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Thematic article

Health care in correctional settings: The health needs of women prisoners

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Abstract

In the Italian scientific community, the sociology of health has seldom examined penitentiaries (Ronco, 2018), and even more rarely, the specific context of women's prisons. While international literature offers broader insights (Kouyoumdjian et al., 2015), studies focused on women remain marginal and predominantly quantitative. This article addresses this gap by adopting a micro sociological perspective to examine the interactions shaping care and custody practices through the voices of incarcerated women. The empirical data stems from a year-long research project in a female section of an adult penitentiary in central-northern Italy. Employing a triangulation of methods — participant observation, document analysis, and discursive interviews — the study captures the narratives and strategies used by women to address their care needs (Sterchele, 2021). Despite the challenges of qualitative research in carceral settings (Sbraccia & Vianello, 2010), the findings highlight health as an urgent daily issue. In prison, women face intersecting layers of oppression: as detainees in a system designed for men (Rostaing, 2017), and as patients subjected to a medical authority that marginalizes "profane" knowledge (Pizzini, 1990). Furthermore, as female patients, they experience a specific medicalized gaze that differs significantly from the male experience (Carlen, 1983; Sim, 1990). Consequently, this study emphasizes the necessity of an intersectional and gender-specific lens to fully understand the carceral context. While prison paradoxically represents the first point of contact with continuous healthcare for some (Massaro, 2018), the environment remains structurally inadequate for female vulnerabilities (Pecorella, 2018).

Keywords: prison institution, correctional health care, women prisoners, women's health, female bodies.

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What kind of health — or what gender?

The sociology of health in Italy has rarely crossed the threshold of a penitentiary, much less a women's penitentiary[1]. Even where studies in custodial contexts have been most prolific, such as in the Canadian and Anglo-Saxon literature, the space devoted to women has been limited and marginal (Kouyoumdjian et al., 2015). Moreover, the topic has been studied mainly from clinical, medico-pharmacological and psychological perspectives rather than sociological ones[2]. Across contexts, scholarly attention has largely focused on reproductive and sexual health (Valentino, 2016) thereby neglecting a range of other essential aspects that are closely linked to the experience of female prison inmates that cannot reduced exclusively to the experience of motherhood (Valentino, 2016). This highlights the need to take into account the reality of the detention context, the spaces and resources dedicated to them, the life course often linked to previous experiences of victimisation, the need for a gender medicine-oriented approach. More broadly, one cannot overlook the specific social construction of the female gender and the influence that gender affiliation exerts on health conditions and perceived well-being[3]. Likewise, one cannot ignore the historical perspective of the clinical medical gaze toward — deviant — women (Carlen, 1983; Sim, 1990). Practices of control and the systematic invisibilisation of female bodies have long informed medical knowledge and practice. This has led to a specific form of clinical (dis)interest: on the one hand, the female body has been ignored, subsumed under a supposedly universal male neutrality; on the other hand, it has been placed under surveillance due to its perceived ambiguity — caught between culture and nature, sexuality and reproduction — making it a body subject to greater medicalization (Ranisio in Cozzi, 2012). As Pitch (2006) writes, the female body is:

> nature over which [masculine] culture had to exercise its dominion. In this sense, as the most natural of male bodies [...] it still represents [precisely because of its reproductive capacity] a threat and a danger. It is not coincidence that the female body is more medicalised than the male, its preventive practices more punctual and extensive, the self-vigilance it requires more intense (Pitch, 2006, p. 99, Author's translation).

This is particularly evident in the history of women's internment and detention, where processes of medicalisation have served to control, feminise and domesticate female inmates (Carlen, 1983).

[1] Despite being a cornerstone of Italian medical sociology, research on social health inequities has frequently overlooked the carceral context(Massaro, 2018).

[2] Furthermore, sociological research in this field has been traditionally dominated by quantitative methodologies (Rodelli & Sterchele, 2022).

[3] The literature (Biancheri, 2014; Marmot, 2005) highlights the influence of gender on certain indicators such as life expectancy, healthy life years, morbidity rates, healthcare services access, as well as unmet medical needs (or care avoidance).

Accordingly, it is necessary to move beyond a gender-blind perspective, one that not only fails to account for how needs, desires, and deprivations vary according to the gender of imprisoned subjectivities (Sonnini, 2024), but also assigns gender exclusively to women/mothers, implicitly assuming the masculine as a neutral default[4]. In contrast, focusing on gender — in this case, the feminine[5] — brings to light key issues regarding identity and power relations (Scott, 1986), and opens up the possibility to explore aspects that have remained overlooked in previous works addressing the complex issue of medical care in prisons. From a microsociological perspective, the study aimed to explore the conditions of possibility and the interactions that constitute care and custody practices within the female prison, through the voices, narratives, and life experiences of incarcerated women. Although these women are placed within a spatial configuration where agency is severely restricted, they strive to implement strategies of adaptation and resistance to meet their care needs (Sterchele, 2021).

Notes on methodology

This work is based on empirical data collected during a one-year research project conducted in a female unit within a male adult penitentiary in central-northern Italy[6]. Through the triangulation of methods, including interviews, document analysis, and ethnography (Cardano, 2011), the study aimed to explore and reconstruct the meaning structures that shape the experience of illness, health, and well-being in prison, considering the subjective factors that influence how these experiences are lived (Morsello, 2017). Despite the methodological challenges related to accessing the prison field (Ferreccio & Vianello, 2014), qualitative research enables the exploration of this area from a processual and relational perspective, fostering a deeper understanding of the participants' viewpoints[7]. Notwithstanding the challenges inherent in conducting research within a

[4] On the one hand, science reinforces male domination; on the other, it conceals this power by presenting the masculine as 'genderless' and neutral. As the dominant norm, it is treated as self-evident and thus requires no explanation (Boureau, 1989).

[5] However, it is not intended to interpret the "feminine" as an ahistorical and monolithic category, in binary opposition to the masculine. Rather, the aim is to conceive this category — as well as the masculine — as a historical element of perception and social representation, one that reinforces symbols, norms, policies, and subjective identities, while shaping general metaphors of power" (Boureau, 1989, p. 919).

[6] To ensure the anonymity and privacy of all research participants, the name and specific location of the correctional facility have been omitted.

[7] It is important to underline that there are inherent limitations to the interviewee–interviewer relationship. On the one hand, the "inmates code" (Sykes, 1958) is not always easily interpretable by outsiders. On the other hand, it is crucial to reflect on the researcher's positionality. The relevance of the researcher's own presence — their way of being in the world — calls for an explicit acknowledgment of their standpoint in relation to the themes and the context under study (Cardano, 2020, p. 211). The observer is never politically neutral, not only because of their ideas or beliefs, but due to their material and embodied characteristics-such as gender and race. Reflection on one's own material and symbolic power should prompt the knowing subject to take responsibility for the political and ethical implications of producing knowledge about the lives

highly restrictive environment such us prison, which may constrain and inhibit freedom of expression, the study was widely received by the women prisoners. This environment is frequently described through the recurring leitmotiv "this is radio prison" (field notes) an expression that captures a context in which privacy is scarce, as everything is visible and overheard. They felt both empowered and responsible toward their fellow inmates and, more broadly, the entire female incarcerated population, as it gave them the opportunity to highlight the real issues. A woman interviewed claims that:

> *The media always focus on menstruation and the lack of pads, but that's not the real problem — there are far more pressing concerns[8]!*

The enthusiasm observed is closely linked to a basic desire to speak and share personal experiences. Frequent digressions and emotional outbursts generally reveal a lack of communication, trust, and listening, as well as the isolation to which they are subjected (Ronco, 2018). A total of twelve incarcerated women participated in the interviews, selected through a process that balanced the needs of the research with the requirements set by the prison administration[9]. As Sbraccia and Vianello (2016) argue, it should not be overlooked that the institution proposes the most "presentable" subjects and those who could least hinder the work of the operators not necessarily the intention of manipulating information but also as an attempt to translate and adapt researchers' requests to the everyday context of the penitentiary. In general, for social scientists wishing to conduct ' discovery-oriented research Cardano, 2011), inside the prison, the path is rather complex and difficult (Gariglio, 2018) since it requires a series of formal

and bodies of others (Becker, 1967). Without falling into a retreat into the personal, it is nevertheless important to state that the researcher is a young, white, able-bodied woman from a middle-class Italian family. Being young, unmarried, childless, Southern, and free (i.e., not incarcerated) also proved to be significant factors during fieldwork.

[8] The interviews were translated from the original Italian. This translation process inevitably influenced the structure, idiomatic expressions, and overall expressiveness of the responses.

[9] The sample included eight Italian women -comprising two from Southern Italy, two of 'second-generation' migrant background, and four from other regions- alongside four foreign nationals, primarily of Romani and Sinti origin. Demographic profiles show that while two participants were under thirty, the majority were between forty-five and sixty years old. Most had limited formal education and had been employed in low-skilled sectors prior to their incarceration; however, during their time in prison, the majority took part in vocational training or internal work programs. Participants were selected according to the following criteria:

- Legal Status: Only women with a final, definitive conviction were included.
- Institutional Experience: Priority was given to those with frequent interactions with the healthcare system to ensure depth of data.
- Feasibility: Interviews were assessed based on emotional stability and linguistic accessibility.
- Communicative Profile: prison officers steered the research toward individuals they categorized through the lenses of logorrhea or lamentatio. The selection was guided by a dual objective: to enrich the research as much as possible with detailed narratives, while simultaneously occupying the inmates' time by providing them with an opportunity to vent. In this sense, the officers steered the researcher toward women characterized by logorrhea or lamentatio, viewing the interview as a pragmatic way to manage these more 'demanding' individuals by granting them a space for their grievances.
- Stratification: The sample aimed to reflect the intersectional diversity of the prison environment, accounting for age, nationality, and length of sentence

steps, necessary and unavoidable to access the field. The prison world is impenetrable (Goffman, 2010) to the outside world, and it grants access to its structures and information with great difficulty. As a result, numerous obstacles arise throughout the research process, from the design phase to the stage of textualization. The research topic, however, may have facilitated and, consequently, expedited the entry procedures, as it was perceived as relatively unintrusive: the healthcare issue was not directly related to the prison administration, and the only individuals involved would have been the incarcerated women, not the healthcare staff. The decision to interview only women raised more hesitations than outright resistance:

> *Are you sure you only want to hear from the detainees? There's a huge gap between what they say and the reality! It would be better to ask the section doctor. He's a good person, and he does much more than his duty* (Field notes during a meeting with prison administration staff).

As Becker argues: "Credibility and the right to be heard are distributed unequally within the ranks of the system'" (Becker, 1967, p. 241). Incarcerated women find themselves at the lowest ranks of power, as detained female patients[10]. In light of this, it becomes even more crucial to highlight the right to speak what only they can say (Foucault, 1971). It is therefore essential to amplify the voices of those who are imprisoned, to listen to their stories, their needs, and their life plans (Vianello & Degenhardt, 2010). Even though these women find themselves in an environment where they cannot intervene physically in a transformative way, they employ strategies that allow them to navigate and exploit existing channels to their advantage (Sterchele, 2021, p.157).

Health in everyday life contexts

Talking about health in prison often feels rhetorical, if not overtly paradoxical. From the outset, one runs into the seemingly obvious: "*How can you stay here?"; "You're in prison, not at home, what do you expect?"; "If things don't work outside, imagine what it's like in here"* (interviews). Living in such a facility drastically lowers one's expectations, and consequently, complex concepts like health, care, and "well-being" are often reframed and reduced, sometimes to mere survival. The WHO biopsychosocial model thus appears to give way to a minimalist definition of health as the "absence of disease,", a sort of necessary litotes aimed at *"surviving"* and "*not letting oneself*

[10] The dimensions of class and race must also be taken into serious consideration in this context.

die" (interviews). Although specific diseases and etiopathogenesis exclusively linked to incarceration are not recognized, even when frequently occurring alongside environmental factors, health protection in prison presents particular specificities related to the unique characteristics of the population, the penitentiary context, and the accessibility of services[11] (Mancinelli et al., 2019). First and foremost, the experience of incarceration, with its inherent restrictions on freedom, constitutes a significant health risk factor (Neisser, 1977). Finding oneself in an environment over which one has little control and, in many cases, no decision-making power, such as choosing one's food, coupled with the inward withdrawal caused by the limited opportunities for action and thought due to the absence of alternative options, tends to worsen individual health conditions, which are carefully and thoroughly monitored. Significant in this regard are the testimonies of two women recounting their experiences during the first days of incarceration:

> *I have to be honest: the first few months here I felt a bit unwell. I had so many phobias! I would see a pimple and immediately get alarmed, worried, thinking, "What could that be?" I couldn't go online; I couldn't ask my relatives... So, I suffered a bit. But then you overcome that fear because... it's obvious, you're in prison. Let's be clear, there's this impact!*

> *Entering here is traumatic! The first time, you see things and think, "Where am I?!" You feel unwell, you see people you don't know, um, you see the environment – the small cell, another person you don't know — and that's difficult! It depends on who that person is, whether they are dangerous or not… even though the section officers know where to place you, it's actually not always so easy.*

Detention facilities themselves are regarded as the primary health risk factor. The forced sharing of confined and poorly maintained spaces is widely recognized as one of the main structural determinants of health risk. Moreover, the fragile balance that inmates try to establish within a cell or housing unit is frequently disrupted, especially given the high turnover that characterizes female incarceration. A woman who has been living in the facility for almost two years- experiencing incarceration for the first time- questions the very idea of "healthiness" in prison:

[11] Moreover, it is difficult to obtain a comprehensive overview of the current situation, as the context is is characterized by the highly fragmented. Access to, effectiveness of, and delivery of healthcare services vary significantly across regions, and persistent disparities also exist between individual institutions, which often function as "isolated worlds" (Buffa, 2013). First and foremost, the forms of incarceration for women are highly diversified: women's prisons, female sections within male institutions, ICAM (Institutes for Incarcerated Mothers), nursery units, and dedicated sections for transgender women. These distinctions significantly affect the availability of treatment programs, the delivery of services, and the principle of territoriality of the sentence -that is, the proximity to one's place of origin and, by extension, to personal networks of care and affection. In addition, other contextual factors play a major role: the proximity to external hospitals, the type and scope of internal healthcare services, the level of prison overcrowding, and the institutional management approach adopted.

> *I don't know much about pharmacology, but, uh* [sighs], *prison isn't exactly something that's good for your health, even just as an idea, just the idea itself* [with a wry smile]! *Then, we're forced to live two to a cell in a space that's really... well, these cells are as big as this wall, that's it* [indicates the space]. *There's a bunk bed, two lockers, a small table, and stools. Then there's a door, a bathroom, and a window; the bidet doesn't work, and then there's the toilet. Two people, I mean* [laughs]. *It's a bit challenging because you're sharing a cell with a stranger, you're with a person you don't know...*

The enforced cohabitation with an *"otherness"* often perceived as hostile or potentially "contaminated" in a confined space with no escape routes or alternatives, is experienced as an additional form of punishment. The mandatory closeness to people who are profoundly unfamiliar — whether due to cultural background, language, or the nature of their crimes — is experienced as deeply exhausting. The testimonies of two women are illustrative in this regard: the first is experiencing incarceration for the first time, while the second has previously been detained in other facilities.

> *No, because either way, you're locked up like an animal, and… then there's this mix of offenses, you meet people who do things in their normal lives – things that, for them, are normal — but for me, they're traumatic every time. Because these things just don't exist in my world, you know?*

> *Moving from one prison to another, I developed a phobia. I said to myself, "My God, I touched one toilet, then another…" I started to feel anxious — what if it's a transmissible disease? I really got carried away by anxiety! I'm scared of being HIV positive, I'm scared of lice in the cell. And you know what? Fear plays tricks on you! It makes you feel like these things are real, and then you fixate – it's normal…*

Hygiene is thus perceived as a form of antidote, often pursued obsessively in response to overcrowding and the lack of personal space.

> *They clean* [referring to the cleaning staff], *but there are still too many people, and hygiene is just not there – and that already brings a shift... it's really hard. I clean every single day, every day. They say* [referring to other inmates] *I'm obsessed, but for me, it's normal.*

Continuous exposure to risk factors contributes to the deterioration of overall well-being and, in some cases, directly to the onset of specific illnesses. In fact, the longer one lives in particularly adverse conditions – marked by chronic stress — the greater the likelihood of experiencing poor health (Marmot, 2005; Illich, 1977). In this regard, the daily experiences shared by the interviewed women are particularly revealing:

> *I had a herniated disc before and I've had surgery twice, but it came back again here. This neck pain — I didn't have it before, it started here. This pain in my arm – I didn't have that either, it started here... I didn't have any of this before.*
>
> *I've had rheumatic pain since before I was incarcerated, but obviously in here, with the cold and the showers... there are a lot of us, and sometimes you don't get your turn right away... sometimes the environment is just cold. Let's say that for someone with these kinds of problems... everything gets worse, the pain really intensifies.*

As highlighted by both national (Rastrelli, 2016; Zoia, 2005) and international research (WHO, 2009), the women who participated in this study reported the onset or the worsening of various health issues. These include sleep disturbances, prolonged exposure to stress, gastrointestinal problems, menstrual disorders such as amenorrhea and dysmenorrhea, as well as the emergence of hearing and vision impairments. Here is what some of the incarcerated women shared:

> *With the glasses I had, I couldn't see well anymore — I've lost a lot of diopters because of these bars here* [she points to them]. *Being in such small spaces affects your eyesight. It's inevitable to lose diopters when you're always indoors, always looking through the bars. It's constant... inevitable. Outside, I only wore glasses for reading, almost exclusively for reading. Now, I have to wear them even to work or do other things because without them I struggle — I really need to wear them.*
>
> *To be honest, when I first got here, my period didn't come... it's only been back for five or six months now. My period can come two or three days early-or sometimes it came twice a month because of the stress. I went to see a gynecologist. Now that I have my period regularly, it's too heavy — I bleed a lot!*

Evidence from (Ahmed, 2016; Kouyoumdjian et al., 2015) shows that female inmates generally present with far more complex health issues compared both to their male inmate counterparts and to the general free population. From the outset, women tend to have more severe health needs due to widespread poverty, discrimination, street lifestyles, and victimization processes (Ahmed, 2016), as well as difficulties accessing social and healthcare services in the community (Lines, 2006). Recent data presented at the Agorà Penitenziaria 2019, the 20th National Congress of the Italian Society of Prison Medicine and Health (SIMPSe), reveal the critical mental health conditions within Italian prisons: 50% of inmates suffer from a mental disorder and 25% from psychoactive substance dependence. While male inmates show higher rates of substance (50.8%) and alcohol-related disorders (9.1%), female prisoners display a greater prevalence of psychiatric comorbidities, pathological temperaments, and personality disorders (Dario & Giampà, 2022).

Among women, the most frequent diagnoses include neurotic and adjustment disorders (36.6%) and psychotic affective disorders (10.1%), with self-harming behaviors affecting 20–24% of inmates annually, compared to less than 1% in the general population. This pattern highlights a distinctive

vulnerability in women's mental health within prison. Further evidence from the ROSE network study[12] confirms the health fragility of incarcerated women, showing significantly high rates of hepatitis B and coinfections (HIV, HCV, HBV) across five female institutions[13]. Consequently, incarcerated women stand at the intersection of psychiatric labeling, poverty, and social neglect, their bodies bearing the marks of these overlapping forms of exclusion.

As Ben-Moche (2017) emphasizes, public and security policies often show a more or less linear correlation between psychiatric institutionalization, medicalization, and criminalization of certain marginalized populations – such as the homeless – who become subject to a process of "racial criminal pathologization" (Ivi, p.7). A revealing testimony comes from a woman who has long been supported by local social services and who has experienced severe housing instability throughout her life, alongside economic and family difficulties. She initially lived in public housing but, following an eviction, spent several years homeless on the streets, exposed to repeated abuse and violence:

> *If you're sick, you're easier to catch... anything can happen to you! I don't even know why I'm here. If you live on the street, it's easier to get picked up! The thing is, if you scream, you disturb the public order [...] They put me here because they didn't know where else to put me. The fact is illness brings you to prison even if you didn't commit a crime... They could have used other methods, but not prison. This is not the place to get treatment! [...] But that's how it is: if you're ignorant and don't have a lawyer, you end up in jail and serve the whole sentence, or they assign you a public defender* [She cries]!

Furthermore, experiences of victimization – often directly or indirectly underlying the committed offense — have a significant impact on health. Incarcerated women show higher rates of emotional, physical, and sexual abuse (Saxena & Messina, 2021). Literature (Campbell, 2002; Coker, 2007) has firmly established the link between violence – in its physical, psychological, or sexual forms – and both physical and mental health conditions, as well as the emergence of risky behaviors such as alcohol, drug, or psychotropic medication abuse among affected women. Consistent with these findings, health needs and, consequently, the use of healthcare services in prison are higher than in the general population. Accordingly, incarceration severely affects women's health and well-being both during imprisonment and after release, further exacerbating the health disparities they already face due to gender, race, and social class.

[12] Available at: https://www.gendermedjournal.it/archivio/2696/articoli/27579/

[13] Recognizing these gender-specific health disparities, the World Health Organization, in its report "Women's Health in Prison: Correcting Gender Inequity in Prison Health" (WHO, 2009), urges Member States to implement gender-sensitive prison health systems. This includes training prison and healthcare personnel in gender-specific approaches to mental health, reproductive health, and trauma care, and ensuring continuity of treatment upon release. The WHO also advocates for alternatives to incarceration, particularly for women with minor offenses or young children, to mitigate the compounded effects of detention on physical and mental health.

The prison healthcare system: More or less eligibility[14]?

The inadequacy of the prison healthcare system seems to be a widely accepted fact, so much so that it is often mentioned as something obvious and self-evident, as one inmate effectively points out:

> *Health, in my opinion, is a truly critical issue in prison… I don't know how it could be improved… Over the years, I've spoken with several prison ombudspersons[15], including the current one, who is a very special, attentive, and supportive person who has done a lot for us inmates. Back then, there were more funds and volunteer work was more active…*

Repeatedly, the narratives reveal a form of "normalization" expressed as resignation and justification of violations of rights and personal dignity (lack of privacy, right to access to preventive care, etc.). Interviewee:

> *That night I felt really bad, I had severe pain and cramps* (she points to her abdomen- she was recently diagnosed with a uterine fibroid). *I called the officers. They came twice to check on me. They said that if I really couldn't manage, they would call the doctor... but he's on the other side, in the men's unit... So, I stayed here and waited for it to pass... I stayed awake all night... How did I feel? Well, how could I feel? Bad, disappointed in myself for being here again! Here, rules are rules, what could I do? We're in prison, not on vacation!*

For example, lack of privacy seems to be inherent to the prison institution itself (Ronco, 2018): on one hand because of the cramped and often overcrowded spaces, and on the other because of the control requirements imposed by the prison administration. This leads to a limited concept of privacy, which "always has to keep in mind that we're in prison... you can't have what you have outside!" (interview). Similarly, another woman shares her experience:

> *There's something really serious here, in my opinion one of the worst things to consider: it's unacceptable to constantly hear the officer yelling — shouting loudly at you, saying "Go, you have to see the gynecologist!" or calling you and yelling,*

[14] The title of this section draws inspiration from Sbraccia (2007). On the concept of "less eligibility," see Sbraccia (2007), Sterchele (2020) and Schneider (2022). For a broader theoretical perspective on the social function of prison violence and the political economy of punishment within this framework, see White (2008) and De Giorgi (2006). For the seminal work on the concept of less eligibility, see Rusche and Kirchheimer (1939).

[15] National Guarantor for the Rights of Persons Detained or Deprived of Liberty.

> *"Where do you have to go?". Zero privacy. Especially this constant shouting is, to me, a form of abuse: yelling is the first form of aggression. Hearing constant yelling makes you always feel attacked. For them, aggression is only physical, but verbal aggression exists too…*

Another serious issue concerns access to specialist medical appointments, both within the facility and at external hospitals: *"that's where the bottleneck is"* (interview). In particular, the greatest difficulties arise with ophthalmologists, orthopedists, and especially dentists. The recurring refrain is: *"either you collapse and pass out, or they let you die!"* (interview). Thus, if an inmate has an emergency, a diagnosed condition, or a serious illness, care is provided promptly; otherwise, there is little chance of receiving attention and appropriate treatment. Waiting, which often turns into a delayed diagnosis, seems to be a recurring feature of prison healthcare. This issue frequently comes up in the stories told by incarcerated people:

> *You have to wait, wait, wait here! They left* [she refers to doctors] *me like this for five months with an open tooth because I caught Covid and was put in a quarantine unit. I stayed there for ten days, then I came out of quarantine, Covid passed, but those five months with the open tooth still went by and no one called me* [she weeps in despair].

The time elapsed between booking a medical appointment and the actual consultation is significantly prolonged. Regarding specialist visits outside the prison, the process tends to be even longer due to the shortage of penitentiary police personnel, limited resources, and lack of proper coordination. Therefore, this marked delay appears to be an intrinsic characteristic of the system.

> *The procedure requires registering with the nurse in the morning, but it can take months, sometimes many months, before the ophthalmologist is called. It is truly a burden — the ophthalmologist — because the wait times are extremely long* (laughs ironically).

Another major problem is night-time care. At night, that slowness is perceived as unbearable because it can prove fatal. The absence of a 24-hour medical facility in the ward is a source of anxiety and fear. The presence of only one doctor for the entire prison is perceived as a serious deficiency and injustice, especially when compared to the male unit, and it can generate feelings of abandonment and helplessness. Emergencies, therefore, further complicate the situation and lead to significant delays. Fear of the nighttime and resulting insomnia are recurring themes in the narratives of incarcerated women. The following interview excerpts illustrate the depth and prevalence of these concerns.

> *At night, we don't have a doctor in our unit… if someone gets sick, they have to call a doctor from another wing — there's never anyone here during the night. Never. They always call from another building. No doctor comes here at night… There's only one doctor for the whole place, but there should be someone available 24/7, especially here in the women's unit. And we don't even have a nurse here! That's a serious issue. And it's not just me — every girl here feels the same way, because we don't feel safe, you know?*

Another woman expresses her frustration and anger:

> *Come on!!* [angrily, clearly annoyed] *Sometimes he* [the doctor] *doesn't even come — because the officer calls and tells him: "She has a headache, back pain, stomach pain… whatever". And he just says, "Give her some paracetamol, some ibuprofen" Come on!! You never know what could actually be happening!"*

Overall, patients feel marginalized within their own therapeutic and care pathways: although they retain to accept or refuse treatment, the system provides little opportunity for empowerment or the development of autonomy. Such constraints appear to significantly undermine their self-esteem and sense of self-efficacy.

You know… you're already inside, and you depend on them for everything, so they're the ones in control. It's awful being in someone else's hands, having them tell you what to do: "Come here!", "do this!". Sometimes it really gets to you… sometimes I think [shakes her head with visible sorrow], *"Look at me, I have to rely on all of you". And when they take you down to the medical block for a check-up: "Sit here! Move there". It just makes you feel awful.*

Often, agency is reduced to the mere acceptance or refusal of medication — a practice that, in some instances, serves as a coping strategy or even an explicit form of resistance. The following interviews illustrate this dynamic:

> *Look, I signed the papers to refuse the blood pressure medication, because I know that once you start, it's like a marriage with no divorce. So, if I begin taking that medicine, I'll be stuck with it for life. I told them: "Please, give me a few days. I just got here!! Give me time to process this change.*

> *Now I can manage, I'm okay, but at the beginning, no… because when you first come in, you're not well. They need to look at you, to listen to you… that's what matters, because medication isn't enough — you need to be heard, you need to be listened to! At first, I was taking the drops* [implied: to sleep], *but I didn't take them for very long. Then one day I said to myself, "To hell with this — why should I be taking these drops if they're only making things worse?" I need to face these things on my own, so I stopped taking them. From that day on, throughout my entire incarceration, I*

> *haven't taken anything — not a single medication. I only took something for one week, just once I asked for three drops, and that was it.*

Another strategy involves 'gritting one's teeth and carrying on' (interview), deferring treatment until after release unless it is strictly urgent. This approach, however, significantly compromises perceived well-being and can lead to deteriorating health conditions and delayed diagnoses.

More broadly, therapeutic continuity is often compromised due not only to the typically short sentences served by women (Antigone, 2023), but also by high healthcare staff turnover (Ronco, 2018). Consequently, the encounter with the prison system tends to fragment healthcare trajectories (Sered & Norton-Hawk, 2013), fostering a sense of disempowerment rooted in the loss of autonomy. This environment further inhibits the formation of trusting relationships; indeed, daily interactions in prison are frequently marked by mutual distrust and suspicion (Ronco, 2018):

> *I suffered from depression, so I came here with my own treatment, my own medications, which I've continued to take and never changed, because I'm terrified of these psychiatrists — I don't trust them at all. I've been hospitalized before at* [Name of the hospital]. *Maybe I should change after all these years... but no, no* (shakes her head).

In order to access healthcare in everyday prison life, incarcerated women must be seen as "legitimately ill" rather "faking it"; they must, in essence, qualify as "credible patients".

> *The doctor told me, "Go to Lourdes!", because they always saw me crying. And I was- oh poor me! - crying from the pain-I thought my head was going to explode! I was so scared and so stressed out, and I was terrified that they wouldn't help me here. I thought, "They're going to let me die!" I kept putting in requests to see the doctor, but no one ever called me. I cried and said I was in pain, that my head was about to burst. I felt myself swelling inside, I swear it felt like my bones were going to explode.*

There is an inherent disadvantage in being 'perceived as a prisoner' (Sonnini, 2024); this label tends to eclipse all other identities, profoundly affecting the quality of care, from active listening to clinical treatment. A woman says:

> *There are… some who really treat you like, like "you are the prisoner", you can't know something they don't know. And if they realize you have a bit more intelligence or a bit more education, well, they keep punishing you continuously…*

Over time, the women interviewed say, recount learning a specific 'code' that enables them to maintain adequate visibility, ensuring they receive care while distancing themselves from those

perceived as 'imaginary sick.' The successful strategy involves asserting oneself and projecting strength -specifically a form of 'muscular' and masculine toughness.

> *I've had some really dramatic moments, truly dramatic, really bad: I was put in a corner and sometimes I wasn't considered at all. Maybe because of my personality, maybe because I'm a bit shy, always saying "Excuse me", "Please". Be patient, here sometimes you have to be a little tougher! Sometimes my personality has penalized me, but…"*

It is essential to recognize that personal resources -such as communication skills, educational level, social integration, and language proficiency- play a crucial role in facilitating effective interactions with healthcare professionals. These factors directly influence a patient's capacity to navigate the doctor-patient relationship, which is inherently characterized by an unequal power dynamic (Freidson, 1970). At the same time, for some women, prison serves as a primary point of entry into the national healthcare system, or at least a significant opportunity to access consistent primary care that was previously unavailable to them in the community (Harner & Riley, 2013).

> *Imagine! Here, they discovered things I didn't know I had outside. For anything, they're there; honestly, not even outside! For example, here they do tests to check for infectious diseases, and they did that too. I mean, they did everything and more for me...*

As noted in other studies, one of the very few positive aspects of imprisonment — namely, the possibility of accessing healthcare services, sometimes for the first time — is described by many of the women interviewed as a kind of "luxury" (Vaughn & Carroll, 1990), a condition perceived almost as a privilege when compared to the marginalization and exclusion they experienced outside prison.

> *Since I've been here, I must say, since I arrived, I've had all the possible and imaginable tests, and they found things that, unfortunately, who knows how long they had been going on...*

For marginalized groups — including migrants, the homeless, and the poor — prison increasingly functions as a *de facto* welfare institution, or *"welfare sui generis"* (Melossi, 2006). It provides access to employment, healthcare, and education that an increasingly selective and weakened public welfare system fails to guarantee (Tognetti Bordogna, 2016). This *"welfare of the undesirables"* (Verdolini, 2022) supports individuals marked by extreme social and material deprivation — the *outsiders* (Sterchele, 2020).

Labor market transformations and the neoliberal retrenchment of essential social services have paradoxically positioned prison as a primary point of entry for social and healthcare services among those living in severe marginality. These individuals often face insurmountable formal or structural

barriers in the community (Sbraccia, 2007). As Massaro (2018) notes, the level of marginalization can make prison the first context in which detainees encounter previously inaccessible healthcare. In this way, prison addresses the voids left by an increasingly strained welfare state, particularly for vulnerable populations (Tognetti Bordogna, 2016). Some professionals even describe incarceration as an "opportunity" for detainees address their health needs (Ballesi &Trimboli, 2022). The inherently pathogenic effects of imprisonment — stemming from unhealthy environments and afflictive conditions (Gallo & Ruggiero, 1989; Gonin, 1994; Mosconi, 2005; Saponaro, 2018)can be mitigated by the availability of healthcare, which in some cases is perceived as preferable to services in the community (Sbraccia, 2007; 2018).

This perspective highlights how incarceration extends beyond prison walls, shaping the lived worlds of "surplus populations" (Gilmore, 2007; Tyner, 2013) and imposing the principle of less eligibility upon imagined "others" — the unemployed, the homeless, or the undocumented (Carlbom, 2003).

Care: A personal matter?

Incarcerated women often describe prison as the institution that "never says no" (Verdolini, 2022). It is viewed as "the people's house" — a space populated by a mix of personalities described as demanding, disorganized, and frequently in need. Living in constant proximity to this social density forces women to renegotiate their sense of self, leading to a form of "cultural reorganization" (Goffman, 1961) and, at times, sparking a process of differentiation -a way of drawing clear boundaries between oneself and others. In other words, inmates are not viewed as a monolithic group; there are *"prisoners and then there are prisoners"* (interview). Labels quickly emerge, such as "the junkie", "the psycho", or even "the total psycho" (field notes).To navigate this environment, an informal classification system takes shape, sorting individuals based on two criteria: authenticity and responsibility. The former concerns the perceived legitimacy of one's suffering; inmates seen as genuinely struggling are distinguished from those perceived to be exaggerating, faking, or acting as "hypochondriacs":

> *There are so many hypochondriacs here. It's like the boy who cried wolf — what happens when you really get sick? No one believes you anymore.*

The second distinction (responsibility) is between inmates who care for their health and those who demand care while engaging in self-destructive or unhealthy habits. In this regard, the following interview excerpt is interesting:

> *Some people drink coffee like it's water. You can't say you're feeling sick if you're smoking a pack a day and downing ten coffees. What do you expect? Of course you're going to feel bad.*

The category of *"the junkie"* is frequently invoked to highlight perceived behavioral irresponsibility, these individuals are often seen as solely responsible for their condition, having *"brought it upon themselves"* (interview).

> *From what I see, in terms of attention — let's say for those who have a real problem* (emphasis) — care is certainly provided. *But for those who are junkie — well! — they come here and then want a whole lot of medicine or substitutes, I don't know…*

The category of women labelled as *"psychiatric", "seriously psychiatric"* or *"particularly psychiatric"*, though often viewed irresponsible- is seen as deserving of a different kind of attention due to their specific condition; they are perceived as lacking the capacity to understand or intend.

> *You see them locked up there; it's like locking up an animal in a cage. When they get out, they come out furious because they are not able to understand or intend. Basically, they ask themselves: "Why am I here, locked up" They don't even know if they committed a crime because mentally they are not in the right place, and, well, you have to see these people, it breaks my heart… Let's be honest: when we commit a crime, we know what we did, and only then do we start… there's rehabilitation, even if it's not really like that (laughs, raising eyebrows), you know you committed a crime and you're paying for it. But these people don't know… they basically don't even remember what they did… they are mentally unwell, yet many are brought here because no one knows where else to take them, I can't really explain it… The only thing is they are not treated, they are not treated!*

The figure of psychiatric inmates is often invoked to highlight the anomalies and dysfunctions of the prison system (Ronco, 2018):

> *The open regime ruined the prison, or rather, the social isolation… there used to be your hour of outdoor time. Nowadays, there are more psychiatric inmates, more crack users… maybe because the mental hospitals have been closed.*

> *This prison, in my opinion, is the people's house, you know* [she smiles slightly]. *I think maybe it's where they place those who don't fit in other prisons… this is just my idea, not… just an observation. Anyway, when I used to clean the ward, it was always full — not like now. There were people who needed care, who you'd have to take the water cap off for because maybe they'd hold it in to drink it… There has to be someone to look after these people; they can't just be thrown in there.*

Consequently, the segregation of individuals deemed particularly dangerous — whether due to psychiatric conditions or their health status, such as inmates living with HIV -is a widely accepted solution.

> *Psychiatric patients and drug addicts can't stay with us.*

This spatial segregation reassures those who perceive themselves as "healthy" by distancing them from perceived dangers, while ostensibly allowing the "sick" to receive treated. Such practices belong to a set of tacit, unwritten rules — well known to all actors within the carceral field — that guide their actions, beliefs, and behaviours. In this context, relationships are deeply permeated by prejudice, stereotypes, and mutual distrust. This informal classification distinguishes between the "truly sick" and the "imaginary sick", who are consequently deemed more or less deserving of care. The prison system's fixation on malingering (Ronco, 2018), infiltrates all levels of social interaction: not only between inmates and staff, but also between prisoners and medical personnel, and significantly, among the prisoners themselves. Consequently, health is perceived less as a right to be claimed and more as a privilege to be earned. Access to care is contingent upon to the ideal patient archetype imposed by medical and penitentiary cultures: one who is responsible, stoic, and neither excessively demanding nor complaining. The sociology of incarceration (Salle & Chantraine 2009; Ronco, 2014; Ronco, 2018; Ronco, 2020) has interpreted the tension between entitlements and rights — typical of the prison environment — as another expression of the punitive culture's tendency to encroach upon the domain of care and the right to health. Healthcare — much like employment, alternative sentencing, and rehabilitative programs — tends to function as a conditional benefit rather than a right to be asserted. Ultimately, this rhetoric appears to have internalized by the incarcerated population itself.

More generally, however, health is experienced as a matter of strictly personal and private management. The individual is highly responsibilized, and an emphasis on self-government becoming a fundamental prerequisite for survival. As Barbara Morsello highlights:

> *The repertoire of subjective choices includes an exclusively individual responsibility regarding one's present and health-related decisions* (Morsello, 2021, p. 24, Author's translation)

This appears particularly paradoxical within the carceral setting, where individuals often have significantly fewer opportunities to negotiate the terms and quality of their own existence. As Lines highlights, a profound correlation exists between the criminalization processes leading to incarceration and social health inequities:

The evidence clearly illustrates the degree to which the health needs of prisoners are far from being met around the world. Indeed, in all regions of the globe, the people committed to prison are those whose social and economic marginalisation places them at increased risk of physical and mental health problems. […] In the words of the WHO, "Ill-health thrives in settings of poverty, conflict, discrimination and disinterest. Prison is an environment that concentrates precisely these issues" (Lines, 2006, p.272).

Solidarity and mutual support

The material conditions of detention, as well as the system of incentives and rewards undermines the formation of bonds of trust and solidarity among incarcerated women. Yet, in the event of a crisis, such as a sudden illness during the day or, more critically, at night, women feel they can rely on their peers for prompt and attentive assistance. When someone falls ill, everyone springs into action: some are motivated by a sense of community, others by pure solidarity towards a person in distress, and some by the memory of help they once received — "they did the same for me" (interview). In any case, the ability to count on one's companions appears to be a certainty.

> [In case of an emergency at night] *Anyway, we all call out, yes, we do! Not everyone calls, not the entire wing starts calling… but usually we, the older ones… some have left and then come back… so I learned this here, I understood it… because when it happened to me, I did the same… when someone is sick.*
>
> *Certainly, among us, yes, we help each other on this! I can rely quite a bit on my companions, and I hope they can count on me as well, of course. When there is a health problem, we are all… well, maybe not all naturally [laughs], but quite a lot here have that feeling… of course, if someone is unwell! Living together, well, you like or dislike some people, but there is good will, and you live with them… I've lived with these people for a long time. It is obvious that when there is a health issue, everything else is put aside and you step up, of course… The only thing is that no one is thin here… but in that moment you don't even know what to do or what to expect if something happens!*

In daily life, the situation is more complex: numerous linguistic, cultural, and emotional barriers interfere with peer relationships. The women interviewed tend to feel they can count on only a limited number of people with whom they share an affinity — *whether* culturally, temperamental, or geographical. The fact that *"you can find just about everything" (interview)* in prison sometimes inhibits cooperation. Given the diversity of crimes and personalities, one might encounter 'the fragile one, the aggressive one, and many who do not follow the treatment path; you see them and

say: *"So it* [the rehabilitative path] *didn't help you, then?"* (interview). Many divisive elements exist within the prison community, including the perceived risk of incurring disciplinary reports from prison staff: *"then maybe because of that person you get a report"*(interview); or *"I am someone who tends to isolate myself, but if you talk too much, you get a report"* (interview). Moreover, it is necessary to consider the shared burden of distress: *"You can't really say anything, they have their problems too"* (interview). Despite these barriers, cooperation among inmates is perceived as precious when it occurs: *'the others'* (interview) can serve as an emotional outlet, offering advice, support, or mediation with both the institution and other prisoners.

> *Sometimes words are more important than a plate of pasta, in my opinion, because sometimes you're down… it's not so much the eating that keeps you alive, but when you're down for whatever reason — health, or something that happened, or because the lawyer didn't come — there are many reasons here, because morale can drop in an instant. Finding people who stand by you matters.*
>
> *We do our shopping together; we buy meat and whatever we feel like cooking, we make our Croatian dishes, we prepare dough and all sorts of things, but others eat with us too… we're not the kind of people who argue, we like to joke around! But we don't disturb anyone, we're always polite.*

It is equally important to feel useful to others, providing care and proximity. This engagement appears to enhance self-esteem and self-efficacy. Another woman shares her experience of supporting newcomers:

> *They all call me "Auntie", they know if they need anything, I'm here. Sometimes they come and call me, and say "Auntie, I need to talk" and I'm there washing dishes, and I say, "Come in" and they ask, "Can I come in?". I say, "Come in". You know, my cell is very clean, I even put up a mirror, and they say, "Can I come in?" and I say "Come". They ask me this and that, and then another "Auntie arrives?" And I never say no. No such thing as no, because if they need me, I talk to them. But when they see me sad, they say "Auntie, what's wrong?"*

Another woman shares her experience of supporting newcomers:

> *For example, today I went to a visitation room, and I saw a young girl all alone, and I looked at her and said: "Are you new?" She said yes… but I saw her there all alone, poor thing, so I asked: "How old are you?" She said twenty-one* [silence]. *You see the person is defenceless… it seemed like I was seeing myself when I entered. So, I said: "Look, now… do you want to come with me* [to my cell]*?" And she said yes. I said: "Okay, we'll make the request, and when my current cellmate leaves, you come with me". Because she has absolutely nothing. And I said: "Oh, you have nothing? Then*

> *don't take the sheets; I have the blanket". See my character? Because in the end, I'm a good person… she's only twenty years old.*

A particularly compelling case involves a woman serving a long sentence, who, after several years of incarceration, voluntarily supports her new cellmate, a recently arrived inmate with no knowledge of the Italian language. In the absence of adequate linguistic and cultural mediation services, this informal assistance becomes a lifeline, especially during medical appointments[16].

> *I had a Thai cellmate, really sweet! She has a name, of course, but we call her Thai because she's Thai, from Thailand! I used to say: "Thai, give this to the doctor" — I'd leave her a written note — "when the nurse passes, write down paracetamol or a medical visit". I did this with her because she told me a bit of her story […] She hit her head and couldn't go to the hospital, then she fell and hurt her leg. She walks okay, but you can see her knee doesn't bend like the other. Around August, a doctor examined her, and she called me because if I talk to her, she understands. She has difficulty understanding Italian, so the first time I went with her, the neurologist asked me: "Do you understand Thai?" I say no* [laughs]! *But she and I understand each other! So, I explained things to her… I feel useful in this way, and I do it willingly, I do it gladly because she needed it, and she learned if I'm with someone in a cell, what can I do? I can't not help them; it's absurd. Moreover, a foreign person, someone who makes you want to care for them!*

Thus, where possible, reciprocity provides incarcerated individuals with a vital support network. This network assists both with the practicalities of daily life -such as administrative tasks and mediation with the penitentiary administration and healthcare system- and with psychological well-being, serving as a source of serenity, decompression, and, to some extent, relief.

Concluding reflections

Untangling the complex interplay arising from the entanglement of "health" and "security," care and control, within the women's prison context is as stimulating as it is challenging. Indeed, it remains a necessary endeavor within a still underexplored field of study (Ronco, 2018).
While it may seem rhetorical, if not paradoxical, to ask whether care can genuinely exist within a carceral space- where control is totalizing (Goffman, 1961) and neglect or unsanitary conditions are often defining features- multiple perspectives exist from which to investigate the interstices

[16] However, these dynamic raises significant concerns regarding privacy protection and the actual effectiveness of communication and mediation, highlighting systemic shortcomings in the way institutional services interact with foreign detainees.

between care and control. This involves exploring the polysemic nature of care, as well as the porosity and multifaceted nature of control. Consequently, several questions arise: what kind of care is provided? Who are the main caregivers within the carceral field? How are competing languages, forms of knowledges, and interests negotiated in a context marked by profound power asymmetries? Furthermore, how do incarcerated populations interpret and enact care within the custodial space? Is there room for collective and horizontal forms of care? This exploratory study has sought to address these questions through observation and close engagement with incarcerated women. Since prison constitutes a privileged observatory for dynamics inherent to the broader social context (Castel, 2019), analysing medical and psychiatric care offers an opportunity to investigate issues that transcend the carceral setting — such as social health inequities, access to services for marginalized groups, the management of psychological distress including self-therapeutic practices, and the complex intersections between gender, healthcare institutions, and social control. The socioeconomic and historical-political context is a crucial driver of suffering and health inequities, which are thus integral to the etiology of disease. Socially and politically structured inequalities become embodied through diverse life trajectories; the iatrogenic effects of neoliberal societies manifest in unequal life expectancies across populations (Cardano, 2008). For those at the margins, this results in an inability to negotiate the terms of their own existence. As Verdolini (2022) suggests, it is vital to analyze the prison system as an integral component of an increasingly selective welfare state that marginalizes specific social groups (Tognetti Bordogna, 2016). In this climate of crisis, the carceral institution functions as a "buffer" or the failures of social services, effectively managing the "welfare of the undesirables" by containing and postponing the problems of social marginality. Ultimately, reflecting on the prison healthcare system opens horizons leading beyond prison walls-to the life contexts of individuals, local welfare and social assistance systems, primary care networks, but also to issues of border management, increasing poverty, and the exacerbation of social inequalities.

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