CHAPTER-II

Women’s Health Outside and Inside Prisons: A Reappraisal of Literature
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The considerable escalation of women sent to prison during the latter twentieth century finally helped shift attention to the various, social, economic and medical needs of this historically neglected population. If one were to rank population subgroups by the seriousness of their health problems, female prisoners would be located near the top of the ladder. There is a growing body of literature that shows female inmates are likely to have more serious health problems than both women and men in the general population largely because of chronic poverty, lack of access to medical care and problematic lifestyles. However, their health problems are also worse than their male counterparts and literature shows women often have less access to services for treatment and prevention than men. Much of the literature on the health of female prisoners and their use of health services during incarceration are based on the findings of researches conducted overseas. In India, this area has not been sufficiently explored, and there is paucity of literature in the Indian context. This chapter attempts to review the available literature in order to provide an insight into the health issues of female prisoners. This chapter is divided into two parts. The first part deals with literature describing the health of women prior to imprisonment and the second part deals with the health of women during imprisonment. Health of women further sub divided into physiological, psychological well-being and maternal health.

HEALTH OF WOMEN PRIOR TO IMPRISONMENT

Peel (1971) in an article entitled The Health of Women discussed about the health status of women in the changing society of modern era. The author discussed about reproductive health problems as well as the increasing health risk behaviour among women. Women form about half of the population and in spite of all the current talk about the equality of the sexes and the liberation of the female, their reproductive function differentiates them from the male. Women on the whole are healthier than men. The female neonate survives the hazards of births better than the male. The death rates in babies of one week, one month, and one year are all significantly lower in the female, and the expectation of life is nearly five years longer. Today, however a
great many changes in the female way of life are occurring which may alter the
traditional pattern of health statistics in the next generation. The greater involvement
of women in full or part time employment in industry, business and the professions
makes them equally liable to the environmental stress and accidents associated with
such a way of life. Since 1964 the overall birth rate has been falling steadily, but at
the same time the percentage of births, both legitimate and illegitimate, to girls under
the age of 20 years has been increasing. Further, during the past three years there has
been a steady increase in the number of terminations carried out in girls of this age
group. When first pregnancies are terminated in the young age, the immediate
physical risks such as hemorrhage, trauma and infection are greater. Moreover, the
emotional turmoil created by a pregnancy, whether terminated or allowed to continue
is for obvious reasons far greater in the emotional and relatively unstable
circumstances that surround so many of these conceptions in the young than when the
problem presents in older women. Apart from this, one another aspect of the women
health which is causing much concern is that in the past ten years there has been an
actual increase in the total deaths from cancer in women by more than ten percent.
Cancers of the genital tract, including breast cancer, represent nearly forty percent of
these deaths. Genital cancers vary widely in their incidence in different countries and
sometimes in different areas within a single country. For example, cervical cancer in
Great Britain has an incidence of about one-third that of India. On the other hand,
cancer of the body of the uterus is ten times more common in England than India. It
has long been known that cervical cancer is directly related to the socio-economic
status of the community. Cancer of the body of the uterus is becoming more frequent
because it is a disease of older women and women are living longer. However, this is
not the only factor. There is a relationship between this disease and obesity as well as
diabetes, both of which are also increasing in an affluent society. Therefore, there is a
situation in which improvement in the standards of living and better education may be
reducing the incidence of one disease while causing an increase in the incidence of
another. The author views that women themselves must play the leading part, firstly
by taking full advantage of all that is available to them during pregnancy and secondly
by accepting an even larger measure of responsibility in the care of their children not
only during childhood but into adolescence. Better nutrition in childhood and
adolescence leads to better physical health by the time the age of reproduction is
reached, and this is far more important than nutrition during pregnancy which has in
all probability tended to be over emphasized. Better education and a wider distribution of available services are additional factors responsible for improved reproductive performance. These trends are a contribution towards improvement in the health of women not only by reducing many of the physical disabilities that arise from repeated childbearing but also by reducing anxieties and tensions associated with the upbringing of very larger families with strictly limited material resources.

Velkoff and Adlakha (1998) in an article entitled Women’s Health in India discussed about health status of women in India. They focused on five key issues related to women i.e., reproductive health, violence, nutritional status, unequal treatment and Human Immunodeficiency Virus (HIV) problems. The authors attempt to highlight that the health of Indian women is intrinsically linked to their status in society. Research on women’s status shows that the contributions Indian women make to families often are overlooked and instead they are viewed as economic burden. Women typically have little autonomy, living under the control of first their father’s then their husbands and finally their sons. However, the wide variation in cultures, religions, and lack of development among India’s 29 states and 7 union territories, it is not surprising that women’s health also varies greatly from state to state. As far as reproductive health is concerned many of the health problems of Indian women are related to or exacerbated by high levels of fertility. Maternal morbidity and mortality are two health concerns that are related to high levels of fertility. The high levels of maternal mortality are especially distressing because majority of these deaths could be prevented if women had adequate health care services. The proportion receiving no care varied greatly by educational level, state, religion, caste and place of residence. Further, unwanted pregnancies terminated by unsafe abortions also have negative consequences for women’s health. Despite a large increase in the number of women using contraceptives and limiting their fertility, there is still unmet need for contraceptives in India. The socio-economic factors are strongly related to both fertility and contraceptive use. Another problem is that the births that take place in non-hygienic conditions or those are not attended by medical personnel are more likely to have negative outcomes for both the mother and child. According to the National Family Health Survey, nearly three-quarters of all births took place at home and two-thirds of all births were not attended by trained medical personnel. Another issue related to women’s health is violence against women, which mostly occurs in
the home and/or perpetuated by near or dear one (relatives/husband). The most pervasive forms of violence against women in India are dowry death, rape and beating. While studies have shown that dowry related violence against women occurs among all sub-groups of the population, the rates are higher among poor and the lower castes. Majority of them reported that rapes are committed by family members. Generally, police have not been helpful to women in domestic violence case, and there are few community support program available to these women. Several studies indicate that nutrition is another serious health concern that Indian women face. Research shows that fifty to ninety percent of all pregnant women in India suffer from anemia. It is the major cause of maternal ill health and mortality. The negative effects of malnutrition among women are compounded by heavy work demands, poverty, childbearing and rearing as well as special nutritional needs of women resulting in increased susceptibility to illness and consequent higher mortality. Many studies show that one of the reasons for the poor health of Indian women is the discriminatory treatment girls and women receive compared to boys and men. Differential treatment of girls and boys in terms of feeding practices and access to health care is among the factors responsible for higher female mortality. Causes of deaths for children aged 1 to 4 show girls dying at a higher rate than boys from accidents, fever and digestive disorders, all causes that are related to living conditions and negligence. Another problem of women’s health is rapid increase of HIV/AIDS. Despite the alarming growth of the epidemic, most women in India have very little or no knowledge of AIDS. The NFHS found that a large majority of Indian women had never heard of AIDS. Even among those who had heard of the disease there were many misconceptions about modes of transportation and treatment of this disease.

Abbott, Wallace, and Tyler, (2005) in their book entitled *An Introduction to Sociology: Feminist Perspective* highlight that women play a dominant role in health care systems, both as providers of care and as patients. Women have the major responsibility in the domestic sphere, for providing informal health care for husbands, children and other dependents. The history of women healers, explored the roles that women play in the health care system, analyzed the ways in which health inequalities affect women. Medical knowledge has played a powerful role in constructing popular images of women as inferior to men and as controlled by their bodies’ health. Until the development of feminist sociology little attention was paid to gender as a key
variable in understanding health. Feminists highlight the key role that women play as unpaid health care workers; they also draw attention to the ways in which conflicts develop between informal and paid providers, and the extent to which paid providers are unaware of the needs of the unpaid carer. The multiple roles that women play affect their physical and mental well-being. Women and men have different health care needs as men are more likely to have accidents while they are young but only women give birth to children. Indeed poor women with young children bear a particularly heavy burden and this has adverse consequences for their health. Women at home with young children are more likely than other to suffer from clinical depression. The discourse of health assumes that women will care for the members of their family when they are unwell and takes for granted, as natural, the health care work that women do in the domestic sphere. It also assumes that mothers will prioritize the needs of their children, putting their needs and care above their own needs and if necessary they will sacrifice themselves for their children. Gender inequalities in health care provision and the ways in which specific health care needs of women are ignored have been highlighted by feminists, including the ways in which the focus on explaining male authority has obscured the millions of premature deaths that women experience simply because they are women. Furthermore, feminists regard medical knowledge as highly gendered and part of the means by which gender division in society are maintained, modern medicine acts as a form of patriarchal control over women. Medicine not only reflects discriminatory views of women but serves to reproduce these views by actively stereotyping and controlling women who deviate from them. Women often experience the health care system as paternalistic and their own experiences and knowledge are ignored and downgraded. Although it is recognized that men and women do have different health experiences, little account has been taken of the sex/gender system in examining the pattern of health and illness.

Payne (2006) in his book entitled The Health of Men and Women analyze the relationship between gender and health. He shows that both men and women are affected by the shifting patterns (i.e., increase from communicable diseases to non communicable diseases) of health but there are important differences between them in how they are affected. Almost half of the increase in non communicable disease relates to cardiovascular conditions, which are experienced differently by women and
men. The rapidly increasing global burden of tobacco related illness is unequally distributed between women and men, HIV/AIDS is more prevalent among women and the marked increase in mental health problems is also experienced differently by women. The study explores the influences of sex and gender on health for both men and women, in order to understand the differences and the similarities between them, the relative importance of biological and socially constructed differences and the way these intersect with each other and with other factors affecting the health of men and women. Feminist thinkers in particular have argued that in health, the delivery of health care, medical research and the orientation of western medicine, women remain at disadvantage to men. This is most obvious in the health of women in developing countries where women have less food and less access to the economic and social capital of the household, but it is also true in more developed countries where women are also more likely to experience poverty, deprivation and social exclusion than men. As far as, their reproductive health is concerned women are particularly at risk especially in developing countries. There are other diseases where biological risk factors may act to increase women’s vulnerability. Women may be more at risk of lung cancer. These differences are related to sex specific genetic factors. Medical research continues to study major life threatening conditions using solely or largely male samples and this puts women further at risk. Further, class based inequalities may restrict access to health promoting resources such as a healthy diet, and increase the likelihood of living in poor quality or overcrowded housing and in deprived neighborhoods with high levels of pollution and poor resources.

Barry and Yuill (2008) in their book entitled Understanding the Sociology of Health argue that a man or women is not a fixed entity but is frequently defined by the needs and attitude of a society at a given time. Therefore, the status of men and women are located in very distinct and different social roles. These social roles require them to act in certain ways which are generally speaking, good for men but bad for women, the more feminine a role the lower status it tends to have and this can lead to poor health performing. A feminine role also carries much more pressure than performing male role. Women do experience more ill health then men because of the demands of their social roles. Further, women have a different experience of mental health care and mental illness from men. Women suffer higher levels of stresses due to their gender specific roles in society. Pressures created by expectations of what it is
to be feminine, the experience of stress and poverty all have potential negative consequences for the mental health of women. As far as morbidity is concerned women have some form of biological advantage in terms of life expectancy. However it also depends on multiple and diverse factors for example, levels of health care, the levels of poverty and endemic illness.

Biradar and Someshekhrappa (2015) in their article entitled *Health, Health Role, and Health Status of Indian Housewife: Some Issues* focus on the health of women especially the role of housewife in family and its impact on their health status. They are of the view that employment generally has positive effect on women’s health and housewives reported higher rates of illness than the working women. In Indian society woman is solitary care taker in family as she is always blended with one or the other activity where she habitually neglects her own health. Studies reveal that housewives are more likely to be under stress and isolation if they do not have freedom and social contacts within and outside home. This has adverse impact on women undergoing pregnancy, lactation and motherhood. Factors such as marital instability, lack of husband-wife communication, children tensions and family conflicts, have lot of impact on health status of housewives and women in general. Further, women, particularly housewives are more at risk at home where gender based violence is found to be one of the reasons for gender based victimization which leads to unwanted pregnancy, infection, miscarriage, gynecological problems, depression and many other forms of partial and permanent disability which affects health of housewives. It was found that women staying at home suffer disproportionately from inadequate housing, poor nutrition, poor sanitation, indoor air pollution, cooking in poor ventilated homes are hundred times more exposed to the unacceptable level of suspended smoke particles which is six times higher than other household members. Biological and social factors affect women’s health throughout their lives and have cumulative effects. Girls who are fed inadequately during childhood undergo stunted growth, leading to high risk of pregnancy complications and sexual abuse. Different health and nutritional problems affect women at different stages of life cycle from infancy to childhood, and from adolescence to adulthood comprising of reproductive years and post-reproductive period. Female genital mutilation also increases the chance of poor physical and mental health in later years. Apart from these health problems, other problems such as diabetes, blood pressure, heart diseases, joint pains,
respiratory problems, back pain also occur. Besides, mental health problems such as stress, anxiety, depression, frustration, mood swings are increasingly found among women. Further, the socio-economic conditions determine their access to health care. Individual and community perceptions of health care are important determinants of health seeking behaviour. As long as disability and disease are considered natural or predestined, women will suffer unnecessary from conditions which can be prevented or treated. The neglect of women’s health in our society has increased the risks of mortality and morbidity rates. The increasing costs of health care deprive poor women of better health care services especially in private hospitals. Health and health care system have lot of significance to housewives as they are more prone to health problems. Sometimes reproductive and other health problems need specialized treatment and diagnoses which is possible only in private hospitals, clinics etc. If care and treatment is not provided regularly, then the possibility of morbidity, mortality, and nutritional deficiency can be seen among women with having effect on child health causing infant mortality, low birth weight, under nutrition, infectious disease etc.

HEALTH OF WOMEN DURING IMPRISONMENT

Physiological Well-Being

Physical health can be defined as an essential part of overall health of an individual which includes everything from physical fitness to overall wellbeing. In general incarcerated women have worse physical health than women and men in the general population as well as incarcerated men.

Collines and Collines (1996) developed a document through findings from the National Institute of Corrections, U S Department of Justice, entitled Women in Jail: Legal issues. It explains that although women make up only a small minority of the prison population but their number have risen dramatically over the past decade. As might be expected most female inmates come from disadvantaged backgrounds with education and employment rare and abuse common. A survey of the histories of female jail inmates found that more than forty four percent of women reported that they had been either physically or sexually abused at some time before entering jail out of them over thirty percent reported such abuse before the age of eighteen, compared to thirteen percent of men reported prior abuse. Further, the low number and percentage of female inmates in most jails resulted in lack of gender specific
services and program. Eighty percent to ninety percent of jails which offer intake screening and/or mental health services those specific to women are often poor or absent. These services vary from basic gynecological examination to pregnancy related concerns including obstetric examinations, child birth and abortions. Approximately, half of all jails do not offer these services to women inmates. Although, less than five percent of female are pregnant at the time of intake, the pregnant inmate present an extremely serious situation for jail officials because of factors such as poor socioeconomic conditions and drug use before incarceration. This produce a greater demand for medical care and can require more extensive medical training for jail staff who must be able to recognize when such care is needed. Sexual harassment by correctional staff is another potential problem that can confront the female inmate. The physical assault, vulgar sexual remarks, and lack of privacy all contribute to an unacceptable level of anxiety marked by significant depression, frequent headaches, insomnia, fatigue, anxiety, irritability, nervousness, and a loss of self-esteem and constituted cruel and unusual punishment. The legal principle upon which courts evaluate conditions and practices generally apply equally both to men and women, however relatively little legal attention has been given to applying these legal principles to female inmates. The result that is common in jails across the country is that female inmates continue to receive fewer programs, live in poorer conditions, and generally are not treated in a way substantially equivalent to that offered to male inmates.

Covington (1998) in his study entitled Women in Prison: Approaches in the Treatment of our most Invisible Population views that there are many reasons for the growing numbers of women in the criminal justice system but the primary one is the increase in drug related conviction and the advent of mandatory sentences for these offences. However, female prison populations differ from their male counterparts in several significant ways. Firstly, they are less likely to have committed a violent offense and more likely to have been convicted of a crime involving alcohol, other drugs or property. It is important to point out that many property crimes are economically driven, often motivated by the abuse/addiction of alcohol and other drugs and/or poverty. A 1994 study done in California showed that 71.9 percent of women had been convicted on a drug or property charge versus 49.7 percent of men. Men also commit nearly twice the violent crimes that women do. Women are
significantly less violent than their male counterparts, and show more responsiveness
to prison programs, although they have less opportunity to participate in them than
male prisoners do. However, imprisonment affect more adversely to women. They
suffer more from physical, psychological and reproductive ill being than men. For
instance, one major health concern in prisons is AIDS. In a study done with 400
female volunteers in a Massachusetts's prison, 35 percent of the women tested were
HIV positive, compared with 13 percent of the men. Further, women who have
children feel enormous guilt about being absent from their children’s lives and worry
about whether they will still have custody of their children when they get out.

National Criminal Justice Reference Service [NCJRS], England (1998) conducted a study entitled Health Issues Specific to Incarcerated Women: Information for State Maternal and Child Health Programs. For the purpose of study surveys were
designed to acquire factual information from State Department of Corrections and Administrators of Prisons and Jails that house women. All State Correctional Departments and at least one prison in each state as well as jail administrators were
surveyed from 50 country jurisdictions. The study shows that the number of
incarcerated women in the United States has increased dramatically. Poverty and
addiction appear to frequently motivate criminal acts by women. The most common
offences committed by women in local jails are property offences, violent and public
order offences are less common among women. Women entering state prison are less
likely than men to have a violent criminal history and they are more likely than men
to have no previous sentences. Women entering the correctional system represent a
population already at high risk for communicable diseases, substance abuse and
mental health problems. Therefore, incarcerated women represent a population clearly
at high risk for health problems, including problems that may affect the children and
eventually the general public. In addition, many women in the correctional system are
caught in a cycle of crime and dependency. With increasing numbers of women
entering and exiting the prison system, there is a compelling need to ensure that
mechanisms are in place that can adequately address these health issues. Recognizing
that women entering the correctional systems are more likely to be affected by
communicable diseases than women in the general population, it is of utmost
importance to provide screening and appropriate treatment. Untreated women
returning to the community following a period of incarceration may place themselves
and others at risk for further health complications. In addition to standard health care needs, pregnant women entering the correctional system have health concerns specific to prenatal, post-partum and infant care. There are also specific needs for women who have decided to terminate the pregnancy, such as provision of counseling, medical treatment and family planning services. Although most pregnant incarcerated women would be considered at risk for complications, access to specialists including obstetricians and gynecologist is often limited in correctional systems because of cost and transportation issues. The number of incarcerated men historically has far exceeded that of incarcerated women, limited attention has been paid to the unique health concerns of this population. Therefore, most programs in women’s correctional facilities are based on models designed for men. The period of incarceration presents an opportunity to provide treatment and support as well as to improve the health status of this population. Therefore, offering public health assistance and expertise to correctional facilities is an important means for addressing the gaps in services and programs for women in the correctional system. In addition such efforts will benefit the health of individuals in the communities to which these women return.

Webb and Hubbard (2006) ex-prisoners, in an article entitled Voices of Incarcerated and Formerly Incarcerated Women describe their experiences of living in prison. Webb stayed for seven years and Hubbard stayed for eight years in Georgia State Corrections System. Their experience of prison life revealed the pathetic condition of women prisoners because of the lack of appropriate, timely and sufficient medical care. They also expressed the stresses and strains experienced by them as well as the failure of the mental health and social service system in encouraging rehabilitation among prisoners. Errors in diagnosis, administration of wrong medications, and lack of medications were just a few problems faced by women prisoners. There was lack of emergency medical care. It was hard to get medical attention if inmates had emergency inside the cell and need to see someone right away. Issues related to improper nutrition and a dietary standard inside the prison was also another common problem among the inmates. A lot of health problems come from improper diets and limited time to eat. Most of the time women inmates were allowed five to seven minutes to eat their meals. This led to digestive and severe stomach problems. Although drug use was not the greatest problem women in prison faced but it was the pattern of thinking that they were not worth the effort to do better,
be better or have better that sends them into a spiral of self destruction. The consequences of being unaccountable, inconsistent and uncommitted led them to continue their sufferings.

Arriola, Smith, and Farrow (2006) in their article entitled *Criminalizing the Victim: Interpersonal Violence in the lives of Incarcerated Women* attempt to highlight the prevalence of violence among incarcerated women and consequences of this violence on the physical health of women prisoners and their accessibility of health care facilities. Incarcerated women appear to be most affected by interpersonal violence. Available data indicated that women are more often the victims of violence than the perpetrators of violence. The repeated experience of extreme physical or sexual abuse whether at the hands of loved ones or strangers causes severe disorders in women’s life and places them on a life trajectory that often leads to incarceration. Most of the women prisoners were often homeless just prior to incarceration and prisoners who were homeless were more likely to report physical impairment or medical problems than those with more stable housing situation. These inmates had higher rates of illness for infectious diseases, respiratory and digestive conditions, genitourinary disorders, headaches, ear disease, skin and musculoskeletal diseases compared to their male counterparts. A history of physical and sexual abuse is highly correlated with drug abuse, prostitution and unsafe sex practices such behavior prior to incarceration places women prisoners who have been victimized at high risk for sexually transmitted diseases and HIV/AIDS. Fear and shame often prevent women from seeking medical help for physical or sexual abuse while in the community they maintain regular health visits for themselves and their children. Thus female inmates either prior to incarceration and post incarceration do not receive medical treatment for either intimate partner violence or drug abuse. Without help, stress as well as physical and mental harm continue unabated.

Plugge, Douglas, and Fitzpatrick (2006) in a research article entitled *The Health of Women in Prison: study findings* conducted by the Department of Public Health University of Oxford to examine the health of women prisoners in England and Wales. For the study five hundred and five women’s sample were taken from two busy remand prisons in England and Wales over a six month period. Questionnaire was used as a tool for data collection. The findings of the study suggest that women prisoners have specific health needs which differ from those of male prisoners. They
also experience more ill health with high level of mental disorders, drug misuse, alcoholism and infectious diseases including poor physical, psychological and social health in prisons. Their health was worse than that of the group within the general population who had the poorest health. In the research women prisoners responses indicated that their constructions of healthiness were not limited only to notions of the lack of disease but they also emphasized good mental health, social integration, resilience and inner strength as important dimensions of good health. When they were asked to describe their own concept of health in the light of this statement woman’s assessment of their health status prior to imprisonment was complex. In the study some women were able to describe ways in which they had enjoyed good health before imprisonment. This perception was related to reports of balanced nutrition, good mental health, physical activity and the absence of behaviors such as excessive smoking or drinking which might have an adverse consequence on health. More commonly women reported a range of factors that had compromised their health prior to imprisonment, including problematic drug use in which drug dependency had led them to neglect their health. The study revealed sharp contradiction between the women who had histories of problematic drug misuse and those who did not, on the issue of impact of imprisonment on their health. Non-drug using women reported that imprisonment led to a decline on their health. They reported being less active, having poor nutrition and greater incidence of illness particularly the restrictions of the regime on their ability to self care and to maintain their own health. For drug using women the situation was more complex they were often in denial themselves about the extent of the harm that drug misuse had caused to their health. There was also a profound sense of fear and dread surrounding detoxification. However, over time those women, who had undergone detoxification, noted the real benefits to their health as a result. As far as positive impacts are concerned, for many women with chronic addiction problems, imprisonment provided housing, regular meals and a respite from the drug use and associated violence as a result women described improvements in their mood, eating and sleeping pattern and in their weight. It shows that stay of women in prison provide positive result for some women. As far as an overview is concerned about the impact of imprisonment on health of women, it provide more negatively on their physical and psychological aspects of health. The dirty environment of prison with unhygienic sharing of facilities, overcrowding with a lack of fresh air, ventilation and with limited access to personal hygiene products, the
situation was problematic. Further, lack of sanitation inside cell was especially unpleasant when women woke to find that their periods had started and that they would have to wait, sometimes for hours to be unlocked to access a toilet.

Arriola, Braithwaite, and Newkirk (2006) in their article entitled *An Overview of Incarcerated Women’s Health* provide a general overview of health issues and availability of health care facilities for women in prison. However, some behaviors and health conditions are particularly relevant to the lives of women prisoners that are the use of illicit drugs and drug addiction, unprotected sex with multiple and high risk partners and mental health problems. The poor health status of incarcerated women reflects the inequalities that exist in the political, social and economic structure of the larger society. Unfortunately the growth in the female prison population has not led to an increase in specialized services for women. Health care services for incarcerated women continue to be subpar, with less availability than the care offered to male offenders. Health care professionals those work in correctional environment often appear inhuman because of ambivalent feelings towards the women. It was reported that medical exams were often cold and impersonal often conducted by male physicians and, that they do not explain what they are doing, which serves to further traumatize an already terrified women. In most settings where women receive health care including the correctional settings the psychological issues are not addressed although these issues may have a major impact on the health problems of women prisoners. This lack of attention to psychological issues also leads to exacerbation of physical health complaints, which presents non specific pain and sense of uneasiness. When women come to the medical staff with these complaints they are often overlooked because clinicians become desensitized and take on the correctional jargon that they just want attention.

Braithwaite (2006) in his article entitled *Understanding How Race, Class and Gender Impact the Health of Incarcerated Women* highlighted the effect of incarceration on physical, mental and social well being of women and factors behind increasing number of incarceration of minority prison population. Further, for poor women of color their race, class and, gender make the environment of prison particularly harsh for them. Historically, women have been under represented at all levels of the criminal justice system. This under representation of women has resulted in a criminal justice system created by males for males in which the diverse needs of
women are forgotten and neglected. Women entering the correctional system represent a population already at high risk for communicable diseases, substance abuse and mental health problems. Medical issues that relate to reproductive health and to the gynecological issues that surround imprisonment of single female heads of household are often overlooked. Women in prison complain of the lack of regular gynecological and breast exams and argue that their medical concerns are often dismissed as exaggeration. Additionally, many imprisoned women are survivors of physical and sexual abuse and have lacked previous health care in their communities. These factors put them at even greater risk for having high risk pregnancies and for developing life threatening illness such as HIV/AIDS, Hepatitis C, and cervical cancer. The large increase in the number of female inmates over the last twenty years required the attention to the diverse needs of women and it is important to understand the many factors contributing to the increase of women’s incarceration. Women prisoners are more likely to drink or use illegal drugs for self-medication than male offenders because drug use offers them psychological comfort and a way to escape from pain that stems from extensive histories of sexual and physical victimization. Despite being imprisoned and presumably safe from harm in prison they were victims of sexual abuse by prison staff during routine medical examination. Although female inmates have largely not resorted to violence to make their concerns heard, they also feel that women prisoners view that prison staff do not respect them or seek to meet physical, psychological and social needs.

Baucom, Baucom, Brown, and Mouzon (2006) in an article entitled Tuberculosis: No Longer the “White Plague” reviewed the global and national impact of Tuberculosis (TB) on the health of women and the potential impact of gender disparity and cultural bias on women behind bars. Tuberculosis is an airborne disease and human beings are the only known transmitters of it. Signs and symptoms of TB disease may include hemoptysis, cough, night sweats, weight loss, fatigue, chest pain and chills. Outbreaks of TB in prisons in Russia, Spain and India as well as other countries have been seen throughout this century. This is directly related to the increased rates of incarceration of women secondary to substance abuse. Women prisoners affected by Tuberculosis are more likely to be poor, substance abusing, homeless, and victims of sexual and domestic violence. Rates of TB among female reflected the racial and ethnic disparity found in the general population. TB cases
among incarcerated men and women is hundred times greater than that of the general population so the most common denominators among the victims of TB that incarcerated women share are race, gender, poverty and drugs. Women’s social histories and experiences prior to incarceration strongly affect their health needs which in turn affect the manner in which the medical staff delivers its services. The stigma attached to any disease is much more devastating to women than to men as it extends more often to her children and her family. Women inmates often have a basic lack of health education and comprehension regarding the impact of disease on health. They may feel overwhelmed by the challenges posed by chronic disease or other health conditions. To these women TB treatment is not grasped as an opportunity for wellness but another burden while incarcerated. Women have gender disparities directly related to the correctional environment that impact their potential compliance to various treatment options related to TB and other diseases. These women have unique cultural and social interactions with medical providers and custody staffs that provide increased barriers to treatment and care while incarcerated. Social isolation from other women inmates who may serve as support may be severed when an inmate is placed in respiratory isolation. This compulsory segregation may be difficult for women who are already isolated from children, are single parent and add to disobedience if one cannot offer increased visitation with children or members of the patient’s family as an incentive. Directly Observed Therapy (DOT), a base of World Health Organization (WHO) and Communicable Diseases Center (CDC) recommendations for TB treatment is often compromised in prisons.

Groot, and Maddow (2006) in their article entitled *HIV/AIDS Infection among Incarcerated Women* describe the prevalence of higher rates of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) among female prisoners and the factors that give rise to the high rate of HIV/AIDS among this population. Incarcerated women have higher rates of HIV infection than men because women have particularly high rates of HIV risk factors in the community both before and after incarceration, including drug use, sex work, childhood sexual abuse and physical abuse. There are many factors affecting the HIV prevalence rate, it includes demographic considerations such as race, health and behavioral issues including sex and drug use as well as more complex social issues like poverty and sentencing laws. Each of these factors contributes to poorer health, decreased access to adequate and
affordable health care, and/or increased exposure to community violence. The presence of these factors alone do not cause poor outcomes in itself, but they each influence women’s chances of participating in activities that lead to incarceration and put them at risk for HIV infection. For a variety of social and economic reasons incarcerated women may have little access to HIV/AIDS services in the community. Therefore, time in prison presents an important opportunity to learn about HIV infection, acquire prevention skills, get tested and gain access to HIV/AIDS treatment and other health care facilities. For many individuals it is difficult to consider sensitive and life changing issues such as HIV/AIDS in correctional setting. Incarcerated women who know that they are HIV positive do not always seek care in the prison health units, preferring instead to postpone care until they are released and can return to the care of community-based clinicians who have engaged their trust. Trust and sensitivity are key ingredients to a successful HIV management program for incarcerated women. Discharge planning programs initiated during incarceration can also help connect women to community medical services, drug treatment and support services that provide child care, safe affordable housing, job training and employment opportunities that will all serve to increase a woman’s ability to continue to care for her own health needs. Overall incarceration provides a critical opportunity for the education; diagnosis and medical care of HIV infected women as well as a public health opportunity to reduce the spread of HIV infection.

Macalino (2006) in his article entitled Hepatitis C Virus Infection among Incarcerated Women examined the prevalence of Hepatitis C Virus (HCV) among women prisoners and also highlight reasons why HCV is a serious health concern for incarcerated women. Although female inmates comprise a smaller segment of the incarcerated population compared to males they may actually represent an incarcerated population with higher risk of contracting HCV. While incarceration does provide a brief window of opportunity to access health care, the two most common reasons that incarcerated individuals remain untreated for HCV are cost and length of treatment. Female inmates are often housed in smaller facilities where it is more difficult to maintain confidentiality. The stigma associated with HCV infection and the desire of women to maintain the maximum level of privacy which is not possible in an incarcerated setting may prevent them from accepting and/or adhering to treatment. Even if eligible women initiate treatment for HCV while incarcerated,
they may be released during the six-to twelve month course of therapy and when they reintegrate into the community, HCV continuation of treatment may not be their highest priority. Correctional facilities offer an opportunity to implement the Communicable Diseases Center’s (CDC) strategy to prevent and control hepatitis C virus infection and diseases. This strategy combines primary prevention activities (i.e., screening and testing of blood products, risk reduction counseling, and implementation of infection control practices), secondary prevention activities (i.e., identification, counseling and testing of persons at risk and medical management of infected persons), surveillance and research.

McQUEEN (2006) in her article entitled *Cardiovascular Disease* attempts to highlight Cardiovascular Diseases (CVD) among women in prison as well as the role of incarceration to provide an opportunity of health care. Women make up a small percentage of the confined population and in spite of an increasing rate of incarceration there is a dearth of information available regarding their cardiovascular status. Most studies only address substance abuse, mental health problems, and sexually transmitted infection in women behind bars. There is a belief in society that heart disease is a man’s problem and women are more likely to survive a heart attack is not unfamiliar attitude in the current medical arena. It is true that cardiovascular events causes most deaths in men and women’s heart disease presents 10 to 15 years later than men but in retrospect cardiovascular disease has always been an equal opportunity threat. Societal myths say that women are expected to experience adverse health outcomes merely due to incarceration. However, there is no literature to support the idea that incarceration alone directly leads to adverse outcomes. In fact, experiences reflect quite the contrary. Most of the patients receive better medical care while incarcerated and for many the care received during incarceration is the first encounter with any health care provider. Literature indicates that the overall cost of medical care for females is typically high than males in the free world and the same appear to be true for those who are incarcerated. Women were found to be less receptive of medical recommendations and more demanding of the time of medical and correctional personnel than men. The author’s encounters with the female population were for sick call problems related to gynecological, dermatological, or various musculoskeletal pains. There is clearly a demand to find the necessary resources to provide a more comprehensive approach to the management of
cardiovascular disease in all women; education should be the first priority. Confinement is an isolated opportunity to offer education and treatment. Collaborative efforts between community and correctional practitioners could lead to improvement in sharing patient’s information and the joint development of practice guidelines. This will help to maintain continuity of care upon release.

Wolf, Bloom, and Krisberg (2008) in their study entitled The Incarceration of Women in California emphasize that female incarceration has increased dramatically and disproportionately in recent decades. While the total number of California male prisoners grew 866 percent between 1979 and 2007. The number of female prisoners grew 892 percent during the same period. Women are particularly vulnerable to policy changes because they are more likely than men to be incarcerated for drug related or petty, nonviolent property crimes and these types of arrests drive women’s high rates of incarceration. Further, drug use, risky sex behavior, inadequate health care, poverty and histories of sexual and physical abuse put women at risk for a number of physical and mental health issues. Incarceration facilities often perpetuate physical health problems due to lack of appropriate sanitation and overcrowding. The most prevalent infectious diseases in women’s prisons are Hepatitis C, HIV/AIDS and STDs. Prisoners affected by HIV and Hepatitis C, are further disadvantaged because they cannot access more effective treatments widely used in community. These inadequacies in prison health care for women have consequences beyond individual women as they often leave prison and return to their communities with untreated and sometimes new infectious diseases. Mental health treatment constitutes the largest unmet need in incarcerated women’s health care service provision. Incarcerated women have high rates of depression, anxiety, post-traumatic stress disorder and substance abuse. Instead of addressing women’s multitude of underlying issues mental health treatment often consists of prescribing medication. Further, women in prisons are especially at risk for reproductive health problems due to histories of sexual abuse, high rates of sex work and prior limited access to health care services. Without early detection, treatable conditions can have extremely serious outcomes such as miscarriage, infertility or lead to life threatening disease i.e., cancer. Incarcerated women face many institutional obstacles in accessing health care. In addition, they often complain of delays in receiving their medication. Further, there is
no continuity of care for incarcerated women. Even women with serious health issues or who are pregnant are left without care.

Penal Reform International Organization [PRIO] (2008) conducted a study entitled Women in Prison: Incarcerated in a Man’s World viewed that over half a million women and girls are held in penal institutions around the world, the largest populations being in the United States, the Russian Federation and Thailand. Everywhere, women are a minority in national prison populations but their numbers are increasing in many countries. The increase in women’s imprisonment is fuelling the global trend towards the overuse of imprisonment and reflects the under-use of constructive alternative sanctions. Some common factors that lead to women’s imprisonment are that, they have committed petty, non-violent offences, they come from impoverished and marginalized parts of society and they tend to have a background of physical and emotional abuse, mental health problems and alcohol or drugs dependency. Women’s imprisonment is closely related to poverty, both as the reason for women’s offences and because women often cannot afford legal services or to pay fines and bail. Female prisoners are often primary or sole carers and their incarceration can have a devastating effect on their family, particularly on young children. The fact that there are fewer women in prison means that there are a smaller number of women’s prisons. The consequences of this include women being held at a greater distance from their communities and families, that is a particular hardship for women with children. Women who report domestic violence may be ignored or further abused by the police. Conditions for women in pre-trial detention are often worse than for sentenced prisoners and women may face harsher sentences because of perceptions that only bad women commit criminal offences. Moreover, women’s ethnicity, nationality or sexuality can add to their disadvantage. Therefore, the health status of prisoners is generally lower than that of the general population and women’s health needs may be seriously neglected in a male-dominated prison system. Many women prisoners have a background of physical and sexual abuse or of alcohol and drug dependency and have not had adequate health care prior to their incarceration. Women in prison often have a higher level of mental health problems than women in the general population. Mental illness is often both a cause and a consequence of imprisonment. The rates of self harm and suicide are often greater among female than male prisoners and both are higher than in the outside community. Motherhood is a
factor that appears to protect women in the community against suicide but this protection does not apply in prison where mothers are separated from their children and those serving long sentences may lose their opportunity to have children. Female prisons held in low security accommodation could only be hospitalized or receive dental treatment at a restrictive high security facility with the result that a number of women are refused for medical treatment. At the most basic level, prison authorities around the world fail to cope with women’s menstruation. They fail to provide sanitary napkins and provide them only as part of medical supplies or sometimes withhold them as punishment. Further, privacy, adequate bathing and washing facilities are often lacking.

Douglas, Plugge, and Fitzpatrick (2009) in their article entitled The Impact of Imprisonment on Health: What do Women Prisoners Say? discussed the impact of imprisonment on women’s health. They highlight the women prisoners’ perceptions of the effects of imprisonment on their health and well-being and the implications for custodial and health care practice. The authors conducted a qualitative study in 2005 in two local women’s prisons in England receiving remand and sentenced prisoners. For the purpose of study, focus groups and individual interviews were conducted only of those women who were detained for at least one month. The study shows that the impact of imprisonment on women’s health was mixed but was largely perceived to be negative. This included the immediate shock and disorientation of imprisonment, isolation from their families and the larger tedium implications for their physical and mental health. However, the impact was not uniform and there were important differences between women. Prisoners in the UK tend to come from socially marginalized backgrounds where persistent health inequalities remain. Studies reported higher rates of mental ill health, problematic substance misuse, communicable diseases such as HIV and hepatitis, smoking and chronic illness or disability. Women prisoners reported higher rates of violent victimization and ill health on a range of physical and mental health indicators. By its inherent nature, imprisonment is contradictory to improving human health. The ethos and experience of imprisonment, the increased control and surveillance, that prison based health programs represent the prioritization of criminal justice aims over health interventions, the stigmatizing attitudes and the poor practice of prison health care providers make highly problematic the claims of those who argue for the health
promoting potential of prisons. Given the psychological stresses of imprisonment, separation from families, loss of control of their own lives and living in proximity to those with severe mental illness or other significant health needs, women perceive that coping with imprisonment was a testament to their emotional strength. Several women also gave vivid accounts of having witnessed successful suicides during sentences and the enduring psychological trauma of this. Despite efforts by the prison authorities to address the problems, women complained of unclean facilities and several accounts of vermin infections. On the other hand, women with substance misuse problems commented that the period of their imprisonment allowed them space to comprehend the reality of how their addiction had affected their health and the changes that they had observed. For some women prison offered an opportunity to get the help that they needed. Better nutrition, a stable routine and an opportunity to access health care and drug treatment services were important opportunities. Sexual abuse, exploitation and domestic violence were often a feature of these women’s lives. By separating women from their partners, imprisonment offers a respite from the abuse. An important respite from risky lives that compromise health can have benefits for the health of women prisoners. Prisoners with the lowest standard of self care outside prison can experience health improvement. Other studies have identified beneficial health outcomes of imprisonment, including during pregnancy.

Indig, McEntyre, Page, and Ross (2009) conducted a study entitled 2009 NSW Inmate Health Survey: Key Findings Report to explore the health status of the New South Wales (NSW) prison population. The study was conducted by taking a random sample of 996 participants. The findings of the study shows that the physical and mental health problems, drug use, alcohol dependence, and blood-borne viruses all are highly prevalent among prisoners. Over half of participants were overweight, the largest increase in overweight and obesity was found among women. In comparison to their counterparts, women experienced more heart related problems such as chest or angina pain and high blood pressure. Moreover, the most prevalent conditions reported by older women were poor eyesight, asthma, arthritis and back problem. As far as mental health is concerned the three most common mental health conditions were depression, anxiety and drug dependence. However, many of the women never having accessed any form of health care in the community. For many inmates incarceration does provide an opportunity to address their health issues in a relatively
stable environment in which access to and continuity of health care may be easier to achieve than in their personal circumstances in the community. It was reported that majority of prisoners had used illicit drugs, compared to just over a third in the general community however there have been important changes over the course of the surveys in injecting drug use. Further, a striking finding from the survey was the substantial drops in the proportion of the participants who were Hepatitis C antibody positive.

According to the World Health Organization [WHO] (2009) report (based on the study conducted by United Nations Office on Drugs and Crime) entitled Women’s Health in Prison: Correcting Gender Inequity in Prison Health women’s status in society is low, they are deprived and their social status affects their health status in society as well as in prisons. The health status of prisoners is generally much poorer than that of the general population and women in prison often have more health problems than male prisoners. Women in prison frequently come from deprived background and many have experienced physical and sexual abuse, alcohol and drug dependence, and inadequate health care before imprisonment. Women who have experienced violence and abuse before they entered prison may have 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 problems including problems related to reproductive system of women. Many women have chronic and complex health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnourishment and poor health care in society. Drug dependent women offenders have higher prevalence of tuberculosis, hepatitis, toxemia, anemia, hypertension, diabetes and obesity compared to male offenders. Women are marginalized and their socially deprived backgrounds also place them at high risk of acquiring HIV infection and other infectious disease.

Kumar, Kumar, Pattankar, Reddy, and Dhar (2009) conducted a study entitled Health Status of Prisoners in a Central Jail of South India in the central prison of Gulbarga over a period of one year, to access the health status of convicted life term inmates of prison and to study their socio-demographic profile. For the study, three hundred convicted prisoners were interviewed. The result of the study showed that the prison population consisted of an over representation of numbers of the most marginalized groups in society with poor health and chronic untreated conditions.
Their health problems are neglected and they carry a much greater burden of illness that is determined both by the environment out of which they come and by the prison in which they live. In India, there are about 1276 prisons with an authorized accommodation of 2,77,304, however the total number of prison inmates is nearing four lakh indicating severe overcrowding in prisons. Inside prisons, the lack of adequate facilities, inflict punishment twice, formerly by incarceration and second by illness. There are problems of drug abuse, alcoholism, trauma, homicide, suicide, violence, neuropsychiatric, epilepsy, stress manifestations, HIV infections and AIDS, sexually transmitted diseases, tuberculosis, skin infections and so on. The prevalence of tuberculosis in the present study was high when compared with that of the general population in India; this could be because of over-crowding, poor living condition, and close contact with one another. The study revealed that the majority of prisoners one hundred and ninety one (63.67%) were morbid. The reasons for major morbidity may be prolonged contact between prisoners, inadequate chlorination of water, inadequate water supply, taking bath occasionally because of non-availability of water and so on.

A Jailhouse Lawyer’s Manual (2011) entitled *Chapter 41: Special Issues of Women Prisoners* written and updated by members of the Columbia Human Rights Law Review, highlights that since majority of the prisoners are male, prison programs often focus on issues faced by male prisoners and overlook those faced by female prisoners. Female prisoners and their advocates have used the equal protection clause of federal and state constitutions to get programs and services for women substantially equivalent to those provided to their male counterparts. According to the law men and women prisoners are similarly situated and discriminated on the basis of their gender. The court can allow discrimination between male and female prisoners who are similarly situated only if the differing treatment has a fair and substantial relationship to achievement of the State’s correctional objectives. This means that prison can treat men and women differently if the different treatment is substantially related to the prison’s goal, such as safety and security. Research has shown that female prisoners have different and often more severe, health problems than male prisoners. Many women prisoners 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. Women prisoners also suffer from mental illness at
higher rates than male prisoners. However, the prison environment does not always take into account women’s specific health needs. For example, prisons often do not provide accessible hygiene products during menstruation, adequate nutrition for pregnant women or specialized care for women who are infected with diseases like HIV/AIDS. However, women have a federal right under the Eighth Amendment to receive adequate medical care for serious needs.

Alves, Maria, and Teixeira (2016) in their study entitled Health Conditions Prior to Imprisonment and the Impact of Prison on Health: Views of Detained Women highlight that detained women have certain health conditions prior to incarceration. These conditions can improve, worsen or remain the same in prison, depending upon the previous background, the characteristics of the prison and the arrest experience. The study was conducted in 2011, on the fifteen respondents of Portugal women prison through semi-structured interview schedule. The incarcerated women are mostly characterized by their pre-incarceration health risks such as addiction, trauma, prostitution and homelessness. Prison could represent an environment that promotes the reduction of health risk behaviors, interrupts histories of maltreatment and facilitates access to health care, including the diagnosis and treatment of disease as well as the implementation of preventive services and health education plans. In this sense, prison can affect populations that are rarely reached by primary health care, working on a public health level. The findings of the study reveal that imprisonment proved advantageous for the women who suffer with chronic illness, drug addiction and victims of interpersonal violence. Women inmates were of the view that certain characteristics of prison i.e., noise, overcrowding, diet, behaviour of the other inmates, routines, clinical services, job opportunities, isolation, length of imprisonment and legal issues determine their health status. The routine of daily life was identified as a factor that prevents inmates from having more positive health behaviour. The financial compensation for work is crucial for maintaining health habits in prison. Unemployed inmates have a negative influence on health due to lack of money and the excessive cost of necessities and goods inside prison. However, quality of food, availability of health cares services and the opportunities to maintain an effective and continuous monitoring of disease influence health status positively. In general, the inmates with chronic diseases, substance abuse and who live in adverse conditions prior to imprisonment reported benefits in their health status since entering
prison while, women without previous illness did not report it beneficial. Women have central roles in family routines, when they are detained, they see themselves forced to leave their families which results in high level of anguish and suffering and enhances deterioration of their mental health. Therefore, separation from family is a source of distress for most of the inmates because of their concern about their family and their sense of helplessness. The effect and limitations of clinical services not only in supporting the mentally ill but also during urgent situations were perceived as harmful to the health of this group. However, in an adverse environment, these conditions provide some positive changes with clinical services playing a crucial role not only in the diagnosis and treatment of disease but also in the process of drug detoxification. In addition, the prison environment swept some women away from abusive relationships and risky habits, yielding a positive influence on their health.

**Psychological Well-being**

Mental health can be defined as a state of well-being enabling individuals to realize their abilities, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental illness involve disturbances of thought, experience and emotion, serious enough to cause functional impairment in people making it more difficult to sustain interpersonal relationships and carry on their jobs and sometimes leading to self destructive behavior and even suicide. Unfortunately, in most parts of the world, mental health and mental disorders are not accorded anywhere near the same degree of importance as physical health. Rather, they have been largely ignored or neglected (http://www.who.int/mental_health/en/investing_in_mnh_final.pdf). The situation is worse in prisons. Women in prison have higher levels of depression anxiety, phobias neuroses, self mutilation and suicide compared to the general population and male prisoners.

Turner, and Tofler (1986) conducted an empirical study entitled *Indicators of Psychiatric Disorder among Women admitted in Prison* in Holloway prison in Southern England. Holloway is a modern built prison for women in North England. For the purpose of study seven hundred and eight women were selected as a sample. The bases of psychiatric disorder were drug abuse, self harm and history of psychiatric treatment as indicators instead of detailed personal histories, offences and mental health status of the prisoners. The findings of the study suggest that women with a psychiatric history were significantly older than women with no such
condition. Women with a history of deliberately cutting themselves were significantly younger. Over a quarter of the women have deliberately harmed themselves and nearly a third was taking some form of psychotropic drugs. The study shows three key points regarding women prisoners. Firstly, there remains a need for psychiatric unit in a women’s prison. The prison unit may have expertise in detoxification and withdrawal from drugs with links to outside services. Secondly, changes in the organization of the psychiatric unit may well be required in structure, staffing and philosophy of management as recommended by the Holloway Project Committee. Finally, a prison with its controlled environment is a suitable place for the treatment of personality disorders, drug dependence and deliberate cutting. Progress in these poorly understood problems of psychopathology would benefit not just the victim but society in general.

Fickenscher, Lapidus, Walker, and Becker (2001) conducted a study entitled Women behind Bars: Health Needs of Inmates in a Country Jail in Oregon (Multnomah county jail) to assess the prevalence of behavioral risk factors and correlates of poor self reported health among incarcerated women. For the purpose of study two hundred and sixty-four women were interviewed by using a structured questionnaire. It was found in the study that women constitute the fastest growing segment of incarcerated population in the US including both jail and prison inmates. Despite the growing number of female inmates in jails and prisons little documentation exists on behavioral risk factors and health care status of these women. It is also pathetic that female jail inmates are typically of low socio-economic status have low level of education, histories of physical and/or sexual abuse. Women in jail frequently reported limited access to health care prior to incarceration, history of homelessness and participation in high risk behavior such as engaging in unprotected sex for money or drugs.

Martel (2001) in an article entitled Telling the Story: A Study in the Segregation of Women Prisoners attempts to highlight the women’s experiences during and after segregation. An empirical study was conducted by taking sample of twelve segregated women in Canadian Prisons. Literally, meaning of segregation is isolation or separation. Segregation is a prison practice used for separating and isolating a prisoner from the general inmate population for reasons ranging from safety (e.g. protective custody) to punitive purposes (e.g. disciplinary segregation).
Although segregation is practiced similarly in men’s prisons (deprivations and humiliation are often generalized practices), women will have a unique sense of their confinement in segregation because this sense is intertwined with the gendering project of the prison regime and their own disadvantaged position in society. In sum, women prisoners are placed in segregation to counter or circumscribe particular types of violence that often result from the oppressive nature of imprisonment (e.g. self induced violence, fires, drugs etc) or from assumptions about femininity (e.g. mouthing off, swearing, fighting, tattooing). Segregation as practiced in federal and provincial prisons in Canada is generally abusive. Segregation violence is prevalent in both (provincial & federal) systems and although it takes different forms in each apparatus, neither is more or less oppressive than the other. Suicide and drug overdoses are frequent occurrences with women in segregation in Canadian federal prisons. Segregation is experienced by the participants as rejection, abandonment, dehumanization and as a general lack of acknowledgement of their existence. Women reported intentionally harming themselves in the hope of being transferred from segregation to the institutional health services unit or a community hospital. Half of the participants experienced difficulties with being in crowded or noisy rooms, anxiety, reactions, paranoia, fear or utter hate of being around people, especially soon after being reintroduced to the general prison population. To adapt such overwhelming feelings, many women willingly isolate themselves from the rest of the prison population. This isolation from human contact eventually led them to experiences feeling of invasion of their personal space when in the presence of unsolicited or intimate human contact.

James, and Glaze (2006) in their article entitled Mental Health Problems of Prison and Jail Inmates show that female inmates had higher rates of mental health problems than male inmates. The findings of the study show that an estimated 73 percent of females in State prisons had a mental health problem compared to 55 percent of male inmates. In Federal Prisons, the rate was 61 percent of females compared to 44 percent of males and in local jails, 75 percent of females compared to 63 percent of male inmates. The same percentage of females in state prisons or local jails understood that in the past 12 months they had been diagnosed with a mental disorder by a mental health professional. This was almost three times the rate of male inmates who had a mental health problem. The rate of mental health problems also
varied by the age of inmates. Inmates aged 24 or younger had the highest rate of mental health problems and those aged 55 or older had the lowest rate. Among state prisoners, an estimated 63 percent of those aged 24 or younger had a mental health problem, compared to 40 percent of those aged 55 or older. The high rate of symptoms of mental health disorder among jail inmates may reflect the role of local jails in the criminal justice system. Jails are locally operated correctional facilities that receive offenders after an arrest and hold them for a short period of time, pending accusation, trial, conviction, or sentencing. Among other functions, local jails hold mentally ill persons pending their movement to appropriate mental health facilities. While jails hold inmates sentenced to short terms state and federal prisons hold offenders who typically are convicted and sentenced to serve more than one year. In general, because of the longer period of incarceration, prisons provide a greater opportunity for inmates to receive a clinical mental health assessment, diagnosis, and treatment by a mental health professional. State prisoners who had a mental health problem were over two times more likely than those without to report being physically or sexually abused in the past. Jail inmates who had a mental health problem were three times more likely than jail inmates without to have been physically or sexually abused in the past. Over a third of state prisoners who had a mental health problem said they had used drugs at the time of the offense, compared to over a quarter of state prisoners without a mental problem. Also, over a third of local jail inmates who had a mental health problem used drugs at the time of the offense, compared to a fifth of jail inmates who did not have a mental problem.

Newkirk (2006) in an article entitled Anxiety Disorders and Major Thought Disorders attempts to highlight that anxiety disorders are the most prevalent disorders among women in the general population as well as in prison. The diagnoses of Substance-Induced Anxiety Disorder require the presence of prominent anxiety, panic attacks, obsession or compulsions. The anxiety causes cognitive changes such that a person has difficulty in thinking and learning new information because of a sense of confusion. Many women in prisons are admitted with many problems and issues such as most of the women have children, whom they are separated from and have concerns about their well being and concerns about medical disorders that were not addressed prior to incarceration because of lack of health care in community. Women who have histories of abuse are more likely to encounter depression and anxiety.
When they were asked by clinicians about the feelings of depression, worry or anxiety, many women were unable to express them clearly because of it clinicians prescribe medication to alleviate some of the surface anxiety and worry. At that time women need to listen and understand them. Medication without an opportunity to address the issues only serves to mask the problems. As women talked more about their abuse histories, it has come to light that many incarcerated women were sexually or psychologically abused by corrections staff, most often men. Such correctional environment triggers traumatic flashbacks among women prisoners. Human Rights Watch research entitled Women’s Rights Project (1996) reported that this abuse has taken the form of vaginal, anal and oral rape. Male officers use threatened and physical force as well as their authority to provide or deny goods and privileges to compel the women to have sex with them. These situations inadvertently serve to retraumatize many women who already have problems dealing with their issues.

Robinson, and Thompson (2006) in an article entitled Mood Disorders in Incarcerated Women discuss about mood disorders among women in prisons and the effect of incarceration on their mental health. Incarceration poses extreme and uncontrollable challenges in the areas determined to be the most likely cause for depression in females. Unfortunately, the proportion of women in prison has grown at an alarmingly greater rate than men since 1990. A paucity of empirical data exists on this population regarding mood disorders. In an examination of mental health of female prisoners at the time of incarceration and six months later, high levels of depression (24.7%) has been found among them. The sources of the high depression included separation from family, worries about children, and loss of control of their own lives. A survey conducted (1997) on Texas jail inmates revealed that even though men and women associated childhood abuse with depression, women’s depression was more strongly associated with childhood abuse than men’s depression. Prison life brings loss of space and privacy. This invasion of space coupled with the continuous presence of intimidating officers and the potential for sexual or physical assault by officers or inmates which offers a poor environment for abuse recovery. The powerlessness that most of these women already feel as a result of their previous abuse and exploitation is further exacerbated by the necessity to comply with prison procedures. Women in prison frequently lose their husbands, boyfriends, children and housing when incarcerated. Disconnection from family may be especially devastating
for the female inmates, in that women have a unique need for extensive social support. Women prisoners frequently have a long and severe history of self harm, which may include up to ten or more lifetime suicide attempts or chronic self mutilation. The increased risk of substance abuse in women associated with traumatic events (i.e. sexual assault) may be affected by emotional experiences (i.e. discouragement, feelings of inadequacy and demoralization) often associated with depression.

The World Health Organization [WHO] (2009) report (based on the study conducted by United Nations Office on Drugs and Crime) entitled *Women’s Health in Prison: Correcting Gender Inequity in Prison Health* focused on the mental health problems of women prisoners. Women in prison generally have more mental health problems than women in the general population. 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. Existing research indicates that women in prison are more likely to engage in self harm. Women are also far more likely than men to harm themselves repeatedly, one third of men and half the women who harm themselves do so repeatedly. A study conducted by the Bureau of Justice Statistics of the United States Department of Justice showed that seventy-three percent of the women in the state prisons and seventy five percent of the women in local prison in the United States of America have symptoms of mental disorder verses twelve percent of women in the general population. In England and Wales ninety percent of women in prison have diagnosable mental disorders, substance use or both, and nine of ten women in prison have at least one of the disorders i.e., neurosis, psychosis, personality disorder, and alcohol abuse or drug dependence. Women’s mental health is likely to deteriorate in prisons that are overcrowded, where prisoners are not differentiated based on proper assessment and prison programs are either nonexistent or inadequate to address the specific needs of women. The harmful effects on mental illness are exacerbated when women do not feel safe and if they are supervised by male staff members who make them feel at risk of further abuse. The rates of mental disorders among imprisoned women are higher in the remand population than in the sentenced population.

Cox, and Lawrence (2010) in their Article entitled *Planning Services for Elderly Inmates with Mental Illness* view that today the elderly inmates are the fastest
growing incarcerated population in most States throughout the US. In the jail population inmates 55 years and above stayed close to two percent of the total population. The Surgeon General Reports highlight that nearly twenty per cent of those who were aged 55 and older experienced mental disorders that are not part of normal aging. The most common mental disorders among elders were depression, Alzheimer’s disease, alcohol, drug abuse and anxiety. Suicide risk is a major concern for elderly adults because an elderly inmate is facing increased stress such as significant loss of hearing. Depression in older women not only causes distress and suffering but it can lead to physical, mental and social decline. It is the preeminent risk factor for suicide in older inmates. Fifty percent of elderly inmates sent to prison when they were 60 years or older were first time offenders, and that elderly first timers were frequently found to be anxious, depressed and to experience incarceration as a form of psychological trauma. Upon release the elderly inmate with mental health problems would face many reentry challenges, including paying for daily living expenses, medical and psychiatric care, finding safe housing and social support. Many inmates are released into the community while still being treated for communicable and chronic disease or mental illness.

Math, Murthy, Parthasarathy, Kumar, and Madhusudhan (2011) study entitled Mental Health and Substance Use Problems in Prisons; the Bangalore Prison Mental Health Study: Local Lesson for National Action was conducted by National Institute of Mental Health and Neuroscience (NIMHANS), Bangalore. The study shows high proportion of mental and physical health problems among prisoners. A significant number of women were diagnosed as having a serious psychotic disorder namely schizophrenia. Two out of every hundred prisoners reported having attempted suicide sometimes in the past and more than seven per hundred had deliberately caused injury to themselves. Of those who had made an attempt of deliberate self harm after coming to prison nearly fifteen for every hundred under trial prisoners received a diagnosis of antisocial personality disorder. Further, a collaborative study between NIMHANS and the National Commission for Women in 1998, examined mental morbidity among women in the central prison Bangalore and found high levels of mental distress such as unhappiness, worrying, poor sleep and appetite. The important fact about women prisoners was that, they were significantly older compared to men. They faced problems of both under and over nutrition with one in four being underweight and
approximately a similar proportion overweight or obese. This raises important concerns about the lack of exercise in prison and a greater risk to non communicable diseases like hypertension and diabetes.

**Maternal Health**

Reproductive health or sexual health/hygiene addresses the reproductive processes, functions and system at all stages of life. Healthy reproductive systems, processes, and function are imperative components of adequate overall health. However, many internal as well as external factors may challenge an individual's ability to maintain reproductive health. The environment, in which an individual lives, both natural and physical, may present important risk that may directly influence reproductive health (http://apps.who.int/ceh/capacity/introductionreproductive.pdf). Incarcerated women often come from disadvantaged environments and have high rates of chronic illness, substance abuse, and undetected health problems. Most of these females are of reproductive age and are at high risk of unintended pregnancy and sexually transmitted infections, including HIV (http://www.acog.org/).

Fortenberry, Warren, and Clark (2006) in their article entitled *Carrying in the Criminal Justice System: Prenatal Care of Incarcerated Women* discussed issues related to prenatal care and provided a review about birth outcomes as well as availability of prenatal health care for pregnant women in prison. However, women are only a small proportion of the inmate population. Traditional systems have failed to allocate substantial resources towards adequate health care for women particularly pregnant women. Many individuals feel that because these women were convicted of a criminal offense they should not be given the same opportunities as women in the general population and they should not have access to quality health care. However incarcerated women deserve quality care despite what may not be available to women in the general population. As the saying goes two wrongs don’t make a right. The health care needs of women in prison are unique especially surrounding the labor and delivery process, however very limited information is available regarding the birth outcomes of pregnant inmates. Incarceration of women has positive as well as negative birth outcomes. As far as positive outcomes are concerned, some studies have shown that the birth outcomes for women in prison are better than outside the criminal justice system. In such studies positive outcomes are often attributed to the prison environment itself, which may serve to protect pregnant women from the
adverse consequences associated with negative and unhealthy life styles. For example, incarceration may provide high-risk women with an environment where alcohol and illicit drug use is prohibited or at least restricted, physical stress is reduced due to limited demanding physical labor and in some cases access to quality prenatal care is provided. Further, women incarcerated for a longer period of time also appeared to have a greater increase in the birth weight of their infant. On the other hand, studies show that women who are pregnant during incarceration have increased health-risk due to stress produced from the prison environment and that this increase in health risks ultimately leads to negative birth outcomes. It has been reported that incarcerated pregnant women have a high incidence of certain conditions that resulted from poor nutrition, anemia, bleeding during early pregnancy and multiple hospital admissions during pregnancy. Incarcerated women’s risk of poor health outcomes is increased by the lifestyle many women led prior to incarceration. This lifestyle often filled with unfavorable histories including previous obstetric and gynecological complications, exposure to numerous sexually transmitted diseases, inadequate health care, poor nutrition, low socioeconomic status, violence, mental health problems and poor overall health. Further documented negative birth outcomes for incarcerated women include high rates of fetal and infant mortality, intrauterine growth retardation, preterm labor and delivery and numerous conditions that necessitate intensive care of newborn. Additionally, anticipation of the labor and delivery process and separation from their newborns immediately after delivery are major stressor that may influence the onset of negative birth outcomes experienced by incarcerated pregnant women. The routine use of restraints during transport and labor is considered a crude, inhuman and degrading practice that seldom has any justification in terms of security concerns. The mother-infant separation at the end of hospitalization period is perhaps the most significant stressor that negatively affects the experiences and birth outcomes of incarcerated women and their children. The level of psychological distress, anxiety, and stress during and after a pregnancy in a correctional facility potentially influence numerous birth outcomes. Certain mothers are at risk for longer labor, needing medication due to increased discomfort during labor and increased needs for medical intervention as a result of the physical and emotional limitations placed on them in labor and delivery. There are several barriers that prevent women from receiving appropriate prenatal care in correctional facilities. Correctional systems are often limited in their financial resources, without adequate monetary
resources, they simply cannot afford to employ adequate medical personnel and to purchase expensive up to date equipment for prenatal screenings and care.

Clark (2006) in an article entitled *Reproductive Health among Incarcerated Women* discussed about the reproductive health problems of women prisoners. He views that the increasing number of incarceration of women coupled with the fact that the health care issues for women prisoners traditionally been an afterthought of male-oriented correctional officials, female offenders have and are receiving health care services that fail to adequately address the totality of reproductive health. In fact it is only in recent years that the issue of prenatal care has been perceived as a high priority and provided as an essential service for the pregnant inmate. The importance of intake screening in prison settings cannot be over emphasized as this is the one best opportunity to proactively evaluate potential problems and to implement steps to prevent disaster. The entire intake process is burdened with the urgency to get people into the system, classified ready for court, and assigned appropriate housing. Linked with the fear and anxiety of being incarcerated getting detailed health information is not always at the top of the priority list for either staff or patients. Most of the screening tools inquire about medical problems, current medications, hospitalizations, communicable diseases, and thoughts of harming one’s self. In the case of female inmate, this list obviously leaves the area of reproductive health unexplored for potential problems. Up to eighty percent of the females arrested may be chronic substance abusers and under the influence of illegal drugs at the time of arrest and many of these abused substances affect their regularity of the menstrual cycle, it is not unusual for an arrestee to have no clue about the last normal menstrual cycle and whether there is a possibility of an unknown pregnancy. Perhaps the most alarming task is raising the level of awareness about women’s reproductive health care issues and convincing the decision makers/resource allocators that the investment of appropriate funding would positively impact the quality of the services that provide and represent a major step towards practical risk management.

The Quaker United Nations Office [QUNO] (2008) study entitled *Women in Prison: A Commentary on the UN Standard Minimum Rules for the Treatment of Prisoners* discusses the impact of imprisonment on the reproductive health of women. In spite of the fact that UN Standard Minimum Rules for the Treatment of Prisoners ensure that pregnant prisoners should be provided with the same level of health care
as is provided to women not in prison including access to obstetricians, gynecologists if required, and midwives or birthing practitioners appropriate to their culture. The health care facilities in prisons are inadequate to meet their specific needs concerning pregnancy, birth and post natal care. Generally, women constitute a minority of the prison population usually between 2 percent to 8 percent. Prison systems are almost invariably designed for the majority male prison population, from the architecture of prisons, to facilities for healthcare, family contact work and training. As a consequence prisons tend not to meet the needs of women prisoners and women in prisons are affected by imprisonment in a particularly harsh manner. Women who are pregnant while in prison have particular health and nutrition needs. They require appropriate facilities and medical care to monitor their pregnancies. Many will need to be educated about pregnancy and require counselling and support throughout. Such provisions are often unavailable or woefully inadequate. In some cases pregnant women are held separately from the rest of the prison population, which may lead to their suffering from isolation and lacking access to facilities, on the other hand where pregnant women are integrated with the rest of the prisoners they may be at greater risk of diseases, violence or of having their needs overlooked. Poor prison conditions and lack of proper care and facilities may place at risk both the health of the women and the health or even life of her unborn child. The high level of stress that accompanies incarceration in itself has the potential to adversely affect pregnancy. Further, in prison it is not uncommon for a woman to discover she is pregnant at the same time she discovers that she is HIV positive. The anxieties shared by most pregnant women about their baby are heightened by fear of inflicting their baby with HIV. Depending upon the country and the prisoner woman may give birth either in prison or at a public hospital. In some countries, women prisoners are shackled during childbirth. Once born the child requires immunization and regular health checks. As during pregnancy, breastfeeding women have particular health and nutrition needs that are often unmet in prison. It was found that pregnancy during incarceration must be understood as a high risk situation both medically and psychologically for mothers and their children. There should be 24 hour access to advice from midwives on whether the woman needs to go to hospital. Further, in women’s institutions there shall be special accommodation for all necessary pre-natal, post-natal care and treatment.
Kasdan (2009) in an article entitled *Abortion Access for Incarcerated Women: Are Correctional Health Practices in Conflict with Constitutional Standards* shows that despite the legal consensus that incarcerated women must have adequate access to abortion care, many correctional staff refuse to facilitate such access. Whether, they do so because they do not understand their obligations or because they intentionally neglect those obligations. In spite of the fact that imprisonment carries with it the restrictions, even loss of many freedoms, it does not completely strip individuals of their most basic constitutional and human rights. Consistent with this the right to decide whether to continue a pregnancy or to have an abortion is not lost as a result of criminal punishment and incarceration. A women right to decide whether to bear a child falls within the scope of bodily autonomy and privacy protected under the constitution. However the ways in which prisons handle a women’s abortion request are often shielded from public scrutiny and they can be enormously varied. Women are incarcerated at the central and state prisons. Accordingly, policies and practices of prison and jail officials and the experience of pregnant women in their custody may differ dramatically from state to state and country to country. Despite these challenges, understandingly incarcerated women’s ability or inability to access reproductive health care, including abortion is key to developing strategies to advance their reproductive health and rights. The study also reveals that health care providers endorse that the degree to which incarcerated women are able to obtain reproductive health care services especially abortion, varies significantly among correctional institutions. However, the fact is that either the prison authorities provided facilities for abortion or not women receive little or no logistical assistance in arranging, paying for and getting to the appointment. In other words, incarcerated women are not receiving the full range of needed pregnancy related services. Moreover, the gap in abortion services is only part of the larger challenge to identify and improve the range of reproductive health services that incarcerated women need.

The World Health Organization [WHO] (2009) report (based on the study conducted by United Nations Office on Drugs and Crime) entitled *Women’s Health in Prison: Correcting Gender Inequity in Prison Health* illustrates that reproductive and sexual health rights are considerably constrained in prisons. The reproductive health problems of women inmates and their rights to the accessibility of reproductive health care facilities are neglected in prison. Women in prison are a high risk group for
sexual and reproductive health diseases, including cancer and sexually transmitted infections. 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. Women who have experienced abuse may as a result engage in high risk sexual behaviour, which further increase their risk of acquiring sexually transmitted infections. Besides, many prison authorities all over the world fail to cope with women’s menstruation. Further, privacy and adequate bathing and washing facilities are often not provided. Adequate health care during birth is clearly essential for the mother and child. However, many women in prison do not have access to any education in breathing and birthing techniques to help prepare them for the birth. Similar to pregnant women, breastfeeding women have specific health and nutrition needs that are often unmet in prison. Some women in prison diagnose that they are pregnant and HIV infected at the same time. The mental burden of being in prison, having a new pregnancy and discovering HIV infection can be very devastating for these women. Therefore, they require empathy and counselling to ensure the best possible conditions for the mother and baby in this complex situation. It is very important that pregnant women who require antiretroviral therapy have free access to it. Treating a pregnant woman living with HIV not only addresses her individual health needs but also dramatically reduces the risk of mother to child transmission, particularly for women at an advanced stage of the disease who have a higher risk of such transmission. Further, premature birth may be more common among pregnant women living with HIV than among those without HIV.

A project conducted by Correctional Association of New York’s [CANY] (2015) entitled Reproductive Injustice: The State of Reproductive Health Care for Women in New York State Prisons reports on conditions of confinement for women in prisons run by the New York State Department of Corrections and Community Supervision. The findings of the study show that the women inmates faced serious problems in accessing appropriate health care and the challenges of securing gender specific care during incarceration. Women in prison across the country face similar problems in accessing adequate reproductive health care and humane treatment. Further, the explosion in the number of incarcerated women has only exacerbated these problems. However, the massive overuse of incarceration does not affect all women equally. Majority of women in prison are mothers, often of small children and
many were caring for their children on their own before imprisonment. Women in prison also have limited access to information and virtually no say over decisions, even basic ones like which doctor they see or whether they will see a doctor at all. Women universally reported that they did not get sufficient food during their pregnancies. Further, pregnant women experienced the problem of inadequate heat and ventilation, too little privacy and infestation of pests in their housing areas. They also faced problems during childbirth, including the denial of family support and the routine separation of women from their newborns in the hospital. They explain that while some nurses and doctors treat them well other are rude and hurry them through appointments. Providers often communicate poorly and the insufficient opportunities exist for them to learn about health issues outside of medical appointments. Gynecology care experiences were deeply traumatizing for some women especially survivors of abuse. Solitary is a dangerous setting for pregnant women yet some women were held in solitary at some point during their pregnancy. They explain that they often had to wait weeks to see a gynecologist and clinicians routinely violated their confidentiality by speaking with them through a closed cell door. Majority of women did not receive enough sanitary napkins and toilet paper each month. In order to get additional supplies prisons require women to obtain a medical permit, a process that is humiliating and unjustified. Women in prison are not allowed to receive contraceptives. Even women who used hormonal contraception in the community for medical reasons other than pregnancy prevention, such as irregular periods and uterine bleeding face serious difficulty in getting it once they are in prison.

**Post-Release Health Care Services**

It is significantly important that all-encompassing preventive testing and treatment programs in correctional settings linked with continuity of care clinics in the community upon release would likely not only decrease the morbidity and mortality of disease among released prisoners but also potentially decrease transmission of STDs and other communicable diseases to non-infected persons within the community. Post release services also critical in preventing high rate of recidivism (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2828190/).

Howells (2000) in his study entitled *Treatment, Management and Rehabilitation of Women in Prison: Relevance of Rehabilitation Principles* discuses that the increased number of women in prison in developed countries is not doubtful
because women constitute the most rapidly growing segment of the prison population. However, majority of all women are imprisoned for non-violent and drug-related offences. Research shows that rehabilitation and treatment needs of some important groups of offenders are neglected, particularly women and indigenous offenders. In practice, the risks of most concern to correctional administrators and staff, and perhaps to women offenders themselves, may be risks of harm to the self and immediate family caused by psychological and psychiatric dysfunction, substance abuse and so on. Duty of care and humanitarian considerations may be more salient as determinants of selection for treatment for women offenders rather than the re-offending risk which is emphasized in the typical, men-focused studies. The Correctional Services of Canada regarded that a key task in considering the treatment and rehabilitation of women prisoners is the identification and assessment of their needs, both criminogenic and non-criminogenic. These aspects of identification require a comprehensive assessment system capable of identifying areas of need. Pre-release courses for women would need to have a clearer focus on relapse prevention and even more emphasis on developing skills for survival and independence in the community. The Survivors of Abuse and Trauma programs in Canada assist female offenders in dealing with and working through the violence they have experienced. The Mother-Child Program provides mechanisms that foster and promote stability and continuity for the child in its relationship with mother. The development of these programs is the responsibility of each institution and region and may include multicultural, recreation and leisure, vocational and educational, peer support team and health programs. Finally, the principles of Risk, Needs and Responsivity are indeed useful in sharpening thinking about what needs to be done in managing women in prison in a more coherent, effective and humane way.

Boutwell, Kendrick, and Rich (2006) in an article entitled Discharge Planning for Incarcerated Women discussed physical, emotional and social stresses experienced by incarcerated women, role of screening for these problems, and discharge planning programs for women prisoners. Key elements of successful discharge planning programs model include the establishment of ongoing relationships with service providers prior to release and continuing of care with same providers after release. It is well established that incarcerated women are high risk individuals who are traditionally underserved in their social needs. They have higher
rates of substance abuse, mental illness, and infection with HIV/AIDS and other Sexually Transmitted Diseases than their male counterparts. Despite the high prevalence of physical, emotional and social stresses in the lives of incarcerated women, screening for such problems occur inconsistently throughout correctional system. It is estimated that fewer than ten percent of drug abusing women are offered substance treatment while in prison. Many inmates receive opportunity for diagnoses of physical or mental illness for the first time while in the correctional system. The failure to link them with medical, addiction, and/or psychosocial services in the community leaves them lacking the knowledge, skills and support which is necessary to access the resources to manage their illness following release. During the first hours and days after release women are highly vulnerable to relapse to drug use and/or criminal activity, re-entering abusive relationships, returning to unstable living environment, and failing to address medical condition. Despite the fact that a lack of community based transitional planning has been identified as a significant factor of relapse to drug use and criminal activity among released inmates, the majority of incarcerated individuals are released into the community with nothing in place to help change the circumstances that led to their incarceration.

Thus, it can be summarized that female prisoners are a minority within prison populations worldwide usually accounting for between two per cent and nine per cent of the prison population in a country. Historically, women have been underrepresented at all levels of criminal justice system. This underrepresentation of women has resulted in a criminal justice system created by males for males in which the diverse needs of women are forgotten and neglected. Although women make up only a small minority of the prison population but their number have risen dramatically over the past decade. Generally, most women inmates come from disadvantaged background with education and employment rare and abuse common. They also experience more ill health with high level of mental disorders, drug misuse, alcoholism and infectious diseases including poor physical, psychological and social health in prisons. The poor health of incarcerated women reflects the inequalities that exist in the political, economic and social structure of the larger society. They have higher rates of illness than men for infectious disease, respiratory and digestive conditions, genitourinary disorders, headaches, ear diseases, skin and musculoskeletal diseases. These health conditions can improve, worsen or remain the same in prison,
depending upon the prior background, the characteristics of the prison and the arrest experience. Several studies suggest that imprisonment proved advantageous for the women who suffer with chronic illness, drug addiction and victims of interpersonal violence. Most of the prisoners receive better health care while incarcerated and for many the care received during incarceration is the first encounter with any health care provider. Women prisoners have different health needs from male prisoners that require responsive correctional programs that address trauma and abuse, medical care, mental health, parenting and children relationships and vocational training. Literature reveals that women prisoners are more likely to be suffering from certain mental illness, drug addiction and a tendency to self harm than male prisoners. However, this is not adequately recognized by the correctional system. Women prisoners have same rights to health care as the general population but as a group they have different needs. This means that health care delivery in prison needs to differ from health care in the community in order to achieve the same level of care. Unfortunately, the growth in the female prison population has not led to an increase in specialized services for women. Health care services for incarcerated women continue to be subpar, with less availability then the care offered to male prisoners and the women in the community.