



## IMPRISONMENT AND HEALTH: ISSUES AND CONCERNS

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**Abstract:** *Prison health is an inevitable part of public health as there is intensive interaction between prisons and society. Prisoners do not represent a homogeneous segment of society. Many have lived at the margins of society, are poorly educated and come from socio-economically disadvantaged groups. They often have unhealthy lifestyles and addictions such as alcoholism, smoking and drug use, which contribute to poor general health and put them at risk of disease. The prevalence of mental health problems is very high and some prisoners are seriously mentally ill and should be in psychiatric facility rather than in prison. The rise in prison population has resulted in overcrowding and communicable diseases, such as HIV and Tuberculosis are more prevalent in prisons than in the community. Many prisoners have had no contact, or very limited contact, with health services in the community before they were detained in prison. The situation is further more pathetic among women prisoners. Women who enter prison usually come from marginalized and disadvantaged backgrounds and are often characterized by histories of violence, physical and sexual abuse. In comparison to their free world female and incarcerated male counterparts, female prisoners suffer more frequent and serious diseases and injuries and tend to place a greater demand on the prison health service than men do. Health care in women prisons received little attention because female prisoners are a small percentage. Correctional institutions have struggled to provide adequate health care to women prisoners; however, a close look at the needs of women in prison and related health aspects raises issues of gender insensitivity and inequity, of human rights neglect and general lack of public health concern. Prisoners are from our community and they return to our community. Rehabilitation of prisoners is one of the most important goals of incarceration and the correctional system might be the last best chance of change and improvement. The period of incarceration no matter how long or short provides the window of opportunity to improve the health care of prisoners as well as to arrange for follow-up in the community upon their release. Access to, as well as quality of, health services in prison is of vital importance. The present paper thus attempts to increase the visibility of health status and access to health care of prisoners in general and women prisoners in particular. Addressing health in prisons is essential in any public health initiative that aims to improve overall public health.*

**Keywords:** *Prisons, Diseases, Medical Facilities, Incarcerated Females, Passive Victims, Secondary Effects.*

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Within a range of punishments meted out historically by societies' penal systems, the 'modern' prison, a punishment carefully deliberated and proportionately measured for different offences, emerges as the most prevalent and also the most problematic. It is intended to improve people but it generally makes them worse. Prison does not stop people continuing to commit the acts that caused them to go there in the first place. It is also very ineffective in reducing crime rate. Prison is also a place with great potential for human rights abuses. Article 10 of the International Covenant on Civil and Political Rights says: *"All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person"* Yet, in the prisons of the world humanity and respect in the treatment of prisoners are the exception rather than the rule. The UN Special Rapporteur on Torture visited Russia in July 1994 to establish whether the conditions in the pre-trial prisons could be regarded as torture, he said after a visit to two such prisons in Moscow: *"the Special Rapporteur would need the poetic skills of a Dante or the artistic skills of a Bosch adequately to describe the infernal conditions he found in these cells."* (Stern: 2000:420).

Speaking to a committee of the Russian parliament, the Duma, in 1994, General Uri I. Kalinin, head of the Penitentiary Department of the Russian Ministry of the Interior, said: *"I have to confess that sometimes official reports on prisoners' deaths do not convey the real facts. In reality, prisoners die from overcrowding, lack of oxygen and poor prison conditions.... Cases of death from lack of oxygen took place in almost all large pre trial detention centres in Russia. The critical situation in SIZOs (pre trial prisons) is deteriorating day by day: the prison population grows on average by 3500-4000 inmates a month"* (Stern: 2000: 420-21). So, prison is a penalty with many disadvantages. In developing countries these disadvantages are compounded. Prisons are for them an expensive colonial legacy. It is disastrous to take a large group of people, render them totally unproductive and then have to feed, clothe and care for them. All this amounts to a huge burden on scarce resources. For many with bad sewerage problems, infestation, no doctors, no medicines, little water and acute overcrowding, a prison sentence can be a death sentence. Prisons are places where the discrimination of the outside society shows itself starkly. All around the world prisons are full of the poor, the unemployed, the disadvantaged and the mentally ill.



For many poor and minority men being sent to prison is just one of the social and economic injustices they can expect to face in their lives. (Stern: 2000)

In India prison constitute the largest area of penal administration. According to Prison Statistics, 2012, there are about 1304 prisons which house much more than their actual capacity ([http://ncrb.nic.in/PSI-2012/Snapshots\\_2012\\_ver\\_%206.pdf](http://ncrb.nic.in/PSI-2012/Snapshots_2012_ver_%206.pdf)). Prisons continue to be located and structured more or less as they were in colonial times, and any change that has been made has been incorporated somewhat clumsily into the old system that basically served the triple colonial aims of order, economy and efficiency. An analysis of criminal justice statistics would show that a vast majority of the prison population consists of undertrials. In fact, their proportion has increased rapidly over the years. In the absence of separate institutions for undertrial prisoners, these ever increasing numbers have been largely responsible for the deteriorating conditions within prison. Most prisons are still housed in dilapidated buildings and outmoded structures. The traditional architecture provides for bare minimum facilities for human existence. The environment that the prisoners are invariably subjected to is not only dreary, dull and depressing, but also non-functional from the viewpoint of the modern concepts of an individualized correctional treatment (Singh: 2000).

The protection of the basic human rights that prisoners are entitled to has emerged as the most vital aspect of prison reform.

In his most famous work, *The State of Prisons in England and Wales*, the 18<sup>th</sup> century prison reformer, John Howard, discussed the then newly passed *Act for Preserving the Health of Prisoners in Gaol, and preventing the Gaol Distemper*. Enacted in 1774, the Act was the first Parliamentary legislation in Britain to specifically address health in prisons. It was thus one of the earliest pieces of such legislation in Europe, if not the world. The principles enshrined in this more than 230 years old law are notable for their relevance to a contemporary examination of the right to health of prisoners. More than two centuries later, the principles outlined in the Act continue to form the framework of state obligations in international law to safeguard the health of prisoners. In the 200 years since the Act defined proper standards of medical care for prisoners in English jails, a comprehensive international legal framework has developed guaranteeing the right to health of all persons deprived of their liberty worldwide. However, the emergence of this international human



rights regime has no more resolved the global problem of prison health than the Parliamentary legislation in 18<sup>th</sup> century England assured prisoners of proper medical treatment and living conditions. The UN Committee of Economic, Social and Cultural Rights, the independent expert body which monitors state compliance with the obligations under the International Covenant on Economic, Social and Cultural Rights has stated, “*health is a fundamental human right indispensable from the exercise of other human rights*”. On this basis, the health status of prisoners is a measure to assess the degree to which the rights of persons in detention are fulfilled or denied in a much broader sense ([http://www.ahrn.net/library\\_upload/uploadfile/file3102.pdf](http://www.ahrn.net/library_upload/uploadfile/file3102.pdf)). Principle 9 of the UN Basic Principles for the treatment of prisoners provides that prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation. Rule 26 of the Standard Minimum Rules requires that amongst others, the Medical Officer shall regularly inspect the quantity, quality, preparation and service of food and the hygiene and cleanliness of the institution and the prisoners (<http://www.humanrightsinitiative.org/artres/Health%20in%20Prisons.pdf>). Close to home, the Indian Prison Act of 1894 lays down certain legal provisions to ensure that health aspects of prisoners are considered. It becomes mandatory under this law to have a hospital or proper place for the reception of sick prisoners at every jail. There is also supposed to be a Medical Officer in every jail who shall have charge of the sanitary administrations of the prison. The Act also specifies that any prisoner who is ill, wanting medical attention will be immediately shown to a doctor (<http://www.humanrightsinitiative.org/artres/Health%20in%20Prisons.pdf>). Once a person is in official custody, his health and well being becomes the absolute responsibility of the state. Factors such as lack of supervisory controls, funds, medicines or doctors would not be held responsible for any failure to discharge this responsibility. Keeping this fact in view, very elaborate rules have been framed in the Jail Manuals, police regulations and other rules for medical checkup at the time of reception and during the custody of the persons under detention. These have been supplemented by judicial decisional laws handed down by the Apex Court. The Supreme Court of India in its judgment in Parmanand Katara vs Union of India (1989) ruled that the state has an obligation to preserve life of every person whether he is innocent or a criminal liable to be punished under the law (Tripathi: 2009).



In reviewing international data on prison health, one can only conclude that the denial of the fundamental human rights of people in prison, including the right to health, is occurring on a global scale. For example, the rate of Tuberculosis (TB) infection among incarcerated populations is as much as one hundred times higher than that found outside of prisons and in many countries is one of the leading causes of mortality among prisoners. According to Dr. Jaap Veer, *“there is clear relation between TB and poverty, no wonder that TB in prisons is generally more prevalent than in civil society in general”*. Within prisons, the risk of the spread of TB is heightened by poor overcrowded prison conditions, illustrating the important relationship between environment conditions in prison and the health status of prisoners. Inadequate medical infrastructure or inconsistent access to medications heightens the risk of developing multi-drug resistant strains of TB within prison populations. As a result, multi-drug resistant TB is common in the prison system of both high-income and low-income countries. The multi-drug resistant strains of the disease, which are only treatable with expensive second-line TB therapies whose availability is strictly controlled and which require as much as two years continuous administration, pose an increased risk of illness, or even death, to prisoners and prison staff, as well as to the population outside of prisons. But TB is just one example of health problems that are magnified within the prison environment. According to the WHO, prisons are places where two of the greatest public health problems facing all societies overlap, the epidemic of HIV/AIDS and the harmful use of psychotropic substances such as alcohol and illegal drugs. In many countries, this intersection fuels very high rates of blood-borne diseases, such as HIV and hepatitis C, among prisoners who share equipment such as needles or syringes to inject drugs. As a result, rates of HIV and hepatitis C infection are significantly higher among prison population than in the community outside of prisons. High rates of HIV and other infectious diseases in prisons can lead to alarmingly high rates of mortality among prisoners. ([http://www.ahrn.net/library\\_upload/uploadfile/file3102.pdf](http://www.ahrn.net/library_upload/uploadfile/file3102.pdf))

Developing countries like India face challenges of both communicable diseases as well as non-communicable diseases. Both the type of diseases adds not only to mortality but also morbidity in society. A study conducted in Nagpur to investigate the cause of deaths of people in custody from the year 2000 to 2004 indicated that tuberculosis contributed to 30% of the total deaths followed by ischaemic heart disease 17%. Furthermore, 7.14% of



inmates had anaemia and 5.71% had hypertension. Another similar study from Maharashtra prisons reported that tuberculosis related deaths were maximum at 52% followed by coronary artery disease. Data from the Central Prison, Bangalore, reported 17 deaths in 2006, 22 deaths in 2007, 38 deaths in 2008 and 29 deaths in 2009. Analysis of the 38 deaths in 2008 indicates HIV as the cause in 26%, cardiac causes in 23%, cancer in 17% and TB in 9% (<http://www.academia.edu/1185394/2>. PRISON AND HEALTH). In a study conducted in Madhya Pradesh it was reported that medical facilities in most of the 109 jails of the state were in a state of disarray. There was a severe dearth of medical personnel, which not only includes doctors but also laboratory technicians and operators. In many jails the equipment was lying completely unused as there was no paramedical staff available to run them. In such jails all over the state, government doctors are appointed on a part-time basis with a remuneration of only Rs. 175 per month for holding additional charge of prisons, which proves to be discouraging and hence they are unwilling to work. Police escorts to refer ill prisoners to outside hospitals were very insufficient. This is evident from the fact that in 2002 only 2968 police personnel were provided against a requirement of 12,726 escorts. This serious shortage means that timely medical treatment is most often an exception rather than the rule. In most jails there are no vehicles to transport prisoners to hospitals during exigencies. Tuberculosis was rampant and accounted for approximately 40% of deaths in the jails of the state. However, there were no TB specialists and hence diagnosis of the disease became difficult. Other major diseases afflicting the prisoners were anaemia, dysentery, skin diseases and respiratory problems (<http://www.humanrightsinitiative.org/artres/Health%20in%20Prisons.pdf>). In yet another study conducted on the inmates of Tihar Jail, New Delhi, male respondents admitted having sex with men and that they were sexually active in the prison also. One such respondent was drug addict and had sex with multiple 'same sex' partners (inside the prison) as barter for his favourite drugs. The data clearly brings out that sexual activity goes on even in the regimented set up of the prison. Due to fear and humiliation, it is not easy to obtain exact statistics regarding sexual activities but both the consensual and non-consensual sex is quite evident among prisoners. An inmate reported that sexual assault or forced sex is a reality of the prison life and so is the fear of forced sex. Often it is cruel and violent in nature and consequently increases the chances of HIV transmission. However, prison administration



does not accept that there exists homosexuality in the jail and as such there are no specific policies to address the problem. This is also perhaps to avoid any legal implications as homosexuality is prohibited under Section 377 of IPC. On the other hand, first hand information gathered from inmates reveals that homosexuality does exist in jail, whether jail authorities acknowledge it or not. Essential HIV/AIDS interventions do not exist and no confidentiality is maintained with regard to the inmates testing HIV positive. (Dr. Dasi & Bist: 2013)

In a workshop on 'Prisons and Human Rights' organized at Bhopal by the Commonwealth Human Rights Initiative (CHRI) in collaboration with the Madhya Pradesh Human Rights Commission (MPHRC), the problems relating to the health of prisoners and lack of adequate medical facilities in Indian prisons received considerable attention. Reference was made to a study of custodial deaths carried out by the National Human Rights Commission, which revealed that a high percentage of deaths were attributable to the incidence of tuberculosis among prisoners. In recent times, there has also been a disturbing rise in the percentage of HIV positive inmates. Inmates have to live in extremely unhygienic conditions, with little concern for health or privacy. Most toilets are open, denying the prisoner his basic right to privacy and human dignity and are also dirty. Water shortage being the rule than the exception the toilets prove to be the ideal breeding grounds for health hazards and epidemics. There is often little provision for support from family or friends and the prisoner is solely dependent on his custodians to provide him adequate medical facilities. Quite often the prison authorities do not take this responsibility as seriously as they should. Medical checks are routine and complaints of ill-health are not attended to urgently. This brings the systemic problems to surface. The sanctioned strength of doctors and paramedical staff in many prisons is much less than what is required. The shortage of staff was highlighted by the fact that Jabalpur jail in M.P. was sanctioned strength of three doctors way back in 1956 when the number of inmates in that prison was only 550 to 600. Even when the prison population increased to about 4000, the number of doctors remains the same. Even in a high profile jail like Tihar, in 1995, out of the seventeen sanctioned posts of medical officers, only six were occupied. Out of these six, two were always on leave. Therefore, for a prison population of 9000 inmates only four medical officers were available, of which three worked during the day and one at night. Non-availability of



adequate medical facilities for prisoners is largely due to the lack of full time doctors as well as lack of basic infrastructure, like well equipped ambulances, stretchers, dispensaries, hospital beds etc. sometimes, the prisoner may need expert and urgent medical attention which is not available within the jail premises. The *Mulaizha*, which is the first medical examination of the individual when he is admitted to the prison, should be detailed and thorough but generally it is regarded as a mere routine and done perfunctorily. ([http://www.humanrightsinitiative.org/publications/prisons/bhopal\\_98\\_workshop\\_report.doc](http://www.humanrightsinitiative.org/publications/prisons/bhopal_98_workshop_report.doc).)

In addition to the infectious diseases, mental health in prison is a growing international concern. The UN Special Rapporteur on the Highest Attainable Standard of Health, who is appointed by the UN Human Rights Council to report on the status of the right to health around the world has expressed concern that people with mental health problems are often *“misdirected towards prison rather than appropriate mental health care or support services”*, creating a disproportionately high rate of mental illness within penal institutions. In Europe, the WHO estimates that as many as 40% of prisoners suffer from some form of mental illness and as a result are up to seven times more likely to commit suicide than are people outside of prisons. The Special Rapporteur has noted that although poor prison conditions *“tend to exacerbate mental disabilities --- there is often little access to even rudimentary mental health care and support services”*. Prisoners with mental illness are also vulnerable to violence ([http://www.ahrn.net/library\\_upload/uploadfile/file3102.pdf](http://www.ahrn.net/library_upload/uploadfile/file3102.pdf)). The National Commission on Correctional Health Care in the US found that on any given day, between 2% and 4% of inmates in state prisons was estimated to have Schizophrenia and between 2% and 4% were estimated to have a manic episode. Between 13% and 18% of prisoners were estimated to have experienced a major depressive episode during their life time. Available data indicates that the prevalence of mental illness in prison settings is significantly higher than the prevalence in the general population and it is approximately 3 – 6 times higher than the general population. Secondly, substance use disorders (alcohol, nicotine, cannabis, cocaine and other drugs) are the most frequently diagnosed condition and thirdly, the other commonly occurring mental disorders are depression, anxiety disorders, personality disorders and psychosis. However, there is paucity of data regarding the mental morbidity in prisons from the Indian subcontinent. To explore the mental health morbidity in Indian prisons, a study was undertaken by National Institute of Mental Health





Neurosciences, Bangalore, in the Central Prison Bangalore in collaboration with Prison Department, Karnataka (2011). The study reported that a large part of the mental morbidity is contributed by substance abuse and its related consequences. 67.3% of the prison population reported ever using (lifetime) tobacco in some form in their lives and 43.5% of resident prisoners fulfilled diagnostic criteria for lifetime alcohol dependence and 14% for current alcohol dependence. After excluding substance abuse 27.6% prisoners had a diagnosable mental disorder. 2.2% of the prison population had a diagnosis of psychosis, primarily Schizophrenia. This was twice that of the general population. Despite increasing evidence that addiction/substance use is a treatable disease of the brain, most individuals do not receive treatment. Involvement in the criminal justice system often results from illegal drug-seeking behavior, intoxication related violence, and participation in illegal activities. Treating these substance using offenders provides a unique opportunity to decrease substance abuse and reduce associated criminal behavior (<http://www.academia.edu/1185394/2>. PRISON AND HEALTH).

Factors in prisons that may adversely affect mental health include overcrowding, dirty and depressing environments, poor food, inadequate health care, physical or verbal aggression. Lack of purposeful activity, lack of privacy, lack of opportunities for quiet relaxation and reflection aggravate mental distress. The availability of illicit drugs can compound emotional and behavioural problems in prison. Reactions of guilt or shame, anxiety of being separated from family and friends and worries about the future also compound such mental distress. Timely identification, treatment and rehabilitation are almost non-existent in many prisons, particularly in the developing countries. In some countries, mentally ill people are inappropriately locked in jails because of inadequate mental health services. In many others, people with substance abuse problems are often sent to prison rather than for treatment. In developed countries where institutional care for the mentally ill has declined and community care is not optional, prisons have become custodians of persons with mental illness, which is also known as “*trans-institutionalization*”. Such persons languish in prisons for several years as they are unfit for trial. Prisons in the developing world, in addition to having many of the problems faced in prisons of the developed countries, also have other challenges. These include inadequate penal and judicial systems and prison resources, with resultant delays in access to justice and speedy trial. Inadequate attention



to the human rights of persons in prison, including the right to decent living, clean and congenial existence, speedy trial, information and communication and right to health care, particularly mental health care, further aggravates the situation (<http://www.academia.edu/1185394/2>. PRISON AND HEALTH).

Despite the demonstrable need for countries to provide proper standards of primary medical and mental health care to fulfill the health rights of people in detention, few prison regimes boast health services that meet international human rights standards. As reported by Human Rights Watch, *'complaints about medical care, or lack thereof were --- among the most frequent we heard in prisons throughout the world ---. A complaint we heard almost everywhere was that prisoners were denied medical care because of indifference [and] neglect ----. Health care for most of the world's poor is inadequate; for prisoners, often the poorest of the poor, it is usually miserable'*.

While the Human Rights Watch report dates from 1993, little has changed in the intervening years. A 2001 review of international prison condition noted:

*Living conditions in prisons have certainly not improved uniformly in the past decade and in many countries overcrowding has made these conditions even worse. The recognition of the rights of prisoners across jurisdictions has been uneven and progress uncertain.*

The evidence clearly illustrates the degree to which the right to health of prisoners is far from fulfilled ([http://www.ahrn.net/library\\_upload/uploadfile/file3102.pdf](http://www.ahrn.net/library_upload/uploadfile/file3102.pdf)).

## **WOMEN IN PRISON**

The considerable escalation of women sent to prison during the latter 20<sup>th</sup> century finally helped shift attention to the various social, economic, and medical needs of the historically, neglected population. Women are usually imprisoned for petty and non-violent crimes, mainly for property and drug related offences, and often come from socially disadvantaged communities. In comparison to their free world female and incarcerated male counterparts, female prisoners suffer more frequent and serious diseases and injuries and require and utilize more medical and mental health services. Women especially mothers in prison have special physical and psychological needs. However, correctional institutions continue to offer inadequate healthcare to women inmates and far less than what they offer male offenders. A familiar justification that explains the disparity is that female inmates compose a much smaller portion of the correctional population than men and thereby, warrant less



attention and investment by the state. Other matters which make the situation worse are firstly, the disproportionate prevalence of chemical dependencies among female offenders commonly report far more health problems than those without them. Secondly, unlike their male counterparts, females' complicated reproductive systems introduce other types of health problems that current correctional systems are ill prepared to handle. For instance, female prisoners suffer considerable gynecological disease (cervical cancer) and terminal or chronic health problems such as HIV and Hepatitis (<http://www.udel.edu/soc/tammya/pdfs/Issues%20in%20the%20Availability%20of%20Healthcare%20for%20Women%20in%20Prison.pdf>). Further, health care for pregnant women in prison is often far from equivalent to that available in the community. Women in prison seldom have access to any maternal education during pregnancy to help prepare them for the birth. The nutrition offered in prisons often fails to meet pregnant women's needs. After giving birth, women in prison are frequently discouraged from breastfeeding as it is perceived as interfering with prison routines, even while it is widely recognized that breastfeeding is the best method of infant feeding. There is also often a lack of support for women who have been victims of sexual or physical violence before their imprisonment (<http://www.who.int/bulletin/volumes/89/9/10-082842/en/index.html>).

Similar to research findings on physical health problems, women inmates' mental health problems are both more frequent and more serious than their male counterparts. Harlow (1999) in a survey of US prison population reported that 24% of men and 36% of women inmates received mental health services at some point during imprisonment. Also, women inmates more often disclosed obtaining professional counseling or being prescribed medications for mental illness. There is also considerable evidence that women are prescribed more psychotropic drugs than males and that medical staff frequently prescribe these drugs without checking to determine whether the inmate is pregnant which is a dangerous practice. The leading mental illness problems among female prisoners include physical and sexual abuse/trauma, victimization, depression and substance abuse. Women in prison have higher rates of antisocial personality disorder, borderline personality disorder and post traumatic stress disorder. Women are most often verbally abusive and report numerous suicide attempts (<http://www.udel.edu/soc/tammya/pdfs/Issues%20in%20the%20Availability%20of%20Healthcare%20for%20Women%20in%20Prison.pdf>). A report on health



care in prisons in England and Wales (1998/9) reported that the range and frequency of physical health problems experienced by prisoners appears to be similar to that of young adults in the community. However, prisoners have a higher incidence of mental health problems, in particular, neurotic disorders, compared to the general population. In male prisoners, the prevalence of any neurotic disorder in the week before the study was, 59% in remand and 40% in sentenced prisoners. In female prisoners, 76% and 63% of remanded and sentenced prisoners respectively have a neurotic disorder. In prisons, as in the community, neurotic symptoms and neurotic disorders are more common among female than the male population. A study of psychiatric disorders among prisoners in UK and Wales, 1997 demonstrated that, while 28% of the women in the general population reported sleep problems, 62% of sentenced women and upto 81% of those on remand reported sleep problems. While 11% of women in the general population reported depressions, 45% of women prisoners reported symptoms of depression. Panic and phobias were also significantly more common among remand prisoners. ([www.nimhans.kar.nic.in/prison/chapter\\_8\\_co\\_al\\_disorders.pdf](http://www.nimhans.kar.nic.in/prison/chapter_8_co_al_disorders.pdf)).

Very little evaluation has been carried out to assess and address common mental and physical disorders among women prisoners in India. A study commissioned by the National Commission for women in the Central prison, Bangalore 1998, reported that women prisoners face problems of both under and over nutrition with one in four being underweight and approximately a similar proportion, overweight or obese (26.3% higher) compared to 10.9% of male prisoners who are overweight or obese. This raises concerns about the lack of exercise in prison and a greater risk to non-communicable diseases like hypertension and diabetes. 17.9% of women prisoners reported use of tobacco in some form. Chewing tobacco was more common among women (12.7%) compared to smoking (5.1%) among women resident prisoners, 3% reported ever using alcohol. The study also found higher rates of symptoms of common mental disorder among under trials compared to convict prisoners. Common symptoms were unhappiness (73% versus 43%) worrying (65% versus 29%), poor sleep and appetite (65% of under trials). In another study of prison mental health, 2011 of 197 women who were interviewed for psychiatric morbidity, 2.5% had dysthymia (minor depression), 4.6% had specific phobia, 1.5% social phobia and one person had a panic disorder. ([www.nimhans.kar.nic.in/prison/chapter\\_8\\_co\\_al](http://www.nimhans.kar.nic.in/prison/chapter_8_co_al)



disorders.pdf). A survey of the women prisoners of Lucknow, 2011 revealed that the situation is more pathetic for women prisoners, who are aged (60+). Most of such women are alleged for dowry-related offence. At such an age they suffer from specific physical and psychological disabilities, which are rarely taken care of (<http://www.rnw.nl/english/article/female-inmates-lucknow-fight-ill-health-and-stigma>).

It is thus evident that a continuum of care is missing to successfully treat female prisoners' medical and mental health problems. Persistent inattention to the unique healthcare profiles of women prisoners is likely to result in an inadequate understanding of important illnesses and conditions not commonly experienced by men. Continued indifference would have great economic and social costs to society for current and future generations. According to Acoca (1999), *"healthcare issues are a tsunami and will engulf social justice, and many other issues, within the next decade if we don't make them a priority"*. (<http://www.udel.edu/soc/tammya/pdfs/Issues%20in%20the%20Availability%20of%20Healthcare%20for%20Women%20in%20Prison.pdf>)

## **CHILDREN IN PRISON**

Among the many ways women in prison differ from their male counterparts, the most significant may be the most overlooked. Most of the incarcerated women are mothers. Imprisonment of women affects her children adversely and they turn out to be the hidden and passive victims of their mother's incarceration. Sometimes care-dependent children stay with their mother in prison. The limit of ages and also of the maximum stay differs from country to country. However, in the international fora the stay of babies and young children in prison is more and more criticized. In the Summary Report Mothers and Babies in Prison it is said *"prisons do not provide an appropriate environment for babies and young children often causing long term developmental retardation"*. It was reported that even in normal illness of a child lies a great source for irritation between the warders, the mothers and other inmates. For example, getting teeth is normally often painful and frustrating, but inside prison it is even worse to handle. Further, in a separate mother-child unit, if one child does not feel well and cries a lot, it has its effect on the other children and their mothers. It is therefore believed that even in a modern prison system with good intentions on the part of the management and rather good facilities for children, there is a danger of over



estimating the possibilities of creating a child friendly climate in prison. In essence, prison in itself is incompatible with raising children.

The plight of children in prison has drawn attention of the researchers in India as well. In India jail rules developed locally under Prison Act accept the right of the imprisoned mother to keep her child with her until 5-6 years of age. The Jail Committee (India), 1919-20 whose report is considered as the landmark in the history of prison reforms noted that in the Jail Manual of most provinces it is laid down that if a female prisoner has with her at the time of admission a child under 2 years of age which is still at the breast or if a child is born to a female prisoner in prison, it may be allowed to remain with the mother until is 2 years of age. It was suggested to the committee that this rule might be amended so as to allow any female prisoner to retain a child until it is 4 or with the approval of the superintendent, even upto 6 years of age, if she so desires. It is unlikely that the child will be prejudicially affected by being in the prison upto the age, while it is in many ways better that the mother should be allowed to retain possession of it unless she has friends or relatives with whom to leave it. Several studies have been conducted in India to assess the living conditions of children living in prison. A report by the Tata Institute of Social Sciences on the provision of facilities for minors accompanying their mothers in prison was prepared. The report says that prison environments are not conducive to the normal growth and development of children. Prof. Apte, Founder Trustee, Saathi, endorsed the finding of the study conducted by the Tata Institute of Social Sciences (TISS). Another study undertaken by the National Institute of Criminology and Forensic Sciences, New Delhi, 2000 came out with the following important facts:

- Most children were living in difficult conditions and suffered deprivation relating to food, health care, accommodation, education and recreation.
- There were no programmes for the proper bio-psycho-social development of children in prison. Their welfare was mostly left to the mothers.
- Most mother prisoners felt that their stay in jail would have a negative impact on the physical and mental development of their children.

A project on women prisoners and their dependent children undertaken by G.B. Pant Institute of Studies in Rural Development, Lucknow, 2006 reported that children in prison are devoid of normal environment essential for proper growth and development. Unhealthy



environment and deprivation of homely facilities is likely to create psycho social problems among such children which many later lead to juvenile delinquency (Sadiq, 2013)

Whether the children are staying in prison along with their incarcerated mothers or are left outside the effect of mother's imprisonment is too serious to be ignored. It demands not only human right but also human concern. On the whole, at the very least they have lost a safe and secure childhood. Cunningham and Baker (2004) have aptly remarked, "*the long term price of incarceration as a form of punishment could well be seen in the prosecution of the next 'next generation'.*" (<http://www.voicesforchildren.ca/report-Dec.2004-1.htm>)

### **PRISONER'S FAMILY**

Most prisoners are member of a family. While prisoners experience the primary effects of imprisonment, their families experience the secondary effects.

A qualitative exploratory study conducted in New Zealand (commissioned by the National Health Committee and conducted by Wesley Community Action) sought the views of prisoner's families about the effects of imprisonment on the health and well-being of themselves, their children and their imprisoned family members. The respondent of study overwhelmingly reported that the primary health effect of having a family member in prison was stress. Factors which contributed to the stress were: Primarily, most adult family members were worried about their relative in prison. The degree of concern for a family member in prison appeared to be related to how the person would manage in prison, drawing on their own knowledge of the prison system and what they observed of the prisoner during visits and in letters. A number of respondents expected that their family member would be a victim of violent and/or sexual assault in prison. A significant theme to emerge from discussions with families was the lack of information from the prison authorities. Receiving scant information about the prisoners' health and wellbeing tended to exacerbate people's stress and feelings of anxiety about their relative. Relationships between partners were significantly affected by the prison experience. Partners of prisoners felt particular effects such as the loss of companionship and the stress of bringing up children alone. Financial effects were varied and in some cases families suffered in several ways. These effects related to either a reduction in household income caused by the withdrawal of the prisoner's former income and/or the cost to the family members of providing financial support to the prisoner. Compounding the loss of the prisoner's income



to the household, in some cases the remaining partner gave up work because of the need to care for children as a sole parent. Respondents were asked about whether the stress they experienced had any effect on their physical health. A number of people in the study reported that they had existing health conditions (unrelated to having a family member in prison). These included illness such as diabetes, cardiovascular issues and vision problems. However, in some cases respondents reported a marked worsening in their symptoms which they attributed to their family member being in prison. Respondents substantiated their views with the following experiences:

*People with diabetes commonly experience giddiness, I never have but when [my son] went to prison I did briefly.*

-Parent of prisoner

*I've had a heart attack ... The stress on my heart wasn't too good. Just the worry. The lead up to the sentencing ... not long after that I had a heart attack. I shouldn't be smoking and then again I shouldn't be drinking but really at the end of the day ... I was getting those pains during the court [process] – when she was going through the court process. (p. 39)*

-Parent of prisoner

A few of the women interviewed were pregnant at the time their partner went to prison and reported pregnancy related health issues, some of which they felt may have been exacerbated by their partner going to prison. One of the respondent sustained injuries that her family attributed to her behavioural response to her mother going to prison. Among the older and middle-aged respondents who had adult children in prison, stress induced high blood pressure was reported. Stress affected some people's eating and sleeping patterns, with consequent poor health effects. Whereas, still others reported that they increased their drinking and smoking due to the stress. Alcohol and drugs were widely used at least at some times to relieve emotional effects, especially by those who had a partner incarcerated. In few cases people talked about giving up involvement in sport or exercise when their partner went to prison. The factors underlying this are mixed relating to feeling depressed with their partner in prison and having sole responsibility for children resulting in a lack of opportunity for such activities. Older respondents who had acquired the care of grand children as a result of their own children being in prison spoke of tiredness and feeling drained. Discussing the effects of imprisonment for very young children which had both physical and emotional effects, respondents reported that breast feeding was stopped





when the mother went to prison. Respondents whose partner was in prison also talked about giving up breast feeding due to feeling 'down' and stressed about not having their partner around. They described not having the will to look after their baby properly. Parents, siblings and grandparents with the care of grandchildren observed behavioural effects in children that they related to children missing their parents and being angry with them. Children were described as being rebellious, fighting at school or bullying others. (<http://nhc.health.govt.nz/system/files/documents/publications/the-health-of-prisoners-families.pdf>)

## **SUGGESTIONS**

The public health implications of substandard health care in prisons continue to grow as correction institutions, educators and community bodies fail to properly address health care issues involving prisoners. Prejudice plays a key role in erecting barriers that prevent prisoners from receiving the same quality of health care that is afforded to free members of society. Politicians with their *"lock'em up and throw away the key"* attitudes, further exacerbate the problem. Doctors and nurses working in jails and prisons face ethical conflicts that are unfamiliar in a community context. Prisons are designed primarily to carry out court instructions and protect society from those who have committed crimes. Reformation is secondary to detention. Although prisons are not normal health care settings, prisoners undeniably have health care needs that must be addressed. Prisons can provide a corrective and rehabilitative role only if the issue of health of prisoners is adequately addressed. Major areas requiring action include.

In a workshop on Prisons and Human Rights organized at Bhopal by CHRI in collaboration with MPHRC, 1998, an example of the inhuman treatment extended to the prisoners in the prisons in India was brought to the notice of the people. It was reported that a prisoner in Rewa jail lost an eye because the cataract could not be diagnosed and attended to in time. Sometimes, when the cells are closed, the warden who has the keys to the cells is not available, as a result of which quick medical aid is not possible in case of an emergency. In another instance the doctor was required to administer injections through the bars as they could not have the cell opened. Thus in many cases, besides lack of resources, it is the existence of a dehumanized system in the prison which contributes to the problem. It is, therefore, important to humanize the relationship between the prisoner and the prison



staff so that the latter are sensitized to the needs of the prisoners and regard themselves as the caretakers of the inmates.

The *Mulaizha*, which is the preliminary medical examination of the prisoner, should be thorough and detailed in order to obtain knowledge of the prisoner's ailment at the time of entry and thus prepare the treatment plan.

Drug addiction is on increase in prisons and in many cases leads to other diseases, such as AIDS and Tuberculosis. A careful monitoring of such cases is needed alongwith adequately equipped drug-de-addiction centres. These centres can be organized on the line of *Aashiyana*, a drug de-addiction centre in Tihar jail. Further, NGOs should be encouraged to work inside the prisons and their efforts should be supported and supplemented by those of prison authorities.

Besides suffering from physical ailments, prisoners also undergo considerable stress and trauma during their stay in prison. It is therefore felt that active counseling must be made available to the prisoners to overcome these problems. Counseling should aim not merely at providing temporary relief by pulling them out of their depression, but at instilling hope and sense of purpose in them and by equipping them with skills that may prove useful upon release.

Most prisons are not equipped with an effective communication system that would inform the concerned authorities in case of a medical emergency. Besides establishing such a system, inmates must be thoroughly briefed about how to seek medical aid in case of emergency.

HIV and AIDS treatment programme in the jail is a daunting task due to inadequate resources and administrative support. Therefore, more attention needs to be paid to expand the resources for facilitating correction and improving medical care. At the same time, the jail staff needs sensitization through training programmes, which would increase the ability of the staff to manage and understand the issues related to health, hygiene and sexuality among jail inmates. There is also a need for the involvement of peer group approach in disseminating of information regarding HIV/AIDS. Further, to effectively address the problem collaboration between prison services, public health systems, social work agencies and civil society organizations should be promoted.



Many and even a majority of the Indian prison population are just those awaiting trial, people who may be innocent or in for minor crimes unable to get bail. Thus, in the first place, prevention of imprisonment becomes imperative. 'Bail not Jail' would be the desired goal of the justice system. Women, due to their ignorance are not receiving the benefit of proviso to section 437 Cr.Pc, according to which they can be released on bail even in non-bailable cases. Prisons authorities, lawyers, Lok Adalats and NGOs can take up the cases of women undertrials and as far as possible prevent their stay in prison.

## **CONCLUSION**

In all regions of the world, the people committed to prison are those whose social and economic marginalization places them at increased risk of physical and mental health problems. They are incarcerated in overcrowded, unsanitary and stressful conditions, alongside others who share the same increased health vulnerabilities. Further, the public health system accords a low priority for prisoners and prison policies have focused little on improving health services within the prison. Rapid turnover and frequent movement of undertrials in Indian prisons makes them difficult settings in which to quantify the prevalence of various diseases. The problem of poor prison health is not one limited to prisoners and prison authorities. Indeed, health experts and international organizations have consistently emphasized the fact that the issue of prison health cannot be isolated from broader public health concerns, as the vast majority of people in prison are eventually released back into the community. Therefore, the fulfillment of the right to health of persons in detention is not only a matter of pressing concern for persons in detention but also integrally linked to state obligations to fulfill the right to health within the population as a whole.

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