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Criminal Justice System, Health and Imprisonment in India

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***Abstract*—**Imprisonment is an expansive concept, as it is regulated by laws under criminal justice system of the state. The state sets principles of punishment to control offenders and also puts limits to excess punitive control. One significant way through which it exercises control is through rules governing healthcare of imprisoned population. Prisons signify specialized settings which accommodate both medical and legal concerns. The provision of care operates within the institutional paradigm of punishment. This requires the state to negotiate adequately between goals of punishment and fulfilment of basic human rights of offenders. The present study is based on a critical analysis of prison healthcare standards in India, which include government policies and guidelines. It also demonstrates how healthcare is delivered by drawing insights from a primary study conducted in a correctional home in the state of West Bengal, India, which houses both male and female inmates. Forty women were interviewed through semi-structured interviews, followed by focus group discussions. Doctors and administrative personnel were also interviewed. Findings show how institutional practices control women through subversion of the role of doctors to prison administration. Also, poor healthcare infrastructure, unavailability of specialized services, hierarchies between personnel and inmates make prisons unlikely sites for therapeutic intervention. The paper further discusses how institutional practices foster gender-based discriminatory practices.

***Keywords*—**Imprisonment, imprisoned women, prison healthcare, prison policies.

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I. Introduction

IMPRISONMENT is the most popular form of legal punishment. It leads to spatial, material and discursive limitations on those in prisons [1]. The "pains of imprisonment" has been described as deprivation of liberty, goods and services, heterosexual relationships, autonomy, and safety [2]. Prisoners come to be tamed, suppressed and reduced to docile bodies under the state apparatus [3]. It is the state and its criminal justice system that sets limits to punishment of those behind bars. This influences the conditions of prison environments [4]. The treatment, thus prescribed and rendered by the state becomes subjective in the day their day realities of the imprisoned population or what [5] would term as the everyday local culture of punishment.

The state also decides the type of healthcare that is delivered in prisons. Healthcare can increase the quality of life of people in a total institution [6]. It can also lead to fulfillment of human rights. There arises a need to address the health concerns of the imprisoned population. Health in prisons has been addressed from various perspectives. One is a life course perspective, which takes into consideration health differentials that exist as a result of age, gender, and the living conditions of prison inmates prior to imprisonment [7], [8]. Another approach to prison health is from standpoint of public health, in which it is argued that since prisoners are eventually released to the communities, prisons are to offer safe and healthy environments and ensure prevention, early intervention, containment of diseases [9]. Healthcare in prisons is also upheld so as to protect the basic human rights of individuals. No crime should be punished in a cruel, degrading or in an inhuman manner. Prisoners are entitled to healthcare as per community standards [10], [11].

Several international organizations such as the United Nations and the World Health Organization have formulated policies on healthcare in prisons. These guidelines and recommendations have incorporated the above perspectives for guaranteeing adequate healthcare in prison settings. There are also some documents on how to address gender-specific health care needs of imprisoned women [12], [13]. India does not have any particular document on healthcare in prisons. Several prison policies include chapters on healthcare. The present paper looks into such policies in the context of India and provides a critical review of the same. The second section of the paper offers an example of how healthcare is delivered in a particular prison. Based on a primary study among forty women, it explores the various aspects of the process and delivery of healthcare in prisons and how it affects the health of women.

II. Prison Healthcare Polices in India

A. Indian Prison Scenario

There are 1387 institutions for detainment in India which includes 131 central jails, 364 district jails, 758 sub jails, 19 women's jails, 54 open jails, 20 borstal schools (for minors and juveniles), 37 special jails (high security facilities) and 4 other jails [12]. The terms 'jail' and 'prison' are synonymous in the Indian context. The management and administration of Prisons is a State subject and is governed by the Prisons Act, 1894 and the Prison Manuals of the respective States and Union Territories. It is centrally enforced by the Ministry of Home Affairs and administered by Inspector General of Prisons in states and Union Territories. The criminal justice system of India allows various state governments a degree of autonomy in running the police, courts and corrections sectors.

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The Constitution of India (Article 14) states that the State shall not deny any person, equality before the law or equal protection of the laws, within the territory of India. The freedom to citizens like the freedom of speech and expression, or the freedom to become member of an association, as guaranteed by Article 19 of the Constitution, can be enjoyed by prisoners even when their freedom to movement is curtailed due to imprisonment. Articles 21 and 22 of the Constitution guarantee that even convicts shall be not deprived of their life and personal liberty [14]. From a human rights perspective, offenders still possess rights of access to basic educational resources, medical care, self-esteem, adequate nutrition, and access to leisure activities, healthy living conditions and opportunity to work while maintaining a balance between demands of custody and individual need for correction and rehabilitation. They also have constitutional right to treatment of serious emotional disorders. That is, physical, social, and psychological human needs are to be met.

Table I offers a glimpse of the Indian prisons as per the Prison Statistics Report 2014:

TABLE I
AN OVERVIEW OF INDIAN PRISON STATISTICS [15]

Demographic Characteristics	Number
Prison population	4,18,536
Male	4, 00, 855 (95.8%)
Female	17,681 (4.2%)
Convict *	1, 31,517 (31.4%)
Undertrial *	2, 82,879 (67.6%)
Occupancy rate**	117.40%
Male convict	1,26,114
Male under trial	2,70,783
Female convict	5,403
Female under trial	12,096
Children***	1577

*The total percentage of convict and undertrial does not add up to 100 as the rest fall under the category of detenues and others.
**Occupancy Rate = Inmate population x 100 /Total capacity.
*** Children are allowed to stay in prisons till six years of age.

The prison population rate in India (per 100,000 of national population of approximately 1.26 billion) is 33. As the statistics reveal, there is overcrowding in Indian prisons. This is because of the huge number of prisoners under trial. [16]

B. Policies on Prison healthcare

India does not have any exclusive documents related to healthcare in prisons either at the national or at state levels. Issues of healthcare have been covered marginally in the form of chapters in prison policies and documents. The United Nations resolutions are not legally binding on member states. However, The United Nations Declaration of Human Rights (UNDHR), 1948 was adopted by the Constitution of India in 1950 in the form of Fundamental Rights. The UNDHR stipulates that the state may only limit rights and freedoms of a prisoner – for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society. It states that no one shall be subjected to torture or to cruel, inhuman or degrading treatment and punishment. The rule applies to prisoners as well [17].

India adopted the United Nations Standard Minimum Rules for the Treatment of Prisoners in 1955, which states that every prisoner has the right to enjoy all the rights entrusted to a normal human being subjected to reasonable restrictions by the international human rights [18]. It also ratified the International Covenant on Civil and Political Rights, 1966 (ICCPR) in 1979 and became bound to incorporate its provisions in law and practice. ICCPR stated that the prisoners have the right to protection against torture and other cruel, inhuman or degrading treatment. Since then there has been a considerable shift in provisions of punishment to those of rehabilitation and reformation of the prisoners [19].

Over the years, many prison reform committees have been formed to restructure management and provide facilities for the prisoners. The jail management and administration as it operates in India even today, is based on the Prisons Act, 1894, which advocates Retributive and Deterrent form of punishment [20]. However, over the years since India's independence, there has been a move towards rehabilitation of prisoners, with recommendations suggested by various committees to standardize prison facilities and practices and for formulating a uniform policy and amendments in the Prison Act 1894.

In 1957, the Government of India appointed an All India Jail Manual Committee whose report stated that "the institution should be a centre of correctional treatment, where major emphasis will be given on the reduction and reformation of the offender". Many landmark judgements of the Supreme Court of India were passed on the right to life of imprisoned people and which declared custodial violence, unnecessary handcuffing, and solitary confinement as unlawful. The All India Committee on Jail Reforms under the chairmanship of Mr Justice A. N. Mulla submitted a report in 1983, proposing several rights for prisoners such as Right to Human Dignity, Right to Minimum Needs, Right to Communication, Right to access to law, Right against arbitrary prison punishments, Right to meaningful and gainful employment, Right to be released on due date. The Committee also suggested that there is an immediate need to have a national policy on prisons. The National Police Commission (1977-80) looked into issues such as arrest, detention in custody, interrogation of women and delay in investigation. It also made wide ranging suggestions to amend laws and procedures to cut down on delays at the investigation and the trial stages [21].

In 1987, the National Expert Committee on Women Prisoners under the chairmanship of Justice Krishna Iyer submitted its report. It called for uniform model prison and model police manuals indicating rights, standards and facilities to be maintained specifically for women in detention. It is significant to note that this committee has made important suggestions regarding the rights of women prisoners who are pregnant, as also regarding child birth in prison, medical examination, education and recreation, nutrition for children and pregnant and nursing mothers [22].

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The more recent acts include the All India Model Prison Manual Committee, 2000 and the Parliamentary Committee on Empowerment of Women, 2001-02. The National Policy on Prison Reform and Correctional Administration (2007) has called for upgrading prison infrastructure and made some prisoner-friendly recommendations with emphasis on rehabilitation [23]. However, there has been no follow up of such recommendations. State correctional departments have failed to adhere to these guidelines due to constraints in budget, lack of personnel and general attitude that prevail towards prisoners. Prison reforms have also not sufficiently addressed healthcare issues, especially for those who require specialized care, such as women and the elderly. Further, no distinct recommendation has been provided to address dearth of doctors in a number of prisons across the country, for preventive as well as curative measures for prisoners suffering from HIV or AIDS, old age health problems. No guidelines have also been laid out for prescribing special diet to specific categories of prisoners. Thus, the lack of guidelines has made it difficult to implement measures to ensure and deliver adequate healthcare to prisoners [24].

A recent development in prison reforms in India, is the approval of a new Prison Manual in 2016. It draws from the recommendations of The Standard Minimum Rules for the Treatment of Prisoners, 1957 which have been revised and adopted as Nelson Mandela rules in 2015, to which India is a party. It embodies many best international recommendations and. It recommends bringing medical services within the domain of the State Medical Services/ Health Department instead of the prison department. Another significant section of the manual is on special provisions for women prisoners, their safety and reformation., the manual stipulates comprehensive health screening for women prisoners, including tests to determine presence of sexually transmitted or blood-borne diseases, mental health concerns, existence of drug dependency, etc. It also recommends Sensitization and training of staff on gender issues and sexual violence; Educating women about preventive health-care measures; Enabling proper counselling and treatment for those suffering from psychological disorders; Focussed after-care and rehabilitation measures to ease women's re-integration into society; Restrictions on punishment by close confinement to pregnant women, women with infants, etc.; Counselling programs focused on women, especially those who have been victims of abuse and focus on removing any further damage that imprisonment may have on a female inmate. It also includes Provisions for holistic development of children, including provision of food, medical care, clothing, education, and recreational facilities; pre-natal and post-natal care to pregnant women offenders; nutritional requirements of children and provision of clean drinking water; a well-equipped crèche and a nursery school for children [25]. The challenges ahead will be to gear up for the implementation of these rules at the state level.

The present study has been carried out in the state of West Bengal. The prisons in the state are governed by the West Bengal Jail Code, 1968, which is being revised as per the provisions of the West Bengal Correctional Services Act, 1992. The code marginally addresses issues of appointment of medical staff, medical facilities to provide in correctional homes, medical screening and how to handle mentally ill prisoners [26]. Chapter XIII of West Bengal Correctional Services Act is titled medical administration and medical care. It suggests that female prisoners should be kept in a separate wing under the supervision of a female medical officer. It also gives the provision of psychiatrists if necessary for the treatment of lunatics in prison. The act also gives recommendations about the transfer of sick prisoners from one correctional home to another or to the hospitals.

Chapter XIX of the Correctional Services Act is titled Female Prisoners. There is no mention of healthcare of women. The chapter deals with accommodation, classification and privacy of women in the sense of restrictions of male staff to enter the ward without permission, employing women in particular kinds of work. It also states that children are to be provided with car and nourishment. The section under Gender-specific health care states that gender-specific health-care services at least equivalent to those available in the community shall be provided to women prisoners [27]. It only ensures health check-ups to be carried out in a manner that safeguards privacy, dignity and confidentiality. It nowhere mentions the specific health concerns that women face as a result of their gender and ways to address these problems. It only ensures health check-ups to be carried out in a manner that safeguards privacy, dignity and confidentiality. It nowhere mentions the specific health concerns that women face as a result of their gender and ways to address these problems.

From the perspective of prison healthcare policies, several international standards have established a series of policy frameworks which put social justice values, gender equality, and the underlying importance of human rights of prisoners. Human rights jurisprudence advocates that no crime should be punished in a cruel, degrading or in an inhuman manner. The status of prisoner does not imply that they have a reduced right to appropriate health care. Prisoners retain their fundamental right to enjoy good health, both mental and physical. It has also been emphasized that healthcare quality and access should be broadly equivalent to the services provided in the community.

Prison practices, as seen in the Indian prisons, come to be guided by state manuals which makes only a cursory look at gender as a determinant of health. A review of the Indian prison policies shows that gender specific health needs of women is lacking. There is also no mention of health promotion in Indian guidelines. No special policies are yet to be made that pertain to women or gender considerations. Women's experiences are rarely acknowledged as legitimate source of data or for establishing frameworks of action.

III. Prison Healthcare in an Indian Prison

A primary study was carried out to understand how healthcare was implemented in an Indian prison. A correctional home (as prisons have now to be termed) in the India state of West Bengal was selected as the field of study.

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A. Respondent Profile and Study Location

The study was carried out among forty women the correctional home. Out of this, twenty women were in the age group of 18-35 years; eleven women were under the age group of 36-50 years; nine women were above 50 years of age. Fourteen inmates were convicts and 26 were under trial.

There are 3500 inmates on an average the correctional home. The number of women was around 300. Women are kept in an enclosed facility within the main prison premise. The female ward comprises a garden area, a hospital and a school building. Inmates and children are kept in a two-storied building, referred to by the inmates, as wards. Both convicts and under-trials are made to stay together. As women do not cook in the home, there is no kitchen situated inside the ward. Inmates stay inside their wards or cells during what is called the 'lock-up time' in prison terminology. It includes the time period between 1 p.m. to 3 p.m. in the afternoon and from 5 p.m. in the evening till 6 a.m., the following day. At other times, they are free to come out and spend time in the compound within the boundaries of the female ward. The wards in both the correctional homes, where women are confined, are characterized by constricted space within the expanse of the prison. The architectural layouts restrict physical mobility. There are not many activities that women can engage in.

There is a room, referred to as the hospital. It can be said to be more like a sick bay having ten beds lying close to each other. It has attached toilet and bathroom. There is a hospital-in -charge and a helper who also occupy two beds in the hospital. A blood pressure instrument, a thermometer and some other medicines to be given for cold and fever on emergency purposes are kept in the hospital. At the entrance door of the hospital, there is a table and a chair. These are used by doctors during their visits to the female ward. Inmates stand in the queue outside the hospital for the check-ups.

B. Data Collection and Analysis

The present study used semi-structured interviews and focus group discussions for data collection from with forty women, which open up the scope for dialogue-- space for thinking, reflecting and narrating. A minimal structure with a pre-formulated questionnaire with mostly open-ended questions was essential to guide the interview process. The interview schedule was based on preliminary pilot study conducted, a year prior to the field work. It was pre-tested through interviews with few inmates, the doctors and the prison officials.

Permission was sought from the Inspector General, Prisons, West Bengal and access to the respondents was through the Superintendents and Welfare Officers, who delegated the work to wards-in-charge who were convicts having served for several years. The superintendents and welfare officers of each home initially made the researcher meet some of the wards-in-charge who were convicts having served for several years. These convicts served as key informants. The criteria for sampling was to include inmates who had a prior or persistent health problem and had visited the doctor. Purposive sampling was used to select the respondents. Early respondents were asked to identify and refer other people who met the inclusion criteria. The sample was purposive in the sense that respondents were chosen based on the objectives of the study. Interviews were mostly carried out on a one-to-one basis. Focus Group Discussions were also carried out which enabled the researcher to further engage respondents to elaborate on their collective experiences. Doctors were also asked to share their views.

Informed consent of inmates was taken prior to each interview through briefing the objectives of the study and ensuring confidentiality of information shared by inmates. Due to low literacy level among the respondents, the objectives of the study and informed consent were to be verbally communicated to them, on a one-to-to-basis, prior to each interview. After that, inmates could decide if they wanted to share their views. Early respondents were asked to identify and refer other people who met the inclusion criteria. As permission was not granted for digitally recording interviews, field notes were manually written after interviews. A thematic analysis was done based on the entire data set, which is discussed in the following section.

IV. Results

Based on the data collected, the following themes have been generated and described below. The themes are healthcare infrastructure of the prison; medical interactions between doctors and inmates; and specialized services.

A. Healthcare Infrastructure

Prisons conduct a preliminary form of screening of inmates when they first enter prison. This includes recording the health concerns, if any, that the women at present face. Both national and international policies on prison healthcare have emphasized the need for screening of inmates on entry which as per the Bangkok rules, 2011, should include comprehensive screening to determine primary health care needs, including sexually transmitted or blood-borne diseases; mental health care needs; the reproductive health history of women prisoners and related health issues; dependency and sexual abuse and other forms of violence suffered prior to imprisonment [28]. There is a health screening proforma that needs to be filled up. The doctor asks the women if she has a medical history. Their height and weight are measured and recorded at the main entrance on entry. The screening procedure is based on the doctor's verbal interaction with the women. He usually asks if there has been a history of abuse or battering and whether pregnant. In case the inmate has been transferred from another correctional home on medical grounds, she is often directly admitted to the jail hospital.

The doctors also offer OPD (Outpatient Department) services, when they visit the female ward. There is also an indoor facility in the form of the hospital, as mentioned above, where inmates are admitted as and when recommended by doctors. Prisons also offer referral services for inmates who need to go to an outside hospital for pathological tests or

treatment. The prison has tie-ups with several government hospitals.

In prisons, doctors are part of the administrative machinery. The doctors have to abide by the regulations of the prison administration. Their roles were limited. For example, gastrointestinal problems were reported by the majority of women under study. Doctors agreed that gastro-intestinal problems constituted a persisting concern among inmates, for which they had to prescribe digestive tablets and syrups on a daily basis. However, they also admitted that medicines could not help much in this regard; Food was an issue that needed to be addressed in order to minimize health concerns. Lack of physical exercise on account of the restricted space and inability to engage in lifestyle activities further aggravated the particular problem. Thus, it can be seen that there are limitations in the extent to which doctor can address and minimize health problems. Thus, their assumptions, values and preferences the extent to which they facilitate adaptation and functioning, determines the type of care to be delivered.

Another instance in which prison administration influence the role of the doctors is the provision of special diet. Special diet was given to those inmates who were recommended by the doctors mostly on grounds of medical problems. In addition to the regular food, it comprised like fruits and non-vegetarian items on a daily basis, if they were recommended by prison doctors. While in general diet, egg, mutton and fish was provided once every week, the 'special diet' comprised one of these items on a rotational basis every day. It also brings into light the subversion of medical authority by the prison administration. Some inmates, as a result of privileged personal backgrounds prior to imprisonment or due to seniority as convicts in prison had the power to wield such form of social capital, in the form of access to special food. Endowing such privileges to select groups of inmates broke the apparent homogeneity among prison inmates and created boundaries among them. Such construction of "sick identities", uncontested and legitimized in prison involved negotiation with the power of the state to allow some relaxation of rules. Access to special diet, among such inmates, was a distinctive means of perpetuating and regaining power and authority in prisons. So the question here arises as to what it takes to be a "legitimate patient" in prison. The special diet was one such provision, the access to which was actualized through the creation of "sick identities for vested interests of both the inmates and the prison administration.

B. Medical Encounter

Access to care was difficult in terms of being able to visit the doctor and seek treatment as per one's choice. The ward-in-charges, would, in many instances, act as gatekeepers and decide when an inmate was actually in need of visiting the doctor. An inmate was often not allowed access if she was found to frequently make requests to consult the doctor, no matter what the illness was. An inmate said, "Yesterday I wanted to see the doctor. The ward-in-charge told me, "How many times will you see him. You went last week". But I am having these stomach cramps and I have to argue and convince her to allow." Also, the scheduled visits of doctors often did not match the time of inmate when they were not locked up. They had the persuade the prison warder (female guard on duty) to open the locks.

Accessibility to healthcare was also determined by the promptness in receiving medicines. In the prison under study, the pharmacy was in the male section. The medicines were to be procured from the available stock. The women pointed out that it took one to two days to get the medicines.

The hierarchies between prison and personnel can be illustrated in the case of doctors and the doctor-patient interaction. Observations of the medical encounters that took place in the prison hospital on a doctor's visit revealed that inmates were often unable to communicate well to the doctors about their problems. It can be said as incarcerated women saw health as protection and punishment whereas prison health care system understood health as individualism and responsibility. This creates and perpetuates the "moral distance" [29]. The institutional arrangements of our society are characterized by the preoccupation of doctors' voices owing to their superiority in terms of special knowledge possessed that overshadows the muffled voices of patients [30]. For example, body pain was cited as a health concern by many inmates. They perceived and expressed pain to the researcher as a whole body event, involving both mind and body. They associated it with the sedentary lifestyle in prisons or their persisting stress which got embedded in their day to day due to imprisonment. However, pain was differently articulated to the doctors in the spaces of 'care'. The perceived pain would translate to its physical symptoms as pains in the muscles and joints, pains in the upper back, headaches and vision problems, chest pains and breathing problem to present a weak and vulnerable body to seek treatment and care. As one inmate said, *"What will I say to the doctor? Worrying the whole day is making me sick? Who will listen to that? The doctor says why did I not think before killing my daughter-in-law? I did not kill her. I was not there at home when she burnt herself. The case is going on. They arrested my son also"*, a woman said. Thus the cause or source of problem as perceived by inmates did not get expressed in their accounts or enactment of pain to the doctors. They, thus remained outside the realm of how health came to be coded, institutionally organized and treated.

Prisoners are entitled to free healthcare. But they cannot choose the physician. They have to conform to the diagnosis and prescriptions by the prison doctor just as they have to conform to prison norms and conduct. The prison context also leads to specific procedures of dispensing treatment. Consent for treatment, while technically available, is limited by the fact that prisoners have no choice in selection of care provider. Another way in which a medical interaction in prison becomes different from that in the community is the perceptions of both the doctors and inmates. Doctors saw prisoners as malingering their health problems in order to receive medicines or to get something to their favour, for example, not going to the court. Similarly, inmates often did not trust the doctors. Doctors were seen as part of prison authorities. if the doctor is seen to

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be part of the very repressive institution, the institutional trust breaks down as a result of which doctor's encounter also becomes ruptured. The institutional arrangement of prison is such that there is a strict hierarchy between the prisoners and staff. Doctors also work for the prison authorities and so they 'administer' treatment rather than provide treatment. More than the doctors, inmates expressed dissatisfaction with the treatment received.

C. Specialized Services

The prison was not conducive for acute care. Women in need of acute care were referred to outside hospitals for check-ups and need-based treatment. However, such women often reported delay in treatment. The dates that doctors decided for hospital visits were often delayed. Also, the medicines that hospital doctors prescribed were not always available. Gender-based healthcare was also not offered. International policies have been emphasizing on the specific gender-based needs of women in prisons, Indian policies remain almost silent. The West Bengal jail code, which is followed in the prison, as mentioned above, does not specify recommendations for women. It was observed that though a number of women complained of problems of menstruation and other gynecological problems, a female doctor was not recruited. Thus, the minority status of women can be seen as forging gender-based discriminatory practices.

V. Conclusions and Suggestions

A review of existing policies shows that there is no comprehensive policy on prison healthcare. Women, in particular, as the study demonstrated remain particularly neglected as there are no specific provisions for catering to their healthcare needs. If we claim to adopt rehabilitative strategies, prison healthcare needs to be improved.

Health as a human rights discourse as it relates to prisoners must be addressed critically and with an eye towards the unique experiences of imprisoned population. Medical practice in the community and that in the prison context should be guided by the same ethical principles. This requires policy making and implementation of the same. Steps should be taken to first analyse the determinants of health of women in prison so as to assess their health status. Prison doctors can play a big role in assessment of needs and also implementing actions for health promotion, thus facilitating changes in prison health policy.

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