UNODC
United Nations Office on Drugs and Crime

WORLD HEALTH ORGANIZATION
EUROPE

# Women's health in prison

## *Correcting gender inequity in prison health*

**2009**

## ABSTRACT

In 1995, the WHO Regional Office for Europe launched the Health in Prisons Project, supported by the WHO Collaborating Centre for Health and Prisons in the Department of Health, United Kingdom. The Project works within a network of countries committed to protecting and promoting health in prisons in the interests of prisoners, of staff and of public health. Representatives from the ministries responsible for health in prisons in about 36 countries in the WHO European Region attend the annual conference and network meeting of the Project. The network combines shared experience with expert advice to produce guidance for countries wishing to improve health care and circumstances in their prisons and, in particular, to develop their role in preventing the spread of disease. The network aims to maximize an important opportunity for promoting health in a marginalized group and contributing to general public health in their communities. At the request of the Member States involved, the WHO Health in Prisons Project, together with partner organizations and experts and with the support of the United Nations Office on Drugs and Crime, the Quaker Council for European Affairs, the Quaker United Nations Office, the Sainsbury Centre for Mental Health, the AIDS Foundation East-West and the European Monitoring Centre for Drugs and Drug Addiction, has reviewed all issues affecting women's health in the criminal justice system and has especially considered the gross inequities in women's health in prisons. The Project has adopted the enclosed declaration and background paper as evidence fully justifying the recommendations and call for action in its conclusion.



### Keywords

PRISONS
PRISONERS
WOMEN'S HEALTH
EUROPE

EUR/09/5086974



Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (http://www.euro.who.int/pubrequest).


Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (http://www.euro.who.int/pubrequest).



**© World Health Organization 2009**

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

# Contents


Foreword ........ v

Acknowledgements ........ vii

Kyiv Declaration on Women's Health in Prison ........ 1

Introduction ........ 8

*Need for a declaration on women's health in prison* ........ 8

*Objectives of a declaration on women's health in prison* ........ 9

*Definitions* ........ 9

Women, prison and society ........ 10

*Facts and figures* ........ 11

*Human rights standards and international conventions* ........ 12

*Women in prison and society* ........ 15

*Relationships ........ 15*

*Girls in prison ........ 15*

*Older women in prison ........ 16*

*Foreign national women in prison ........ 16*

*Children of women in prison ........ 17*

Women's health and prison ........ 20

*Need for gender-specific health care* ........ 20

*Organization of health care services for women in prison* ........ 21

*HIV, hepatitis C and other infectious diseases* ........ 22

*Substance use* ........ 24

*Mental health and mental ill health* ........ 26

*Self-harm and suicide ........ 28*

*Learning disabilities* ........ 29

*Sexual health and reproductive health* ........ 29

*Pregnancy, postnatal care and breastfeeding ........ 31*

*Violence and abuse* ........ 32

*Multiple and complex treatment needs* .......... 34
*Pre-release preparations and continuity of care after release* .......... 35
How can the situation be improved? What can, should and must be done? .......... 38
*Recent developments and emerging plans* .......... 35
*Recommendations* .......... 35
Concluding remarks .......... 38
References .......... 50

# Foreword

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

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

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

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

The principles and recommendations of the Kyiv Declaration on Women's Health in Prison are important steps towards improving health systems and addressing the health needs of women involved in the criminal justice system. I hope that this report, which outlines the evidence and the expert opinions considered at the special conference held in Kyiv in November 2008, will convince all Member States to adopt and implement the Kyiv Declaration in fulfilment of their commitment to human rights and health promotion for all.

*Nata Menabde*
WHO Deputy Regional Director for Europe

## Acknowledgements

We would like to thank the following experts for their valuable contributions to this publication.

Isabel Yordi Aguirre, WHO Regional Office for Europe

Tomris Atabay, Justice and Integrity Unit, United Nations Office on Drugs and Crime, Vienna, Austria

Mark Bellis, Coordinating Centre for the Work Strand on Violence and Health, University of Edinburgh, Scotland, United Kingdom

Rachel Brett, Quaker United Nations Office, Geneva, Switzerland

Michael Browne, Healthcare and Drug Strategy, HMP and YOI Holloway, London, United Kingdom

Ingrid Lycke Ellingsen, Prison Health Expert Group, Northern Dimension Partnership in Public Health and Social Well-being, Norway

Andrew Fraser, Collaborating Centre for Prison Health, Scottish Prison Service, United Kingdom

Mignon French, Women Offenders' Health, Department of Health, London, United Kingdom

Alex Gatherer, Temporary Adviser, Health in Prisons Project, WHO Regional Office for Europe

Fabienne Hariga, HIV and AIDS Unit, United Nations Office on Drugs and Crime, Vienna, Austria

Paul Hayton, Collaborating Centre for Prison Health, Department of Health, London, United Kingdom

Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, Portugal

Rachel Hunter, Women Offender's Health, Department of Health, London, United Kingdom

Natalya Kalashnyk, State Department on Enforcement of Sentences, Kyiv, Ukraine

Morag MacDonald, Women's Offender Health Research Interest Group, Birmingham City University, United Kingdom

Ruth Elwood Martin, Clinical Professor, Vancouver Foundation Community Based Clinician Investigator, Vancouver, Canada

Lesley McDowall, Healthcare, HMP and YOI Cornton Vale, Scottish Prison Service, United Kingdom

Nick McGeorge, Quaker representative, United Nations Commission on Crime Prevention and Criminal Justice

Sheila McNerney, Leeds Chlamydia Screening Programme, Leeds, United Kingdom

Katherine Moloney, WHO Regional Office for Europe

Liz Scurfield, Quaker Council for European Affairs, Brussels, Belgium

Mia Spolander, United Nations Office on Drugs and Crime, Vienna, Austria

Nancy E. Stoller, Department of Community Studies, University of California, Santa Cruz, United States of America

Laura Thorne, Prisons and Criminal Justice, Sainsbury Centre for Mental Health, London, United Kingdom

Corey Weinstein, American Public Health Association, Washington, DC, United States of America

Our special thanks go to Alex Gatherer for his tremendous help and support in drafting this publication.

We are very grateful to the Quaker Council for European Affairs for their financial contribution to a Round Table on Women's Health in Prison in June 2008 and to the Collaborating Centre on Prison Health for hosting the Round Table in the premises of the Department of Health in London, United Kingdom in June 2008.

Lars Møller, Manager, Health in Prisons Project
Brenda van den Bergh, Technical Officer, Health in Prisons Project
WHO Regional Office for Europe

# Kyiv Declaration on Women's Health in Prison

1. We, the government-recognized representatives of ministries concerned with health in prisons, the WHO Collaborating Centre in the Department of Health, United Kingdom, representatives of the United Nations Office on Drugs and Crime, the Quaker Council for European Affairs, the Quaker United Nations Office, the Sainsbury Centre for Mental Health, the AIDS Foundation East-West and other international organizations with expert knowledge of health in prisons throughout Europe and in the United States of America, **note with concern** that current arrangements in criminal justice systems for dealing with women offenders often fail to meet their basic and health needs and are therefore far short of what is required by human rights, by accepted international recommendations and by social justice.

2. **We have been made aware** that the facts concerning women in prison are complex and challenging and can make addressing their health needs very difficult.

    - While women constitute a very small proportion of the general prison population (the median level in Europe is 4.9%, with high variation between countries) the recent rate of increase in the number of women in prison is greater than that for men. In Europe, there are about 100 000 women in prison every day.

    - The majority of offences for which women are imprisoned are non-violent, property or drug-related, and many women serve a short sentence, which means that the turnover rate is high.

    - As women in prison are frequently victims of physical and sexual abuse, prison authorities and custodial staff should promote their dignity and safety and protect women in prison from bullying and abuse of any type. Male custodial officers should not be responsible for the direct supervision of women. They should never have routine physical contact with them, or have access to living and bathroom areas.

- The number of women held in pre-trial detention in many countries is equivalent to or even larger than the number of convicted female prisoners. Pre-trial detainees may have limited contact with other prisoners, fewer opportunities for health care and vocational or job programmes, and restrictions on family contact, including visits, which disproportionately affects women with children as well as the children themselves.

- The prevalence of mental health problems is high among women in prison, and these problems are infrequently addressed adequately. High rates of post-traumatic stress disorder and substance use disorder affect the majority of female prisoners. Women in prison are more likely to self-harm and commit suicide than male prisoners.

- A large proportion of women in prison have experienced a lifetime of victimization, including child abuse, neglect and domestic violence. There is a close link to the woman's criminogenic pathway and her mental and physical illness.

- Since foreign national women, girls and older women in prison are minority groups within a minority of the prison population, their needs are easily overlooked.

- Due to the small numbers of women in prison, countries generally only have a few prison facilities for women. Women are therefore often placed far from home, which further strains family ties.

- Many women in prison are mothers and usually the primary or sole carer for their children. It is estimated that, in Europe, around 10 000 babies and children younger than two years of age are affected by their mother's imprisonment. When considering all children younger than 18 years old, the number affected by their mother's imprisonment is much higher, counting hundreds of thousands.

- When women give birth or have care of a baby while in prison, it is important to have a regime that allows the mother to nurture and bond with her child. The age until which

children can stay with their mothers in prison varies widely across Europe. Three years is the most common age limit.

- The prevalence of HIV, other bloodborne diseases and sexually transmitted infections among women prisoners is often higher than among male prisoners.

- There is a lack of objective, reliable and comparable information about drug use prevalence and risk behaviour and about service needs and provision to women in prison that could inform the planning of adequate health services (including drug treatment) and support an evaluation of their quality and effectiveness.

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

    - The prison environment does not always take into account the specific needs of women. This includes the need for adequate nutrition, health and exercise for pregnant women and greater hygiene requirements due to menstruation such as the availability of regular showers and sanitary items that are free of charge and may be disposed of property.

    - Mental illnesses, including drug problems and traumatization, are infrequently addressed. There are shortcoming in recognized standards of evidence-based treatment such as substitution therapy, psychotherapy, counselling, training, peer support and harm-reduction measures.

    - There are often deficiencies in the provision of training provided to prison staff. Gender-sensitive training and training on the specific health needs of women in prison should be widely available in all systems.

- There is a challenge in many prison systems to balance respect for and the dignity of the woman in prison with surveillance and security in the prison while providing care and treatment.

- It is not uncommon for women in prison to discover at the same time that they are pregnant and HIV infected. The mental burden of being in prison, having a new pregnancy and discovering HIV infection can be devastating for the woman, and this is seldom adequately addressed in custodial environments.

- The provision of an effective system of prison inspection and oversight carried out by an independent body and with a confidential complaint system is essential in preventing violence and abuse within the prison. Such systems are often lacking.

- Prison policies and programmes are seldom specifically tailored to the needs of women, especially in the vital area of pre-release programmes and resettlement.

- Pre-release interventions, including interventions specifically aimed to reduce the acute risk of drug-related death among women prisoners in the first weeks after their release, are very important but often do not take place.

- Continuity of care (throughcare) upon release is of utmost importance and should be the responsibility of prison staff, health care staff and social care authorities in the community together, but this continuity of care is often not guaranteed.

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

   **Member States at the government and policy-making levels** should urgently review their current policies and services for meeting the basic and preventive and curative health (care)

needs of women at all stages of criminal justice systems and, where necessary, introduce changes to meet the following.

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

4.2 The **important principles** that should be followed in deciding what should be done to improve current practice should include the following.

- **Pre-trial detention and imprisonment** should be used as a last resort in the cases of women who have committed non-violent offences and who do not pose risk to the society. The imprisonment of pregnant women and women with young children should be reduced to a minimum and only considered when all other alternatives are found to be unavailable or are unsuitable.

- All policies affecting women in the criminal justice system must **recognize the gender-specific needs of women and the significant variation in need** that can exist between different groups of women.

- Health service provision and programming should specifically address **mental illness, in particular substance use disorders and post-traumatic stress disorder**. This is essential to any prison health care system.

- If children are involved, **the best interest of the children must be the main and determining factor** in decisions regarding women's imprisonment, including putting the needs of the children first when considering whether and for how long the children should stay with their mother in prison.

- Health service provision in prison must recognize women's gender-specific health care needs and should be individualized, framed and delivered in a **holistic and humane manner**.

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

- **comprehensive and detailed screening** when first admitted to prison and regularly throughout their stay; this should cover socioeconomic and educational background, health and trauma histories, current health status and an assessment of skills held or required;

- an **individualized care, treatment and development** plan, to be prepared by joint effort between different health care providers and all other staff likely to be involved in a woman's care and custody in consultation with the women themselves;

- **primary health care** services provided in the prison, which are outlined to the woman during the important induction period; her rights to access, including emergency access, to confidentiality, to privacy and to health information and promotion activities, should be made clear, preferably by means of an easily understandable written pamphlet;

- **specialist health care**, which is readily provided and adjusted to meet the needs of women, such as for mental health, including help with a legacy of abuse and post-traumatic stress disorder; chronic health conditions, HIV and AIDS including counselling and support, hepatitis, tuberculosis and other infectious diseases; drug and alcohol dependence; learning disabilities; and reproductive health, with access to specialist health care being explained to the woman in prison when discussing her individual care plan; and

- **pre-release preparations that are adequately planned and provided in order to ensure continuity of care and access to health and other services after release;** health and social care cannot be provided in isolation from community services; just as health and nursing staff must maintain professional contacts with their peer groups, so must all services within prisons have good links to the equivalent services in the community.

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

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

- that every prison that is required to house women prisoners have a written policy showing that the practices in that prison are sensitive to the special needs of women and that the staff have undergone gender-sensitive training; and

- that where and whenever children are involved, their needs and best interests be clearly seen as the first and main consideration in what is provided for them.

5. **We have agreed** to collaborate with the WHO Health in Prisons Project and its partners so that, **over the next three years,** guidance on the implementation of this Declaration will be produced from the experiences gained from the initiatives and good practices already underway in different parts of the WHO European Region and made available to all countries in Europe. Within their respective mandates, WHO, the United Nations Office on Drugs and Crime and the European Monitoring Centre for Drugs and Drug Addiction will cooperate to improve the monitoring of prison health, including drug addiction issues. We will consider how we can assist all countries in monitoring progress towards better, fairer and more gender-sensitive services, made available for women in all parts of the criminal justice system.

# Introduction

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

> As prison sentences have been designed for men and by men, women are always an exception. It is a challenge to find special solutions to meet the needs of imprisoned women.
> (Kurten-Vartio, 2007)

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

Women's rights while in prison are the same as men's rights, but women seldom have equal access to these rights. As prison systems have been primarily designed for men, who comprise more than 95% of the prison population in most countries, prison policies and procedures often do not address women's health needs. Data on the health of women in prison and the health care provided for them are rare, because most prison data are not gender specific.

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

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

This is a background paper for the Kyiv Declaration on Women's Health in Prison, which was discussed and adopted during the WHO International Conference on Prison Health in November 2008.

The paper reflects the evidence from literature research and the best evidence provided by experts on women's health in prison, who are listed under acknowledgements.

## *Objectives of a declaration on women's health in prison*

The objectives of a declaration on women's health in prison are:

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

## *Definitions*

The following definitions apply in this paper.

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

**Girl**: a female person younger than 18 years of age.

**Older woman**: a female person 50 years or older.

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

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

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

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

# Women, prison and society

This section contains scientific evidence and recommendations by international health agencies, scholars and other experts on the health of women in prison.

## *Facts and figures*

1. More than half a million women and girls are held in prisons throughout the world, either as remand or sentenced prisoners. In Europe, about 100 000 women and girls are in prison (United Nations Office on Drugs and Crime, 2008). Women constitute a very small proportion of the general prison population worldwide, usually between 2% and 9% of a country's prison population. Only 12 prison systems worldwide report a higher percentage than that. The median level in Europe is 4.4%. In Europe, Spain has the highest percentage of women in prison (almost 8%) and Azerbaijan the lowest (less than 1.5%) (Walmsley, 2006; WHO Regional Office for Europe, 2009).

2. Although women are a minority in national prison populations all over the world, the female prison population is increasing. This increase in women's imprisonment is part of a global trend towards the increasing popularity and use of imprisonment and a corresponding under-use of constructive alternative, non-custodial sanctions. This applies particularly to drug offences and non-violent theft (Penal Reform International, 2007). Most female drug offenders could be dealt with more effectively by alternatives to imprisonment specifically targeting the drug problem rather than by imprisonment (United Nations Office on Drugs and Crime, 2008). Further, the rate of increase in the number of women in prison is much greater than that for men (Bastick, 2005). For instance, in England and Wales, the number of women in prison has increased by more than 200% in the past 10 years versus a 50% increase in the number of men in prison during the same period (Prison Reform Trust, 2006). Some of the increase is the result of global displacement of women due to war, social unrest, economic crises and gender-insensitive criminal justice systems.

3. Many women in prison serve a short sentence, which means that the turnover rate is high. Most offences for which women are imprisoned are non-violent, property or drug-related (Quaker Council for European Affairs, 2007). Worldwide, women are more often imprisoned for drug offences than for any other crime (Taylor, 2004). Drug couriers frequently use women, often from low-income countries, to smuggle drugs across borders for a small amount of money (United Nations Office on Drugs and Crime, 2008).

4. In many countries, the number of women held in pre-trial detention is equivalent to or even larger than the number of convicted female prisoners (United Nations Office on Drugs and Crime, 2008). Pre-trial detainees may have limited contact with other prisoners, fewer opportunities for health care and vocational or job programmes and restrictions on family contact, including visits, which disproportionately affects women with children and these children (Penal Reform International, 2007).

5. Women in prison frequently come from deprived backgrounds, and many have experienced physical and sexual abuse, alcohol and drug dependence and inadequate health care before imprisonment (Penal Reform International, 2007). Further, women entering prison are more likely than men to have poor mental health, often associated with experiencing domestic violence and physical and sexual abuse (United Nations Office on Drugs and Crime, 2008).

6. Because there are few women's prisons, women convicted of a wide range of offences are often imprisoned together. The overall regime is then determined by the maximum-security requirements of a very few high-risk prisoners. Overall security requirements are designed for the male prison population and, as such, discriminate against women in prison, who are mostly imprisoned for non-violent offences and do not need a high security level (Penal Reform International, 2007).

## *Human rights standards and international conventions*

> The concept of equality means much more than treating all persons in the same way. Equal treatment of persons in unequal situations will operate to perpetuate rather than eradicate injustice.
> (Office of the United Nations High Commissioner for Human Rights, 1994)

7. Women who are imprisoned are still covered by human rights legislation. The Universal Declaration of Human Rights (United Nations, 1948) says that the state may only limit the exercise of a person's rights and freedoms – including the rights and freedoms of a person who is a prisoner – "for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society".

   The main United Nations standard relating to the human rights of women, providing the basis for realizing equality between women and men, is the Convention on the Elimination of All Forms of Discrimination against Women (United Nations, 1979). In Article 2, the States Parties:

   > … condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:
   >
   > (a) to embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;
   >
   > (b) to adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
   >
   > (c) to establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
   >
   > (d) to refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
   >
   > (e) to take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;
   >
   > (f) to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women; and
   >
   > (g) to repeal all national penal provisions which constitute discrimination against women.

8. The main international standards relating to the protection of the human rights of prisoners and to ensure that prisoners' treatment aims to facilitate their social reintegration include:
   - the United Nations Standard Minimum Rules for the Treatment of Prisoners (United Nations, 1955);

- the Basic Principles for the Treatment of Prisoners (United Nations, 1990);
- the 2006 European Prison Rules (Council of Europe, 2006);
- the European Parliament (2008) resolution on the particular situation of women in prison and the impact of the imprisonment of parents on social and family life;
- the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (United Nations, 1988); and
- the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2004).

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

The United Nations Standard Minimum Rules for the Treatment of Prisoners (United Nations, 1955) and other standards prohibit discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Principle 5 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (United Nations, 1988) states the following.

> Measures applied under the law and designed solely to protect the rights and special status of women, especially pregnant women and nursing mothers, children and juveniles, aged, sick or handicapped persons shall not be deemed to be discriminatory. The need for, and the application of, such measures shall always be subject to review by a judicial or other authority.

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

## *Women in prison and society*

### Relationships

9. When women enter prison, they are dislocated from their families and their social support network. One of the challenges for people when they return to the community after release from prison is to get those relationships operating again. Facilitating visits is a very important part of that (Penal Reform International, 2007).

10. Because fewer women are in prison than men, there are fewer prisons for women. Consequently, women are often imprisoned far away from their homes and families, causing serious problems in the attempt to preserve strong family ties (Quaker Council for European Affairs, 2007). The distance and costs involved in visiting women imprisoned far from home pose a major obstacle to regular visits (United Nations Office on Drugs and Crime, 2008). Their imprisonment far away from home also seriously challenges the women's resettlement after release.

### Girls in prison

11. Since girls in the juvenile justice system may be easily overlooked because they represent only a small group, special attention must be devoted to the particular needs of girls.

12. The number of girls in the juvenile justice system has increased dramatically in recent years. In the United States of America, for instance, girls currently comprise about 25% of the total population in juvenile justice facilities (Kelly et al., 2007). However, the proportion of girls in prison within the total women's prison population is low (Quaker Council for European Affairs, 2007).

13. Because of their small numbers, girls are sometimes accommodated in the same sections as adult women in prison. International standards state that girls and adult women in prison should be imprisoned separately. However, if separate imprisonment would lead to fewer opportunities for education than if they are imprisoned together, safeguards should be put in place so that girls do not mix with women with serious long-term criminal histories. Girls in

prison might have the same problems and often have the same backgrounds as adult women in prison. For instance, at least some of the girls in prison are mothers and may be the primary or sole carers for their children.

14. Little is known about the health needs of imprisoned girls, but concern is emerging regarding substance misuse, mental health problems, poor sexual health and poorer general physical health on a range of indicators (Douglas & Plugge, 2008). For instance, girls are increasingly at risk of HIV infection and may also be mothers.

## Older women in prison

15. Older women (older than 50 years) in prison represent a small proportion of the overall female prison population. However, their imprisonment poses particular issues, such as the possibility of compassionate release and special (health) requirements.

16. As a minority within a minority, the special needs of older women in prison are rarely considered separately. However, older prisoners may need greater and often more specific health care than younger prisoners. For some older women, the effects of the menopause may particularly affect their health care needs, and they may have different personal care needs as well (Quaker Council for European Affairs, 2007). Further, they might have special requirements regarding physical problems and limitations.

## Foreign national women in prison

17. Foreigners are vastly overrepresented in the criminal justice system of most countries in Europe. On average, more than 30% of the women in prison who are foreign nationals are imprisoned for drug offences (Quaker Council for European Affairs, 2007; United Nations Office on Drugs and Crime, 2008).

    Another common reason for imprisoning foreign national women is their illegal status in a country. Foreign national women may have dependent children in the country of arrest or in

the country of origin, and police, prosecutors and courts should always take into account their parental status (United Nations Office on Drugs and Crime, 2008).

## Children of women in prison

18. Concern about women in prison must be broadened to include the children of women in prison. United Nations General Assembly 2003 resolution A/RES/58/183 on human rights in the administration of justice invited "governments, relevant international and regional bodies, national human rights institutions and non-governmental organizations to devote increased attention to the issue of women in prison, including the children of women in prison, with a view to identifying the key problems and ways in which they can be addressed …".

19. Most women in prison are mothers and usually the primary or sole carer for their children. Research from many countries has shown that, when fathers are imprisoned, the mother usually continues to care for the children. However, when a mother is imprisoned, the father often does not continue to care for the children, resulting in large numbers of children being institutionalized (United Nations Office on Drugs and Crime, 2008). For instance, in the United Kingdom, when mothers are imprisoned, in 80% of the cases the father does not look after the child (Anne Owers, Salter Lecture, Yearly Meeting, Quakers in Britain, 23 May 2008). Families can also break up if women are held in remand awaiting trial and if sentences are for short periods of time.

    The Howard League for Penal Reform, a nongovernmental organization in the United Kingdom, has estimated that about 10 000 children in Europe younger than two years are affected by their mother's imprisonment (Council of Europe, 2000). The number of children younger than 18 years old who are affected is much higher: hundreds of thousands.

20. In many countries, babies born to women in prison stay in prison with their mother, and very young children may accompany their mothers into prison. Facilities vary widely between and within countries. Some countries have mother and baby units, with special facilities to support the mother and the child's development. In others, babies live in the prisons without the state officially noting or monitoring their presence and without any special provision being made for them. In prison, facilities to ensure the safety, health and development of a

child are often lacking or inadequate. Nevertheless, studies (United Nations Office on Drugs and Crime, 2008) have shown that young children who are forcibly separated from their mothers experience long-term developmental and emotional harm.

When mothers and their children are separated, mothers may not see their children again or may lose track of them. Sometimes this is due to the costs involved in arranging their visits to the prison. Other times it is because the mother rejects the relatives taking care of the children or because the mother has lost custody of the child (United Nations Office on Drugs and Crime, 2008). These mental and developmental problems tend to stay with children throughout their lives.

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

The children's preferences should always be considered, and prison policies should promote and facilitate the participation of children in the decision-making, duly considering their age (Alejos, 2005).

The Constitutional Court of South Africa (2007) ruled in *M v The State* that the statement of the Constitution that "[a] child's best interests are of paramount importance in every matter concerning the child" applies when sentencing a child's primary caregiver. Further, it issued guidelines to "promote uniformity of principle, consistency of treatment and individualisation of outcome".

21. The age until which children are permitted to stay in prison with their mothers varies considerably across the WHO European Region. With a range from zero to six years old, the age of three years is the most common age limit for children to stay with their mother in European prisons. Norway is the only European country that totally prohibits children from staying with their mother in prison (Quaker Council for European Affairs, 2007). There could be a relationship between the category of prison, the average length of sentence and the policy governing children staying with their mothers in prison. For instance, the age until

which children can stay with their mothers in an open prison is often higher, and the surroundings and facilities can be more suitable for children.

22. Contact between mothers inside prison and their children outside prison may be severely and/or inappropriately restricted. In some countries, mothers are temporarily separated (such as by stopping visits) from the children to punish the mother (Robertson, 2008). Children are a life-sustaining force for many prisoners, and breaking up the bond between the mother and child is often punishment of the worst kind for the mother (United Nations Office on Drugs and Crime, 2008) and strongly affects her physical and mental health. It also punishes the child, who has done nothing wrong.

23. Being imprisoned far away from their homes is a particular hardship for women with children. Research has shown that maintaining the ties with children reduces the chances of a woman prisoner's offending on release (Quaker Council for European Affairs, 2007).

24. Children of prisoners have committed no crime and therefore should not suffer as if they had. The children who live in prison should lead lives of at least as good quality as the life they would live outside prison. Facilities should always include good nutrition, decent playing areas and, where appropriate, kindergarten facilities. The best interests of the children should be the primary consideration at all times (Robertson, 2008). Arrangements should be made for children residing in prisons to leave at any time if this is considered to be in the best interests of the child (Alejos, 2005).

25. Children outside prison who have a parent imprisoned may experience a range of psychosocial problems during the imprisonment of a parent, including: depression, hyperactivity, aggressive behaviour, withdrawal, regression, clinging behaviour, sleep problems, eating problems, running away, truancy, poor school grades and delinquency. Further, parental separation can be experienced as desertion or abandonment, which can worsen the distress for the children (Quaker Council for European Affairs, 2007).

# Women's health and prison

## *Need for gender-specific health care*

26. Women in prison often have more health problems than male prisoners. As indicated before, many have chronic and complex health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition and poor health care (Canadian HIV/AIDS Legal Network, 2006; WHO Regional Office for Europe, 2007a). Drug-dependent women offenders have a higher prevalence than male offenders of tuberculosis, hepatitis, toxaemia, anaemia, hypertension, diabetes and obesity (Covington, 2007). Mental illness is overrepresented among women in prison, as 80% have an identifiable mental disorder. Two thirds have post-traumatic stress disorder (Zlotnick, 1997) and two thirds a substance-related disorder (WHO Regional Office for Europe, 2007b). The frequency of comorbidity is substantial. Mental illness is often correlated with prior victimization (Zlotnick, 1997). Women's prisons require a gender-specific framework for health care that pays special attention to reproductive health, mental illness, substance use problems and physical and sexual abuse. Timely access to all services available for women outside prison should be available for women inside prison. As with all prisoners, confidentiality of medical records should always be guaranteed.

27. Women in prison in western Europe tend to request more health services than men. For instance, in Italy, women in prison ask to see a physician or nurse about twice as often as men in prison (Zoia, 2005). This ratio might be even higher in other western European countries. Among the reasons for their higher demand for health services are their higher needs for care related to a history of violence and abuse, drug use problems and reproductive needs.

28. Some of the specific needs of women in prison should be tackled by taking advantage of the time they are in prison to provide education about preventing illness and maintaining good health, especially HIV and other sexually transmitted infections. Further, vocational and job-training programmes should be offered.

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

29. Women's specific health care needs are often unmet in prison. The prison environment does not always take into account the specific needs of women, such as accessibility to regular showers, the greater need for personal care products due to menstruation, the need to make sanitary napkins and the like available free of charge and to dispose of them properly and adequate nutrition for pregnant women and for women with such diseases as HIV. Women's normal human functions, such as menstruation, reproduction and the need for exercise, are too often medicalized. For example, health care personnel do not need to approve or manage access to sanitary napkins and the like or exercise for healthy women.

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

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

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

31. Women in prison need free access to a full range of health and dental services, as outlined in *Health in prisons: a WHO guide to the essentials in prison health* (WHO Regional Office for Europe, 2007a).

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

32. Women in prison often have marginalized and socially deprived backgrounds, which place them at high risk of acquiring HIV infection. Many may already be living with HIV when they enter prison (Reyes, 2000). Women are at greater risk than men of entering prison with such sexually transmitted infections as *Chlamydia* infection, gonorrhoea and syphilis and also with HIV. This results from high-risk behaviour, including sex work and an increased likelihood of being a victim of sexual abuse (Covington, 2007).

33. Women have a considerably greater risk of contracting HIV and hepatitis C from sexual activity than men. The women who engage in injecting drug use have a particularly high risk through sharing syringes and needles. They might have had unprotected sex with their drug partners or have been engaged in sex work. Women's cultural and societal conditions might be such that they are not in a position to control their own sexual lives (Bastick, 2005; Reyes, 2000; WHO Regional Office for Europe, 2007a).

34. Women in prison should always have access to condoms as well as dental dams, given the possibility of sex within prisons. As a basic rule, however, sex involving staff and prisoners should be prohibited under all circumstances.

35. Sexually transmitted infections other than HIV (such as *Chlamydia* infection, gonorrhoea and syphilis), which are quite common among women in prison and often undetected, are a major factor in the spread of HIV, as they enhance transmission and diminish people's general resistance (Reyes, 2000).

36. Prison systems should ensure that prisoners living with HIV receive prevention, treatment, care and support equivalent to that available to people living with HIV in the community, including antiretroviral therapy (WHO, 2007a). Clean needles and syringes should be

provided to prevent women from sharing them and thus prevent the spread of HIV and other infectious diseases. Evidence indicates that providing needles and syringes reduces HIV transmission in prison (WHO, 2007b). If needles and syringes are not allowed in prison, other harm-reduction measures should be accessible. Harm-reduction measures should also apply to tattooing and piercing practices.

37. The *WHO guidelines on HIV infection and AIDS in prisons* (WHO, 1993) contain the following recommendations specific to women in prison.

    a) Special attention should be given to the needs of women in prison. Staff dealing with detained women should be trained to deal with the psychosocial and medical problems associated with HIV infection in women.
    b) Women prisoners, including those who are HIV-infected, should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to infant, or through sexual intercourse. Since women prisoners may engage in sexual intercourse during detention or release on parole, they should be enabled to protect themselves from HIV infection, e.g., through the provision of condoms and skills in negotiating safer sex. Counselling on family planning should also be available, if national legislation so provides. However, no pressure should be placed on women prisoners to terminate their pregnancies. Women should be able to care for their young children while in detention regardless of their HIV status.
    c) The following should be available in all prisons holding women:
        - gynaecological consultations at regular intervals, with particular attention paid to the diagnosis and treatment of sexually transmitted diseases;
        - family planning counselling services oriented to women's needs;
        - care during pregnancy in appropriate accommodation;
        - care for children, including those born to HIV-infected mothers; and
        - condoms and other contraceptives during detention and prior to parole periods or release.

38. The minimum standards and guidelines that apply to tuberculosis control among male prisoners should apply to women in prison. The WHO minimum standards for tuberculosis control programmes are reflected in the *WHO status paper on tuberculosis* (WHO, 2007c),

including complete access to tuberculosis diagnosis and treatment for all prisoners entering the prison system.[1]

## *Substance use*

39. Drug offences are one of the most common crimes women commit in Europe, and drugs are key to women's offending. Drug offences can be categorized as: (1) offences to obtain drugs, (2) offences committed under the influence of drugs; and (3) offences related to the illegal supply of drugs, unrelated to drug dependence.

    A study in 1999 by the Bureau of Justice Statistics of the United States Department of Justice reported that almost one in three women in prison admitted to committing the offence to obtain money to support their need for drugs (Wolf et al., 2007). Further, a high percentage of women in prison have a drug problem, and research has shown that problematic drug use rates are higher among women than among men (Quaker Council for European Affairs, 2007). Female prisoners in the European Union are more likely to inject drugs than are male prisoners (European Monitoring Centre for Drugs and Drug Addiction, 2004). It is estimated that at least 75% of women arriving in prison have some sort of drug- or alcohol related problem at the time of arrest (Fowler, 2002; WHO Regional Office for Europe, 2007a). In many countries, not enough is known about women in prison with substance use problems, including their treatment experiences, effective treatment models and interventions. Relatively few international, national or local studies exist on the prevalence of substance use and associated problems addressing gender issues (United Nations Office on Drugs and Crime, 2004).

40. A study in England and Wales (Plugge et al., 2006) showed that:
    - more than 85% of women smoked tobacco before they entered prison versus a national average for women of 24%;
    - 42% of women in prison drank alcohol in excess of government guidelines before imprisonment versus 22% of women in the general population; and

[1] The KNCV Tuberculosis Fund is preparing guidelines on controlling tuberculosis in prisons, which will apply to male and female prisoners.

- 75% of women in prison had taken an illicit drug in the 6 months before imprisonment, whereas only 12% of the general population had taken an illicit drug in the past 12 months.

41. Generally, women with substance use problems:
    - have fewer resources (education, employment and income) than men;
    - are more likely to be living with a partner with a substance use problem;
    - take care of children;
    - have more severe problems at the beginning of treatment for substance use; and
    - have higher rates of trauma related to physical and sexual abuse and concurrent mental disorders than men, especially post-traumatic stress disorder and other mood and anxiety disorders (United Nations Office on Drugs and Crime, 2004).

42. A major concern is that women in prison frequently do not gain access to drug treatment programmes and that the programmes are not designed for women in any case. Treatment programmes for women may help women to feel safe and supported and make it easier to pay attention to gender-specific issues (Quaker Council for European Affairs, 2007). A gender-sensitive approach to women's health care should therefore take into account the need to provide specialized addiction treatment programmes for women in prison (United Nations Office on Drugs and Crime, 2008).

    Many imprisoned women return to the community without receiving any addiction treatment while in prison (Zurhold & Haasen, 2005). For instance, in California, 70% of the women in prison need drug treatment, but only 14% actually receive treatment while in prison (Weinstein, 2005). The lack of drug treatment facilities in the community should not be a reason for imprisoning women.

43. The evidence that drug substitution treatment for prisoners with substance use problems works and is cost-effective is overwhelming. Substitution treatment should be available for all women in prison with opioid-dependence problems. Attention should be paid towards achieving progress in implementation and in developing whatever support for staff is required, including developing clear guidelines (WHO Regional Office for Europe, 2005).

Further, continuity of treatment should be guaranteed when a woman enters prison, is released from prison or is moved to another prison. Because female prisoners are frequently transferred, which interrupts treatment, individual prisons have difficulty in monitoring success rates.

44. Drugs are one of the main causes of prison security measures such as internal body searching, restrictions of visits and restrictions of home leave. These measures can be particularly punitive for women. A balance has to be found between humane treatment and making efforts to ensure that prisons are free from illicit drugs (Quaker Council for European Affairs, 2007). The main focus should always be on the prisoner and not on the staff or administration. Balancing respect for and the dignity of the woman in prison and surveillance and security in the prison while providing care and treatment is always a challenge. In achieving this balance, prison staff should involve the prisoners.

45. Anti-drug measures, as well as treatment programmes, should acknowledge the presence of illicit drugs in prison. The European Monitoring Centre for Drugs and Drug Addiction (2004) states that "… some prisoners continue their pattern of drug use and others start using drugs in prison. Studies that are available show that between 8% and 60% of inmates report having drugs while in prison and 10–36% report regular drug use …".

## *Mental health and mental ill health*

46. In addition to substance use disorders, women in prison have alarmingly high rates of mental health problems such as post-traumatic stress disorder, depression, anxiety, phobias, neurosis, self-mutilation and suicide. This is frequently a result of lifetime abuse and victimization. Research indicates that women in prison have mental health problems to a much higher degree than both the general population and male prisoners (Bastick, 2005). For instance, a study conducted by the Bureau of Justice Statistics of the United States Department of Justice showed that 73% of the women in state prisons and 75% of the women in local prisons in the United States of America have symptoms of mental disorders versus 12% of women in the general population (Covington, 2007). In England and Wales, 90% of women in prison have a diagnosable mental disorder, substance use or both, and 9 of 10

women in prison have at least one of the following: neurosis, psychosis, personality disorder, alcohol abuse or drug dependence (WHO Regional Office for Europe, 2007a).

47. High rates of unresolved trauma and socioeconomic disadvantage that characterize a large proportion of women prisoners predispose this population to mental ill health and self-harm. Studies suggest that mental illness among women in prison often both causes and results from imprisonment (Penal Reform International, 2007). A short stay in prison, even on remand, may damage a woman's mental health and family life and yet does little or nothing to stop her from offending again. The damage is made much worse when women are imprisoned far from home and receive inadequate health care during and after their time in prison (Rutherford, 2008). Women's mental health is likely to deteriorate in prisons that are overcrowded, where prisoners are not differentiated based on proper assessment and prisoner programmes are either non-existent or inadequate to address the specific needs of women. The harmful effects on mental illness are exacerbated when women do not feel safe and if they are supervised by male staff members who make them feel at risk of further abuse (United Nations Office on Drugs and Crime, 2008). The prevention of mental health harm on admission and efforts to promote the mental health of women should be considered (WHO Regional Office for Europe, 1999). Promoting mental health and well-being should be central to a prison's health care policy (WHO Regional Office for Europe, 2008), and mental health screening on entrance should be part of normal procedure.

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

    Whether a woman's mental ill health improves or worsens while imprisoned depends on several factors including the prison structure, the treatment options, including the availability of trauma-responsive programming and the facilities and services provided to women.

### *Self-harm and suicide*

48. Existing research indicates that women in prison are more likely to engage in self-harm than male prisoners (Quaker Council for European Affairs, 2007). In England and Wales, women were 14 times more likely than men to harm themselves. 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 (WHO Regional Office for Europe, 2007a). Another study conducted in England and Wales showed that 16% of women in prison had harmed themselves in the month before imprisonment (Plugge et al., 2006).

49. In most countries, the rates of self-harm and suicide are higher among prisoners than in the outside community among both men and women (Penal Reform International, 2007). Especially the pre-trial and early periods in custody are a particularly high-risk time for self-inflicted deaths (WHO Regional Office for Europe, 2007a). The Corston (2007) report recommends first-night watches. The risk of self-harm and suicide is also increased in the first period after release. Aftercare should be provided to the women at risk. However, in some eastern European countries, the situation is reversed and the rates of self-harm and suicide are higher in the community than in prison.

50. Outside prison, men are more likely to commit suicide than women, but this is reversed inside prison. Being a mother appears to protect women in the community against suicide, but this protection does not apply in prison if mothers are separated from their children (Corston, 2007).

51. Developing strategies to prevent suicide and self-harm and to provide appropriate, gender-specific and individualized mental health treatment to those at risk need to form a comprehensive element of mental health care in prisons. Staff need to be trained to detect the risk of self-harm and suicide and offer assistance by providing support and referring such cases to specialists. In some systems, self-harm and suicide attempts are penalized, which is unacceptable and exacerbates mental distress even further (United Nations Office on Drugs and Crime, 2008). Those providing effective treatment need to consider and adequately respond to the underlying causes of self-harm and suicide, including underlying trauma issues.

52. Because evidence clearly shows an increased risk of suicidal behaviour among women in prison, policy-makers and prison governors need to be aware that posting a suicide prevention coordinator in each women's prison is good practice. Further, prison personnel need to be trained to be aware of the particular risks of self-harm among women in custody (WHO Regional Office for Europe, 2007a).

### *Learning disabilities*

53. Many terms and definitions are used to refer to learning disabilities, such as mental retardation, mental handicap and intellectual disability. WHO defines a learning disability as a condition of arrested or incomplete development of the mind that can occur with or without any other physical or mental disorders and is characterized by impairment of skills and overall intelligence in areas such as cognition, language and motor and social abilities. This includes people of all ages (WHO, 2007d).

54. Little is known about women in prison and learning disabilities and how many women in prison actually have a learning disability. Criminal behaviour by people with learning disabilities raises difficult questions related to the responsibility of offenders and what kind of punishment and care is suitable (Quaker Council for European Affairs, 2007). Prisoners with learning disabilities and difficulties are unlikely to benefit, and may be excluded, from programmes designed to stop re-offending. Many are victimized and bullied in prison (Prison Reform Trust, 2007).

### *Sexual health and reproductive health*

55. Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide whether, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their

choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child (WHO, 2009a).

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled (WHO, 2009b).

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

56. 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 (United Nations Office on Drugs and Crime, 2008). Women who have experienced abuse may, as a result, engage in high-risk sexual behaviour, which increases their risk of acquiring sexually transmitted infections. Screening programmes for reproductive diseases, such as breast cancer, should be included in the standard procedure in women's prisons.

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

### *Pregnancy, postnatal care and breastfeeding*

58. To protect the health of the mother and of the newborn child, pregnancy should in principle be an obstacle to incarceration, both pre-trial and post-conviction, and pregnant women should not be imprisoned except for absolutely compelling reasons. When a woman in prison is found to be pregnant, the need for her imprisonment should immediately be reviewed and continue to be reviewed throughout the pregnancy. Pregnant women in prison should be considered for non-custodial measures throughout their remaining prison term (Bastick, 2005).

59. Pregnancy affects many areas of a woman's life, including health, diet and exercise requirements (Robertson, 2008). Pregnant women in prison should be ensured a nutritious diet, timely and regular meals (not being kept to a rigid timetable), a healthy environment and regular exercise (United Nations Office on Drugs and Crime, 2008). Further, the difficulties of coping with morning sickness should be considered.

60. Pregnant prisoners should be provided with the same level of health care as that provided to women outside prison, including access to obstetricians, gynaecologists, midwives and birthing practitioners appropriate to their culture. Pregnant prisoners should have access to female practitioners if requested. Women may also decide not to proceed with their pregnancy in prison, especially if they were previously unaware that they were pregnant. Treatment options equivalent to those available in the community should be guaranteed (WHO Regional Office for Europe, 2007a).

61. 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. Depending on the country and the prisoner, women may give birth either in prison or at a public hospital (Bastick, 2005). A public hospital should always be first choice. Regulations governing the transport of pregnant women to a hospital or care centre should be in place (such as facilitating frequent toilet breaks). The use of shackling during labour must be completely banned. Further, male non–health care officers must not be present while women are in labour or delivering.

62. Similar to pregnant women, breastfeeding women have specific health and nutrition needs that are often unmet in prison. Appropriate food must be provided free of charge for breastfeeding women, as well as for their babies, including milk, high-protein products and fresh fruit and vegetables (United Nations Office on Drugs and Crime, 2008). Meals should be provided regularly and flexibly, not being kept to a rigid timetable. Mothers require health checks to ensure that their body is recovering from birth healthily, and to ensure, for example, that they do not have any infection they might transmit to the child through breastfeeding (Bastick, 2005). Being infected with hepatitis C does not contraindicate breastfeeding, because no evidence indicates that breast-milk can spread hepatitis C. Mothers living with HIV, however, are recommended to exclusively breastfeed for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, women living with HIV are recommended to avoid all breastfeeding (WHO, 2009c). Women in prison are often discouraged from breastfeeding, as it is perceived to interfere with prison routines (Bastick, 2005). However, it is widely recognized that breastfeeding is the best method of infant feeding.

63. In the postnatal period, the privacy of mother and baby and family visitors must be respected to provide a good environment for family bonding and feeding. After birth, women should receive appropriate counselling and support and be carefully monitored for depression (Bastick, 2005). Further, in miscarriage, counselling is essential and should always be provided.

### *Violence and abuse*

64. Three times as many women as men report having experienced physical or sexual abuse before imprisonment (Severson et al., 2005). 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 those related to the reproductive system. Trauma is directly and indirectly linked to the criminogenic pathway and both mental

and physical illness (Moloney KP, van den Bergh BJ, Møller LF, submitted). For this reason, addressing unresolved trauma through adequate trauma psychotherapy is important.

65. It is important in the screening process to identify women who are or have been victims of violence and other forms of trauma. If they come from abusive relationships or risk other forms of violence on returning to society, they should be provided with counselling and support extending beyond their period in prison.

66. Women who have experienced family dysfunction and abuse may require assistance to develop healthy parenting styles. For imprisoned women with children or pregnant women, parenting support in both the pre- and postnatal periods should seek to prevent the key risk factors (in both mother and child) of poor mother–child bonding and poor parenting skills. Children who are separated from their mothers need comprehensive support.

67. While in prison, women are vulnerable to abuse, particularly sexual abuse. The fact that prison guards control women in prison makes them powerless in that sense. An effective system of prison inspection and oversight carried out by an independent body that includes a confidential complaints system is essential in preventing violence and abuse within the prison (Penal Reform International, 2007). Every woman in prison has the right to be free from sexual abuse. Women who have been victims of sexual abuse that creates a risk of HIV transmission should have access to post-exposure prophylaxis.

68. Women in prison should be able to see a physician without the presence of prison operational staff, because women are less likely to report possible violence and abuse in prison in the presence of operational staff. Women in prison should be given the choice to be accompanied by a woman (such as a female nurse) when visiting a physician if they prefer. The European Prison Rules and national penal codes give the physician a central role in preventing human rights abuses in custodial settings (Quaker Council for European Affairs, 2007).

69. The minority of women who have perpetrated violent crimes or are identified through screening as perpetrators of violence should be provided with interventions to prevent them from being violent in prison and when they return to society.

### *Multiple and complex treatment needs*

70. A study conducted by the Bureau of Justice Statistics of the United States Department of Justice found that three quarters of the women in prisons in the United States of America who had a mental health problem also met the criteria for substance dependence or abuse (Covington, 2007). Other studies indicate that women with substance abuse problems are more likely than men to have experienced physical and/or sexual abuse (United Nations Office on Drugs and Crime, 2004). A history of violent assault can increase the risk of substance use and post-traumatic stress disorder or other mental health problems (United Nations Office on Drugs and Crime, 2008). For this reason, trauma-responsive programming needs to be a central component of all mental health services in prisons.

71. Previous sexual abuse is statistically associated with self-harm and attempted suicide among women in prison. A significantly higher proportion of women (41%) than men (18%) who had attempted suicide or harmed themselves reported having been sexually abused (WHO Regional Office for Europe, 2007a). In recent decades, an important development in health care is the recognition that trauma plays a vital role in developing physical and mental health problems (Covington, 2007).

72. Women who are alcohol and/or drug dependent are more likely to experience depression, dissociation, post-traumatic stress disorder, other anxiety disorders, eating disorders and personality disorders (Covington, 2007). In addition to substance abuse programs, many women need psychotherapy that specifically addresses past trauma. In addition, as imprisoned women often not only have drug and alcohol dependence but also mental distress, poor health and lack of supportive relationships, they have a unique need for psychoeducational and skills training and for systematic pre-release interventions to prepare them for living in the community (Zurhold & Haasen, 2005).

73. Some women in prison discover 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. Empathy and counselling are always required, to ensure the best possible conditions for the mother and baby in this always

complex situation. Premature birth may be more common among pregnant women living with HIV than among those without HIV, with some studies showing rates up to twice those among HIV-negative women (Reyes, 2000).

It is very important that pregnant women who require antiretroviral therapy have free access to it. For a pregnant woman with indications for antiretroviral therapy, such treatment reduces maternal mortality and morbidity, is the most effective method of preventing mother-to-child transmission of HIV and, by securing the health of the woman, improves the chances that her child will survive. 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. The stage of the pregnancy and the potential side effects of the treatment should always be considered (WHO, 2006).

74. Use of drugs and alcohol during pregnancy can result in diseases, low birth weight, early delivery, poor nutritional status, respiratory diseases and fetal alcohol syndrome. Some of these consequences may be due to the lifestyles associated with substance use such as poor nutrition, lack of health and social care and infectious diseases such as HIV and hepatitis, which may compound any direct effects of illicit substance use on the health of the mother and the fetus (United Nations Office on Drugs and Crime, 2004).

75. In case of multiple needs, such as having two or more illnesses or types of dependence at the same time, illnesses may interact and medicines for treatment may be counterproductive or dangerous. For instance, a woman who has hepatitis and cancer at the same time might need a drug for cancer treatment that harms liver functioning.

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

76. Before they are released, women should have access to programmes to help them to make the transition to life outside prison. These will vary between cultures but might include courses in life skills, parenting and health care (Bastick, 2005). Learning basic household skills, such

as cooking and washing, will already make a big difference for some women in prison and will help them in their life in the community.

However, resources and attention allocated to women's needs in preparing them for release and following imprisonment are generally very inadequate, and collaboration between prison authorities and civil social and health services is often lacking (United Nations Office on Drugs and Crime, 2008). Especially for women serving short sentences, access to programmes is often not provided.

The Quaker Council for European Affairs (2007) recommends that the Member States of the Council of Europe:

a) ensure that prison policies and programmes are specifically tailored to the needs of women, including those in the areas of resettlement; and
b) ensure that the needs of female prisoners upon release, issues such as homelessness, unemployment, workforce discrimination and regaining custody of children, are addressed; if social services were previously involved with a prisoner, then they should be informed when that prisoner is to be released.

77. On release, consistent with the Standard Minimum Rules for the Treatment of Prisoners, all former prisoners must have access to adequate food, clothing, housing and health care and other necessary social services.

Prison authorities should arrange for post-release housing for women in prison, especially those with children. Women may experience that they cannot get their children back with them to stay until they have accommodation but that they cannot get accommodation until they have their children back. This makes it very difficult for these women to get back to normal lives in the community and may contribute to re-offending (Quaker Council for European Affairs, 2007). Prison authorities should cooperate with responsible institutions in the community. Foreign national women are often released in a country other than the one in which they were imprisoned, and contact beyond national borders is therefore important.

78. As foreseen by the Standard Minimum Rules for the Treatment of Prisoners, a prisoner may require ongoing mental health services after release. This is of particular importance for female prisoners, given their high rates of mental illness and given their higher likeliness of having received treatment for a mental health condition while in prison, which needs to be continued in the community (Bastick, 2005; United Nations Office on Drugs and Crime, 2008).

79. Post-release care is essential, and prison authorities should devote particular attention to the availability of treatment and social support services for women on their release. Support from volunteers, inside as well as outside the prison system (such as peer support), can be very helpful in the process. The fact that many women in prison are imprisoned far away from home is a complicating factor.

80. Former prisoners experience high rates of drug-related accidents, overdose and death (United Nations Office on Drugs and Crime, 2007). Strategies are needed to ensure continuity in the treatment of drug users as they move between the prison system and the community (WHO, 2007e).

81. In some cultures, women are at risk of being murdered by their families after release from prison if they have committed what are considered to be "moral offences" or are victims of rape or other sexual abuse. Women may also be at risk of returning to a marriage with a violent partner or being forced into a marriage. These women all need special protection and support, which are very often inadequate compared with their needs (United Nations Office on Drugs and Crime, 2008).

## How can the situation be improved? What can, should and must be done?

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

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

In deciding what can, should and must be done, several important principles should be emphasized and followed.

- First, imprisonment of women should be considered only as a last resort when all other alternatives are unavailable or are unsuitable. This applies even more so to pregnant women and to women with children. Women need to be considered holistically in the context of their offending and their social situation.
- Second, health service provision and programming should specifically address mental illness, especially substance use disorders and post-traumatic stress disorder, as being essential to any prison health care system.
- Third, if children are involved, **the best interest of the children must be the main and determining factor**. The greater social costs to the community and the potential for long-term damage must be understood and accepted. Decisions on the best interests of a child should be based on appropriate advice from a recognized source independent of the courts and prison services.

- Fourth, needs vary significantly among different groups of women; factors such as pregnancy, having responsibility for children, young or old age, dependence problems, histories of violence and/or abuse and others must be important considerations in health plans for these women.
- Fifth, the impact of separation from family and community as well as the inevitable legal and security processes involved can severely harm a woman's mental health, emotional well-being, self-esteem and social and life skills and abilities to varying extents. This is true for everyone compulsorily deprived of liberty but especially for women. Any individual health plan must include **careful, comprehensive and detailed screening**, including socioeconomic and educational background, health and trauma histories, current health status and an assessment of skills held or required so that the individual needs are determined and can be suitably addressed.
- Sixth, although rigid policies should be avoided, given the variation in individual needs in a changing world, **the underlying importance of human rights** should pervade all thinking and all policy development for everyone in compulsory detention.

## *Recent developments and emerging plans*

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

The legal and criminal justice systems are also changing. Some of these plans could have major benefits for women in the criminal justice system. For example, restorative justice approaches, such as family group conferences and sentencing circles, are already being used; restorative justice has been defined as "the use of a restorative process in which the victim and the offender and, where appropriate, any other individuals or community members affected by a crime,

participate together actively in the resolution of matters arising from the crime, generally with the help of a [trained] facilitator" (United Nations Economic and Social Council, 2002).

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

Although these and other developments should be strongly encouraged, improvement throughout the WHO European Region remains slow.

Any call for action related to **women's health and prisons** should best be seen as a whole under the following characteristics.

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

## *Recommendations*

The Health in Prisons Project of the WHO Regional Office for Europe strongly supports the following specific comments and recommendations.

1. **A gender-sensitive criminal justice system is an essential first step to ensure that all stages of the criminal justice system take into account gender-specific needs and circumstances.**

***1.1. Greater and more complex needs***. Women in prison are a small proportion of the prison population, with about 100 000 women in European prisons every day. Women in prison generally have lower income, have higher rates of being abused and have more complex social and health problems than male prisoners. These problems require special attention continually, for the women themselves, for their children and for society as a whole.

***1.2. Costly impact of women's imprisonment***. Most of the women in prison are imprisoned for non-violent and relatively minor offences, but imprisonment strongly affects their health and their children. In every case, the circumstances of the woman and her place in the family and community should be carefully considered before sentencing. Everyone involved in the legal process has to consider all the consequences of the decisions. Fully considering all alternatives to imprisonment is essential to prevent unnecessarily ruining women's lives and harming children and other dependent relatives.

***1.3. A more appropriate level of security***. By far the majority of women in prison do not need to be in high-security facilities and are of no risk to society. If women cannot remain in their places of residence while complying with the court-imposed sentence or if suitable community places are not available, then lower-security prisons specifically designed for women should be established where they can be housed in smaller units and closer to their home.

***1.4. Whole-system approach***. Although this report concentrates on women's health and prisons, the evidence clearly shows that a gender-sensitive approach should apply at all stages of the

criminal justice system, starting from the first contact with the police. It follows that a major aspect of any new approach must be gender-sensitive training for everyone involved, such as police, magistrates, court officials, judges and probation staff.

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

1.6. ***Comprehensive health needs assessment.*** As with everyone before the courts, assessed health needs should be considered so that best placement can be made. For women, whose crimes are often related to drug dependence, the offer of drug treatment in a suitable place should be offered as an alternative to imprisonment. In the same way, those with obvious mental health needs must be sent to a facility able to treat and care for mental illness.

1.7. ***Need for gender-disaggregated data.*** Developing a suitable gender-sensitive prison system and being able to understand and address the particular health needs of women in prison properly and effectively requires increasing gender-disaggregated data on women's health and health needs in prison and stimulating research in this field.

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

2.1. ***Meeting women's special health care needs.*** A gender-sensitive health care system in prisons should reflect the special health care needs of women in prison by providing appropriate facilities and regimens and by allowing easy access to health and social support services necessary for women.

- The services should be based on primary care that takes a holistic approach in assessing these needs and offers a range of services, including health promotion emphasizing self-

care, nutrition and exercise, preventive screening services similar to those available in the local community and advice and help in day-to-day health problems.

- The primary services should be able to cope with many of the more complex health needs, the complex problems and reproductive and sexual health needs of women in prison, through additional training of the health team and their ability to access specialist help. This should include primary mental health support and access to therapy to help to process trauma and to promote the well-being of women with histories of abuse.
- The prison health services need to be aware of and prepared to meet the specific needs of girls and older women in prison.
- The health service should be involved with the other staff members who meet needs for rehabilitation and reintegration through services specially designed for women.

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

***2.3. Appropriate female-male staffing balance***. In the general operation of women's prisons, there is support for a balance of female and male staff as long as the operation of the prison reflects the different day-to-day needs of women. Male custodial officers should not have routine physical contact with women in prison or have access to places where women are commonly undressed such as bathroom areas. Staff should not be in a position of power that undermines women's privacy and modesty. Each prison system should prepare and issue a clear protocol on this staffing issue based on internationally agreed standards and national legislation.

***2.4. Clinical consultations sensitive to personal wishes***. In the prison health service, women should be able to ask for investigation, treatment and care from female nurses and physicians; if this is not possible, male physicians should use a chaperone approach (another woman present during the consultation) when seeing women prisoners. However, as in all

prisons, prisoners should be able to visit a physician without any operational staff being present.

2.5. ***Confidential complaints and independent monitoring***. Women in prison should have access to an independent and confidential complaint system to be able to report in confidence matters such as experiences with violence and/or abuse during their stay in prison.

**3. The human rights of women and of their children must always be dominant; principles of equivalence and of appropriateness of facility and health care must be recognized. The needs of any child involved must be dominant.**

*3.1.* ***Protecting personal and family relationships***. Many women prisoners have children for whom they were the primary or sole carer before they were imprisoned. When they are admitted to prison, the family often breaks up, resulting in many children themselves being institutionalized. Extra efforts must be made to preserve family ties, especially if they have young children who do not accompany them in prison. Regular visits by family members must be facilitated and encouraged, as they are an essential part of keeping family links. The imaginative ways of keeping family ties intact in some countries should be known better and should be considered in places in which the current prison systems for women remain as they are. The stopping of family contact as a punishment must be prohibited in all systems.

*3.2.* ***Maintaining home and external contacts***. The importance of telephone contact needs to be remembered. A well-developed telephone access policy should be present in all women's prisons so that some regularity in calls home should be available without a prisoner having to meet all the costs involved. This may be more difficult for foreign national women, but the overall value of maintaining community links should make it an important part of the prisons' policies.

*3.3.* ***Important role for nongovernmental organizations***. The value of nongovernmental organizations and voluntary groups in maintaining family contact has been shown. Efforts by nongovernmental organizations and volunteers aimed at women offenders, inside as well as outside the prison system, should always be encouraged.

***3.4. Children staying with their mothers in prison***. The question of whether children should stay with their mothers in prison is one of the most difficult national policy decisions. The following are guiding principles.

- The best interests of the child must be the first and main consideration.
- The participation of children in the decision-making should always be promoted and facilitated, taking due consideration of their age.
- If children do stay with their mothers in prison, the facilities must be suitable.
- Clear provisions must be made for the health care and the development of the child.
- There must be suitable regular monitoring and reassessment of the child's welfare.
- It must be agreed that any child can leave the prison at any time if this is in the best interests of that child.

**4. Specialist health care must be provided: for instance, for mental health, including help with a legacy of abuse; for HIV, hepatitis C, tuberculosis and other infectious diseases; for drug and alcohol dependence; for learning disabilities; and for reproductive health.**

***4.1. Strong primary health care and easy and sensitive access to emergency care***. Although a good primary health care service in prisons can deal with many somatic health problems and should be part of a regular screening, assessment and reassessment programme as part of the regular cycle of care, all prisoners can have health care emergencies requiring urgent admission to secondary care or specialist facilities. How this is made available should be part of a prison health care plan and known to prisoners. This is seldom easy with any prisoner, but with women the transport arrangements need to be considered to avoid causing additional stress. Further, the use of interpreters should allow the arrangements to be made clear to foreign national women in prison, and their additional cultural needs should be recognized.

***4.2. Promoting mental health and resilience***. Promoting mental health and well-being should be key to a prison's health care policy. The high rate of self-harm and indeed suicide among women in prison should alert prison governors to the urgent need for strategies and policies for protecting mental health in general and for assessing women who may be at risk. This area of health need demonstrates the importance of a whole-prison approach. All staff

members need to be aware of their role and of how the environment and regimens inside prisons can be modified, positively and beneficially, with improvements in mental resilience among prisoners and staff members. Governors of prisons have an important leadership role here in working with senior staff members to create an ethos in the prison that is conducive to health.

4.3. ***Coping with personal histories of abuse***. Many women in prison have a history of being physically or sexually abused before imprisonment. The mental health problems that can arise from this require specialized mental health support and care as an essential part of health care for women in prison.

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

4.5. ***Tuberculosis control and care***. All prisons should follow the WHO guidelines on tuberculosis control and care in prisons.

4.6. ***Health competencies and equivalence of prevention.*** An important part of health care of special relevance for women prisoners is improving their knowledge and understanding about health matters, to improve their capacity and confidence in protecting and improving their own health. This needs to include knowledge about how certain diseases are spread, especially those that are bloodborne or sexually transmitted and how they can prevent themselves from becoming infected. They need easy and free access to condoms and dental dams. Tattooing and piercing should be discouraged and well regulated, because of the high risk of transmitting infectious diseases among women in prison.

4.7. ***Learning disabilities***. For women in prison with learning disabilities, all health information material should be reviewed and suitably adapted to ensure that they can understand it.

Further evidence on the effectiveness of such a review is required, and further research is needed on women in prison who have learning disabilities.

**4.8.** ***Special gender-sensitive drug treatment facilities***. Health care in prisons should include access to drug treatment programmes, and these could be specialized for women so that they build up women's feeling of being safe and supported. Similar to all the programmes indicated here, the staff members involved should pay attention to gender-specific issues.

**4.9.** ***Substitution treatment***. Drug treatment, including substitution treatment, should be available for women in prison who have drug dependence, and clear guidelines on this have to be developed and include additional training for health care personnel.

**4.10.** ***Harm reduction***. All prisons should have clearly developed harm-reduction programmes as an essential part of controlling the spread of HIV and hepatitis C. Where there is political or staff controversy about some of the proven effective harm-reduction measures, the successful implementation of such schemes in prisons in Spain, for example, should be made known.

**4.11.** ***Serious issues concerning pregnancy inside prisons***. Pregnancy among women offenders raises a series of important issues, including whether this should be an obstacle to imprisonment, where the birth should occur, the facilities for breastfeeding and mother–child bonding and the aspects already mentioned such as the continuing care of the child and whether and for how long the child should stay in prison. There is wide agreement on two points.

- A woman in prison should always ideally give birth outside prison in a public hospital.
- The need for continuing to imprison a mother should continually be reviewed with the aim of moving her to an alternative to prison whenever possible. Experience with new purpose-built and secure mother and baby units is becoming available in some countries in Europe.

**4.12.** ***Treatment for HIV***. According to WHO recommendations, pregnant women in prison living with HIV should always receive antiretroviral therapy.

***4.13. Support for breastfeeding***. Women in prison should never be discouraged from breastfeeding their child unless the woman is living with HIV. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, women living with HIV are recommended to avoid all breastfeeding (WHO, 2009c). The prison must meet the particular health and nutritional needs of a breastfeeding woman.

**5. Pre-release preparations must be planned and provided to ensure continuity of care, and access to health and other services after release must be a clear part of the programme preparing for release. Pre-release planning is a complex challenging issue, due to out-of-area imprisonment, and time for the preparations may be lacking, especially if sentences are short. Nevertheless, the challenges are likely to be well rewarded with considerably improved resettlement, reduced social costs and reduced re-offending.**

***5.1. Continuity of care and pre-release planning***. Strong evidence supports the importance of continuity of care for people with life-threatening conditions such as HIV, tuberculosis, drug addiction treatment and mental ill health problems and for all prisoners if resettlement is to be rightly considered a priority. There are very real barriers to continuity, such as geographical isolation from the prisoner's home area, the breakdown in family ties, the loss of employment and often of housing and the need to ensure that a woman does not return to a home situation of likely abuse. In some cases, the family is reluctant to have her back with them and may refuse.

Some of these steps will help to improve the chances of successful resettlement. A key factor, however, will be the availability of help within the prison in terms of education, vocational training and building self-esteem, a better understanding of human relationships, anger control and personal fitness and life and home skills and capabilities. An issue that has to be addressed is when a mother has her children with her and is thus unable to participate in these activities. Pre-release preparations should start almost on admission. The prison health service should be a full partner with the other services available in prisons so that overall plans for support after release can be made.

In this, as with all matters raised here, the women themselves should be consulted about their needs and about their resettlement requirements.

5.2. ***Important role of nongovernmental organizations***. Resettlement on release can be greatly aided by making use of voluntary and other social groups linking prisons with communities. Nongovernmental organizations can be particularly useful for some basic essentials, such as housing, employment and re-established links to primary health care.

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

## Concluding remarks

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

The associated Kyiv Declaration on Women's Health in Prison is firmly based on this background paper and the evidence showing failures in human rights, in gender equity and in social justice.

## References


Alejos M (2005). *Babies and small children residing in prisons*. Geneva, Quaker United Nations Office, 2005.

Bastick M (2005). *A commentary on the standard minimum rules for the treatment of prisoners*. Geneva, Quaker United Nations Office.

Bogemann H (2007). *Promoting health and managing stress among prison employees*. In: *Health in prisons: a WHO guide to the essentials in prison health*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/prisons/publications/20050610_1, accessed 26 January 2009).

Canadian HIV/AIDS Legal Network (2006). *Women prisoners and HIV/AIDS*. Ottawa, Canadian HIV/AIDS Legal Network.

Constitutional Court of South Africa (2007). *M v The State*. Braamfontein, Constitutional Court of South Africa.

Corston J (2007). *The Corston report: a report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*. London, Home Office.

Council of Europe (2000). *Parliamentary Assembly Recommendation 1469 (2000).* Strasbourg, Council of Europe.

Council of Europe (2006). *European Prison Rules*. Strasbourg, Council of Europe.

Covington S (2007). Women and the criminal justice system. *Women's Health Issues*, 17:180–182.

Douglas N, Plugge E (2008). The health needs of imprisoned female juvenile offenders: the views of the young women prisoners and youth justice professionals. *International Journal of Prisoner Health*, 4:66–76.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2004). *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*. Strasbourg, Council of Europe.

European Monitoring Centre for Drugs and Drug Addiction (2004). *Annual report 2004: the state of the drugs problem in the European Union and Norway.* Lisbon, European Monitoring Centre for Drugs and Drug Addiction (http://ar2004.emcdda.europa.eu/en/page096-en.html, accessed 26 January 2009).

European Parliament (2008). *Resolution on the particular situation of women in prison and the impact of the imprisonment of parents on social and family life*. Brussels, European Parliament.

Fowler L (2002). *Drugs, crime and the drug treatment and testing order*. London, NAPO – Trade Union and Professional Association for Family Court and Probation Staff (ICCJ Monograph, No. 2).

Hayton P (2007). *Protecting and promoting health in prisons: a settings approach*. In: *Health in prisons: a WHO guide to the essentials in prison health*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/prisons/publications/20050610_1, accessed 26 January 2009).

Kelly P et al. (2007). *Health interventions with girls in the juvenile justice system. Women's Health Issues*, 7:227–236.

Kurten-Vartio S (2007). *Women in prison: social, economic and cultural rights of female prisoners.* Brussels, European Parliament (http://www.europarl.europa.eu/hearings/20070626/femm/kurten_vartio_en.pdf, accessed 26 January 2009).

Martin RE (2008). *Rationale, description and implications of a participatory health research project in a Canadian women's prison* [dissertation]. Manchester, University of Manchester.

Office of the United Nations High Commissioner for Human Rights (1994). *Discrimination against women: the Convention and the Committee*. Geneva, Office of the United Nations High Commissioner for Human Rights (Fact Sheet No. 22).

Ogloff J, Tye C (2007). Responding to mental health needs of female offenders. In: Sheehan R, McIvor G, Trotter C, eds. *What works with women offenders*. Devon, Willan Publishing.

Penal Reform International (2007). *Women in prison: incarcerated in a man's world*. London, Penal Reform International (Penal Reform Briefing No. 3).

Plugge E, Douglas N, Fitzpatrick R (2006). *The health of women in prison: study findings*. Oxford, Department of Public Health, University of Oxford.

Prison Reform Trust (2006). *Bromley briefings prison factfile*. London, Prison Reform Trust.

Prison Reform Trust (2007). High numbers of people with learning disabilities and difficulties held behind bars [press release]. London, Prison Reform Trust.

Quaker Council for European Affairs (2007). *Women in prison: a review of the conditions in Member States of the Council of Europe*. Brussels, Quaker Council for European Affairs.

Reyes H (2000). *Women in prison and HIV*. Geneva, International Committee of the Red Cross.

Robertson O (2008). *Children imprisoned by circumstance*. Geneva, Quaker United Nations Office.

Rutherford M (2008). *The Corston report and the government's response: the implications for women prisoners with mental health problems*. London, Sainsbury Centre for Mental Health.

Severson M, Postmus JL, Berry M (2005). Incarcerated women: consequences and contributions of victimization and intervention. *International Journal of Prisoner Health*, 1:223–240.

Taylor R (2004). *Women in prison and children of imprisoned mothers: preliminary research paper*. Geneva, Quaker United Nations Office.

United Nations (1948). *Universal Declaration of Human Rights*. New York, United Nations.

United Nations (1955). *Standard Minimum Rules for the Treatment of Prisoners*. New York, United Nations.

United Nations (1979). *Convention on the Elimination of All Forms of Discrimination against Women*. New York, United Nations.

United Nations (1988). *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*. New York, United Nations.

United Nations (1990). *Basic Principles for the Treatment of Prisoners*. New York, United Nations.

United Nations Economic and Social Council (2002). *Basic principles on the use of restorative justice programmes in criminal matters*. New York, United Nations (Resolution 2002/12).

United Nations Office on Drugs and Crime (2004). *Substance abuse treatment and care for women: case studies and lessons learned*. Vienna, United Nations Office on Drugs and Crime.

United Nations Office on Drugs and Crime (2008). *UNODC handbook for prison managers and policymakers on women and imprisonment*. Vienna, United Nations Office on Drugs and Crime.

Walmsley R (2006). *World female imprisonment list*. London, International Centre for Prison Studies.

Weinstein C (2005). *Men's hands off women prisoners*. Oakland, California Prison Focus.

WHO (1993). *WHO guidelines on HIV infection and AIDS in prisons*. Geneva, World Health Organization (http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf, accessed 26 January 2009).

WHO (2006). *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access: recommendations for a public health approach*. Geneva, World Health Organization (http://www.who.int/hiv/pub/mtct/pmtct/en, accessed 26 January 2009).

WHO (2007a). *Interventions to address HIV in prisons: HIV care, treatment and support*. Geneva, World Health Organization (Evidence for Action Technical Papers; http://www.who.int/hiv/pub/advocacy/idupolicybriefs/en, accessed 26 January 2009).

WHO (2007b). *Interventions to address HIV in prisons: needle and syringe programmes and decontamination strategies*. Geneva, World Health Organization (Evidence for Action Technical Papers; http://www.who.int/hiv/pub/advocacy/idupolicybriefs/en, accessed 26 January 2009).

WHO (2007c). *Status paper on prisons and tuberculosis*. Geneva, World Health Organization (http://www.euro.who.int/prisons/publications/20050610_1, accessed 26 January 2009).

WHO (2007d). *Atlas: global resources for persons with intellectual disabilities*. Geneva, World Health Organization (http://www.who.int/mental_health/evidence/atlas_id_2007.pdf, accessed 26 January 2009).

WHO (2007e). *Interventions to address HIV in prisons: drug dependence treatments*. Geneva, World Health Organization (Evidence for Action Technical Papers; http://www.who.int/hiv/pub/advocacy/idupolicybriefs/en, accessed 26 January 2009).

WHO (2009a). Reproductive health [web site]. Geneva, World Health Organization (http://www.who.int/topics/reproductive_health/en, accessed 26 January 2009).

WHO (2009b). *Sexual health*. Geneva, World Health Organization (http://www.who.int/reproductive-health/gender/sexualhealth.html, accessed 26 January 2009).

WHO (2009c). *HIV and infant feeding*. Geneva, World Health Organization (http://www.who.int/child_adolescent_health/topics/prevention_care/child/nutrition/hivif/en/index.html, accessed 26 January 2009).

WHO Regional Office for Europe (1999). *Mental health promotion in prisons: report on a WHO meeting, The Hague, Netherlands, 18–21 November 1998*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/prisons/publications/20050610_1, accessed 26 January 2009).

WHO Regional Office for Europe (2005). *Status paper on prisons, drugs and harm reduction*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/prisons/publications/20050610_1, accessed 26 January 2009).

WHO Regional Office for Europe (2007a). *Health in prisons: a WHO guide to the essentials in prison health*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/prisons/publications/20050610_1, accessed 26 January 2009).

WHO Regional Office for Europe (2007b). *Fact sheet on prisons and mental health*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/prisons/topics/20071010_1, accessed 26 January 2009).

WHO Regional Office for Europe (2008). *Trenčín Statement on Prisons and Mental Health*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/prisons/publications/20050610_1, accessed 26 January 2009).

WHO Regional Office for Europe (2009). Prison health database [online database]. Copenhagen, WHO Regional Office for Europe (http://data.euro.who.int/HIP, accessed 26 January 2009).

Wolf AM et al. (2007). Responding to the health needs of female offenders. In: Sheehan R, McIvor G, Trotter C, eds. *What works with women offenders*. Devon, Willan Publishing.

Zlotnick C (1997). Posttraumatic stress disorder (PTSD), PTSD comorbidity, and childhood abuse among incarcerated women. *Journal of Nervous and Mental Disease*, 185:761–763.

Zoia D (2005). Women and healthcare in prison: an overview of the experiences of imprisoned women in Italy. *International Journal of Prisoner Health*, 1:117–126.

Zurhold H, Haasen C (2005). Women in prison: responses of European prison systems to problematic drug users. *International Journal of Prisoner Health*, 1:127–141.