



Healthcare Accessibility of Incarcerated Women in Thailand

Kuntida Sriwichian^{a*}, Sila Tonboot^b and Supasit Pannarunothai^b

^aFaculty of Social Science, Naresuan University, Mueang, Phitsanulok 65000, Thailand

^bCentre for Health Equity Monitoring Foundation, Mueang, Phitsanulok 65000, Thailand

*Corresponding author. E-Mail address: ksriwichian@yahoo.com

Received: 14 November 2018; Accepted: 26 February 2019

Abstract

Female inmates are facing higher health risks than males due to physical conditions which cause them to live harder in limited space like in prison. Many articles pointed out that female inmates would have a higher chance of facing greater health sufferings in prison than male. In Thailand, the number of female prisoners reached forty thousand people and is ranked 5th highest rank in the world. Being a prisoner does not make a person less than human; therefore, their human rights shall not be deprived and must prevail. To lift the living standard for female inmates, the United Nations have adopted “the Bangkok Rules” after a prototype prison for women in Thailand has been tested. However, the accessibility to healthcare for female inmates still needs improvements because of high prisoner density. Lack of budget and limited resources also indicate that expanding or building new standard facilities are an unlikely solution. Rather than spending money, we may need to turn and look around what we have, and later develop medical wards that have sufficient resources, while merging the penitentiary’s isolated health care system with the national health services. A medical prison ward should start with the minimum standard requirements in regulating professional services needed, and have these initiated, rather than a mere memorandum of understanding between organizations.

Keywords: Healthcare Access, Incarcerated Women, Prison Health, Bangkok Rules, Prison Health Care Reform

Introduction

The status of being incarcerated conditionally limited female prisoners to protect themselves from various diseases, reaching medical supplies, as well as visiting doctors as needed. Nevertheless, the state of being incarcerated shall not limit their human rights to access health care at an equal standard as ordinary people. Human rights should not be violated in whatever circumstances as the World Health Organization (WHO) declared the fundamental human rights as “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (World Health Organization (WHO), 2006; Ghebreyesus, 2017). Recently, the views of the international community for Prisons in Thailand were unimpressive as a result of how we treated our female prisoners, for example, depriving women of essential health services (Supawatanakul, 2016), overcrowded facilities which lead to insufficient food and hygienic detention problems, and inadequate health care resources due to the high prisoners to medical staff ratio. According to several articles, it is widely accepted that female inmates are encountering greater sufferings than male inmates, since women tend to face higher mental illness as well as reproductive condition (Braithwaite et al., 2005; Black et al., 2007; Fazel and Seewald, 2012).

In 2018, the number of female prisoners was 45,933 in Thailand or 13.7 percent of its total prisoners. The figure was almost twice from the last 10 years (26,403 female prisoners), but the proportions to total prisoners remained stable at 13–15 percent (see table 1).

**Table 1** The Number of Female Prisoners in Thailand During this Decade

Year	Female Prisoners	Total Prisoners	% Female
2008	26,403	188,398	14.01%
2009	30,020	212,058	14.16%
2010	31,017	215,997	14.36%
2011	35,888	251,812	14.25%
2012	37,919	247,764	15.30%
2013	42,458	292,743	14.50%
2014	46,615	322,998	14.43%
2015	45,201	311,623	14.51%
2016	41,936	306,043	13.70%
2017	42,772	322,634	13.26%

The number of the female prisoners in Thailand was the fifth highest in the world after the United States of America, China, Russia, and Brazil (211 870, 107 131 plus an unknown number in pre-trial and administrative detention, 48 478, and 44 700, respectively, Walmsley, 2017). How a small country like Thailand is having such a high rate of female prisoners compared to the population of the first four countries is worth thinking. Overcrowded female prisons could aggravate the situation of the female inmates' living conditions (International Federation for Human Right (FIDH), 2017). The Central Women's Correctional Institution (CWCI) in Bangkok reported the prison's high occupancy rate of 187%, almost twice overcapacity, where the sleeping space for a female inmate was about 0.45 metre-width. Moreover, overcrowded prison also affected the adequacy of healthcare, sanitation, nutrition, and etc.

Healthcare program for female inmates in Thailand starts with a set of new entry medical examinations. If a major illness is detected, she will be referred to the prison's medical center and later returned to her original cell. In the case of severe illness, treatments rarely happen at the hospital outside the prison (Bing III and Albano, 2017). Receiving medical services at the hospital outside the prison requires 2 personnel to go with a patient (see figure 1; Health Administrative Department, 2016).

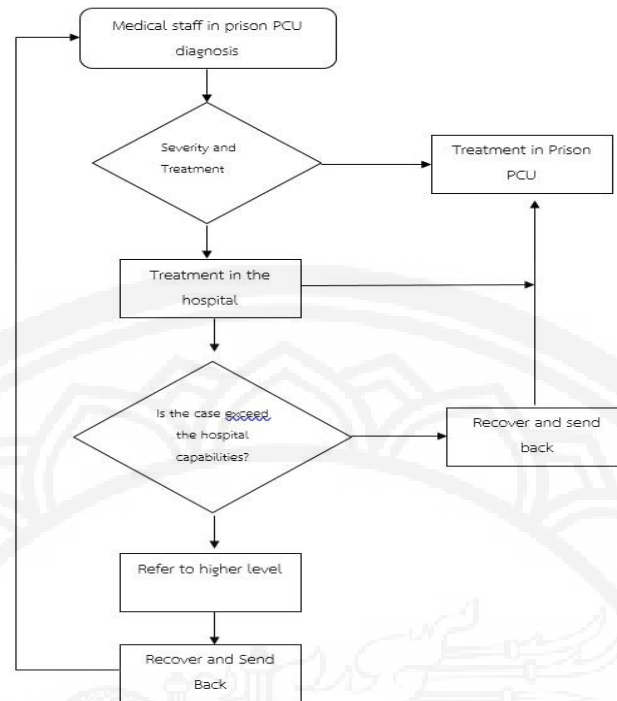


Figure 1 Illustration of Prison Patient Referral Process in Thailand

Despite reasonable standard operating procedures, many reports revealed that treatments in Thailand prison were insufficient and improper. Prachatai.com reported the overburdened and underfunded healthcare unit in Thai prison. Another report said, “Do not get sick in prison because you only get paracetamol to cure everything,” (Supawatanakul, 2016). The statement is in agreement with the United Nations Committee on the Elimination of All Forms of Discrimination against Women (CEDAW)’s report that CWCI is unable to provide adequate healthcare services. Its medical center has one nurse on duty (Parliament, 2017), doctors visit the center 2–3 times a week, and medical care is unavailable at night. Female prisoners face a long waiting period for treatment, and generally, paracetamol was prescribed to treat most ailments (International Federation for Human Right (FIDH), 2017).

In several prisons, there are only 3 medical workers in service for 4,000 to 8,000 prisoners (Bangkokbiznews, 2017). The Fédération Internationale Des Ligues Des Droits De L’Homme (FIDH) published their report which highlights the shortage of healthcare staff. The report further revealed the former prisoner’s quote that “The first thing I was told when I got there [to CWCI] was that I must not get sick because if I got sick, I’d be better off dead” (Fédération Internationale Des Ligues Des Droits De L’Homme, 2017) One of the reasons behind is because security officers must accompany a sick prisoner to the hospital. Facing with a prison staff shortage in all areas, this appeared to affect the decision-making on whether they should send an ill prisoner to the hospital now or later.

Suppose that a prisoner escaped during his referral process from prison to the hospital, or did not return to jail within 90 days, the administrative staff will face severe punishments such as a 2-year prison sentence (HFOCUS, 2018). On the other hand, it is not only a challenge of the department of correction to face its limited health resources, but prisons also must overcome the fake demands for health care services of its detainees. The length



of time spent in a similar condition such as of the prisoners' cell encourages them to over-demand health care services for a change of environment (Junthong, 2017).

Current Health Cooperation for Incarcerated Women

All those mentioned problems do not conclude that the prison administrators were unable to perceive them, rather these are issues which require proper and dynamic management. Since 2002, Thailand has activated a universal coverage health scheme which allows all Thai nationals to reach the government health service with an affordable 30 Baht a visit copayment. Prisoners are not exempted; thus the prison health services have been periodically developed from time to time. Managed by the National Health Security Office with shared responsibilities of the Ministry of Public Health and the Ministry of Justice, they established medical centres in the prisons. There are nurses and doctors in charge in few jails, but most prisons are regularly visited by doctors and nurses from the hospitals of the Ministry of Public Health. For cases which required complicated treatments, prisoners shall be referred to these hospitals.

In 2004, the Department of Disease Control (DDC), Ministry of Public Health launched the tuberculosis and HIV control plan in jails. This was later developed into a memorandum of understanding in 2011 between the DDC and the Department of Correction of the Ministry of Justice to monitor these health conditions in prisons.

In 2014, the committee of government health service accessibility for prisoners was set up at the Prime Minister's Office. A feasibility study on health policy of health service management system in prisons was handed to the cabinet in 2015. Subsequently, in 2016, the guideline of health service management system for prisoners has mobilized the cooperation of four government organizations, namely, the Ministry of Public Health, the Department of Correction, the National Health Security Office, and the National Human Rights Commission of Thailand. Specific policy recommendations for the Ministry of Public Health and the Department of Correction are shown in table 2. Unfortunately, after a year of the pilot project, health care accessibility of prisoners in Thailand (Singkasailit, 2016) faced impracticability from its policy to legal framework of health service management for prisoners, especially the risk of referring a prisoner to the hospital which is too high for the prisoner's staff to take.

Table 2 Recommendations for the Ministry of Public Health and the Department of Correction

Ministry of Public Health	Department of Correction
1. The local hospital in the area near the prison should provide enough medical services and resources. In case of limited hospital capabilities, the hospital may acquire services from private sectors within its allocated budget.	1. Provide joint services when referring prisoner to the hospital
2. The hospital in the area shall reach the minimum requirements to secure inpatient bed for prisoners referred from prison as well as arranging places for the prison's staff.	2. Fast-track the services for prisoners and security staff when receiving hospital services
3. The hospital in the area should be able to get capitation subsidy from the NHSO to provide service to the inmates in prison.	3. Facilitate database linkage between prisoner's records and NHSO's database
	4. Provide a video conference to consult with specialist doctors
	5. Create an emergency service system in prison
	6. Self-monitor prisoners with illness and mental disorder

Bangkok Rules and Prison Reform in Thailand

Thailand was remarkable in having the United Nations General Assembly adopted the Bangkok Rules as a crucial tool to upgrade the health treatments for women in prison (United Nations Office on Drugs and Crime (UNODC), 2011; The Economic and Social Council, 2010). The UN attempted to encourage its member states "to adopt the legislation to establish alternatives to imprisonment and to give priority to the financing of such



systems, as well as to the development of the mechanisms needed for their implementation” (United Nations Office on Drugs and Crime (UNODC), 2011; The Economic and Social Council, 2010). The Bangkok Rules mainly focus on providing appropriate health care, treating women humanely, preserving dignity during searches, violence protection, and the prisoners’ children protection.

In Thailand, the implementation of the Bangkok Rules negatively urged the social interaction and treatment standard for women in prison from various causes. It started from 10 prototype prisons, but only 6 were qualified for evaluation in 2017 (Uthaitani prison, Chiang Mai Women Correction Institution, Ayuthaya Provincial prison, Chonburi Women Correction Institution, Sumut Songkram Central prison, and Correctional Institution for Female Drug Addicts). Consequently, eight years after adoption, the implementation of the Bangkok Rules in Thailand has radically changed the quality of life of incarcerated women. These penitentiaries arranged spaces for pregnant inmates, infrastructure environment, inspiration supports, and skill developments. However, health system access issues are yet to improve in many areas such as health resource shortage, policy and regulation problem, and overcrowded prison similar to the implementation abroad (Junlakan et al., 2013; Cerezo, 2016; Cheng and Nesossi, 2018).

Lesson to be Learnt from Developed Countries

The prisons in developed countries are also facing somewhat same situations as in Thailand. There were problems of access to medical examinations, pharmacotherapy, acute care, recidivism, and etc. (Bales et al., 2005; Wilper et al., 2009; Ahmed et al., 2016). Many countries attempted to develop a protocol to persuade nations to pay more attention to the female prisoners and their health. And even though the minimum standard has been set out, following the guidelines were difficult within the shortage of resources (Enggist et al., 2014).

The European Prison Rules is the primary term for members of the Council of Europe and WHO Health in Prisons Project. The latest version adopted on 11 January 2006 states that “every prison is recommended to have the services of at least one qualified general medical practitioner and to have another personnel suitably trained in health care.” This policy ensures that prisoners have access to quality and appropriate health care by providing close links between prison-administered health services and public health to avoid “professional isolation” (Møller et al., 2007; Enggist et al., 2014). The close link, in this sense, suggested that “prison health should be part of the general health services of the country rather than a specialist service under the government ministry responsible for the prisons” which various countries in Europe have started long ago; Norway (1980s), France (1994), and United Kingdom (2002) (Hayton and Boyington, 2006; Enggist et al., 2014). This close relationship among workers in the prison and public health staffs get rid of the obstacles, wrong understanding, and attitudes about the prison viewed as the black box system (Colwel, 2017).

In England, health care personnel (some prison officers with medical training), nursing staff, and medical officers are directly hired as full-time employees by its prison. The prison arranges medical services by contracting general practitioners, dentist, pharmacists, and specialists to its facilities. In most prisons, they also have their in-patient facilities for staff to work where they perform the medical examination at the entry and before the release of prisoners, and medical reports for legal purposes. Moreover, it has been reported that prisoners consulted primary care doctors three (3) times and health care workers about 80 to 200 times a year more frequently than people in the community (Marshall et al., 2000).

In France (Dubois et al., 2017), the general package of the ordinary health system included the model of health security for prisoners. Prisoners are automatically registered in the Primary Fund Health Insurance,

the primary care service provided by Unites de Soins en Milieu Penitentiaire (USMP) managed by the hospital in the area. The associated hospital will set up the primary care unit in prison, while the second line of treatment will be delivered at an associated hospital. As a result, there were 55,000 medical services performed annually. The medical teams included general practitioners (both external and internal doctors), medical specialists, dental surgeons and pharmacists. There were also para-medical teams composed of physiotherapists, nurses, radiology technicians, and medico-social professionals. It was clear that the team need not permanently work there, but rather having high mobility. The standard requirement of human resource for the prison in France is 3.4 GP, 0.5 specialists, 3.2 psychologists, 14.8 nurses, 7.7 psychiatric nurses, 1.6 dentists, 0.4 physiotherapists for 1,000 prisoners (Dubois et al., 2017).

In Scotland (Dubois et al., 2017), healthcare service for prisoners was transferred to the National Health Service (NHS) in 2011. The NHS employed its human resources in prisons for both independent contractors and salary-based workers. In HMP Barlinnie prison, there were 24 nurses, 3 full-time equivalent (FTE) mental health nurses, 0.2 FTE dual diagnosis nurses, 9 addiction nurses, 4 trained staff, 2 Blood Borne Viruses (BBV) specialists, 1 nurse in learning disability, 1 infection control nurse, 4 healthcare assistants, and 3 administrators. However, it was not clear whether other prisons have the same package.

Switzerland (Dubois et al., 2017) has multiple models implemented in different prisons depending on the responsible organization. The facilities of the prisons were set enough for emergency and primary care. For further treatment, the second line of medical care is available at the hospitals. Compared to Thailand, the number of detainees to medical staff ration is quite a contrast. Table 2 shows the number of detainees, GPs, psychiatrists, and other medical practitioners in Switzerland penitentiaries.

Table 3 Models of Prison and Health Staff Information

	Poschwies Prison Zurich	Solothurn Prison	Alstaten Prison
Number of Establishments	1	3	1
Number of Detainees	450	180	40–50
Number of GPs	3 (200%) 2 dentists (80 %)	3 (currently, 1 part-time / establishment: consultation and emergencies)	1 part-time (consultations and emergencies)
Number of Psychiatrists	Inside service of psychiatry and psychology	3 part-time for all establishments	1 part-time
Number of Nurses	/	10 (840%)	1
Number of Medical Assistants	5 (430%)	/	1 part-time
Presence of Medical Services	24 hours/24, 365days/year (with post service)	7 days / 7	During the week from 7 am.to 16.30 pm.

Here is an example data of a prisoner's accessibility to services and seeking consultations. The prisoners in Canton Voud receive GP consultations averaging 2.5 times a year, 11.6 times for nurse consultations, and 2.7 times for psychiatrist consultations. Moreover, chronic somatic or psychiatric health consultation with GP is at 3.3 times, 16.8 times for nurses, and 4.6 times for psychiatrists (Moschetti et al., 2017).



Discussion

The key point of healthcare access for prisoners is about its population management which seemed to be an unreachable goal since it is impossible to relief the prisoner's density. Expanding the capacity of the prison also required a more substantial budget spending. With the high-density condition and health personnel ratio, the medical team in prison must subdue a higher workload. The only way to assist them is to get a medical team outside the prison.

The policy recommendation for the Ministry of Public Health in the literature indicated that hospitals in the area should organize regular doctor visits to prison. These visits are a cooperation arrangement rather than a regulation of the hospitals to follow. A monthly doctor visit seemed to be possible as some prisons have 2–3 times visit per week, whereas, other prisons are barely visited once every 3 months. Having doctors visit the prison is useless if the equipment is insufficient for them to work. To gear up the health service access, setting up a medical ward in prison can be a key model to implement at the national level. The Songkhla model is an excellent example of how to set up a medical ward in the central prison of a province. The Songkhla hospital supports the medical ward in Songkhla Central prison to reduce transferring prisoners to the hospital. The model includes 4 prisons in the area of 11,000 prisoners and a medical ward composed of a doctor, 2 pharmacists, 2 nurses and a computer technician who links the computer system to the hospital network. Since the program has started, the number of illnesses reported has decreased as well as the hospital referral rate. The same report remarked that the doctor, although voluntarily worked for the prisoners, has no desire to visit the prison if there are risks in security.

Both providers and purchasers of health security system in Thailand shall not be separated from each other, but the health policy for prisoners is in limbo. The only Medical Correction hospital in Thailand is under the Department of Correction of the Ministry of Justice. This isolation implies that the medical personnel of the regular hospitals and the Medical Correction hospital are not associated and have been working separately from each other. Since the Medical Correction hospital is unable to set up its services in the regional prisons, merging its system with the provincial hospitals would easily overcome the lack of health care resources in the prison especially when they are of the same regulatory body.

Conclusion and Suggestions

In this article, we try to emphasize the indispensability of the health service system and its accessibility among the incarcerated women in Thailand. We pointed out that the women in prison were left behind from the society and suppressed with their rights to having appropriated health. Being a prisoner might be a life with limitation but ruining a female inmates' health shall not be included in her sentence. Since the United Nations adopted the Bangkok Rules, its implementations in Thailand draw interest among local and international women's organizations and society. Selected prisons were upgraded and evaluated according to the Bangkok Rules 'criteria, but in most jails, accessibility to health services for female inmates did not improve. There were not enough Correction Hospitals, healthcare professionals, and medical equipment in prison. Moreover, investing in correctional healthcare facilities and infrastructures require a significant fund allocation.

As we looked into the health services in developed countries, we found out that a single organization regulated the health services in their prisons and the community. The ministry of health in the countries examined are directly engaged with the medical teams in its prison. Neither cooperation between related departments, as introduced in



Thailand, nor having a memorandum of understanding between different ministries were essential in these countries. Locally, we recognized Songkla's Model of setting up a medical ward in its provincial prison as a more cost-effective alternative than setting up a regional correctional hospital. To avoid professional isolation, this paper recommends a closer relationship between general and prison health systems personnel. And finally, the provision of the Bangkok Rules should be enacted legislation in order to have successful health care service development in prison in the long term.

References

- Ahmed, R., Angel, C., Martel, R., Pyne, D., & Keenan, L. (2016). Access to Healthcare Services During Incarceration Among Female Inmates. *International Journal of Prisoner Health*, 12(4), 204–215. <https://doi.org/10.1108/IJPH-04-2016-0009>
- Bales, W. D., Bedard, L. E., Quinn, S. T., Ensley, D. T., & Holley, G. P. (2005). Recidivism of Public and Private State Prison Inmates in Florida. *Criminology & Public Policy*, 4(1), 57–82. <https://doi.org/10.1111/j.1745-9133.2005.00006.x>
- Bangkokbiznews. (2017, December 27). Female Nurses in Male Prison...Her. *Bankokbiznews*. Retrieved from <http://www.bangkokbiznews.com/news/detail/786611>
- Bing III, R. L., & Albano, B. (2017). Thailand, Corrections in. In *The Encyclopedia of Corrections*. Retrieved from <https://onlinelibrary.wiley.com/doi/10.1002/9781118845387.wbeoc099>
- Black, D. W., Gunter, T., Allen, J., Blum, N., Arndt, S., Wenman, G., & Sieleni, B. (2007). Borderline Personality Disorder in Male and Female Offenders Newly Committed to Prison. *Comprehensive Psychiatry*, 48(5), 400–405. Retrieved from <https://pdfs.semanticscholar.org/d7e1/d7bcf67a6bd31ad20e458a1869b3557356e3.pdf>
- Braithwaite, R. L., Treadwell, H. M., & Arriola, K. R. J. (2005). Health Disparities and Incarcerated Women: A Population Ignored. *American Journal of Public Health*, 95(10), 1679–1681. DOI: 10.2105/AJPH.2005.065375
- Cerezo, A. I. (2016). Women in Prison in Spain: The Implementation of Bangkok Rules to the Spanish Prison Legislation. *European Journal on Criminal Policy and Research*, 23(2), 133–151. Retrieved from https://www.uma.es/instituto-andaluz-de-criminologia/navegador_de_ficheros/publicaciones-/descargar/women-prison-Spain.pdf
- Cheng, L., & Nesossi, E. (2018). Women Detention and Incarceration in China: The 2010 Bangkok Rules, Domestic Humanitarian Values, and Legal-Political Priorities. *The Chinese Journal of Comparative Law*, 6(1), 50–72. <https://doi.org/10.1093/cjcl/cxy003>
- Colwel, J. (2017). *Caring for Prisoners*. Retrieved from <https://acphospitalist.org/archives/2017/10/caring-for-prisoners.htm>



Dubois, C., Linchet, S., Mahieu, C., Reynaert, J-F., & Seron, P. (2017). Organization Models of Health Care Services in Prisons in Four Countries. In *Health Services Research (HSR)*. Brussels, Belgium: Belgian Health Care Knowledge Centre (KCE). Retrieved from https://kce.fgov.be/sites/default/files/atoms/files/KCE_293_Prisons_health_care_Chapter_4.pdf

Enggist, S., Møller, L., Galea, G., & Udesen, C. (2014). *Prisons and Health*. Copenhagen, Denmark: WHO Regional Office for Europe. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

Fazel, S., & Seewald, K. (2012). Severe Mental Illness in 33 588 Prisoners Worldwide: Systematic Review and Meta-Regression Analysis. *The British Journal of Psychiatry*, 200(5), 364–373. DOI: 10.1192/bjp.bp.111.096370

Fédération Internationale Des Ligues Des Droits De L'Homme. (2017). *Behind the Walls: A Look at Conditions in Thailand's Prisons after the Coup*. Retrieved from https://www.fidh.org/IMG/pdf/rapport_thailand_688a_web.pdf

Ghebreyesus, T. A. (2017, December 10). Health is a Fundamental Human Right. In *Human Rights Day 2017 [Statement]*. Retrieved from <http://www.who.int/mediacentre/news/statements/fundamental-human-right/en/>

Hayton, P., & Boyington, J. (2006). Prisons and Health Reforms in England and Wales. *American Journal of Public Health*, 96(10), 1730–1733. DOI: 10.2105/AJPH.2004.056127

Health Administrative Department. (2016). *The Guidline of Prisoner Healthcare Service System Development in the Prison*. Bangkok, Thailand: Borntobe Publishing. Retrieved from https://drive.google.com/file/d/1aEHjf0MSa9ahqIXq4tl0U1f0Rob_aiAf/view

HFOCUS. (2018). *Songkhla Model the Prototype of Health System Managment for Prisoners*. Retrieved from <https://www.hfocus.org/content/2018/09/16269>

International Federation for Human Right (FIDH). (2017). Female Inmates: Discrimination Behind Bars. In *United Nations Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) 67th Session, 5 July 2017, Thailand*. Retrieved from https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/THA/INT_CEDAW_NGO_THA_27718_E.pdf

Junlakan, L. D., Boriboonthana, Y., & Sangkhanate, A. (2013). Contemporary Crime and Punishment in Thailand. In J. Liu, B. Heberton, & S. Jou (Eds.), *Handbook of Asian Criminology* (pp. 309–326). New York, NY: Springer.

Junthong, E. (2017, December 23). World of Prisoner; the 3 Heavens in Prison. *Post Today*. Retrieved from <https://www.posttoday.com/politic/report/531864>



Marshall, T., Simpson, S., & Stevens, A. (2000). *Health Care in Prisons: A Health Care Needs Assessment*. Edgbaston, Birmingham: Department of Public Health & Epidemiology, Public Health Building, University of Birmingham. Retrieved from <https://insight.oxfordshire.gov.uk/cms/system/files/documents/Health%20care%20in%20prisons.pdf>

Møller, L., Gatherer, A., Jürgens, R., Stöver, H., & Nikogosian, H. (2007). *Health in Prisons: A WHO Guide to the Essentials in Prison Health*. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf

Moschetti, K., Zabrodina, V., Stadelmann, P., Wangmo, T., Holly, A., Wasserfallen, J-B., Elger, B. S., & Gravier, B. (2017). Exploring Differences in Healthcare Utilization of Prisoners in the Canton of Vaud, Switzerland. *PloS One*, 12(10), e0187255. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0187255>

Parliament. (2017). *Correction Act, B.E. 2560. Government: 24*. Retrieved from http://library2.parliament.go.th/giventake/content_nla2557/law21-180260-1.pdf

Singkasailit, W. (2016). *Meeting Results: Annual Meeting of Practical Seminar with Medical Staffs 2016*. Retrieved from http://www.correct.go.th/meds/index/Download/34446_59.pdf

Supawatanakul, K. (2016, December 14). Women Inmates: Lives without Dignity in Thailand's Female Prisons. *Prachatai English*. Retrieved from <https://prachatai.com/english/node/6773>

The Economic and Social Council. (2010). *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules)*. Retrieved from <http://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf>

United Nations Office on Drugs and Crime (UNODC). (2011). United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders with their Commentary. In *The Bangkok Rules*. Retrieved from https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf

Walmsley, R. (2017, November 9). *World Female Imprisonment List* (4th ed.). Retrieved from <http://www.prisonstudies.org/news/world-female-imprisonment-list-fourth-edition>

Wilper, A. P., Woolhandler, S., Boyd, J. W., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). The Health and Health Care of US Prisoners: Results of a Nationwide Survey. *American Journal of Public Health*, 99(4), 666-672.

World Health Organization (WHO). (2006, October). *Constitution of the World Health Organization* (45th ed.). Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf