

## Women in Prison: Health and Mental Health

This brief is based on findings from the *Women's Pathways to Prison* project conducted by the Gender, Health and Justice Research Unit, University of Cape Town (2012). The *Pathways Project* was one of the first in-depth, ethnographic studies on incarcerated women in South Africa. Through an innovative, multi-method project design, the *Pathways Project* explored the reasons why women came into conflict with the law and ended up in prison. Moving beyond classical criminological studies on prison – where positivist survey methods still dominate – our methods culminated in 55 in-depth narratives of incarcerated women. The 'theoretical aim' of the project was to highlight the distinctive nature of female criminality, thereby shifting attention from the all-male focus on crime that has characterised most of South African criminology and prisons research. The study aimed to generate new knowledge around women, crime and incarceration, and to contribute to the formulation of more effective and appropriate correctional policies that take into account the particular context that shapes female criminality and the specific factors that inform women's experiences of incarceration.

Although the intention of our research was not to monitor, document or explore conditions of imprisonment in South Africa, it did explore the way in which women *experienced* imprisonment. One aspect of women's daily life inside a correctional facility that was worthy of attention was the extent to which women had access to health and mental health resources and services, and their experiences with these services in prison.

### Health and Mental Health-Care in Prisons: The Legal Framework

The South African Department of Correctional Services (DCS) is mandated by both domestic and international law to provide a suitable environment for its incarcerated population, including the provision of particular services. The South African Constitution is the cornerstone of South African prisoners' rights and provides the legal framework for the regulation of prisons and the treatment of prisoners. It specifically requires that 'everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment' (Constitution of South Africa, Act 108 of 1998). These broad and foundational guarantees in the Constitution are expanded upon in international treaties. The *United Nations Standard Minimum Rules for Non-custodial Measures* (supplemented by the Tokyo Rules for non-custodial measures)<sup>1</sup>, for instance, provide fundamental guidelines for countries that are signatories. The UN *Standard*

*Minimum Rules* set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions, concentrating on issues such as registration (s. 7), categorisation (s. 8), accommodation (s. 9-14), nutrition (s. 20), medical care (s. 22-26), discipline and punishment (s. 27-32), information given (s. 35-36), contact and visits (s. 37-39) and religion (s. 41) of prisoners. It also sets out guidelines for institutional personnel (s. 46-54), work in prison (s. 71-76), recreation and education (s. 77-78) as well as the treatment of mentally ill (s. 82), pre-trial (s. 84-93), civil (s. 94) and without charge prisoners (s. 95). These rules have also been supplemented by the *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Means for Women Offenders* (known as the *Bangkok Rules*) which address the specific needs and characteristics of women in prison. These rules are inspired by the principles contained in various international conventions and declarations relating to women – many of which South Africa is a signatory to. Guidelines and minimum standards for the provision of health and mental health care services are covered by these internationally recognised mandates, as well as by the *White Paper on Corrections in South Africa* (2005) and the *Correctional Services Act* (1998). The *White Paper on Corrections*, for instance, recognises that health care for inmates requires more than simply addressing specific medical problems: 'The responsibility of the Department is not just to provide health care, but also to provide conditions that promote the well-being of inmates and DCS officials' (DCS, 2005).

<sup>1</sup> Standard Minimum Rules for the Treatment of Prisoners, adopted Aug. 30, 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, U.N. Doc. A/CONF/611, annex I, E.S.C. res. 663C, 24 U.N. ESCOR Supp. (No. 1) at 11, U.N. Doc. E/3048 (1957), amended E.S.C. res. 2076, 62 U.N. ESCOR Supp. (No. 1) at 35, U.N. Doc. E/5988 (1977). See also: United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules), G.A. res. 45/110, annex, 45 U.N. GAOR Supp. (No. 49A) at 197, U.N. Doc. A/45/49 (1990).

## Health and Mental Health-Care in Prisons

International literature has shown that prison populations are often made up of individuals who, prior to incarceration, lived on the margins of society with poor health and health care access (Niveau, 2006). The *White Paper on Corrections* recognises this problem and its relevance for the health and well-being of inmates: ‘...the number of offenders with communicable diseases entering correctional centres is higher than the national average’ (DCS, 2005). Furthermore, living conditions in prisons may contribute to the transmission of infectious diseases independently of individual behaviour. For instance, one study found that incarceration worsened cases of asthma, diabetes, peptic ulcers, epilepsy and weight gain, which is especially common in women due to limited dietary options and a lack of exercise facilities (Kane and DiBartolo, 2002). A variety of factors, some of which will be explored in this brief, contribute to these exacerbated conditions. One problem in particular, the overcrowding of prisons and cells, is a national problem facing the majority of South Africa’s correctional centres. In 2004 it was reported that Pollsmoor’s women’s section was at 129% over capacity and Worcester’s 140% (JIP, 2004). Communicable diseases are more easily and rapidly spread in overcrowded living conditions. Tuberculosis (TB) – of which South Africa has one of the highest rates in the world (USAID, 2009) – in particular, spreads quickly in overcrowded conditions, both in and out of prison. Prisoners living in overcrowded cells – especially large communal cells – are particularly at risk for TB (Amon, 2010). Further, a UK study found that rates of suicide amongst prisoners living in overcrowded prisons were higher than amongst prisoners living in reasonably populated prisons (The Howard League for Penal Reform, 2005).

Representing about 2.3% the South African prison population, female prisoners face the possibility of being overlooked in a prison system dominated by a male majority. Special attention must therefore be paid to the unique and differentiating needs of incarcerated women, as these needs are fundamentally distinct from male prisoners. International literature shows that the most frequent medical problems facing female inmates are ‘drug and alcohol addiction, gynaecological diseases and the exacerbation of chronic health conditions such as hypertension, epilepsy and diabetes – not to mention undetected health problems’ (The Howard League for Penal Reform, 2005). International treaties and provisions on health in prisons have recognised these needs. The Bangkok Rules pay special attention to the heightened vulnerabilities of women in prison, including mental health, family, pregnancy and childcare, reduced access to justice as a result of economic and social disadvantage, as well as specific health care and hygiene needs. Generally, the rules dictate that ‘gender-specific

health-care services at least equivalent to those available in the community shall be provided to women prisoners’ (Rule 10). The White Paper on Corrections in South Africa (2005) and the Correctional Services Act (1998) also recognise the obligation to be aware of the gender-specific needs of female inmates, but these documents are limited in their specificity of the requirements of DCS in this regard.

## Initial Screening and Assessment

The screening of prisoners as they enter prison is a critical part of the admissions process. It is not only important for collecting general information about the sentenced prisoner, but it also provides critical information about how to address immediate and ongoing health and mental health care needs of prisoners. International studies, in countries such as Switzerland, the United Kingdom and the United States, have pointed to the importance of screening inmates upon entrance to prison as a means of identifying unknown illnesses, implementing preventative health-care measures, identifying communicable diseases prior to being housed with others and addressing diseases that need treatment (Niveau, 2006; Kane and DiBartolo, 2002; Watson, Stimpson and Hostick, 2004). The *Bangkok Rules* embody these principles by mandating a comprehensive health care screening for all female inmates in order to determine primary health care needs, including, the presence of STDs or blood-borne diseases, mental health needs, reproductive health history and substance abuse, as well as suffered sexual abuse and other forms of violence (Rule 6 (a)(a)-(e)).

In South African prisons, within six hours of an inmate’s admission, case officers complete an admission risk and needs assessment document (DCS Comprehensive Needs and Assessment G303) that aims to identify emotional vulnerabilities, such as depression or suicidal behaviour, as well as the security risks that the offender poses to staff and other inmates. Within 21 days of admission, a *comprehensive risk and needs assessment* (DCS Comprehensive Needs and Assessment G303A) and *offender profile* (DCS Comprehensive Needs and Assessment G303C) must be completed. These aim to develop a more complete picture of the offender’s history, needs and interests. Parts of the offender profile document and comprehensive assessment require the input of a social worker in order to assess the inmate’s ‘social well-being’. A sentence plan is developed and recorded upon the completion of these procedures. This plan is meant to be used to monitor the rehabilitation of the offender over the duration of their sentence. However, the sentence plan is often partial or incomplete and may not be sufficiently detailed to guide the inmate’s rehabilitation process. The women in our study reported that when asked to record their life histories, they tended to write more about recent events or issues immediately related to their incarceration. Past

experiences with violence and trauma, for instance, are not often documented at this stage of the process. After completing this assessment, women can request an appointment with a psychologist. However, Worcester participants indicated the difficulty in actually scheduling these appointments.

In a focus group (2011) that the GHJRU held with female prisoners, it was revealed that most women are not asked about their reproductive or mental health histories upon arrival at the prison. They reported that nursing staff record blood pressure and weight and while perfunctory physical health screening took place, it was largely on the basis of (non-physical) screening questions about the prisoner's physical health and medications. The international requirements outlined in the *Bangkok Rules* regarding initial health care screening are thus not fully adhered to. Rule 6 of the *Bangkok Rules* specifically provides that a comprehensive screening should take place to identify health care needs, as outlined above (Rule 6 (a) (a)-(e)).

### General Gender-Specific Health Care

The Correctional Services Act (1998) states that DCS 'must provide, within its available resources, adequate health care services, based on principles of primary health care, in order to allow every inmate to lead a healthy life' (Correctional Services Act Chapter 3). However, the women in the *Pathways Project* reported not receiving annual general medical check-ups, routine pap-smears or mammograms. Health care was also reported to be periodic (as opposed to 'routine') and usually provided on the basis of a request by the prisoner. This is not surprising given the findings from a report conducted in 2004 by the Judicial Inspectorate of Prisons who found that for a total population of 245 and 150 female prisoners at Pollsmoor and Worcester prisons respectively, the frequency of medical personnel visits were as follows: doctor once a week, dentist once a month, psychiatrist once a month and psychologist on request (JIP, 2004). The hospital section at Pollsmoor has two nurses and an administrative assistant, with a pharmacy on the premises. Worcester, on the other hand, has only a clinic with two nurses, one contract member and an administrative assistant, but no hospital.

Prisoners reported that they faced a number of other obstacles when attempting to access health care services, in addition to low visitation frequency. These range from the poor attitudes of health care providers to the expense of securing some medical services (such as prescription glasses or dental treatment). Women in our study also noted that prison nurses did not exhibit the kind of compassion and sensitivity expected of health care workers. The infrequent availability of medical personnel means that health care

workers encourage women to suffer through less serious pains and discomforts while waiting to be seen. If feeling unwell or depressed, women are told to use the morning's *Complaints and Requests* procedure to ask for assistance. For medical problems, they are referred to the on-site nurse or the case officer. If a health complaint is recorded, prisoners are monitored over a few weeks before being referred to the doctor. Theoretically, if the complaint is serious then prisoners are referred to the determined referral hospitals. In cases of major illness, most women noted these being addressed appropriately.

Beyond the general limitations in health care posed by the infrequency of medical personnel visits and the inadequate quality of care, access to gender-specific health care arose as an issue in our study. As mentioned earlier, women in our study reported not receiving annual pap smears or mammograms, which is in line with international findings on women in prison reporting a lack of regular gynaecological and breast examinations (Braithwaite, Treadwell and Arriola, 2005). These gender-specific health-care measures are addressed in Rule 18 of the *Bangkok Rules*: 'preventive health-care measures of particular relevance to women, such as Pap smears and screening for breast and gynaecological cancer, shall be offered to women prisoners on an equal basis with women of the same age in the community' (Rule 18). In order to avoid exacerbating previously undetected health issues, and as a matter of providing a health care environment that upholds a preventative health care standard, these gender-specific health care services must be made available more regularly and frequently to female prisoners.

In addition, pregnant women who enter prison face the prison health-care system in a number of ways. Most fundamentally, giving birth raises a variety of health and dignity concerns. Rule 24 of the *Bangkok Rules* clearly states that 'instruments of restraint shall never be used on women during labour, during birth and immediately after birth' (Rule 24). The Correctional Services Act stipulates that the use of mechanical restraints (for example, handcuffs, leg irons and belly-chains) should be limited to circumstances where they are necessary to (i) ensure the safety of the inmate or any other person; (ii) to prevent the damage of property; (iii) where there is a reasonable suspicion that the inmate may escape or (iv) where the court requests the use of mechanical restraint (Correctional Services Act, 1998). Clearly none of these apply in the case of a woman who is in labour. However, in our study two women revealed being handcuffed throughout the entire process of giving birth, despite giving birth in a state hospital. Given that other, less invasive security measures can be put in place during the delivery of a child there is little need for this form of security

measure. It is therefore recommended that the *Bangkok Rules*, which promotes the discontinuance of the use of all instruments of restraint for incarcerated women giving birth, be strongly considered.

### Mental Health and Rehabilitation Programmes

International research has found that 'mental health problems are more prevalent among the prison population than the general population' (Watson, Stimpson and Hostick, 2004). Women entering prison are more likely than men to have poor mental health, often associated with experiences of domestic violence and physical and sexual abuse (UNODC, 2009). They also have a heightened vulnerability to mental illness (particularly depression and anxiety) as a result of both childhood and adult physical and sexual victimisation. Many come to prison as mothers and primary caregivers of children, and are therefore disproportionately affected by separation from children.<sup>2</sup> Others have histories of transactional sex for survival and histories of self-harm. Studies in the United States have found staggering numbers of women in prison with undetected and untreated mental illnesses, many of whom enter prison with both acute and chronic physical problems as well as mental health issues that have long gone unaddressed (Maeve, 1997 cited in Kane and DiBartolo, 2002). Rule 12 of the *Bangkok Rules* provides that 'individualised, gender-sensitive, trauma-informed and comprehensive mental health care and rehabilitation programmes shall be made available for women prisoners with mental health care needs in prison or in non-custodial settings' (Rule 12). These programmes are available to some extent in the prisons where our research was conducted, although not to the extent the *Bangkok Rules* envision. Most mental health programmes and services are offered by external professionals, volunteers or agencies and are dependent on external funding and support. This means that they are not offered as part of "core" rehabilitative services provided by DCS. Programmes relevant to mental health and rehabilitation include: *social skills and development programmes* (Alpha, boundaries, character building, aggression management, teamwork); *personal and social support programmes* (inner healing silence and violence, restorative justice, young in prison, HIV/AIDs support and abuse support); and *drugs and alcohol rehabilitation*. Unfortunately, these programmes are not offered consistently across prisons or within them.

<sup>2</sup> Studies in the U.S. found that approximately 70% of female inmates are mothers of dependent children (Bureau of Justice Statistics, 2000) and maternal incarceration has its own unique stresses and places imprisoned mothers at high risk for mental distress resulting from the disruption in their family life (Kane & DiBartolo, 2002). Our study found that 75% of women are mothers.

South African female prisoners have limited access to a psychologist and only available on request (JIP, 2004). Women at both of the facilities where we conducted our study felt that the counselling and psychological services were severely lacking. At one facility, women are referred to the psychologist by the social worker, or can request an appointment themselves. This facility's one available psychologist is available twice a week for nearly 200 sentenced female prisoners. At the other facility, the social worker appears to provide most of the counselling, as there is no resident psychologist. The social worker conducts admission assessments, provides individual counselling services and runs various rehabilitation groups for nearly 240 female inmates. The women in our study reported that they face similar problems when reporting mental health emergencies, such as severe depression or suicidal feelings. The incident must be reported to a member, who then requests a psychologist, who may only arrive after several days or weeks. Rule 13 of the *Bangkok Rules* requires that 'Prison staff shall be made aware of times when women may feel particular distress, so as to be sensitive to their situation and ensure that the women are provided appropriate support' (Rule 13). The system of referrals for these particularly critical mental health emergencies should be streamlined in order to deal with emergencies in a more timely and responsive manner.

Rule 25(1) of the *Bangkok Rules* also states that: 'women prisoners who report abuse shall be provided immediate protection, support and counselling, and their claims shall be investigated...'. There is unfortunately insufficient capacity at correctional centres to properly address all the cases in which professional counselling is required. Despite this, a more regular, and reliable, provision of basic mental health services is essential to the rehabilitative dimension of imprisonment. At the very least, mental health services should include periodic mental health assessments, rapid responses to emergency mental health situations (for instance, suicidal ideation) as well as contact with prisoners on a more regular basis (mental health care and management). It is also recommended that social workers and psychologists be appointed to address the *specific* needs of female inmates. It became clear in the course of our research that in the absence of sufficient numbers of social workers and psychologists, DCS members and staff have stepped in to assist and act as regular pillars of support for women. In light of the absence of sufficient professional mental health services, training should be provided to properly educate and support the DCS members and staff who are filling this gap. The *Bangkok Rules* address the requirement of sufficient training in Rule 35: 'Prison staff shall be trained to detect mental health-care needs and risk of self-harm and suicide

among women prisoners and to offer assistance by providing support and referring such cases to specialists.'

Waiting for weeks at a time to secure an appointment with a psychologist is a serious concern, particularly in the prison context. Long waiting periods have discouraged women from making appointments with psychologists. With that said, women who have had the opportunity to seek and undergo counselling, psychological and psychiatric services have noted its positive impact on their experience of incarceration. Those who have been able to maintain an ongoing relationship – with either a prison appointed or private psychologist – emphasise how important these relationships are, particularly as a major form of support in prison. These services have assisted women in dealing with addiction, depression and anxiety and childhood trauma and abuse, as well as preparing them for family visits, contact with children and court cases. Due to the positive responses from women who have had the opportunity to utilise these services, the Department should aim to improve the availability of services. However, a number of directives in the *Bangkok Rules* (Rule 25(1); Rule 25(2); Rule 41(b); Rule 41(d)) that speak to mental health care are contingent upon a proper intake assessment and sentence planning process, which has been noted in this brief as presently being inefficient.

The women in this study mentioned other forms of support and rehabilitation, including support groups and individual counselling organised by religious organisations. Specific rehabilitation programmes recommended by the *Bangkok Rules* also exist, to some extent. HIV prevention and treatment (Rule 14), substance abuse programmes (Rule 15) and education and information about preventative health care measures (referred to as "preventive health care services" in Rule 17) seem to be implemented both internally and by outside organisations on an ongoing basis.

## Hygiene

The *Bangkok Rules* provide that 'the accommodation of women prisoners shall have facilities and materials required to meet women's specific hygiene needs, including sanitary towels provided free of charge' (Rule 5). However, one of the most common complaints amongst the women prisoners in our study was that they were only issued with *two* sanitary pads for each day that they were menstruating. In addition, they revealed that prison nurses rarely supply them with painkillers for menstrual cramps when they request them. This basic provision of services does not meet international standards addressing women's hygiene needs. A 2004 report on female prisoners in South Africa reinforced this finding, raising the provision of toiletries, besides sanitary towels, as a cause for concern (JIP, 2004). Prisoners are provided with soap, a toothbrush, toothpaste and sanitary towels, but must

obtain their own shampoo and deodorant. The limited hygienic resources with which prisoners are supplied appear to contravene the standards set out by the UN *Standard Minimum Rules* which provides that 'prisoners shall be required to keep their persons clean, and to this end they shall be provided with water and with such toilet articles as are necessary for health and cleanliness.'

## Nutrition and Exercise

A key feature of basic health care is the provision of nutritious food and opportunities for regular exercise. Section 35 of the South African Constitution recognises the right of all prisoners to access proper nutrition. However, the diet described by the women in this study does not include a sufficient daily intake of nutrients, which also contravenes the norms established in the UN *Standard Minimum Rules*: 'Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served.' At one facility, breakfast typically consists of a cup of coffee and as much porridge as desired, although prisoners must ration one cup of milk and a spoonful of sugar. Lunch comprises of stewed pork, chicken or scrambled eggs, two kinds of vegetables and four slices of bread. And supper includes four slices of bread, a cup of soup, tea or soft drink, a spoon of jam, syrup or, occasionally, peanut butter. Presently there are few – and often no – options, and little variety between daily meals.

Female prisoners raise the quality of this food as a serious (health) concern. Complaints about vegetables being 'rotten' or 'smelly' was explained by a DCS member [WDCS1, 2011] as being due to the food being prepared in the men's prison kitchen by male inmates who select the best meat and vegetables for themselves and leave the less desirable food for the women. Neither of our research sites has kitchen facilities, relying on the neighbouring male sections for prepared meals (JIP, 2004). Fruit was seldom available to the women, adding nutritional restriction to their diets. At Worcester, for instance, the women only receive fruit when it is sent from Brandvlei prison (which happens rarely), and then only after prisoners with HIV/AIDS and other health problems receive the requisite daily/weekly allowance.

Opportunities for exercise are also limited for women, and more restrictive than those available to male prisoners, particularly when comparing exercise opportunities through outside sport and access to exercise equipment. It was reported by the prisoners that access to these activities and facilities are hampered by the lack of available DCS members to supervise inmates. Courtyards offer little in terms of exercise and recreational activities, and at one of the prisons are only available to the women once a day for up to an hour.

## RECOMMENDATIONS

### Overcrowding

As has been presented above, overcrowding often leads to, or exacerbates, other problems that negatively impact prisoners' health, as prison authorities lack the resources to provide for prisoners' needs. In addition, communicable diseases are more easily spread in conditions of overcrowding, particularly those common in South Africa, such as Tuberculosis (Amon, 2010).

- Due to the fact that prison cell overcrowding contributes to the transfer of communicable diseases and exacerbates illnesses to which the prison population is particularly prone, a greater effort should be made to improve prisoners' living spaces. Efforts to reduce overcrowding are recommended.

### Health Screening and Assessment

Research done internationally has highlighted a number of important reasons for screening inmates upon arrival to prison. One study highlighted the importance that this process offers in providing an opportunity for the screening, treatment and prevention of illnesses and diseases, which are often unaddressed in a risk population who have limited access to health care (Niveau, 2006).

- The methods of assessment for women entering prisons for the first time established by the UN *Standard Minimum Rules* and *Bangkok Rules* should be adhered to. For instance, the *Bangkok Rules* provide that women entering prison should be screened for primary health care needs, presence of STDs (including HIV) or blood-borne diseases, mental health care needs, reproductive health history, substance abuse and sexual abuse or other forms of suffered violence (Rule 6). Independent Prison Visitors and the Judicial Inspectorate of Prisons should develop clear guidelines for the monitoring of health and mental health care services in prisons, paying specific attention to the needs of women (as per, for instance, the *Bangkok Rules*).
- Increased attention should be paid to the reproductive health histories of incarcerated women. As outlined in the *Bangkok Rules*, this means that women should be screened on 'current or recent pregnancies, childbirth and any related reproductive health issues' upon entry (Rule 6(c)).
- Due to the known high levels of past experiences of violence and abuse in the lives of incarcerated women, entry assessments should screen for child and adult sexual and/or physical abuse.

- Keeping in mind that international literature has found that substance abuse is one of the main issues in prison health care (Watson, Stimpson and Hostick, 2004), a detailed assessment of drug and alcohol abuse should be conducted upon entrance. This will allow DCS to determine what level of rehabilitation and precaution is necessary for female prisoners with addictions.
- Research conducted in the United States has recognised the difficulty in treating and addressing chronic illness, especially amongst a population that may have short sentences and move among institutions regularly (Thorburn, 1995). Screening for chronic illness must occur more regularly and then a treatment plan must be determined for each prisoner, depending on their needs. Upon release, chronic illness patients should be monitored in coordination with a community health care facility.

### General Health Care

- The frequency of doctor, dentist, psychiatrist and psychologist visits should be increased to meet the needs of incarcerated women.
- International studies have identified that treatment for transmissible diseases are most effective for prisoners when they are started as early as possible and completed before the prisoner is released. If this is not the case, then cooperation with outside health services must be done to assist in the continuation of treatment upon release (Niveau, 2006). Followed by improving what is recommended for the screening and assessment process, prisoners should be administered with treatment as soon as it has been identified that they require medical attention.
- Medical illnesses that are not considered emergencies should be treated with an increased level of urgency and care. Current practice leaves many women to deal with less serious pains and discomforts – that nonetheless require medical attention – on their own, due to capacity issues. A doctor should be available more frequently to deal with such cases. Nurses should not wait for weeks before referring inmates to a doctor.
- International research has found health education to be a positive health care prevention method. Health education should be regularly offered to prisoners, covering a range of topics including the transmission, treatment, prevention, symptoms, risk factors and outcomes of diseases and illness (Niveau, 2006).

## Gender-Specific Health Care

International research conducted in the United States has pointed to the necessity of and need for reproductive health care services to be available to incarcerated women (Clarke et al, 2006). The acknowledgement in the *Bangkok Rules* for gender-specific health services to be 'equivalent to those available in the community' (Rule 10(1)) is in clear contradiction to what was reported by women in our study.

- Gender-specific health care screenings, in particular Pap smears, mammograms and gynaecological check-ups, should be offered annually, in line with the recommended minimum standard.
- Health care professionals working with prisoners should act with increased compassion and sensitivity compared to what was reported by the women in our study.
- Studies done in the United States report that incarcerated women who give birth in prison are routinely shackled during the process (Sussman, 2009). This study asserts that 'shackling women during the birthing process further supports the pervasive beliefs that such women are unfit mothers, that they should not have gotten pregnant in the first place, and that medically adequate and compassionate care is a privilege' (Sussman, 2009). Due to the impact that shackling has on women during birth, and the standard set out by the *Bangkok Rules* that these procedures should not occur, the shackling of incarcerated women while giving birth should be discontinued by DCS.

## Mental Health and Counselling

International studies have identified the importance of providing immediate mental health screening and treatment for inmates, due to the staggering levels of mental illness. For instance, in the United Kingdom it was found that 70% of incarcerated women have two or more mental disorders, and in England and Wales 90% have a diagnosable mental illness (Math et al, 2011). One study indicated that addressing mental health problems for prisoners is contingent upon a standard assessment upon entrance into prison (Birmingham et al, 1996 cited in Watson, Stimpson and Hostick, 2004).

- Access to on-site mental health professionals should be made available on a more frequent and regular basis. To this end, a brief 'mental health needs' survey should be conducted to establish the needs of women with (a) ongoing mental health problems; and (b) a periodic need for mental health support services to inform the extent to which mental health services should be available.

- Considering that female prisoners – both in this study, and internationally – have faced high levels of violence in their lives and are likely to be mothers, increased accessibility of mental health professionals should be a priority for women's prisons.
- Given the reality that DCS members and staff are currently providing emotional support for prisoners in the absence of enough mental health professionals, more training should be made available to equip DCS members and staff to fulfil this role.
- More consistent and successful rehabilitation programmes addressing mental health care needs of women are recommended. International literature has found that programmes adapted specifically for women – while additionally taking language and life experiences into account – are most successful (Carlen and Worrall, 2004).
- International research addressing mental health in incarcerated men and women has recommended the implementation of mental health screening and assessment, as well as monitoring and rehabilitation programming in prisons (Trestman, Ford, Zhang and Wiesbrock, 2007). This recommendation should be applied by DCS so that mental health conditions of inmates do not go unrecognised and/or unaddressed.

## Hygiene

Our study has found that women are limited to two sanitary pads during each day of menstruation. Research in the UK has found that female prisoners in some English prisons face similar issues (Corston, 2007).

- The number of sanitary pads used by women during their menstrual period varies. In order to provide proper hygiene, female inmates should not be limited in the number of sanitary pads they are administered during menstruation periods.

## Nutrition and Exercise

International literature has found that incarceration exacerbates a number of medical illnesses, including contributing to weight gain (Kane and DiBartolo, 2002). This problem is due to the lack of nutritious food options, as well as limited exercise for women in prison. A study in a female prison in India found that one in four incarcerated women were underweight. However, a higher percentage was overweight or obese (26.3%) compared to male prisoners (10.9%) (Math et al, 2011).

- Female prisoners should be allowed access to more open spaces than the small courtyards that are presently available (or allowed the same access to exercise facilities, field sports and other sporting activities available to incarcerated men).
- The availability and frequency of organised sporting activities should be increased. More than two members should be trained to facilitate such activities. Based on the expressed interest of the women, these activities should be scheduled regularly and frequently, instead of occurring on an *ad hoc* basis, when supervision is available.
- The long-term goal of installing kitchens in all women's sections of prisons should be set. Receiving prepared food from kitchens in the men's sections has proven highly problematic as women prisoners' access to similar grade, fresh food is restricted by this current arrangement. Installing kitchens would improve the food quality and provide opportunities for skills development and employment.
- Fruit should be made available daily, if not at every meal. Fresh food can help alleviate depression, and would make women feel more physically comfortable, but is rarely available (Carlen and Worrall, 2004).
- Meal options should vary daily to improve nutrition.

## References

- Amon, J., 2010. The HIV and TB Prison Crisis in South Africa. *The Huffington Post*. [Online] Available: <http://www.hrw.org/news/2010/07/23/hiv-and-tb-prison-crisis-southern-africa> [Accessed 07 July 2011].
- Braithwaite, R., Treadwell, H. and Arriola, K., 2005. Health Disparities and Incarcerated Women: A Population Ignored. *Am J Public Health*, 95, pp.1679–1681.
- Bureau of Justice Statistics, 2000. *Incarcerated parents and their children*. Washington, DC: U.S. Department of Justice.
- Carlen, P. and Worrall, A. 2004. *Analysing Women's Imprisonment*. Devon: Willan Publishing
- Clarke, J.G., Hebert, M.R., Rosengard, C., Rose, J.S., DaSilva, J.M., and Stein, M.D., 2006. Reproductive Health Care and Family Planning Needs Among Incarcerated Women. *American Journal of Public Health*, 96 (5), pp.834-839
- Corston, Baroness J. 2007. *The Corston Report*. London: Home Office.; Carlen, P. 1983. *Women's Imprisonment: A study in social control*. London: Routledge.
- Math, S.B., Murthy P, Parthasarathy, R., Naveen Kumar, C., and Madhusudhan, S., 2011. Mental Health and Substance Use Problems in Prisons: Local Lessons for National Action. Publication, National Institute of Mental Health Neuro Sciences, Bangalore.
- Niveau, G., 2006. Prevention of infectious disease transmission in correctional settings: A review. *Journal of the Royal Institute of Public Health*, 120 (1), pp.33-41.
- Judicial Inspectorate of Prisons (JIP), 2004. *Women in South African Prisons*. A publication prepared by the Judicial Inspectorate of Prisons in Support of the 16 Days of Activism Campaign Unite Against Women and Child Abuse. Cape Town: Judicial Inspectorate of Prisons.
- Kane, M.K., and DiBartolo, M.C., 2002. Complex Physical and Mental Health Needs of Rural Incarcerated Women. *Issues in Mental Health Nursing*, 23(3), p.212
- South African Department of Correctional Services (DCS), 2005. *White Paper on Corrections in South Africa*. Pretoria: Department of Correctional Services.
- Sussman, D., 2009. Bound by Injustice: Challenging the Use of Shackles on Incarcerated Pregnant Women. *Cardozo Journal of Law & Gender*, 15, pp.477-502
- The Howard League for Penal Reform, 2005. *Briefing paper on prison overcrowding and suicide*. [Online] Available at: <http://www.nacro.org.uk/data/files/nacro-2005112200-33.pdf> [Accessed 07 July 2011].
- Thorburn, K.M., 1995. Health Care in Correctional Facilities. *Western Journal of Medicine*, 163 (6), p.560-566.
- Trestman, R., Ford, J., Zhang, W. and Wiesbrock, V., 2007. Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut's Jails. *The Journal of the American Academy of Psychiatry and the Law*, 35(4), pp.490-500
- United Nations Office on Drugs and Crime (UNODC), 2009. *Women's health in prison: correcting gender inequity in prison health*. [Online]. Available at [http://www.unodc.org/documents/commissions/CND-Session51/Declaration\\_Kyiv\\_Women\\_60s\\_health\\_in\\_Prison.pdf](http://www.unodc.org/documents/commissions/CND-Session51/Declaration_Kyiv_Women_60s_health_in_Prison.pdf) [Accessed on 2 July 2011]
- United States Agency for International Development, 2009. *Infections Diseases: South Africa*. [Online] Available at: [http://www.usaid.gov/our\\_work/global\\_health/id/tuberculosis/countries/africa/safrica\\_profile.html](http://www.usaid.gov/our_work/global_health/id/tuberculosis/countries/africa/safrica_profile.html)
- Watson, R., Stimpson, A. and Hostick, T., 2004. Prison health care: A review of literature. *International Journal of Nursing Studies*, 41 (2), p.119-128.

