have at least one of the following: neurosis, psychosis, personality disorder, alcohol abuse and drug dependence (WHO/Europe (a), 2007).

48. High rates of unresolved trauma and socio-economic disadvantage which characterize a large proportion of women prisoners predispose this population to mental ill-health and self-harm. Studies suggest that mental illness among women in prison is often both a cause and a consequence of their imprisonment (Penal Reform International, 2007). A short stay in prison, even on remand, may damage a woman's mental health and family life, yet does little or nothing to stop her offending again. The damage is made much worse when women are imprisoned long distances from home and receive inadequate health care during and after their time in prison (Rutherford, 2008). Women's mental health is likely to deteriorate in prisons that are overcrowded, where differentiation of prisoners based on a proper assessment is not made and prisoner programmes are either non-existent or inadequate to address the specific needs of women. The harmful effects on mental illness are exacerbated when women do not feel safe, if they are supervised by male staff and feel at risk of further abuse (UNODC, 2007). The prevention of mental health harm on admission and efforts to promote mental health of women should be considered (WHO/Europe, 1998). Promoting mental health and well-being should be central to a prison's health care policy (WHO/Europe, 2008) and mental health screening upon entrance should be part of normal procedure.

Other studies are showing that the rates of mental disorders among imprisoned women are higher in the remand population compared to the rates found in the sentenced population. This would imply that the mental illness rates do in fact not increase over time in prison. It also suggests that women with mental illnesses are likely to be arrested and imprisoned as a result of their mental illness, particularly for relatively minor crimes for which they should be hospitalized instead of imprisoned (Ogloff, 2007).

Whether a woman's mental ill-health is improving or worsening during her stay in prison depends on several factors including the prison structure, the treatment options including the availability of trauma-responsive programming and facilities and service provision afforded to women.

### **Self-harm and suicide**

49. Existing research indicates that women in prison are more likely to be suffering from a tendency to self-harm than male prisoners. (QCEA, 2007). In England and Wales, women were found to be 14 times more likely than men to harm themselves. Women are also far more likely than men to harm themselves repeatedly. A third of men and half of the women who harm themselves do so repeatedly (WHO/Europe (a), 2007). Another study conducted in England and Wales showed that 16% of women in prison self-harmed in the month prior to their imprisonment (Plugge, 2006).
50. The rates of self harm and suicide are in most countries, both for men and women, higher than in the outside community (Penal Reform International, 2007). Especially the pre-trial and early period in custody are recognized as being a particularly high-risk time for self-inflicted deaths (WHO/Europe, 2007). The Corston Report recommends first night watches

(Corston, 2007). The risk of self harm and suicide is also increased in the first period after release. It is important that after care is provided to those women at risk. In some Eastern European countries however, the situation is reversed and the rates of self-harm and suicide are higher in the community than in prison.

51. Outside of prison men are more likely to commit suicide than women but the position is reversed inside prison. Being a mother appears to protect women in the community against suicide but this protection does not apply in prison where mothers are separated from their children (Corston, 2007).
52. Developing strategies to prevent suicide and self-harm and to provide appropriate, gender specific and individualized psychological and psychiatric treatment to those at risk, need to form a comprehensive element of mental health care in prisons. Staff need to be trained to detect risk of self-harm and suicide, and offer assistance, by providing support and referring such cases to specialists. In some systems self-harm and suicide attempts are penalized, which is unacceptable and exacerbates mental distress even further (UNODC, 2007). Effective treatment needs to consider and adequately respond to the underlying causes of self-harm and suicide including underlying trauma issues.
53. Because of the clear evidence of increased risk of suicidal behavior among women in prison, policy makers and prison governors need to be aware that it is good practice to have a suicide prevention coordinator posted in each women's prison. Also, prison staff needs to be trained to be aware of the particular risks of self-harm among women in custody (WHO/Europe, 2007).

## ***Learning Disabilities***

54. Many terms and definitions are used to refer to learning disabilities, such as mental retardation, mental handicap and intellectual disabilities. WHO defines a learning disability as a condition of arrested or incomplete development of the mind that can occur with or without any other physical or mental disorders and is characterized by impairment of skills and overall intelligence in areas such as cognition, language, and motor and social abilities. This includes children, adolescents, adults and the elderly population<sup>19</sup>.
55. Little is known about women in prison and learning disabilities and how many women in prison actually have a learning disability. Criminal behavior by people with learning disabilities raises difficult questions around the responsibility of offenders and what kind of punishment and care is suitable (QCEA, 2007). Prisoners with learning disabilities and difficulties are unlikely to benefit, and may be excluded, from programmes designed to stop re-offending. Many of them are victimized and bullied in prison (Prison Reform Trust, 2007).

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<sup>19</sup> See: [http://www.who.int/mental\\_health/evidence/atlas\\_id\\_2007.pdf](http://www.who.int/mental_health/evidence/atlas_id_2007.pdf)

## **Sexual health and Reproductive health**

56. Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child<sup>20</sup>.

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled<sup>21</sup>.

The rights for reproductive and sexual health can be considerably constrained in prisons but wherever possible, the rights should be maintained as much as possible. Subject to the wishes of the women in prison themselves, conjugal visits should be available.

57. Women in prison are a high-risk group for sexual and reproductive health diseases, including cancer and sexually transmitted diseases. This is particularly due to the typical background of women in prison, which can include injecting drug use, sexual abuse, violence, sex work and unsafe sexual practices (UNODC, 2007). Women who have experienced abuse may, as a result, engage in high risk sexual behavior which places them at a heightened likelihood of sexually transmitted infections. Screening programmes for reproductive diseases, such as breast cancer, should be included in the standard procedure in women's prisons.

58. Many prison authorities around the world fail to cope with women's menstruation. They fail to provide sanitary napkins, only providing them as part of medical supplies or sometimes even withholding them as a punishment. Privacy and adequate bathing and washing facilities are often not provided (Prison Reform International, 2007). Sanitary napkins and the like of a type that the woman finds easily acceptable and proper disposal possibilities need to be freely available and easily accessible to women in prison at all times. Frequent access to showers needs to be provided (WHO/Europe, 2007)

## **Pregnancy, post-natal care and breastfeeding**

59. In order to protect the health of the mother and of the newborn child, pregnancy should in principle be an obstacle to incarceration, both pre-trial and post-conviction, and pregnant women should not be sent to prison unless there are absolutely compelling reasons to do so.

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<sup>20</sup> WHO Reproductive health and research: [http://www.who.int/topics/reproductive\\_health/en/](http://www.who.int/topics/reproductive_health/en/)

<sup>21</sup> WHO Reproductive health and research, gender, sexual health: <http://www.who.int/reproductive-health/gender/sexualhealth.html>

When it is apparent that a woman in prison is pregnant, the need for her imprisonment should immediately be reviewed, and continue to be reviewed throughout the pregnancy. Pregnant women in prison should be considered for non-custodial measures throughout their remaining prison term (Bastick, 2005).

60. Pregnancy affects many areas of a women's life, including health, diet and exercise requirements (Robertson, 2008). Pregnant women in prison should be ensured a nutritious diet, timely and regular meals (not being kept to a rigid timetable), a healthy environment and regular exercise (UNODC, 2007). Also, the difficulties of coping with morning sickness should be sympathetically considered.
61. Pregnant prisoners should be provided with the same level of health care as is provided to women outside of prison, including access to obstetricians, gynecologists, and if required midwives or birthing practitioners appropriate to their culture. Access to female practitioners should be possible if requested. Women may also decide not to proceed with their pregnancy in prison, especially when they were previously unaware that they were pregnant. Equivalent treatment options as are available in the community should be guaranteed (WHO/Europe, 2007).
62. Adequate medical attention during birth is clearly essential for mother and child. However, women in prison often do not have access to any education in breathing and birthing techniques to help prepare them for the birth. Depending upon the country and the prisoner, women may give birth either in prison or at a public hospital (Bastick, 2005). A public hospital should always be first choice. Regulations governing the transport of pregnant women to a hospital or care centre should be in place (e.g. facilitating frequent toilet breaks). There must be a complete bar on the use of shackling during labor. Also, male non-health care officers must not be present while women are in labor or delivering.
63. As during pregnancy, breastfeeding women have particular health and nutrition needs that are often unmet in prison. Appropriate food must be provided free of charge for breastfeeding women, as well as for their babies, including milk, high protein products and adequate amounts of fresh fruit and vegetables (UNODC, 2007). It is important that meals are provided regularly and flexible, not being kept to a rigid timetable. Mothers require health checks to ensure that their body is recovering from birth healthily, and to ensure, for example, that they do not have any infection that they might transmit to the child through breastfeeding (Bastick, 2005). Being infected with Hepatitis C is not a contraindication to breastfeed, because there is no evidence that Hepatitis C can be spread by mother milk. HIV-infected mothers however, must not breastfeed their child<sup>22</sup>. Often women in prison are discouraged from breastfeeding, as it is perceived to interfere with prison routines (Bastick, 2005). However, it is widely recognized that breastfeeding is the best method of infant feeding.
64. In the post-natal period, the privacy of mother and baby and family visitors must be respected so as to provide a good environment for family bonding and feeding. After birth, women

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<sup>22</sup> Source: CDC (Centre for Disease Control and Prevention): <http://www.cdc.gov/breastfeeding/disease/index.htm>

should receive counseling and support, and be carefully monitored for depression (Bastick, 2005). Also in case of a miscarriage, counseling is essential and should always be provided.

## ***Violence and abuse***

65. Women are more than three times as likely as men to report having experienced physical or sexual abuse before their imprisonment (Severson, 2005). Women who have experienced violence and abuse before they entered prison, may be suffering from low self-esteem, poor coping skills and lack of confidence. Victimization also contributes significantly to poor health outcomes in terms of mental ill-health and physical health complaints including gynecological complaints. Trauma is directly and indirectly linked to the criminogenic pathway and both mental and physical illness (Moloney 2008). For this reason, addressing unresolved trauma through adequate trauma psychotherapy is of central importance.
66. It is important in the screening process to identify women who are or have been victims of violence and other forms of trauma. If they come from abusive relationships or are at risk of other forms of violence on their return to society, they should be provided with counseling and support, extending beyond their period in prison.
67. Women who have experienced family dysfunction and abuse may require assistance to develop healthy parenting styles. For imprisoned women with children or pregnant women, parenting support in both the pre- and post-natal periods should seek to prevent the key risk factors (in both mother and child) of poor mother-child bonding and poor parenting skills. Comprehensive support is also necessary for children who are separated from their mothers.
68. While in prison, women are vulnerable to abuse, particularly sexual abuse. The fact that women in prison are under the control of prison guards makes them powerless in that sense. The provision of an effective system of prison inspection and oversight done by an independent body and with a confidential complaints system is essential in preventing violence and abuse within the prison (Penal Reform International, 2007). Every woman in prison has the right to be free from sexual abuse.
69. Women in prison should be able to see a doctor without the presence of prison staff, because in the presence of operational staff, possible violence and abuse of women in prison are less likely to be reported. Women in prison should be given the choice to be accompanied by a woman (e.g. a female nurse) when visiting a doctor if they prefer. The European Prison Rules and national Penal Codes give the doctor a central role in the prevention of human rights abuses in custodial settings (QCEA, 2007).
70. The minority of women who have perpetrated violent crimes or are identified through screening as perpetrators of violence should be provided with interventions to prevent them from being violent in prison and when they return to society.

## ***Multiple and complex treatment needs***

71. A study conducted by the Bureau of Justice Statistics found that three quarters of the females in prisons in the USA who had a mental health problem also met the criteria for substance dependence or abuse (Covington, 2007). Other studies indicate that women with substance abuse problems are more likely than men to have experienced physical and/or sexual abuse (UNODC, 2004). A history of violent assault can increase the risk of substance use and post-traumatic stress disorder or other mental health problems (UNODC, 2007). For this reason, trauma-responsive programming needs to be a central component to all mental health service provision in prisons.
72. Previous sexual abuse is statistically associated with self-harm and attempted suicide among women in prison. A significantly higher proportion of women (41%) than men (18%) who have attempted suicide or harmed themselves reported having been sexually abused (WHO/Europe, 2007). Over the last decades an important development in health care is the recognition that trauma plays a vital role in the evolution of physical and mental health problems (Covington, 2007).
73. Women who suffer from an alcohol and/or drug dependency are more likely to experience the following co-occurring disorders as well: depression, dissociation, post-traumatic stress disorder, other anxiety disorders, eating disorders and personality disorders (Covington, 2007). In addition to substance abuse programs, psychotherapy which specifically addresses past trauma is necessary for many women. Additionally, as imprisoned women often not only suffer from their dependency but also from psychological distress, poor health and lack of supportive relationships, there is a unique need for psycho-educational and skills training and for systematic pre-release interventions in order to prepare them for living in the community (Zurhold, 2005).
74. It is not uncommon for a woman in prison to discover that she is pregnant and HIV infected at the same time. The psychological burden of being in prison, having a new pregnancy and discovering HIV infection can be very devastating for the woman. Empathy and counseling are always required, to ensure the best possible conditions for mother and baby in this always complex situation. Premature birth may be more common among pregnant women with HIV, compared to those without HIV with some studies showing rates up to twice those among HIV negative women (Reyes, 2000).

It is very important that pregnant women who require antiretroviral treatment have free access to it. For a pregnant woman with indications for ART, such treatment reduces maternal mortality and morbidity, is the most effective method of preventing mother to child transmission of HIV and, by securing the health of the woman, improves the chances of survival of her child. Treating a pregnant woman living with HIV not only addresses her individual health needs but also dramatically reduces the risk of a mother-to-child-transmission, particularly for women at an advanced stage of the disease who have a higher risk of such transmission. The stage of the pregnancy and the potential side effects of the treatment should always be taken into consideration (WHO, 2006).

75. Use of drugs and alcohol during pregnancy can result in diseases, low birth weight, early delivery, poor nutritional status, respiratory diseases and foetal alcohol syndrome. Some of

these consequences may be due to the lifestyle associated with substance use such as poor nutrition, lack of medical and social care, and infectious diseases such as HIV/AIDS and hepatitis, which may compound any direct effects of illicit substance use on the health of the mother and the foetus (UNODC, 2004).

76. In case of multiple needs, such as suffering from two or more illnesses or dependencies at the same time, it is always important to realize that illnesses may interact and medicines for treatment may be counterproductive or dangerous. For instance, a woman who suffers from Hepatitis and cancer at the same time might need a drug for her cancer treatment that is toxic to liver function.

### ***Pre-release preparations and continuity of care after release***

77. Before they are released, women should have access to programmes to help them with making the transition to life outside prison. These will vary between cultures, but might include courses in life skills, parenting and health care (Bastick, 2005). Learning basic household skills, like cooking and washing, will already make a big difference for some women in prison and will help them in their life in the community.

However, resources and attention allocated to women's needs in preparing them for release and following imprisonment are generally very inadequate and collaboration between prison authorities and civil social and health services is often lacking (UNODC, 2007). Especially for women serving short sentences, access to programmes is often not provided.

The Quaker Council for European Affairs (QCEA) recommends that The Member States of the Council of Europe:

- a) make sure that prison policies and programmes are specifically tailored to the needs of women, including those in the areas of resettlement;
  - b) ensure that the needs of female prisoners upon release, issues such as homelessness, unemployment, workforce discrimination and regaining custody of children, are addressed. If social services were previously involved with a prisoner then they should be informed when that prisoner is to be released (QCEA, 2007).
78. On release, consistent with the Standard Minimum Rules for the Treatment of Prisoners, all ex-prisoners must have access to adequate food, clothing, housing and medical care, and other necessary social services.

Prison authorities should arrange for post-release housing for women in prison, especially those with children. Women may experience that they are unable to get their children back with them to stay until they have accommodation, but that they are unable to get accommodation until they have their children back. This makes it very difficult for these women to get back to normal lives in the community and this may be a contributing factor to re-offending (QCEA, 2007). Cooperation of prison authorities with responsible institutions in the community is essential. When the woman is a foreign national, she will be released in a country other than where she was imprisoned and therefore contacts beyond the borders are important.

79. As foreseen by the *Standard Minimum Rules for the Treatment of Prisoners*, after release a prisoner may require on-going psychiatric services. This is of particular importance for female prisoners, given their high rates of mental illness and given their higher likelihood of having received treatment for a mental health condition while in prison, which needs to be continued in community (Bastick, 2005; UNODC, 2007).
80. Post-release care is essential and prison authorities should devote particular attention to the availability of treatment and social support services for women on their release. Support from volunteers, inside as well as outside the prison system (e.g. peer support), can be very helpful in the process. The fact that many women in prison are imprisoned far away from home is a complicating factor.
81. Former prisoners experience high rates of drug-related accidents, overdose and death (UNUODC, 2007). Strategies are needed to ensure continuity in treatment of drug users as they move between the prison system and the community (WHO (c), 2007).
82. In some cultures women are at risk of murder by their families after release from prison, if they have committed what are taken in their culture to be 'moral offences', or are victims of rape or other sexual abuse. Women may also be at risk of returning to a marriage with a violent partner or being forced into a marriage. These women are all in need of special protection and support, which unfortunately is almost always inadequate in meeting their needs (UNODC, 2007).

## How to improve the situation? What can, what should and what must be done

The evidence is clear, consistent and compelling: the current arrangements in criminal justice systems for dealing with women offenders are failing to meet basic needs and are far short of what is required by human rights, by accepted international recommendations and by social justice. While it must be stressed that imprisonment for a small number of women offenders is right and appropriate, there are too many wrongly and inappropriately imprisoned.

Imprisonment is a serious sanction, with loss of liberty too often meaning loss of other rights; these losses are particularly damaging for women and children. The problems are many and complex and improvement will need concerted action by a wide range of people who can make a difference. The following has to be taken against a social background in which there remains too great a lack of gender sensitivity in all policies and an unacceptable gap in gender equality in many societies.

In deciding what can, what should and what must be done, there are several important principles to be emphasized and followed:

- First and foremost, imprisonment of women should be considered only as a last resort, when all other alternatives are found to be unavailable or are unsuitable. This applies even more so for women with children. The essential need is for women to be considered in a holistic way, in the context of their offending and their social situation.
- Second, health service provision and programming should specifically address mental illness, in particular substance use disorders and post traumatic stress disorder, being essential to any prison health care system.
- Third, if children are involved, **the needs of the children must be the main and determining factor**. The greater social costs to the community and the potential for long term damage must be understood and accepted. Decisions on what are the best interests of a child should be based on appropriate advice from a recognized source, independent of the courts and prison services.
- Fourth, it is not acceptable **to fail to recognize the significant variations in need** which can exist in different groups of women; factors such as pregnancy, having responsibility for children, young or old age, dependency problems, histories of violence and/or abuse and others must be important considerations in health plans for these women.
- Fifth, the impact of separation from family and community as well as the inevitable legal and security processes involved can severely damage a woman's mental health, emotional well-being, self-esteem and social/life skills and abilities to varying extents. This is true for all those compulsorily deprived of their liberty, but counts especially for women. An essential part of any individual health plan **must be careful, comprehensive and detailed screening**, including socio-economic and educational background, health and trauma histories, current health status and an assessment of skills held or required so that the individual needs are determined and can be suitably addressed.
- Sixth, while rigid policies should be avoided, in recognition of the variability in individual needs in a changing world, **the underlying importance of human rights** should pervade all thinking and all policy development for all those in compulsory detention.

## Recent developments and emerging plans

The evidence and expert advice received in the preparation of this paper clearly showed that there are new approaches and new plans being produced in various parts of Europe. Many of the public services involved are experiencing change, such as in policing, in probation services, in community facilities and in initiatives by NGOs. The trend in new services is to give greater emphasis to alternatives to custody and providing much more effort to assessing and managing women in their place of residence rather than in a custodial setting, especially if they have committed a non-violent or relatively minor crime.

The legal and criminal justice systems are also changing. Some of these plans could have a major beneficial effect on women in the criminal justice system. For example, restorative justice approaches, such as family group conferences and sentencing circles, are already being used; restorative justice has been defined as ‘the use of a restorative process in which the victim and the offender and, where appropriate, any other individuals or community members affected by a crime, participate together actively in the resolution of matters arising from the crime, generally with the help of a (trained) facilitator.’ (*United Nations Economic and Social Council: basic principles on the use of restorative justice programmes in criminal matters*).

There are also developing ideas in health promotion in prisons, especially women’s prisons. These involve a more participatory approach, using community development methods (Martin, 2008) and further use of a whole prison approach (Hayton, 2007) and of a self-help network as already is in use on parts of Germany (Bogermann, 2007)

While these and other developments should be strongly encouraged, improvement throughout Europe remains slow.

As regards **women’s health and prisons**, any call for action should best be seen as a whole under the following characteristics:

1. A gender sensitive criminal justice system is an essential first step to make sure that gender specific needs and circumstances are taken into account at all stages of the criminal justice process;
2. A gender sensitive prisons policy has to be developed for every prison system to meet basic health and welfare needs of women in prison;
3. The human rights of women and of their children must always be dominant; principles of equivalence and of appropriateness of facility and health care must be recognized. The needs of any child involved must be dominant.
4. Specialist health care must be provided: for instance for mental health including help with a legacy of abuse; for HIV/AIDS, Hepatitis C, Tuberculosis and other infectious diseases; for drugs and alcohol dependencies; for learning disabilities; and for reproductive health;
5. Pre-release preparations must be planned and provided in order to ensure continuity of care and access to health and other services after release must be a clear part of the preparations for release programme. It must be recognized that pre-release planning is a complex challenging issue, due to out of area imprisonment, and lack of time available for the preparations especially if sentences are short. But the challenges are likely to be well rewarded with much improved resettlement, reduced social costs and reduced re-offending.

## Recommendations

The World Health Organization's Health in Prisons Project strongly supports the following specific comments and recommendations:

**1. A gender sensitive criminal justice system is an essential first step to make sure that gender specific needs and circumstances are taken into account at all stages of the criminal justice system.**

**1.1. Greater and more complex needs.** Women in prison are a small proportion of the prison population with about 100,000 women in European prisons every day. But women in prison are in general from much poorer backgrounds, have higher rates of abuse and have more complex social and health problems than male prisoners. These problems need special attention continuously, for the women themselves as well as for their children and indeed for society as a whole.

**1.2. Costly impact of women's imprisonment.** Most of the women in prison are imprisoned for non-violent and relatively minor offences, yet the impact of imprisonment on their health and on their children is very high. In every case, the circumstances of the woman and her place in the family and community should be carefully considered before a sentence is passed. All those involved in the legal process have to consider all the consequences of their decision. A full consideration of all alternatives to imprisonment is essential to prevent the unnecessary ruining of women's lives and harm to children and other dependent relatives.

**1.3. More appropriate level of security.** By far the majority of women in prison do not need to be in high security and are of no risk to society. If it is not possible to manage the position with women remaining in their places of residence or if suitable community places are not available, then lower security prisons, specifically designed for women should be established where they can be housed in smaller units and closer to their home.

**1.4. Whole system approach.** While this report is concentrating on women's health and prisons, it is clear from the evidence that a gender sensitive approach should apply at all stages of the criminal justice system, starting from first contact with the police. It follows that a major aspect of any new approach must be gender sensitivity training for everyone involved, such as police, magistrates, court officials, judges and probation staff.

**1.5. Pre-trial detention only sparingly used.** Pre-trial detention for women and indeed for all offenders should be used as sparingly as possible to avoid the inevitable damaging effect on them and particularly on her and her family. When pre-trial detention is unavoidable, special procedures should be in place for pre-trial women with a special focus on a woman's vulnerability during the first period of detention and the higher risk of self-harm including suicide in this group. The issues mentioned later as regards babies and children could also arise at the pre-trial stage.

**1.6. Comprehensive health needs assessment.** As with all those before the courts, assessed health needs should be considered so that best placement can be made. In the case of women, whose crimes are often related to drug dependency, the offer of drug treatment in a

suitable place should be an alternative to imprisonment. In the same way, those with obvious mental health needs must be sent to a facility able to treat and care for mental illness.

**1.7. Need for gender dis-aggregated data.** In order to develop a suitable gender-sensitive prison system and being able to understand and address the particular health needs of women in prison in a proper and effective way, the availability of gender dis-aggregated data on women's health and health needs in prison has to be increased and research in this area has to be stimulated.

**2. A gender sensitive prisons policy has to be developed for every prison system to meet basic health needs of women in prison.**

**2.1. Meeting the greater health care needs.** A gender-sensitive health care system in prisons should reflect the greater health care needs of women in prison through provision of appropriate facilities and regimes as well as allowing easy access to the health and social support services necessary for women.

- The services should be based on a primary care service which takes a holistic approach in assessing these needs and offer a range of services from health promotion with emphasis on self-care, nutrition and exercise, through preventive screening services as are available in the local community, to advice and help in day-to-day health problems.
- The primary services should be able to cope with many of the more complex health needs, the complex problems and reproductive/sexual health needs of women in prison, through additional training of the health team and their ability to access specialist help. This should include primary psychiatric support and access to therapies able to help process trauma and promote the well-being of women with histories of abuse.
- The prison health services need to be aware of and prepared to meet the specific needs of girls and older women in prison.
- The health service should be involved with the other members of staff who are together meeting the needs for rehabilitation and re-integration through services specially designed for women.

**2.2. Gender sensitivity training.** All staff working with women in prison should have attended gender-sensitivity training courses and additional health education courses in order to be confident that they understand issues such as the needs of pregnant women, the effects of having a history of physical and sexual abuse and the factors likely to lead to self-harm and increased suicide risks.

**2.3. Appropriate female/male staffing balance.** There is unfortunately evidence to support the policy that male staff should not have access to the living quarters of women in prison. In the general operation of women's prisons, there is some support for a balance of women and male staff as long as the running of the prison reflects the different day-to-day needs of women, for example in access to warm showers and easy free availability of feminine hygiene requirements. While it may be appropriate to have mixed gender staffing in some countries, male prison staff should not be in contact positions with female prisoners or have access to living quarters unless accompanied by female staff senior enough to supervise them.

- 2.4. *Clinical consultations sensitive to personal wishes.*** In the prison health service, women should be able to ask for investigation, treatment and care from female nurses and doctors where ever this is possible; if not, male doctors should use a chaperone approach<sup>23</sup> when seeing women prisoners. However, visits to the doctor should be possible, as in all prisons, without any operational staff being present.
- 2.5. *Confidential complaints and independent monitoring.*** Women in prison should have access to an independent and confidential complaints system in order to be able to report in confidence matters such as experiences with violence and/or abuse during their stay in prison.
- 3. The human rights of women and their children must always be dominant; principles of equivalence and of appropriateness of facility and health care must be recognized. The needs of any child involved must be dominant.**
- 3.1. *Protecting personal and family relationships.*** Many women prisoners have children for whom they were the primary or sole carer before they were imprisoned. When they are admitted to prison, the family will often break up, resulting in large numbers of children themselves being institutionalized. Extra efforts must be made to preserve family ties, especially if there are young children who do not accompany them into prison. Regular visits by family members must be facilitated and encouraged as they are an essential part in keeping family links. The imaginative ways of keeping family ties intact in some countries should be better known and should be considered everywhere while the current prison systems for women remain as they are. The stopping of family contact as a punishment must be prohibited in all systems.
- 3.2. *Maintaining home/external contacts.*** The importance of telephone contact needs to be remembered. A well developed ‘telephone access’ policy should be present in all women’s prisons so that some regularity in calls home should be available without a prisoner having to meet all the costs involved. This may be more difficult for foreign national women but the overall value of maintaining community links should make it an important part of the prisons’ policies.
- 3.3. *Important role for NGOs.*** The value of NGOs (non-governmental organizations) and voluntary groups in maintaining family contact has been shown and efforts from NGOs and volunteers aimed at women offenders, inside as well as outside the prison system, should always be encouraged.
- 3.4. *Children staying with their mothers in prison.*** One of the most difficult national policy decisions to be made, concerns children staying with their mothers in prison. There are some guiding principles here:
- The best interest of the child must be the first and main consideration;
  - The participation of children in the decision-making should always be promoted and facilitated, taking due consideration of their age;
  - If children do stay with their mothers in prison, the facilities must be suitable;

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<sup>23</sup> A chaperone approach means that there has to be another woman present during the consultation.

- There must be clear provision made for the health care and the development of the child;
  - There must be suitable regular monitoring and re-assessment of the child's welfare.
- It must be agreed that any child can leave the prison at any time if that is in the best interests of that child.

**4. Specialist health care must be provided: for instance for mental health including help with a legacy of abuse; for HIV/AIDS, Hepatitis C, Tuberculosis and other infectious diseases; for drugs and alcohol dependencies; for learning disabilities and for reproductive health.**

**4.1. *Strong primary health care and easy and sensitive access to emergency care.*** While a good primary health care service in prisons can deal with many somatic health problems and should be part of a regular screening, assessment and re-assessment programme as part of the regular cycle of care, all prisoners can have health care emergencies requiring urgent admission to secondary care or specialist facilities. How this is made available should be part of a prisons health care plan and known to prisoners. It is seldom easy with any prisoner but with women there has to be some consideration of the transport arrangements so that additional stress is not caused. Also, the use of interpreters should allow the arrangements to be made clear to foreign national women in prison and their additional cultural needs should be recognized.

**4.2. *Promoting mental health and resilience.*** Promoting mental health and well-being should be central to a prison's health care policy. The high rate of self-harm and indeed suicide among women in prison should alert prison governors to the urgent need for strategies and policies for protecting mental health in general and for assessing women who may be at risk. This area of health need demonstrates the importance of a whole prison approach. All staff need to be aware of their role and of the ways in which the environment and regimes inside prisons can be modified, positively and beneficially, with improvements in psychological resilience in prisoners and indeed in staff. Governors of prisons have an important leadership role here, in working with senior staff to create an ethos in the prison which is conducive to health.

**4.3. *Coping with personal histories of abuse.*** Many women in prison have a history of physical or sexual abuse prior to their imprisonment. The mental health problems which can arise from such histories demand the provision of specialized mental health support and care as an essential part of health care for women in prison.

**4.4. *Importance of health screening for HIV and other conditions.*** Women offenders should be screened (with pre- and post-counseling) on entering prison for HIV, Hepatitis C and sexually transmitted infections. Staff in prisons should be trained in dealing with the psychosocial and medical problems associated with these infections among women in prison. Where screening is offered, appropriate funding for follow-up treatments must be provided.

**4.5. *Tuberculosis control and care.*** The WHO guidelines on tuberculosis control and care in prisons should be followed in all prisons.

- 4.6. Health competencies and equivalence of prevention.** An important part of health care of special relevance for women prisoners is improving their knowledge and understanding about health matters, to improve their capacity and confidence in protecting and improving their own health. This needs to include knowledge about how certain diseases are spread, especially those which are blood-borne or sexually transmitted and how they can prevent themselves from becoming infected. They will need easy and free access to condoms as well as dental dams. Tattooing and piercing practices should be discouraged and well-regulated, because of their high risk of transmission of infectious diseases among women in prison.
- 4.7. Learning disabilities.** For women in prison with learning disabilities, all health information material should be reviewed and suitably adapted to ensure their comprehension. Further evidence on the effectiveness of such a review is required and further research in the whole area of women in prison with learning disabilities is necessary.
- 4.8. Special gender sensitive drug treatment facilities.** Health care in prisons should include access to drug treatment programmes and these could be specialized for women so that they build up women's feeling of being safe and supported. As with all the programmes indicated here, the staff involved should pay attention to gender-specific issues.
- 4.9. Substitution treatment.** Substitution treatment should be available for women in prison who have a drug dependency and clear guidelines on this have to be developed, and include additional training for medical and nursing staff.
- 4.10. Harm reduction.** All prisons should have clearly developed harm reduction programmes as an essential part of controlling the spread of HIV. Where there is political or staff unease at some of the proven effective harm reduction measures, the successful implementation of such schemes in prisons in Spain, for example, should be made known.
- 4.11. Serious issues concerning pregnancy inside prisons.** Pregnancy in a female offender raises a series of important issues, ranging from whether or not this should be an obstacle for imprisonment, through where the birth should occur, the facilities for breastfeeding and mother/child bonding, through to the aspects already mentioned such as the continuing care of the child and whether and for how long the child will stay in prison. There is wide agreement on two points:
- a woman in prison should always ideally give birth outside prison in a public hospital;
  - the need for a mother's continued imprisonment should continuously be reviewed with an aim to moving her to an alternative to prison wherever possible. Experience with new purpose built and secure mother and baby units, is becoming available in some countries in Europe.
- 4.12. Treatment for HIV.** According to WHO recommendations, pregnant women in prison who are infected with HIV should always receive antiretroviral treatment.
- 4.13. Support for breastfeeding.** Women in prison should never be discouraged from breastfeeding their child, unless the woman is HIV-infected. The particular health and nutritional needs of a breastfeeding woman must be met by the prison.

**5. Pre-release preparations must be planned and provided in order to ensure continuity of care and access to health and other services after release must be a clear part of the preparations for release programme.**

**5.1. *Continuity of care and pre-release planning.*** There is strong evidence to support the importance of continuity of care for people with life-threatening conditions such as HIV/AIDS, tuberculosis, drug addiction treatment and mental ill health problems and in fact for all prisoners if resettlement is to be rightly considered a priority. There are very real barriers to continuity, such as geographical isolation from the prisoner's home area, the breakdown in family ties, the loss of employment and often of housing, and the need to ensure a woman does not return to a home situation of likely abuse. In some cases, the family is reluctant to have her back with them and may refuse. Some of the steps advocated above will help to improve the chances of successful resettlement. A key factor however will be the availability of help within the prison in terms of education, vocational training and building self-esteem, a better understanding of human relationships, anger control and personal fitness and life and home skills and capabilities. An issue which has to be addressed is where a mother has her children with her and is thus unable to participate in these activities. It is important that pre-release preparations start almost on admission. The prison health service should be a full partner with the other services available in prisons so that overall plans for support after release can be made. In this, as with all matters raised here, the women themselves should be consulted about their needs and about their resettlement requirements.

**5.2. *Important role of NGOs.*** Re-settlement on release can be greatly aided by making use of voluntary and other social groups linking prisons with communities. There are some basic essentials: housing, employment and re-established links to primary health care, with which NGOs can be particularly useful.

**5.3. *Foreign national women in prison.*** The particular needs of foreign national women, girls and older women in prison should be considered and suitable plans should be developed. It is important with women in prison that cultural differences in laws and in criminal justice systems are understood and suitable steps are taken to deal with these issues as part of pre-release planning and support.

### **Concluding remarks**

This background paper provides the overwhelming evidence for change and the comprehensive range of developments necessary to improve the current state of affairs as regards women's health and criminal justice systems and prisons throughout Europe and indeed the world. What can be done is clear and what should be done is now more obvious and acceptable.

The associated WHO Declaration on the Urgent Need to improve women's health in prisons and in the criminal justice systems is firmly based on this background paper and the evidence showing failures in human rights, in gender equity and in social justice.

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