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INVISIBLE, UNDERSERVED, AND DIVERSE: THE HEALTH OF WOMEN IN PRISON

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ABSTRACT

In the United States of America, women are the fastest growing segment of the criminal justice system. They are entering the system with far greater physical and mental health problems than men, but with fewer health services. Additionally, within this expanding population of incarcerated women, are disproportionately represented poor women of color with serious health needs. This article: a) uses an ecosocial model to examine and critique the health and healthcare of women in prison, b) examines social structures that influence incarceration and health status, and c) proposes reconsideration of current prison health services and education.

INTRODUCTION

[W]omen prisoners are twice marginalized, invisible in the “free” world by virtue of their incarceration, and largely overlooked even by prison activists by virtue of their gender...Challenging the hyperinvisibility of women prisoners is central to effective activist and academic work (Angela Davis, 1999, p. xi).

Rates of incarceration of women have soared over the past 20 years. In the United States (U.S.), women constitute 6% of the prison population and share common characteristics of women incarcerated worldwide—increasingly, they are disproportionately poor and minority women (Greenfeld & Snell, 1999; Stern, 1998). Incarcerated women’s health has been neglected by researchers because of the relatively low numbers of incarcerated women compared to men. Nationally, the rate of growth of incarceration of women exceeds that of men and is due to a myriad of societal changes; specifically increased rates can be linked to changes in drug laws. This shift and growth in the incarcerated population affects the type of health challenges prisons face. This new criminal justice landscape creates an environment where aggregates of women with poor health accumulate. Yet, the application of appropriate theoretical frameworks by researchers, that address incarcerated women’s health is sparsely examined or relatively absent in the literature. This article seeks to address this imperative lack by using an ecosocial conceptual framework to explore the intersection of social environments and the health of incarcerated women (Krieger & Zierler, 2001, 1995, 1996).

Ecosocial Framework

Medical models predominantly address biological causes of disease and sometimes include social aspects of health at the individual level. Traditionally, biomedical discourses and practices focus on the person, searching for individual risk factors for disease. After this identification of disease, the primary treatment is risk reduction or prevention strategies that target the individual. In addition, medical models note categories such as race/ethnicity and sex, but tend to ignore the significance of societal oppression (e.g., racism and sexism) on health. Proposed by researchers, newer multilevel, broader models sought to explain factors such as sex/gender, race, and class differences in health that traditional biomedical models have overlooked (Geronimus, 2001; Krieger & Gruskin, 2001; Krieger & Zierler, 1995). An ecosocial perspective is one of several emerging models appropriate for the analysis of the effects of social constructions (e.g., categories) on health and illness.

Ecosocial theoretical frameworks examine how social relations construct patterns of health and illness. Biological bodies move across time through social structures such as race/ethnicity, class, sex/gender, and sexual orientation, as highly nuanced social constructions rather than clear-cut biological or social phenomena. Accordingly, key concepts for ecosocial theory include: 1) embodiment—how the context of society and individual choices is connected to our physical reaction to and biological understanding of women's health and bodies (e.g., microlevel); 2) pathways of embodiment—how the social/material world is shaped by policies and social practices which in turn constructs our ecologic context, our individual and evolutionary histories and our biological and social development (e.g., macrolevel); 3) cumulative interplay between exposure, susceptibility, and resistance—the ecological or specific spatiotemporal influences on health; 4) accountability and agency—who and/or what are responsible for health disparities (Krieger & Gruskin, 2001; Krieger & Zierler, 1995).

The central questions asked by the biological model differ from those asked in the ecosocial theory. A biomedical model asks, "How do humans, as biologic organisms, become ill?" and operates with assumptions that disease is a biologic phenomenon, that individual-level risk factors explain disease distributions in populations, and that interventions are best provided by means of medical services to individuals. In an ecosocial theory, the central question asks, "Who and what drives population patterns of health, disease, and well-being?" and assumes that the distribution of population patterns express how we incorporate biologically, social relations (e.g., social class, race/ethnicity, and sex/gender) into our bodies. Similarly, social, economic, and political conditions shape distributions of determinants of health, disease, and well-being. Therefore, to improve public health, we must implement policies that reduce social and economic inequities, curtail environmental decline, and increase options for social and individual action to improve health (Krieger & Zierler, 1995, p.252).

What researchers do know about the health of incarcerated women resides in a biomedical framework, which shows incarcerated women have very high rates of malnutrition, substance abuse, sexually transmitted infections, and experiences of violence in their lives (Acoca & Austin, 1996; Maraschak & Beck, 2001; Young, 1998). We feel the systematic inquiry for understanding and guiding actions to address the health of incarcer-

ated women is most effective using an ecosocial theoretical framework because multilevel frameworks are better able to address the effects of societal oppression and colonization than are biomedical, or public health models. Table 1 suggests how an ecosocial model might be used to understand the health of women in prison. This article critically examines the health and healthcare of incarcerated women from an ecosocial health viewpoint.

TABLE 1: AN ECOSOCIAL FRAMEWORK TO UNDERSTAND THE HEALTH OF WOMEN IN PRISON

Principles	Application to women in prison
Embodiment	Poor physical and mental health
Pathways to embodiment	Multiple experiences of trauma and abuse; drug addiction; poverty; colonization (the effects of racism, classism, sexism combined)
Cumulative interplay between exposure, susceptibility, and resistance	Family factors (family histories of abuse and drug addiction); living on the street; societal stigma related to drug addiction and prostitution in women; lack of access to health care and drug treatment; lack of treatment for underlying abuse histories; increasing criminalization of women's bodies
Accountability and Agency	Social inequality: racism, sexism, classism; the social construction of drug addiction as a crime and increased punishment of drug-related activities; the lack of definition of basic health care and lack of providing basic health care to women in prison (or before arrest); a societal refusal to address issues of violence against women

An Ecosocial Context for the Escalating Numbers of Imprisoned Women

The colonizing nature of government rhetoric related to the war on drugs, and ensuing actions by those in power (e.g., elites and/or other claimsmakers) reinforce positions of social privilege. For example, poor people of color have been cast in images related to the pimp/drug dealer and the “crack whore.” The term colonization is an explanatory construct to represent a range of experiences and struggles (Taylor, 1999).

Traditionally, colonization refers to the act or process of establishing a colony or colonies. However, the authors follow Mohanty’s (1991) definition: “colonization almost invariably implies a relation of structural domination, and a suppression---often violent---of the heterogeneity of the subject(s) in question” (p. 52).

Colonial practices within the United States invoke ideological representational images, such as the “war on drugs,” and present cultural slogans like “get tough on crime,” “take a bite out of crime” and “making the streets safe,” as some of the strate-

gies to support the imprisonment of marginalized wo/men. Thus, colonization helps to explain the pathways to embodiment within Krieger and Gruskin's (2001) ecosocial model. Colonization results in the embodiment of stigma onto the bodies of incarcerated drug addicted women who disproportionately represent poor women of color. Yet women exercise capacity for agency as they interpret and respond to structural realities and give them meanings for self. According to Ashcroft, Griffiths and Tiffin (1998) agency refers to "the ability to act or perform an action...[such as] engaging or resisting imperial power" (p. 8). Women in prison exert agency by re/conceptualizing their view of personal power.

Obviously, the concept of agency in prisons seems contradictory because it is difficult to instill power in a woman who lives in an institution where she has no power. However, empowerment work can be done in prison if a woman is encouraged to believe that real personal power comes from valuing herself. When a woman trusts her own intuitions and makes choices that are self-affirming, she feels more powerful regardless of whether she is living with an abusive partner or residing in prison. A woman must be helped to see that although she has little control over externals she does have some control over herself. In controlled institutions like prisons, women must be more creative in how they attain a sense of personal power.

Impact of Drug Legislation on the Ecosocial Context.

Drug laws have undergone dramatic changes in the past 20 years. The intended purpose of these new laws was to reduce the supply of drugs, limit access to illegal substances, and eliminate drug dealers and major participants in the drug trade (Glasser, 1999). Major changes in the law increased the penalties for drug possession and drug dealing and justified law enforcements' harassment of people of color. Increased surveillance of poor, inner city communities where drugs and prostitution were more visible proved to be a relatively expedient way to promote a public image of the accomplishment of goals and the diminishment of drug trafficking.

There is little evidence that poor people commit more crimes, use or deal drugs more often than middle class or wealthy people (Leigh & Lindquist, 1998; Reiman, 2001). However, police surveillance of poor communities is much greater. Reiman (2001) proposed that politicians use this current position on crime to "deflect the discontent and possible hostility of middle America away from the classes above them and toward the classes below them" (p. 4). In other words, poor people and people of color, become the targets for the nation's discontent, and incarceration of the lower class who have little recourse or access to legal protection. In other words, the status quo remains unchallenged in part due to this political rhetoric.

Disproportionately represented are women at the extreme lower levels of the drug-dealing hierarchy. Thus, these women are highly vulnerable to arrest (Phillips & Harm, 1998). From 1986 to 1991, the numbers of women sent to prison for drug offenses increased by 433% compared to 283% for men (LeBlanc, 1996). Women arrested for drug-related crimes represent approximately two-thirds of those in prison. The majority of these women committed petty crimes to support their drug addictions and provide for their families, yet they serve longer terms for drug offenses than men who head these

criminal organizations (Greenfeld & Snell, 1999). Because of their positions in the hierarchy, women have little bargaining power. That is, they cannot inform on others to shorten their sentences or hire attorneys to reduce their sentences. Although the legal system in the U.S. guarantees legal counsel to all, often public defenders provide less than adequate counsel because of their heavy caseloads, time constraints and limited resources (Cole, 1999). This results in underprivileged women, and particularly women of color, receiving much harsher penalties than wo/men with financial means (Cole, 1999).

Incarcerated Women and Their Health

Unfortunately, the “war on drugs” has become a heightened continuation of the “war against women” (see French, 1992). Escalating and differential sentencing of cocaine and small-scale street dealers has resulted in a population of women who arrive in prison in poor health.

The embodiment of the war on drugs, as well as the historical and social contexts of women’s lives effect their health before, during, and after incarceration. Embodiment refers to “how we biologically incorporate material and social world in which we live, from conception to death” (Krieger & Gruskin, 2001, p. 138). Social, political, economic, and historical aspects of women’s lives are paramount to understanding individual and social patterns of disease, health and death/mortality. Women’s pathways of embodiment as well as their gendered embodiment of socioeconomic disparities and inequities present a different profile from men in prison.

Profile of Imprisoned Women

Sentencing practices have largely captured women with the following profile: a young, poor, racial/ethnic minority, single mother who has committed a non-violent drug-related crime (Greenfeld & Snell, 1999). Unlike their male counterparts, women in prison have rarely committed violent crimes, and those who are incarcerated for violent crimes were most likely to have assaulted or murdered an abusive intimate partner (Browne, 1987; Richie, 1996).

Nearly everyone is aware of the statistics about African American men and criminal justice—that more black men are under the supervision of the justice system than are in college. However, much less attention has been paid to the plight of African American women who are incarcerated at even higher rates than African American men. While one out of eight women in the U.S. are African American, 50% of incarcerated women are African American (Brinkley-Jackson, Carter & Rolison, 1993; Collins, 1997; Watterson, 1996). Other women of color also experience disproportionate rates of incarceration. Ross (2000) reported that in one western state, Native American women made up 6% of the general population, but 40% of the female inmate population. Latina women are similarly over-represented in prison (Diaz-Cotto, 1996). For many woman of color, imprisonment has become an expected (e.g., normalized) life experience as a marginalized individual (or group) in the U.S. In other words, bodies of color overwhelmingly experience incarceration.

Most women in prison are from the lowest socioeconomic strata of society (Feinman, 1994). In 1994, over half of women in state prisons (53%) had been unem-

ployed before arrest, and 30% had received welfare assistance. Most women who worked before incarceration were in low paying service jobs (Rafter, 1990). Lawrence Greenfeld and Tracy Snell (1999) reported that 60% of female offenders were unemployed or severely underemployed before incarceration (compared to 40% of men). Over one-third had incomes of less than \$600 per month. More than twice as many women report economic need as the motivation for their crimes as men (Girschick, 1999). Compared to men, a higher percentage of women were the primary caregivers of children and the family; thus, family and children issues are more important (Mumola, 2000).

Rarely do women enter the prison system with optimal health or well-being. Variables in the profile of incarcerated women influence their health and health related problems before and during their imprisonment. The majority of incarcerated women have endured lifetimes of poverty, racism, drug addiction, and physical and emotional abuse—over half were abused as children (American Correctional Association, 1990). About 70% have had long-term, chronic problems with addiction to alcohol and/or other drugs (Greenfeld & Snell, 1999). Nearly 90% of women developed drug addictions before they committed any crime (Farabee, Joshi & Anglin, 2001).

Health Problems and Health Care Needs of Incarcerated Women

Health care in most prisons is so poor that it can be considered “cruel and unusual punishment” as women fail to receive treatment for chronic illnesses, get partial or delayed care, are misdiagnosed, are given inappropriate medications, or are subject to constant humiliating and disrespectful treatment (Young, 2000). Shockingly, health care in jails (these facilities hold 35 times more people than prisons do on average) is even worse (Jose-Kampfner, 1995; Yasunaga, 2001). In addition, costs of prison health care have risen faster than any other aspect of correctional costs (McDonald, 1995). This means that access to health care will become an even greater problem. Resources for incarcerated women are scarce and women receive fewer medical and rehabilitation services than do men (National GAINS Center, 1997; Acoca, 1998). Meanwhile, the health needs of this population are numerous. Infectious disease (e.g., human immunodeficiency virus (HIV), sexually transmitted infections (STIs), tuberculosis (TB), Hepatitis C), and mental health problems, are included among the most visible and often cited health issues for this population of women. Following is a brief overview of selected health issues and concerns for women in prison.

General Health Status of Imprisoned Women

A major health concern is HIV/AIDS. Prior to incarceration, many women practice high-risk behaviors that contribute to acute and chronic illnesses. For example, incarcerated women test HIV positive at two to three times higher rates than incarcerated men (CASA, 1998) and at more than ten times the rate of infection in the general population. From 1991-1995, the number of HIV positive women in prison rose by 88% compared to a 28% increase in male prisoners (ACLU, 1999). The rates of HIV infection among incarcerated women range from 3 to 35% depending on geographic region, but are highest in areas of the country where HIV rates are higher in the general population (Schilling, El-Bassel, Ivanoff, Gilbert, Kuo-Hsien & Safyer, 1994). In many prisons,

medication for HIV is a privilege rather than a necessity, and in other prisons where medications are given, the infirmary often runs out of the medications for days or weeks at a time (Rabasca, 1999). In addition, prison health workers do not communicate the importance of treatment plan adherence to prisoners (Chamberlin, 2001). Mutations of the virus and drug resistance result when interruptions in drug treatment occur. Only 10% of state and federal prisons have HIV/AIDS prevention or education programs (Chamberlin, 2001; Maddow, 2000).

Sex education programs are crucial because negative attitudes about condom use are prevalent among incarcerated women (Schilling, El-Bassel, Ivanoff, Gilbert, Kuo-Hsien & Safyer, 1994). Although prior to incarceration, many women were sexually active, studies show that most women are misinformed or have little knowledge regarding sexual health (Covington, 1998; SAMHSA, 2000). Likewise, education about sexuality is one of the most neglected areas in the treatment of incarcerated women. Women often go through treatment programs (e.g., substance abuse, domestic violence, etc) without ever addressing issues of sexuality and intimacy. Carroll, McGinley and Mack (2001) found that 24% of incarcerated women reported a loss of sexual interest and 25% expressed guilt over past sexual experiences, issues that may affect re-unification with partners when they leave prison. Sexuality is an essential area to address because issues around sexuality are a major cause of relapse and recidivism among this population of women (Covington, 1998; SAMHSA, 2000). Creative interventions are necessary to help women integrate their sexual selves, answer their questions, and foster their self-esteem and sexual identities.

Women in prison have special needs related to positive pregnancy outcomes. Statistics show that 6-10% of women who enter the correctional system are pregnant (Gabel & Johnson, 1995). Of all pregnant women in prison, only 4% had received prenatal care since admission (Greenfeld & Snell, 1999). Through-out the U.S., there is a higher than normal rate of miscarriage among pregnant women in prison due to lack of adequate prenatal care, lack of treatment for drug withdrawal, and poor nutrition. For example, in California prisons, the miscarriage rate is 30% (Barry, 1985). Because of their compromised health and the physical environment of prisons, pregnant female prisoners are at higher risk for complications.

Finally, another seldom addressed issue is that of dental health. Dental problems are very common (as high as 83% in one study); yet, in spite of the high prevalence of poor dental health, most women have to wait five to six months to see a dentist. In some settings, dental care consisted almost entirely of extraction (e.g., pulling teeth) (Belknap, 2000; Young, 1998).

Mental Health Status of Imprisoned Women

Correctional facilities have been called “America’s new mental hospitals” (Torrey, 1995) as thousands of mentally ill people are incarcerated for relatively minor offenses. The prevalence of psychiatric disorders among incarcerated women adds to the impaired health of female inmates. Approximately 64% of female prisoners had a lifetime history of mental illness and 46% had symptoms of a major psychiatric disorder in the past six months (Jordan, Schlenger, Fairbank, & Caddell, 1996). Some symptoms defined as

mental illness in contemporary society are often the result of negative coping strategies to deal with oppression, trauma, and abuse.

The incidence of violence against women is high in the United States and affects women from all racial/ethnic backgrounds, socioeconomic classes, ages and sexual orientations. Rates of sexual and/or physical abuse are even higher for incarcerated women. Sixty one percent of the women in state prisons reported that they were physically harmed by their current or prior spouses or boyfriends, and nearly a third by their parents or guardians (BJS, 1999; Pollack, 1997). One in four women in state prisons said they were victims of sexual abuse before age 18 and one in four women were physically abused before incarceration (BJS, 1999).

Histories of physical, sexual, and emotional trauma significantly influence the mental and physical health of women. Studies of incarcerated women with sexual/physical abuse histories found high rates of mental health disorders, including substance abuse, antisocial personality disorder, symptoms of post-traumatic stress disorder (PTSD), depression and anxiety (Fogel & Martin, 1992; Fogel, 1993; Jordan, Schlenger, Fairbank, & Caddell, 1996; Sargent, Marcus-Mendoza & Ho Yu, 1993). Reported to be highest among incarcerated women with histories of abuse were rates of violent crime, illegal drug use, and alcohol use. This pattern of increased risk for substance abuse is consistent with survivors of trauma who are not incarcerated (Herman, 1997).

Women's experiences in prison parallel their experiences of child sexual abuse and domestic violence (Heney and Kristiansen, 1998). An incarcerated survivor will encounter multiple situations in prison that have the potential to remind her of her abuse experience/s. Prison experiences that are similar to abuse include: 1) traumatic violation of physical and sexual boundaries, 2) the distinction between the powerful and the powerless, 3) stigmatization and devaluation, and 4) issues of trust and betrayal. Women react and cope with these conditions through a range of behaviors that include substance abuse, self-injury (including suicide) and violence.

Exacerbating the emotional stress of incarceration in women is their shame, guilt, and worry about the welfare of their children (Carten, 1996). Most incarcerated women are mothers—while 90% of male prisoners can rely on the child's mother to provide care during incarceration, most women do not have this support. Incarcerated women report that 28% of their children are cared for by their fathers, 53% by their grandparents, and 10% are in foster care (Mumola, 2000). Women, who are mothers at the time of incarceration, focus primarily on the well-being of their children and families. The mother's incarceration has much greater impact on her children than a fathers' incarceration and these children are much more likely to have emotional and behavioral problems and end up in legal custody themselves (Gabel & Johnston, 1995).

Health Care Provision in Prison

There are numerous barriers to providing effective health care for incarcerated women. Multiple and complex barriers are present both outside the justice system in the U.S. and inside women's correctional institutions (Acoca, 1998). Internal impediments to basic health care include: a) lack of gender-specific research and programs, b) restrictive institutional policies and procedures, c) lack of access to qualified medical staff, d) prisoner's loss of freedom to engage in basic self-care, and e) physical environments that

are often overcrowded, substandard and stressful (Acoca, 1998; McGaha, 1987; Tucker-Allen, Williams & Wisneski, 1994). Additionally, a health care system where security is the prime objective rather than caring compounds the poor health of women in prison. Punitive security measures and the stigma attached to incarceration severely compromise health care for women in prison.

Maeve (1997) described her orientation to a prison health service where she was told that “empathy would be your downfall,” politeness in an inmate was a sign of manipulation, and that one must never touch an inmate unless absolutely necessary (p. 504). Trainers instructed health care providers to stay distant, aloof, and formal, never referring to inmates by their first names. The result of this type of training is that some health care providers treat female offenders, so desperately in need of physical and mental health services, solely as dangerous criminals instead of human beings with drug addictions and chronic health problems. Reviews of medical records indicate that the majority of health care visits are for legitimate health problems in spite of the attitude and assumptions of many prison staff that most female prisoners are malingerers (Watterson, 1996; Young, 2000).

CONCLUSIONS AND RECOMMENDATIONS

It is clear, from the data above, that incarcerated women are disproportionately poor, drug-addicted, women of color who have histories of high-risk conditions and early trauma, as well as significant physical and mental health problems. For women of color, race, class, sex/gender, and sexuality intersect in complex ways to adversely affect their health and well-being or to embody “disease”. The impact of race on health is a complex one, where socioeconomic status (SES) is a powerful mediator. However, even when SES is controlled, health disparities by race are still evident (Ren, Amick & Williams, 1999). Lack of programs geared specifically to women’s needs and that fail to address racial/ethnic diversity mean most women are underserved or inadequately served and leave prison in worse shape than they entered.

At the beginning of this article, Angela Davis’ (1999) speaks to the responsibility of activists and academics working for social change. She points out “[c]hallenging the hyperinvisibility of women prisoners is central to effective activist and academic work” (p.xi). In order to make visible concerns of incarcerated women, we must select theoretical frameworks that appropriately contextualize the health and lives of imprisoned women. Likewise, such frameworks expose the punitive and difficult conditions in which women earnestly seek to recover and heal. Currently, prisons and jails are unhealthy environments, breeding physical and mental illness and providing training ground for real crime.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

Practice initiatives:

- Improve access to and quality of primary health care services such as, prenatal care, mental health services, substance abuse treatment, peri/menopausal, dental care, educational services and provide preventive services.
- Increase training for security officers about health issues, as they often determine who gets access to medical services.

- Provide comprehensive sex/uality education to women in prison.
- Establish clinical care guidelines for basic health care and decide what standard services should be available to all individuals.

Policy advocacy:

- Provide viable alternatives to incarceration that include treatment rather than punishment for addictions and mental illnesses.
- Relieve stress on the foster care system as well as reduce strain and anxiety in children and other family members by keeping women in their communities, close to their families, and providing substance abuse treatment at home.
- Advocate changing policies that affect humane treatment (e.g., touch, children and visitation).
- Establish a policy regarding basic health care needs.
- Reduce economic and structural inequities in the larger society.

Research and knowledge development:

- Test the effectiveness of gender and ethnic sensitive interventions with incarcerated women.
- Develop more prospective and “objective” (as opposed to only retrospective) studies of health care.
- Examine the effects of oppression/colonization on health (racism, sexism, classism, etc).

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