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Healthcare needs and treatment of women in prison in Serbia*

Adequate treatment, access to healthcare services, and maintenance of the health of all inmates in prison, regardless of gender, should not be treated as a secondary issue by correctional institutions, but rather as a matter of public concern, considering the serious health problems of the prison population. However, correctional systems are required to meet the healthcare needs of individuals in prison with limited resources and while facing significant organisational and ethical challenges (Elger, 2011). Incarcerated women have more specific health problems than men, which imposes additional constraints on correctional institutions and the provision of healthcare services (van den Bergh, Gatherer, Fraser, & Moller, 2011). Additionally, the specific needs of female inmates are often overlooked, and their specific health and social needs remain neglected (Augsburger, Neri, Bodenmann, Gravier, Jaquier, & Clair, 2022). In this paper, the author highlights female inmates as a specific and vulnerable category within the prison system. The aim of the study is directed towards assessing the overall quality of life from the perspective of the health condition of female inmates. Special focus is placed on the physical health of female inmates in the correctional facility for women in Požarevac, with a brief overview of their involvement in specialized treatments conducted in the mentioned prison. The basic results indicate that 55.6% of the sampled population confirmed the presence of illness at the time of the study, with mental disorders (including depression, anxiety, nervousness, stress disorder, etc.) being the most prevalent in 35.4% of the sample, followed by cardiovascular diseases at 27%. Regarding the assessment of quality of life, the highest percentage of respondents, 35.6%, neither rates their quality of life as good nor as bad, while 33% of respondents rated their health satisfaction as unsatisfactory. 86.4% of the respondents are not enrolled in any specialised programs. Among the respondents who are involved in specialised programs, the most represented are those enrolled in the addiction treatment program (detoxification program, methadone therapy, alcoholism recovery program), totalling four of them, which constitutes 57.1% of the inmates involved in any programs.

Keywords: prison, female inmates, treatment, specific needs, health-care needs

Introduction

Although convicted women represent a smaller portion of the overall convicted population in Western European countries, the United States (Raynolds, 2008), as well as in the Republic of Serbia, the worldwide female prison population is increasing (Bartlett & Hollins, 2018) in the last two decades. A significant consequence of the limited representation of women in the overall prison population is that prisons and their systems are typically organized based on the needs and requirements of male prisoners. This applies not

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only to architecture and security but also to all other facilities within the prison system (Fair, 2009), as well as deficiencies or inadequacies in treatment, medical care, protection, and other essential aspects of prison life. Most research has therefore focused on men, the majority population. However, it is precisely this minority status and marginalisation that increases the need to recognise women in prison as a distinct group with distinctive needs (Loucks, 2010). Research on the incarceration of women is important for understanding all the consequences of (increased) incarceration (Monazzam & Budd, 2023), but also for identifying the specific needs of female inmates, which are often overlooked. Furthermore, research can contribute to a better understanding of the need to improve the objective conditions in prisons where women are housed, and to the improvement of strategies and practices for dealing with this vulnerable category. The general and most comprehensive goal of the work is to highlight female inmates as a sensitive and specific category within the prison system. A specific goal of the work is directed towards identifying the healthcare needs of female inmates, specifically focusing on physical health, which in this study represents the perception of physical condition and encompasses activities of daily living. Furthermore, the work presents the results of assessing the overall quality of life and the results of overall satisfaction with health. For this purpose, the WHOQOL-Bref (World Health Organization Quality of Life - Brief Version) questionnaire was used. Additionally, the work provides an overview of specialized treatment modalities implemented in the Correctional Institution for Women in Požarevac and a brief review of the involvement of female inmates in these treatments. The paper provides an overview of the general characteristics of the examined population of convicted women through the analysis of general demographic, criminological, and penological characteristics.

About ("typical") characteristics of imprisoned women

In European penal institutions, the overwhelming majority of inmates are men, representing approximately 95% of the total prison population. Conversely, women account for a mere 5% of inmates (Aebi, Cocco & Molnar, 2023). Research indicates that the proportion of women in prison in any prison system worldwide generally varies between 2% and 9% (Fair, 2009), although in the literature we find data on the increasing rate of convicted women. In 2010, the proportion of women in the prison population was 4.3% (Walmsley 2006 according to Loucks, 2010), while data from 2022 indicate that the proportion of women in the total prison population was 6.9%. In Europe, the percentage of female prisoners remains relatively stable, accounting for approximately 5% of the overall prison population in 2021 (Batrićević et al., 2023). Among countries with over one million inhabitants, the lowest percentages of female inmates (below 3%) are observed in Albania (1.2%), the Republika Srpska in Bosnia and Herzegovina (2.1%), Azerbaijan (2.8%), and Armenia (2.9%). In contrast, the highest percentages (exceeding 7.5%) are found in Cyprus (9.5%), Latvia (8.4%), Czech Republic (8.1%), and Hungary (7.6%) (Aebi, Cocco & Molnar, 2023). In the Republic of Serbia, there is noticeable growth in the number of convicted women in the total prison population. Data indicates that in the year 2000, the proportion of convicted women in the total convicted population was 1.9%, while in 2010, that percentage was 3.1%. The latest available data shows that in 2022, convicted women comprised 4.1% of the total prison population (Aebi, Cocco & Molnar, 2023). There are

several potential reasons for the increasing number of women in prison. The World Health Organization cites global factors such as economic crisis, social inequality and instability, displacement due to war, and criminal justice systems that disadvantage women (WHO, 2014). There are similarities in the type of women imprisoned in each country. Research also indicates that in all countries, convicted women are a group in a very unfavourable position, even among the most vulnerable, and that many convicted women come from environments where abuse and violence were present (Fair, 2009). As a group, female prisoners are often deemed vulnerable (Ginn, 2013). Additionally, female prisoners usually hail from a socioeconomically disadvantaged background, often with no educational qualification, and belong to a minority group (Lewis, 2006 according to Handtke et al., 2015). It is likely that female prisoners have experienced physical and / or sexual abuse, has been a victim of exploitation, and suffers from drug and alcohol abuse. Compared to male prisoners and women living in the community, a typical female prisoner has higher rates of mental health problems, often meeting the diagnostic criteria for a lifetime mental disorder, as well as a greater prevalence of chronic diseases and worse physical health (Fair, 2009: 4).When it comes to the healthcare needs of convicted women, it is important to consider data indicating that women in prison have disproportionately higher levels of health and social needs compared to male prisoners and women in the general population. A large number of women in prison have poor physical and mental health, and many live with trauma (Davies & Scott, 2023). "Female prisoners have specific needs and requirements arising from the nature of their criminal offences, the conditions within prison, and the broader social, socioeconomic and gender context (overall position of women in society)" (Batrićević et al., 2023). Research indicates that convicted women are often the sole caregivers for their children and other dependents (Fair, 2009). In such cases, imprisonment can significantly impact the family structure. Finally, due to their small numbers, women's prisons are rare and may be located in remote regions, posing an additional burden for the convicted woman and her family, and reducing the possibilities for maintaining contacts (Ginn, 2013; Handtke, et al., 2015).

Research indicates that men and women bring qualitatively different life experiences into prison (Jang & Winfree, 2006). For example, the values of female inmates are generally quite traditional, as they, as a group, are focused on family, children, or relationships (Harris, 1993). Ward and Kassebaum (1965: 17) note that the absence of home and family is the most challenging aspect of adjustment for convicted women to prison life. Later, Owen (1998) discovered that the majority of convicted women hold fairly traditional views on gender roles. They see themselves as women and mothers, and relationships with their children are a central event in the lives of many convicted women (Jang, & Winfree, 2006). And precisely the inability of convicted women to fulfil roles that traditionally, in terms of gender and sex, matter to them the most - namely, the roles of mother and wife, produces additional, strong deprivation, stress, and concern, which negatively impacts their adjustment to prison conditions (Špadijer-Džinić, Pavićević & Simeunović-Patić, 2009; Ilijić, 2014). Institutional factors further exacerbate the position of women as convicted individuals (Handtke, et al., 2015). Firstly, convicted women are often incarcerated in prisons that are designed for male (and younger) inmates, who constitute the majority of the prison population (Milićević & Ilijić, 2022; Ilijić, 2023: 546). This means that security

standards are higher than necessary (Fair, 2009; Handtke, et al., 2015). Second, personnel working with female offenders are often not specifically trained to respond to the social and health needs of this population (Lewis, 2006 according to Handtke, et al., 2015). Research on women in prison demonstrates, however, that female prisoners diverge from their male counterparts in that a) they generally end up in prison for different reasons and, once in prison, b) they have other needs (Krabbe & van Kempen, 2017). The conclusion stated by Handke and colleagues (2015), that the needs of convicted women arising from the description of a "typical" convicted woman are not considered in most existing prison structures, seems accurate.

Physical and mental health of female inmates

Research indicates complex and chronic health problems that women face in prison, often persisting even after their release (WHO & UNDOC, 2009). Additionally, certain chronic conditions and illnesses are more prevalent among female inmates compared to male inmates (such as asthma or certain cardiovascular diseases) (McQueen, 2006). Gender differences persist even when accounting for demographic and socioeconomic factors and substance use (Dean, 2006; McQueen, 2006; Augsburger, et. al., 2022). Research suggests that among female inmates, there is a wide range of mental health problems present (Augsburger, et. al., 2022). Mental health problems are overrepresented in the female prison population; approximately 80% have a mental health diagnosis (World Health Organisation, 2021). Women in prison are five times more likely to experience mental health difficulties than women in the general population (Tyler, Myles, Karadag & Rogers, 2019). The uniqueness of women's trauma histories plays a critical role in explaining gender differences in mental health in prison, but also in substance abuse (Grella, Lovinger & Warda, 2013). Last, because of sexual risk behaviours, drug use, sexual abuse, and often marginalized and socially deprived backgrounds, incarcerated women are at increased risks for sexual and reproductive health diseases, including cancers and sexually transmitted infections (Augsburger, et. al., 2022).

Women often endure domestic, physical, emotional, and sexual abuse prior to incarceration, leading to complex and often unresolved trauma that may contribute to criminal behaviour (Gunter et al., 2012; Alves, Maia, & Teixeira, 2016). Research confirms the correlation between trauma and the development of mental difficulties (Jewkes, et al., 2019; Bright, Higgins & Grealish, 2022), which are factors that can contribute to a range of negative outcomes, both in prison and after release. Negative outcomes include the likelihood of becoming victims of violence and assault (Caravaca-Sánchez et al., 2014) and reoffending (Bright, et al., 2022).

Methods

Procedure

The descriptive and exploratory findings presented in this paper are part of the results generated within the framework of a national three-year research project entitled

PrisonLIFE, aimed at enhancing understanding of the quality of prison life[1] for inmates in Serbia (Stevanović, Ilijić & Vujičić, 2024; Batrićević, et al., 2023). The data were collected at the Correctional Institution for Women in Požarevac, which is also the only prison for female convicts in the Republic of Serbia, using a convenience sampling method. The general criteria for inclusion in the study involved the participants being literate and understanding the official Serbian language, as well as being in prison for at least 30 days and voluntarily agreeing to participate in the research. Individuals expressing interest in participation could apply for the study through treatment officers. Data was collected during a single session in the common dining area of the prison, using a paper-and-pencil method. Researchers were available to assist participants with any comprehension issues regarding the survey items. Inmates who participated in the study placed the completed questionnaires in envelopes and handed them to the researchers. All inmates had previously given written informed consent to participate in the study. They were informed about the purpose of the study, as well as that the collected information would be used solely for research purposes. Additionally, participants had the right to withdraw from the study at any time, with guaranteed anonymity.

The data collection procedure was conducted throughout the year 2022. At the time of the research, there were 270 convicted women in the Požarevac women's prison, and 97 of them participated in the study.

Measures

The World Health Organization Quality of Life Brief Version (WHOQOL-Bref) is an abbreviated form of the WHOQOL-100, comprising 26 items (The WHOQOL Group, 1998). The WHOQOL-Bref addresses subjective well-being in four domains: physical health (7 items), psychological health (5 items), social relationships (3 items), and environmental health (8 items) (Ilijić, Pavićević & Milićević, 2024). The results from the domain of Physical Health have been analysed. Additionally, two items measure overall quality of life and general health perception.

The scoring of each WHOQOL-Bref item is based on a 5-point Likert scale, which ranges from descriptors such as “never” to “always”, “not at all” to “extremely/completely”, “very poor” to “very good”, or “very dissatisfied” to “very satisfied”. The WHOQOL-Bref items 1 (Overall Rating of Quality of Life) and 2 (General Health Satisfaction) are intended for separate analysis. Higher scores in all domains indicate better quality of life (Ilijić, Pavićević & Milićević, 2024).

The Physical Health domain captures perceptions of one’s physical state, covering activities of daily living (e.g. q.3. *To what extent do you feel that physical pain prevents you*

[1] In the research of the prison social climate in the Republic of Serbia, which was realised as part of the PrisonLIFE project, the authors were interested precisely in the assessment and measurement of the common subjective experience of prison conditions, which we call the prison social climate (Stevanović et al., 2024). Within the project, the Measuring the Quality of Prison Life Survey (Liebling et al., 2012) questionnaire was used, i.e. the version of the MQPL in the Serbian language that was adapted (Milićević, Ilijić & Vujičić, 2023; Milićević, et al., 2023; Međedović, Drndarević & Milićević, 2023) for research purposes.

from doing what you need to do?), dependence on medicinal substances and medical aids (e.g. 4.q. *How much medical treatment do you need to function in everyday life*?), energy levels (e.g. q.10. *Do you have enough energy for everyday life*?), mobility (e.g. q.15. *How mobile are you*?), pain and discomfort (e.g. q.17. *How satisfied are you with your ability to perform everyday life activities*?), sleep quality (e.g. q.16. *How satisfied are you with your sleep*?), and work capacity (e.g. q. 18. *How satisfied are you with your capacity to work*?).

A single question about overall quality of life is ranked from one (where 1 is „very poor“) to five (5 is „very good“). The second individual question pertains to the overall satisfaction rating with health (where responses are ranked from 1 to 5, where one is "very dissatisfied" and 5 is "very satisfied"). The questionnaire also includes a question regarding the presence of illness (with the options of yes or no. In case of an affirmative answer, the type of illness or diagnosis is recorded). The types of illnesses recorded as free responses are later classified according to the International Classification of Diseases (ICD-10-CM), which is a system of categories assigned to specific diseases based on established criteria.

Data on basic demographic, criminological, and penological characteristics of the examined population, such as age, time spent in prison, participation in education and vocational training, employment status, involvement in specialised treatment programs (and the type of treatment), marital status, educational level before entering prison, classification (department type), and drug use before entering prison, were obtained from the respondents. Data on recidivism - the existence and number of previous imprisonments were collected from legally binding court decisions that are the basis for the execution of prison sentences, as well as files of the convicted persons.

Descriptive statistics

Basic data about the sample

The sample of the examined population consists of 97 female inmates who were serving their sentences at the time of the study in the Correctional Institution for Women in Požarevac. The average age of the respondents is 39.7 years (SD=10.65; range from 21-74). The average age of the inmates at the time of their first conviction is 33.1 years (SD=11.63; range from 12-74). The average length of the imposed prison sentence in the sample of the examined population is 6.2 years (SD=7.12; range from 2-40).

Table 1. The structure of the examined population according to the time spent in prison

Time spent in prison [2]	***Frequency***	***Percent***
Shorter than six months	16	17.4
7-12 months	15	16.3
1-2 years	21	22.8
Longer than 2 years	*40*	*43.5*

[2] Missing data, n=5.

In Table 1, the structure of female inmates based on the length of time spent in prison is presented. The largest number of convicts have been in prison for more than two years, 40 of them or 43.5% of the sample. Next are the inmates who have been in prison for between one and two years, 21 of them or 22.8% of the sample.

Table 2. The structure of the examined population based on their previous incarceration

First-time offenders[3]	***Frequency***	***Percent***
No	23	25
Yes	*69*	*75*

In Table 2, the structure of respondents based on their previous incarceration history is presented. This table shows that the majority of respondents (69 out of a total of 92) are first-time offenders, accounting for 75% of the sample. On the other hand, a smaller number of respondents (23 out of 92) have been incarcerated before, constituting the remaining 25% of the sample.

In the sample of 23 respondents who have been previously incarcerated, the largest number is those who have been in prison once before, specifically 6 of them, which constitutes 27.3%. In second place, in terms of the number of previous incarcerations, are female inmates who have been in prison four times - there are 5 of them, accounting for 22.7%, which is also the highest number of previous incarcerations among the population of female inmates.

In terms of the type of crime, the most prevalent are respondents who have committed crimes against human health, totalling 30 individuals, which constitutes 33% of the sample. Following this, 23 respondents, or 25.3% of the sample, are serving sentences for crimes against life and limb, while the third most prevalent, with 24.2% (22), are respondents who have committed crimes against property.

Table 3. The structure of the examined population based on involvement in education and vocational training in prison

Involvement in education and vocational training[4]	***Frequency***	***Percent***
No	*88*	*97.2*
Yes	2	2.2

In terms of involvement in education and vocational training programs, in the sample of the surveyed population, the largest number of respondents, specifically 88 or 97.2%, are not involved in these programs, while two respondents, or 2.2% of the sample, are attending education and vocational training programs.

[3] Missing data, n=5.

[4] Missing data, n=7.

When considering employment, the most represented are respondents who are employed, with 60 or 66.7% being engaged in work, while 30 or 33.3% are not employed.

The next question for which we collected responses is whether the respondents, at the time of the survey or previously, were involved in any crime prevention programs available in prison, such as anger and aggression management programs, addiction recovery programs, specific programs designed for sexual offenders, etc. In the sample of the surveyed population, the most represented are respondents who have not been involved in any of the mentioned programs, with 90.2%, while only nine respondents, or 9.8%, are involved. The next set of questions pertained to involvement in specialised treatment programs[5]. The most represented are respondents, 76 of them or 86.4%, who are not involved in any specialized programs, while only 12 of them or 13.6% are involved.

Among the respondents who are involved in specialised programs, the most represented are those enrolled in the addiction treatment program (detoxification program, methadone therapy, alcoholism recovery program), totalling four of them, which constitutes 57.1% of the inmates involved in any programs. Two respondents (or 28.2%) are enrolled in cognitive-behavioural therapy programs, and one is enrolled in an aggression control program (14.3%).

Table 4. The structure of the examined population based on marital status

Marital status	***Frequency***	***Percent***
Single	23	24.2
Married	17	17.9
Extramarital union	*29*	*30.5*
Divorced	19	20
Widowed	7	7.4

In Table 4, the structure of respondents based on marital status is presented. The most represented population of respondents is those in a non-marital partnership, numbering 29, which constitutes 30.5% of the sample. Following them are respondents who are single, without a partner, numbering 23 or 24.2%, while the smallest number of respondents are widows, totalling seven, which makes up 7.4% of the sample. If we consider the sample based on whether the respondents have a partner (regardless of the type of relationship - marital or non-marital partnership) or not (single, divorced, or widowed), the most represented are respondents without a partner, 49 of them or 51.6%, while 46 or 48.4% of the sample have a partner.

[5] Missing data, n=9.

Table 5. The structure of the examined population based on education

Educational level	***Frequency***	***Percent***
Unfinished elementary school	8	8.4
Elementary school	27	28.1
High school	*46*	*47.9*
Vocational college or higher	15	15.6

In Table 5, the structure of the surveyed population based on educational level before entering prison is shown. We notice that 46 respondents, or 47.9% of the sample of the surveyed population, completed high school. Without vocational qualifications, that is, only primary education, there are 27 respondents, accounting for 28.1% of the sample. The category of respondents with incomplete primary education consists of two respondents (or 2.1% of the sample) who have no schooling and six respondents (or 6.3% of the sample) who have incomplete primary education. The total number of respondents with incomplete primary education is 8, or 8% of the sample. Regarding previous convictions, 62 respondents, or 64.6%, have not been previously convicted, while 34 respondents, or 35.4%, have been previously convicted. Regarding classification, or placement in departments based on the level of security and convenience, at the time of the survey, the largest number of respondents, 70 of them, or 76.1%, were classified in the closed department of the institution. Twenty of them, or 21.7% of the sample, were classified in the semi-open department of the institution, while there were only two respondents (2.2%) in the open department.

The next question we focused on in the study pertained to drug use before entering prison and whether the respondents had problems with drugs and/or alcohol before entering prison. At the time of the survey, 44 respondents, or 48%, stated that they had used drugs before entering prison, while 47 respondents, or 51% of the sample of the surveyed population, did not use drugs. In response to the question of whether they had problems with drugs or alcohol before coming to prison, the largest percentage of respondents, 55 or 60.4%, did not have problems with either drugs or alcohol. This finding is not surprising, considering the previously mentioned result that slightly more than half of the sample, specifically 51%, did not use drugs before serving their prison sentences. However, if we consider the above-mentioned data, that 48% of the respondents used drugs before entering prison, what is concerning is that only 19 respondents, or 20.9%, also stated that they had a problem with drugs. Fourteen respondents (or 15.4% of the sample) had problems with both drugs and alcohol before entering prison, while three respondents reported having problems only with alcohol. In the end, we were interested in whether the respondents needed help with drug or alcohol rehabilitation upon arrival in prison. To this question, 65 respondents, or 76.5% of the surveyed population, answered negatively. Eighteen respondents (or 21.2% of the sample) stated that they needed help with drug rehabilitation upon arrival in prison. One respondent (or 1.2% of the sample) confirmed that she needed help with alcohol

rehabilitation, while another respondent confirmed needing help with both drug and alcohol rehabilitation.

The structure of the respondents according to their current health status

In this section, the results obtained from the analysis of the Quality of Life questionnaire (WHOQOL-Bref) will be presented, which includes questions about personal assessment of quality of life and health status. The first question[6] is of a general nature and relates to the presence or absence of illness. More than half of the respondents, specifically 50 of them or 55.6% of the surveyed population, answered affirmatively regarding the presence of illness, while 40 respondents (44.4%) answered negatively to the question. Out of the 48 respondents who reported having illnesses at the time of the study, the most common response, accounting for 35.4%, was the presence of mental disorders (including depression, anxiety, nervousness, stress disorder, bipolar disorder, affective disorder, borderline personality disorder, etc.). If we include responses falling under the category of mental disorders and behavioural disorders (such as schizophrenia), we find that 39.8% of responses are related to psychological and psychiatric conditions. The second most common responses, comprising 27%, are related to diseases classified as cardiovascular disorders (including heart problems, angina pectoris, hypertension, thrombosis, stroke, etc.), after which 16.6% of the responses follow regarding the presence of diseases classified as endocrine disorders (thyroid diseases, diabetes, etc.). Next, with a frequency of 7.2% of responses, are diseases classified as musculoskeletal and connective tissue disorders (including joint diseases, spinal disorders, osteopathy, and chondropathy).

In terms of response frequency regarding the type of present illness, responses related to respiratory system diseases contribute 4.1%, including acute respiratory infections, chronic respiratory diseases, lung diseases, respiratory illnesses, etc. Neurological diseases (epilepsy, migraines), gynaecological, and immunological diseases contribute 3.1% of responses regarding the type of present illness at the time of the survey. In the end, the lowest representation of 2.1% pertains to responses regarding the presence of addiction disorders, infectious diseases, and nephrological conditions.

Table 6. The structure of respondents based on the assessment of quality of life (general question)[7]

Quality of life assessment - general question	***Frequency***	***Percent***
Very poor	15	16.7
poor	21	23.3
Neither poor nor good	*32*	*35.6*
Good	15	16.7
Very good	7	7.8

[6] Missing data, n=7.

[7] Missing data, n=7.

In Table number 6, the structure of the surveyed population based on the general assessment of quality of life is presented. We observe that the largest number of respondents, 32 of them, accounting for 35.6%, rate their quality of life as average, with a neutral response, neither good nor bad. If we consider the category of poor quality as a single category with variations from very poor to poor, we obtain data indicating that even 40% of the sample, or 36 respondents, have poor quality of life. Fifteen respondents, or 16.7% of the sample, rated their quality of life as good, while only seven respondents (7.8%) rated it as very good.

The next question from the Quality of Life Questionnaire for which we collected data is 'How satisfied are you with your health?' The results are presented in Table 7.

Table 7. The structure of participants based on satisfaction with health[8]

Level of satisfaction	***Frequency***	***Percent***
Very dissatisfied	16	17.6
Dissatisfied	*30*	*33*
Neither satisfied nor dissatisfied	25	27.5
Satisfied	12	13.2
Very satisfied	8	8.8

As evident from Table 7, the most represented are the respondents who are not satisfied with their health, numbering 30, which constitutes 33% of the sampled population. Furthermore, 16 respondents, or 17.6% of the sampled population, are very dissatisfied with their health. If, similar to the previous question, we consider the category of dissatisfaction with health as a single category with variations in the intensity of dissatisfaction - from very dissatisfied to dissatisfied, we obtain data indicating that 46 respondents are dissatisfied with their health at the time of the study, constituting 50.6% of the sample. The neutral response, indicating neither satisfaction nor dissatisfaction, follows with a representation of 27.5%. Twelve respondents are satisfied with their health, which constitutes 13.2% of the sample. Additionally, eight respondents are very satisfied with their health, accounting for 8.8% of the sample. At the end, the total score for the dimension of physical health from the Quality of Life Questionnaire is 12.97 (SD=3.83; range from 5-20).

Discussion

Based on the results presented in this study, we can highlight several key characteristics of the convicted women, both in terms of demographic, criminological, and penological features, as well as their involvement in specialised treatments, and their health needs and the presence of certain illnesses. We observe that the majority of convicted women included in the study had an average age of 39.7 years. The majority of them had not been in prison before (75% of the sample) and had no prior convictions (64.6%). These findings are

[8] Missing data, n=6.

consistent with the results of other studies indicating that among the population of convicted women, those who are in prison for the first time for their first committed crime predominate (Handtke et al., 2015; Moles-López & Añaños, 2021).

The highest percentage of convicted women have partners or live in cohabitation (30.5%), have completed secondary education (47.9% of the sample), and have been in prison for more than two years. In terms of the type of crime, the most prevalent are respondents who have committed crimes against human health (predominantly those related to illegal drug trade, production and possession), totalling 33% of the sample.

Furthermore, in terms of treatment and classification of the examined population, the most represented are convicted women classified in the closed department within the institution (76.1%), not enrolled in education and vocational training (97.2% of the sample), but the majority are employed (66.7%). In terms of involvement in any crime prevention programs, a staggering 90.2% of the sample is not enrolled in such programs, and 86.4% are not involved in specialised treatment programs. A concerning finding is that although 48% of the sample reported prior drug use before entering prison, only 20.9% confirm having a drug problem, and 21.2% indicate needing help with drug dependency upon arrival in prison.

In terms of physical health and overall quality of life assessed from the aspect of physical health, more than half of the respondents, specifically 55.6% of the sample, confirmed the presence of illnesses at the time of the study. The most prevalent, at 35.4%, are respondents who have mental disorders, followed by cardiovascular disorders (27% of the sample). Similar findings have been reported by other authors who note that the most prevalent disorders among the population of convicted women are mental disorders (Augsburger et al., 2022; Bright, Higgins & Grealish, 2022). The highest percentage of respondents (40%) rate their quality of life as poor (ranging from very poor to poor). Regarding satisfaction with their health status, the most numerous respondents (33%) are dissatisfied with their health condition. The mentioned results indicate that primary healthcare, medical care, and the improvement of mental health within the correctional facility cannot adequately address the extensive needs of convicted women. Convicted women are not involved in appropriate forms of medical and healthcare, and they are not sufficiently engaged in specialised treatment aimed at addressing and controlling dependencies. The high prevalence of mental health problems necessitates specific interventions, especially those that integrate a focus on previous trauma histories. In conclusion, it seems necessary to emphasise once again that healthcare for convicted individuals represents a particularly challenging area within the prison system. At the same time, it is crucial, both in terms of protecting the human rights of all inmates and from the perspective of preventing recidivism, as preserved physical and mental health of convicted individuals is a prerequisite for their successful social reintegration upon release (Pavićević, Ilijić & Batrićević, 2024: 191; Batrićević, 2011: 135-156; Batrićević, Ilijić 2014: 441-450). This is especially true for mental health, the preservation of which poses a particular challenge, as life in prison, often combined with previous victimisation, frequently leads to its deterioration.

Conclusions and recommendations

The number of women in prison is increasing worldwide, including in European countries and the Republic of Serbia. The rise in the number of convicted women underscores the need for a better understanding of all characteristics of this population in order to adapt the conditions under which they serve their sentences to this population. In this context, it is of utmost importance to recognize the health needs of female inmates, identify them, and promptly implement appropriate medical and health services in prisons. Considering that the prevalence of mental disorders in the population of female inmates is higher than in the general population (as well as in the general female population), greater attention must be paid to the mental health of female inmates, as well as to the treatment of those diagnosed with mental disorders. The heightened vulnerability of women in prison presents unique challenges for correctional professionals, especially healthcare providers, particularly when incarceration exacerbates pre-existing mental health issues and previously experienced traumatic events for women.

The findings of this research highlight the need for improved healthcare and support services within the prison, particularly mental health support. Women in need of support for their mental health should be provided with timely and equitable access to the most appropriate gender-specific treatment interventions and environments. Incarceration could represent an opportunity for women to have access to healthcare for their pre-existing medical conditions and to benefit from adequate medical and psychosocial care to prevent further health decline (Augsburger, et. al., 2022). Healthcare services and medical care in prisons should be based on an approach that is gender-specific, gender-compliant, taking into account all characteristics of female inmates, but also personalised, accessible, and equitable. Access to healthcare resources in prison is also important, and supporting and non-stigmatizing and gender-responsive healthcare management is needed. Enhancing access to counselling, therapy, and educational resources can contribute to the overall well-being and successful rehabilitation of the incarcerated women.

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