

Chapter 2

HIV in Prisons

HIV or Human Immunodeficiency Virus has not only posed a major challenge to modern medical science but has also emerged as a serious public health concern. On one hand, the virus eventually leads to AIDS due to lack of any medicine; on the other hand, it is often associated with a lot of stigma, prejudice, fear, and silence. The social denial (of incidence of HIV) and lack of knowledge and awareness regarding the virus often contribute to neglect of care and treatment for people living with HIV (Goyer 2003).

The situation of HIV in the prisons is an issue which is often ignored and neglected. This is mainly because of the fact that prisoners are often the forgotten lot of the society. Coupled with the stigma associated with HIV, prison inmates are often doubly victimized in terms of access to care and treatment (Goyer 2003).

Several issues need to be considered with regard to HIV in prison setting. Prison inmates are at risk of contracting HIV because they engage in high-risk behaviour, viz. homosexuality, use of non-sterile contaminated injecting equipments, tattooing, etc. The risk is aggravated by the prison conditions characterized by overcrowding, boredom, inadequate access to health services, etc. Prison inmates, being a floating population, may infect partners, spouses, and other sexual partners who might not otherwise be at risk. Probably the only possible positive aspect to the issue of HIV in prison is the fact that within the prison premises, the inmates are a captive audience who may otherwise be hard to reach and may ordinarily avoid seeking health services especially related to HIV due to stigma, fear, criminal policy, etc. As a result, prisons present an opportunity for HIV prevention. Thus, it is essential to address the issue of HIV in prison (Burris & Villena 2004).

Although various efforts have been initiated around the world to tackle the situation of HIV in prisons, the initiatives have remained inadequate. Particularly in India, minimal efforts have been made to deal with the issue of HIV in prison. On one hand, there is a dearth of data and literature on HIV in prisons in the Indian context; on the other hand, the kind of intervention made has remained piecemeal and segregated.

In order to carry out a study on the topic of HIV in prisons, it is imperative to develop an overall understanding about HIV and an insight into the issue of HIV and AIDS in the prisons at national as well as global context. In this chapter, an effort has been made to present the concepts and issues in a comprehensive manner through various subsections capturing all the aspects associated with HIV in prisons, viz. clinical manifestation of HIV and its symptoms, epidemiology of HIV in prisons and preventive measures, vulnerability of prison population to HIV, human rights approach to HIV, and ethical issues regarding HIV in prisons.

Clinical Manifestation of HIV and Its Symptoms

The HIV is a virus that attacks the immune system of the human body. Once the virus infects the human body, the immune system of the person becomes weak, making the body 'immune deficient'. Thus, the immune system becomes incapable of functioning properly and cannot fight other infections, making the body vulnerable to many diseases.

HIV attacks the CD4 cells, a type of white blood cells which are responsible for coordinating the immune system of the body. HIV gradually kills the infected host CD4 cells leading to the production of antibodies. Antibodies are cellular defence mechanism of the human body which fights against unwanted organisms attacking the body. The presence of this antibody in the bloodstream confirms the presence of HIV in a person's body. However, it takes 3 months for the body to produce these antibodies after contracting HIV infection. This 3-month period is called the window period and any HIV test conducted during this window period is negative. Moreover, between 6 days and 6 weeks of HIV infection, the body develops symptoms of other illnesses like fever, enlarged glands, sore throat, aching muscles, and sometimes rashes. These symptoms subside within 2–3 weeks and the person may remain free from these symptoms for over 7–11 years. However, in many cases, these initial symptoms may not occur at all. During these 7–11 years, a person may lead a healthy life without any illnesses. However, the person is now living with HIV and can transmit the virus to other individuals. Over a period of time, usually after 11 years, the virus migrates from the blood circulatory system into the lymph nodes, thrives in the lymph nodes, and continues to infect other CD4 cells. CD4 cells continue to decline on an average of 5–10 % (40–80 cells/cubic mm) per year throughout this phase (Dickson 2001). When the CD4 count of the person living with HIV drops below 200 cells/cubic mm of blood, the body's immune system is completely destroyed. The person is now vulnerable to a large number of infections sometimes called opportunistic infections such as TB, cancer, tumour, etc. In addition to these opportunistic infections, the person may also have fever, weight loss, fatigue, lesions, nausea, and diarrhoea. In most cases, once the CD4 count of the patient drops below 10 cells per cubic millimetre of blood, death ensues (WHO, UNODC, UNAIDS 2008; Dickson 2001; Richards 1999; Cusack & Singh 1994; Thomas 1994).

Origin of HIV

There are several opinions regarding the origin of HIV. According to one opinion, the virus was already present in human body and gradually over a period of time became extremely harmful gradually (Mehta & Sodhi 2004). Others believe it originated from monkeys, chimpanzees, germ warfare laboratory and from a small ethnic group of people (Zeichner & Read 2006).

History of HIV

The existence of AIDS was discovered in October 1980–May 1981 by the Centre for Disease Control in the USA (Jaiswal 1992). HIV was identified in 1983 as the infectious agent responsible for many of the symptoms with illnesses associated with AIDS (Cusack & Singh 1994).

In India, HIV was first recorded in April 1986 among ten female prostitutes from Madras¹ in Tamil Nadu. This was followed by the first AIDS patient in the final stage in May 1986 in Bombay,² Maharashtra. This patient was a recipient of unscreened blood transfusion during cardiac surgery in the USA (Kakar 1994; Pavri 1992).

Ways of Transmission of HIV

There are three basic modes of HIV transmission (Dickson 2001; Richards 1999):

1. Unprotected sexual contact: HIV can be transmitted through unprotected sexual intercourse with multiple partners and also through homosexual intercourse between men, if either of the partners is infected. A person having sexually transmitted infection (STI) and engaging in unprotected sexual intercourse may get infected with HIV through open genital sores allowing the virus to enter the bloodstream.
2. Exposure to Infected Blood: Use of non-sterile needle for injecting purposes can cause HIV transmission. HIV is also transmitted through sharing of infected blood and blood products like plasma, red blood cells, etc.
3. Mother to Child Transmission: HIV may also be transmitted from mother to child in womb during pregnancy, during childbirth through exposure to infected maternal blood, and through breastfeeding.

¹Renamed in 1996 to Chennai, the capital city of the Indian state of Tamil Nadu, located in the south of India.

²Renamed Mumbai in 1995, the capital city of the Indian state of Maharashtra, located on the west coast of India.

Diagnosis of HIV

Diagnosis of HIV is done through tests that detect the presence of antibodies that a body produces in response to the HIV infection. Two tests, viz. ELISA (Enzyme Linked Immunosorbent Assay) and the Western Blot test, are widely used (Dickson 2001; Richards 1999).

Treatment of HIV

To date there is no specific cure for AIDS. However, usually when the CD4 count drops below 350 cells per cubic millimetre of blood, therapy known as Antiretroviral Therapy (ART) consisting of antiretroviral (ARV) drugs or a combination of three or more antiretroviral drugs, known as Highly Active Antiretroviral Therapy (HAART), is available to increase the CD4 count. These drugs have to be taken everyday for the rest of the life. In the absence of ART or HAART, treatment for opportunistic infections is prescribed, which does not address the immune deficiency (Mehta & Sodhi 2004; Jaiswal 1992).

Prevalence of HIV: Global Scenario

People living with HIV were reported to be 35.3 million worldwide in 2012. There were 2.3 million new HIV infections globally, showing a 33 % decline in the number of new infections from 3.4 million in 2001. The number of AIDS deaths also declined with 1.6 million AIDS deaths in 2012, down from 2.3 million in 2005 (UNAIDS 2013).

Prevalence of HIV: Indian Scenario

It is estimated that in 2011, there were around 20.9 lakh persons living with HIV. Adult HIV prevalence decreased from 0.41 % in 2001 through 0.35 % in 2006 to 0.27 % in 2011. Similarly, the estimated number of people living with HIV decreased from 23.2 lakh in 2006 to 20.9 lakh in 2011. The four high prevalence states of South India (Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu) account for 53 % of all persons living with HIV in India (National AIDS Control Organisation 2013).

Prevalence of HIV in Prisons: Global Scenario

Jurgens (2007) documented the prevalence of HIV in prisons in various regions of the world:

In Eastern Europe and Central Asia, a review of injecting drug users and HIV infection in prisons found HIV prevalence data for all countries, with the exception of Bosnia, Croatia, Turkmenistan, and Uzbekistan (p. 16).

Lower HIV prevalence was found in prisons in Central Europe, such as in Poland, Czech Republic, Hungary, and Bulgaria, and a much higher prevalence in some of the states of the former Soviet Union—in particular the Russian Federation and Ukraine, but also Lithuania, Latvia, and Estonia. HIV is a growing problem in prisons in some of the states of Central Asia. In South and South East Asia, high prevalence rates are being experienced in some of the countries of this region like Islamic Republic of Iran, Indonesia, Vietnam, and Malaysia, while evidence from India, Pakistan, and Thailand also suggests high rates of HIV among prisoners. The Philippines was the only country for which a study reporting zero prevalence was reported (p. 17).

In East Asia and the Pacific, overall, little research was done and most of the data available were from China and that too between 8 to 10 years old. In Latin America, HIV prevalence among prisoners in Brazil and Argentina was reported to be particularly high. Rates reported from studies in Mexico, Honduras, Nicaragua, and Panama were also high, although generally lower than in Brazil and Argentina. In the Caribbean, only a small amount of information about HIV prevalence in prisons was available. However, rates reported from Cuba, Jamaica, and Trinidad & Tobago ranged from 4.9 to 25.8 %, suggesting that prevalence among prisoners in this region might be high. In Sub-Saharan Africa, very high prevalence rates were reported from countries in southern Africa, such as Zambia and South Africa and in several western African countries such as Cote d'Ivoire, Gabon, Burkina Faso, Nigeria, and Cameroon. However, in other countries, such as Madagascar, Somalia, Senegal, Mauritius, and Niger, low prevalence was found (p. 18).

Much of the information on prevalence was more than 5 years old, so it was possible that it did not accurately reflect the current situation of HIV prevalence in African prisons. In North Africa and the Middle East, one study in Yemen in 1998 found an HIV prevalence rate of 26.5 % among a relatively small sample of prisoners. Most other countries for which data were found recorded prevalence of less than one percent. Very little is known about the situation of injecting drug use and HIV among IDUs in prisons in this region. Extensive data exist from many studies undertaken in Western Europe, Australia, Canada, and the USA (p. 19).

Shalihu et al. (2014) observed that most published scientific literature from North America highlights HIV among prisoners. Dolan et al. (2007) reviewed information on HIV prevalence in 152 low-income and middle-income countries in which information on HIV prevalence in prisons was found for 75 countries. Prevalence was greater than 10 % in prisons in 20 countries. Prevalence of IDUs in prison was greater than 10 % in eight countries. HIV prevalence among IDU prisoners was reported in eight countries and was greater than 10 % in seven of those. Evidence of HIV transmission in prison was found for seven low-income and middle-income countries.

Thus, it is evident from the above that HIV infection is a serious problem in prisons throughout the world and should be urgently addressed.

Prevalence of HIV in Prisons: Indian Scenario

Very little data is available regarding the prevalence of HIV in Indian prisons. A case study conducted at the *Mysore jail* in Karnataka—a state with one of the highest prevalence in India—found that the seroprevalence rate was highest among female inmates, at 9.5 %, and 25 % amongst female inmates who were commercial sex workers (Nagaraj et al. 2000 as cited in Goyer 2003). A study of 377 prisoners housed in three prisons in India found that 6.9 % were living with HIV and all of these inmates were originally from Thailand and Myanmar (Pal et al. 1999 as cited in Lines & Stover 2005). Although exact estimates on prevalence of HIV amongst prisoners are not available, ‘a bag of the envelope calculation’ will suggest that what is commonly present outside the portals of the prison walls should be present inside (Somasundaram & Sundar 1997).

The review of literature by Dolan et al. (2004) revealed that only one study in India found no Injecting Drug Users (IDUs) in one prison, while another found about three inmates (1.2 %) reporting a history of injecting drug use ($n=249$). Another Indian study found 4.9 % of inmates were IDUs in 1997 and this declined to 0.8 % in 2000. In 1993, 488 IDUs in India who had recently been institutionalized for drug use were tested. The largest centre was Manipur Central Jail, and of those tested, 80 % were HIV positive (UNODC 2007; Dolan et al. 2007).

Dolan & Larney (2010) reviewed various studies (Stubblefield & Wohl 2000; Aggarwal et al. 2005; Sundar et al. 1995; Singh et al. 1999; Nag et al. 2006; Pal et al. 1999; Palaniappan 1995) regarding HIV in prisons in India and noted that existing data for HIV prevalence in prisons were from mid to late 1990s. HIV prevalence in individual prisons ranged from 0.5 to 6.9 %. No information on HIV transmission in Indian prisons was found (Table 2.1). One national study (Nagaraj et al. 2000) of HIV prevalence in prisons found that 1.7 % of male and 9.5 % of female inmates were HIV positive.

From the above, it may be said that data on the prevalence of HIV in Indian prisons are limited. However, the data from the National Crime Records Bureau (2012) clearly show that there is overcrowding in the prisons in India. It must be noted that although the NACO considers Female Sex Workers, Men having Sex with Men, Eunuch/Transgenders, Injecting Drug Users, Long Distance Truckers, and male migrants as high-risk groups, it didn’t include prison inmates as one of the high-risk population for the HIV Sentinel Surveillance Round 2008 (National AIDS Control Organisation 2008; International Institute of Population Sciences (IIPS) and Macro International 2007). Thus, in a situation of overcrowding and ignorance regarding HIV among the general population, it is quite apparent that HIV may be quite prevalent in various prisons in India.

Strategies for Preventing HIV in Prisons: Global Scenario

Jurgens (2007) mentioned the following pilot HIV prevention (harm reduction) programmes that were introduced in prisons in many countries throughout the world:

Table 2.1 Information on HIV prevalence in Indian prisons

| Location | Year | Sample Size | HIV Prevalence (percent) |
|---------------------------|-----------|-------------|------------------------------------|
| Nationally | 2000 | Unknown | 1.7 (total) 9.5 (females) |
| Amritsar Central Jail | 2003 | 500 | 2.4 |
| Central Prison, Bangalore | 1993 | 1,114 | 1.8 (males) |
| Ghaziabad | 1999 | 249 | 1.3 (inmates aged 15–50 years) |
| West Bengal | 2000 | 384 | 2.3 |
| Orissa, 3 prisons | 1994–1995 | 377 | 6.9 |
| Chennai | 1995 | Unknown | 3.5 |
| Madurai | 1994–1995 | Unknown | 4.3 (total) 2 (male) 14.2 (female) |
| Tirunelveli | 1995 | Unknown | 0.5 |

Source: Dolan & Larney (2010, p. 698)

- (a) **Mandatory Testing and Segregation:** Prisons in the USA, Moldova, Hungary, the Nizhnii Novgorod region of Russia, and Mexico introduced mandatory testing and segregation of known HIV-positive prisoners.
- (b) **Education:** Knowledge about routes of HIV transmission and risks associated with illicit drugs is delivered through prison staffs and prisoners themselves who act as peer educators (UNAIDS 2004)
- (c) **Condoms:** Distribution of condoms to prisoners is permitted in Australia, Brazil, Canada, Ukraine, Moldova, Estonia, Turkmenistan, Romania, and other regions in the Russian Federation, South Africa, very few US prisons (4 city and 2 state systems), and the UK (only via prescription).
- (d) **Bleach:** In order to sterilize injecting equipments, bleach is made available to prisoners in many prisons in Europe.
- (e) **Needle Exchange or Distribution:** Penal Institutions in Western Europe, Central Asia, Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus distributed syringes via doctors, vending machines, drug counselling services, correctional staff, or external staff.
- (f) **Tattooing:** Guidelines on education and training of prisoner tattoo artist, providing safer tattoo services through a prisoner staffed tattoo shop, and encouraging voluntary screening for blood-borne infectious diseases for tattoo artists have been drafted by the Canadian federal prison system.
- (g) **Methadone Maintenance Treatment (MMT):** Methadone is a long-acting synthetic opiate that is easily absorbed when taken orally once daily. It blocks the effects of the withdrawal symptoms of opium. Thus, MMT discourages the use of non-sterile needle and syringe.
- (h) **Sexual Health Intervention Strategies:** Sexual Health Intervention Strategies were carried out in prisons of Schitomir, Kiev, and Odessa, Ukraine, by conducting training sessions, dissemination of information and educational materials, providing staff and inmates with individual means of protection (disinfectants, condoms, special gloves for staff), establishing regular access to

high-quality STD treatment and counselling, and improving access to psychological assistance and counselling.

- (i) **HIV and AIDS hotline:** In New York, in addition to basic information on transmission and prevention of HIV, regular prevention group meetings, led by a health educator, were organized. An HIV/AIDS hotline was made available to New York state prisoners who used a toll-free telephone service designed to be culturally sensitive. English- and Spanish-speaking counsellors, mostly former prisoners, gave general information, information about prevention, treatment, and referrals.

Strategies for Preventing HIV in Prisons: Indian Scenario

The following select interventions and research studies have been carried out in some prisons in India by various governmental and non-governmental organizations for addressing the issue of HIV in Indian prisons:

The Gujarat State AIDS Control Society, a unit of the National AIDS Control Organisation, initiated a pilot project on behaviour change communication interventions in 1998 in the Surat District Prison. In 2001, the interventions were replicated in nine prisons of the state (UNODC 2007).

A study by UNODC (2007) revealed that homosexual activity, both coercive and consensual, was a reality inside prisons. In this regard, the Hindustan Latex Limited established a technical resource unit to manage targeted interventions under agreement with the Andhra Pradesh State AIDS Control Society. Initially, four prisons were selected for the intervention programme, which was upscaled to eight after a rapid assessment of needs. The intervention focused on behaviour change communication sessions, STD care and counselling, peer education, condom distribution, and a referral system for partner treatment. The process highlighted the need for systematic needs assessment and phased upscaling, sensitization, and involvement of key stakeholders like prison officials and inmates, proper advocacy and sensitization activities, and avoidance of initial media attention in order to provide a greater sense of privacy, security, and freedom to the concerned project implementers (UNODC 2007).

Partnerships for Sexual Health Prison projects in Andhra Pradesh: The Prison Department of Andhra Pradesh in collaboration with the Andhra Pradesh State AIDS Control Society (APSACS) implemented a project from May 2000 to July 2007 on partnerships for sexual health (PSH) in all prisons of Andhra Pradesh. This project aimed to bring behavioural change among the prison inmates from the sexual health perspective in the context of STDs and HIV. The project activities included STD Care and Treatment, STD Counselling, Behaviour Change Communication (BCC) and peer education, and condom promotion³ (CHRI 2008).

³Data obtained from the Office of the Additional Inspector General of Prisons, Hyderabad, August 2007.

Counselling and Testing by Pune AIDS Control Society: Pune AIDS Control Society (PCACS) was involved in counselling and blood testing of prisoners at the Yerwada Central Prison, Pune, from July 1st 2006 twice a week as per the directives by the Maharashtra State AIDS Control Society and permission given by the Pune Municipal Corporation. PCACS was conducting the tests with pre-test and post-test counselling as per the guidelines of the Maharashtra State AIDS Control Society (MSACS). A copy of the reports was handed to the Superintendent of Prison, Yerwada, Deputy Director of Health Services (DDHS), Pune Circle, and MSACS at the end of each month.⁴

Intervention of NGOs in Prisons: The Commonwealth Human Rights Initiative (CHRI) undertook a National Scoping Study of NGOs working for prison reforms across 14 states in India. The study highlighted examples of best practices ranging from grass-roots level to policy framing. A closer look at the work of the various organizations in various prisons in India highlighted the fact that most of the activities were carried out by the faith-based organizations for education or vocational training, and there were few instances where NGOs occasionally conducted some awareness generation activities. There is a dearth of any concrete and sustainable work related to health per se and HIV and AIDS in particular in prisons by NGOs (CHRI 2008).

Sankalp Rehabilitation Trust is a non-governmental organization addressing the problem of drug abuse in the Mumbai Central Prison and Byculla District Prison in Mumbai, Maharashtra. The organization is involved in providing drug treatment services and legal aid to help inmates who were drug abusers prior to incarceration, through individual counselling, group sessions, medical support, legal intervention, family visits, recreational activities, and training to peer educators.⁵

SAPREM (Social Aspiration for Participatory Reforms by Evolved Manpower), an NGO, initiated the PINJRA (Prevention of HIV/AIDS Infection by Joint Relief Action) Project in Kalyan District Prison, Thane, Maharashtra. The various activities carried out by this NGO in the Kalyan District Prison included behaviour change communication, management of sexually transmitted infections, counselling for HIV testing, and training of peer educators. SAPREM in collaboration with the Tata Institute of Social Sciences, Mumbai, organized a one-day sensitization workshop on the need for HIV & AIDS intervention in prisons on May 12, 2007. The need to organize similar workshops in each state to strengthen care and support on HIV & AIDS intervention in prisons and to frame macro-level policy on HIV & AIDS in prisons emerged as the major recommendations of the workshop (SAPREM n.d.).

Intervention by the Government Hospital: The Department of Preventive and Social Medicine of the L.T.M. Medical College & General Hospital, Sion, Mumbai, was implementing a project on inmates living with HIV. The project included

⁴Information collected from the AIDS Nodal Officer and Secretary and counsellors of Pune City AIDS Control Society, 2006.

⁵Information collected through informal discussion with an employee of the organization and researchers' experience of a briefing session by the organization inside the Mumbai Central Prison as a part of the national training programme organized by UNODC and TISS.

counselling session for prisoners living with HIV, pre-test counselling of all prisoners, and conducting HIV-related workshops for the prison staff once a month. The workshops included information regarding the disease, mode of transmission, and treatment.⁶

Efforts by the United Nations Office on Drugs and Crime (UNODC): The UNODC Regional Office for South Asia, New Delhi, in collaboration with Tata Institute of Social Sciences, Mumbai, organized a 5-day national training programme to address HIV prevention amongst incarcerated substance users from February 27 to March 3, 2006. The training was aimed at the Senior/Middle Level Officers from Prisons (Superintendents and Jailors), Police (Anti-Narcotic Cell and the Criminal Investigation Department), and Non-Governmental Organizations from eight Western and Southern States of India. The objective of the programme was to equip the participants with knowledge and information pertaining to substance use and HIV & AIDS in prisons, to sensitize the prison officials and NGOs working on HIV & AIDS prevention in prisons towards the problem of substance use and HIV & AIDS in prison settings, and capacity building of prison officers and other service providers for facilitating training and interventions in the field (UNODC 2006).

In response to the training programme, UNODC and Sankalp organized a one-day sensitization programme regarding HIV & AIDS inside the Mumbai Central Prison premises for the prisoners and staff including the prison personnel, prison medical doctor, and paramedical staff. However, the programme was poorly attended with a few prisoners, prison staff, and paramedical officials.⁷

Vulnerability of Prison Inmates to HIV and the Risk Factors

Socio-economic Conditions

Studies indicate that poverty, unemployment, illiteracy, migration, and displacement may lead to social exclusion facilitating risk behaviour before imprisonment. After imprisonment, they may have language barrier and may have limited access to health information regarding HIV. After release, on deportation to their home countries, they may have limited or no access to prevention, treatment, and medical care services (Lines & Stover 2005).

People living in areas characterized by violence, high rates of crime, and substance abuse are also vulnerable to contract HIV. Apart from substandard housing, overcrowding, and unsanitary living conditions, other factors like unemployment, domestic abuse, dysfunctional relationships, and a lack of security or stability make

⁶Information gathered from the prison record on March 23, 2006.

⁷As stated by the programme coordinator on March 15, 2006, based on his observation made during the national training programme.

people vulnerable. Uneducated and the illiterate people do not have access to HIV education programmes (Goyer 2003).

Age, race, and gender are also significant predictors of HIV infection rates. The presence of sexually transmitted infections (STIs) increases the risk of HIV transmission (UNAIDS 1999).

Lack of Awareness

Both the prison inmates and prison staff have negligible or no knowledge on the various aspects of STIs, HIV, and AIDS, like modes of transmission and prevention, symptoms and diagnostic tests, treatment, care, and support. As a result, they are ignorant about the high-risk behaviours they indulge in, which may expose them to HIV (Goyer 2003).

Apart from these, the following pre-incarceration behaviour may render one vulnerable to HIV.

High-Risk Behaviour Prior to Incarceration

High-Risk Behaviour prior to incarceration includes unprotected sex with multiple partners, commercial sex work, or sex in exchange of drugs (Goyer 2003).

Special Target Groups and Vulnerability

Inside the prison, the following sections of people are considered as special target groups vulnerable to contract HIV:

- (a) Juvenile Prisoners: Juvenile offenders housed with adult offenders may be sexually abused by the older prison inmates.⁸
- (b) Prison Staff: Accidental needle stick injuries from hidden syringes, exposure to human blood or body fluids while administering first aid, indulging in sexual

⁸In India, the Juvenile Justice (Care and Protection of Children) Amendment Act, 2006, prescribes provisions for reformation of young offenders till 18 years of age (The Gazette of India 2006) and the Bombay Borstal Schools Act, 1929, provides punishment for the offenders within the age group of 18 to 21 years of age. However, boys found to be too incorrigible or unsociable to be kept in the Borstal School are transferred to the Juvenile Section of the Yerwada Prison (The Gazetteers Department, n.d.). According to these laws, young offenders are to be lodged in the Juvenile Justice Institutions and Borstal Schools, respectively. These places protect them from sexual exploitation by the hardened criminals and/or by the prison warders (which may expose them to HIV).

activities with male prison inmates, and lack of awareness regarding HIV make prison staff vulnerable to HIV (Goyer 2003).

- (c) **Prison Conditions:** Prisons are plagued by overcrowding, decaying physical infrastructure, lack of medical care, guard abuse and corruption, and prisoner on prisoner violence. Poor living conditions, poor opportunities for personal hygiene and sanitation, poor ventilation and natural lighting, and insufficient health-care measures make prisoners at risk to contract TB, a most common opportunistic infection.
- (d) **Inadequate Prison Medical Facilities:** Lack or poorly developed prison medical facilities, inadequate staff, and non-appointment of female doctor for female inmates make it difficult for prison inmates to access health care (Guin 2007).

Risk Behaviour During Incarceration in Prisons

The following behaviours by prison inmates make them vulnerable to HIV infection:

(a) **Use of non-sterile injecting equipments:** Despite the fact that availability and abuse of drugs are illegal in prisons, drug abuse does happen in various prisons across the world (Jurgens 2007; Goyer 2003). Drug policies which emphasize criminalization over rehabilitation lead to an extremely high incarceration rate amongst drug users and addicts (Goyer 2003).

In the Indian context, the injecting drug users within prisons might be negligible compared to other forms of drug use due to difficulty in smuggling needles and syringes into the prison. However, Singh (2007) notes that anecdotal evidence from previous inmates of the Arthur Road Jail (a jail in Mumbai) had revealed that injecting drug use was common in the jail.

(b) **Unprotected sex in prisons:** Unprotected sexual activity in prison in the form of consensual (anal intercourse), forced, or coercive (rape) together with the presence of sexually transmitted infections (STIs) makes one vulnerable to contract HIV (Carelse 1994). Sex may also be used as a form of currency exchanged for money, protection, space, property, or drugs within the prison. Other factors like whether the accommodation is single cell or dormitory, the duration of the sentence, the security classification, and the extent to which conjugal visits are permitted also influence sexual activity (Lines & Stover 2005). It has to be noted here that Indian prison does not allow conjugal visits by law.

Since sodomy is illegal in Indian prisons, MSM is not openly discussed due to fear of punishment from the prison authorities and stigmatization. Thus, there are no data available neither on its occurrence nor on its frequency (Lines & Stover 2005; Goyer 2003).

In many societies, homosexuality is not an accepted behaviour and social stigma is attached to this sexual orientation. As a result, prisoners engaged in homosexual activities are discriminated by other fellow prisoners and prison staff. This inhibits such prisoners to access safe sex measures such as condoms (in prisons where

condom is made available). Moreover, sexual activity in any form (consensual or coercive) is prohibited under the Prison Act of many countries, which is an impediment for inmates to access safer sex practices or seek medical care for any STI or venereal diseases. Existing studies conducted in different countries across the globe (Australia, Sweden, Austria, Spain, Belgium, Britain, the USA, Philadelphia, Malawi, Zomba) have revealed that the prevalence of high-risk sexual behaviour in prisons is quite high (Lines & Stover 2005; Goyer 2003).

(c) Use of Non-sterile equipments (body art/shaving): Though any form of body art by the inmates (tattooing, body piercing, etc.) is illegal, it is an integral part of the prison culture in many countries like Australia, Canada, Ireland, Spain, and the USA. In order to ensure that none of the participants get caught by the prison staff, these activities are usually done in a hurry in secret places (which in a prison are obviously very unhygienic) using non-sterile equipments (Lines & Stover 2005; UNAIDS 2004). Moreover, in undeveloped/developing countries, many prisoners share razors for shaving purposes, which increase the likelihood of exposure to blood-borne diseases (UNAIDS 2004).

(d) Exposure to human blood and body fluids: Prisoner and prison staff may get exposed to HIV-infected blood and body fluids through assaults, fights, accidental needle stick injuries or concealed syringes, and while providing first aid (Lines & Stover 2005):

The above high-risk behaviours inside the prison may be major causes of HIV transmission in prisons.

HIV-Related Diseases

(a) TB Infection: TB is the most common opportunistic infection for prisoners living with HIV (World Health Organization 2014; Dara et al. 2009; UNAIDS 2004).

India has one of the largest TB population in the world and prisons in India report TB as a major health problem. Many inmates contract the disease after entering the prison. With already weakened immune systems, inmates living with HIV are vulnerable to any infection. TB infection poses a great threat to the general health of inmates living with HIV. Thus, housing these inmates along with those with TB greatly heightens the risk of contracting TB. The risk of the spread of TB is also heightened by poorly ventilated and overcrowded prison conditions. Thus, high rates of HIV and other infectious diseases like TB can lead to alarmingly high rates of mortality among prisoners.

(b) Hepatitis B/Hepatitis C (HCV) Infection: Hepatitis B and C are two forms of Hepatitis. These are transmitted through the use of non-sterile syringes and other injection equipments. Hepatitis B can also be transmitted through unprotected sexual activity or in any situation where blood or body fluids from an infected person enter the body of a person who is not immune. A vaccine is available to prevent Hepatitis B, but there is no vaccine to prevent Hepatitis C (Macalino et al. 2004).

Published studies of HCV in the prison setting include those from Australia, Taiwan Province of China, India, Ireland, Denmark, Scotland, Greece, Spain,

England, Brazil, the USA, and Canada. Majority of these studies have reported that 20–40 % of prisoners were living with HCV, and within study samples, rates of HCV prevalence among prisoners who were injecting drug users were usually two to three times higher than those who have no history of injecting drug use (Macalino et al. 2004).

(c) Sexually Transmitted Infections (STIs): Inmates suffering from STIs are at higher risk of contracting HIV infection and people living with HIV are more susceptible to STI, due to their weak immune system (Lines & Stover 2005; UNAIDS 2004).

Prohibitory Law and Availability of Resources

In countries and prison systems where homosexuality is legal, like Australia, Brazil, Canada, Indonesia, the Islamic Republic of Iran, South Africa, some countries of the former Soviet Union, and a few prison systems in the USA, prison inmates have access to condoms (Jurgens 2007).

In India, homosexuality is a punishable offence under Section 377 of the Indian Penal Code. Naz Foundation, an NGO fighting for the gay rights in India, challenged the validity of Section 377, India's anti-sodomy law, before a division bench of Chief Justice A.P. Shah and Justice Murlidharan of the Delhi High Court.⁹ In response to the petition by The Naz Foundation (India) Trust, the Delhi High Court had decriminalized adult consensual sexual acts in private in 2009. However, the Supreme Court in *Suresh Kumar Koushal v. Naz Foundation* upheld the validity of Section 377, IPC, in December, 2013. The Naz Foundation (India) Trust filed a curative petition challenging the Supreme Court judgement (Naz Foundation files Curative Petition 2014).

Possession of addictive drugs is an offence in India under the Narcotic Drugs and Psychotropic Substances Act 1985 (NDPS). Thus, the two of the major modes of transmission of HIV in prisons, homosexuality and injecting drug use, are illegal in India. As a result, provision of resources for STD/HIV/AIDS prevention such as condoms, water-based lubricants, sterile syringes, needles, bleach, or other disinfectants for cleaning the injecting equipment cannot be distributed within the prison (Singh 2007).

Lack of Confidentiality

Confidentiality of medical information during imprisonment is difficult to maintain and is often breached, especially if it concerns STD/HIV/AIDS. In this study, it was observed that in some prisons, confidentiality regarding HIV-positive status could

⁹Naz Foundation (India) Trust v. Government of NCT, Delhi and Others [Writ Petition (Government) No. 7455 of 2001].

not be maintained mainly due to the special diet that inmates were provided with. In one prison, 'HIV positive' was marked on the medical files of the HIV-positive inmates. Apart from the doctor, HIV-positive inmates were identifiable by the nursing staff in the prison and the police guards who escorted the prisoners to the Government hospitals when referred. Medical personnel were not trained regarding the importance of privacy and confidentiality.¹⁰ Thus, there is very little understanding about the fact that prison inmates have greater need for privacy because they live in closed community where stigmatization, suicide, and violence are common.

Lack of Policy Guidelines on HIV in Prisons

In India, each State has its own prison manual based on the Model Prison Manual of 1960, which obviously was formulated long before HIV was discovered. As a result, each of these State prison manuals lacks any guidelines to address HIV in prisons. The only mention of HIV/AIDS in any policy document relating to the prison administration in India is in the Model Prison Manual 2003 and the National Policy on Prison Reforms and Correctional Administration, framed by the Bureau of Police Research and Development (BPR&D). It suggests provision of isolation rooms to house inmates suffering from contagious diseases like TB, Leprosy, and HIV/AIDS, in each prison hospital (Bureau of Police Research and Development 2003). This guideline, in fact, is more detrimental for an inmate living with HIV who is free from any other co-infection, as it exposes him/her to all other contagious diseases. Moreover, there is no mention of HIV/AIDS in prison setting in the draft report on the National Policy on Criminal Justice framed by the Ministry of Home Affairs (Government of India 2007).

Interestingly, the National AIDS Control Organisation, set up by the Government of India under the Ministry of Health and Family Welfare, in 1992, to address each and every aspect of HIV and AIDS in the country, including ethical aspects, prevention, treatment, care, and support, has completely ignored the incidence of HIV within prisons (National AIDS Control Organisation 2013).

Human Rights Perspective

There are three broad areas which highlight the relationship between HIV and human rights (OHCHR 1996–2004).

- (a) Increased vulnerability: The vulnerability of certain groups of people increases if they are unable to exercise their political, economic, social, and cultural

¹⁰Observation of the researcher during data collection in December 2006 for M.Phil. research study on, 'HIV/AIDS in Prisons: A Human Rights Perspective'.

rights. For example, if the Right to Information is denied to people, they will not be able to access information related to HIV.

- (b) **Discrimination and stigma:** Discrimination and stigma related to HIV may deny rights to people living with HIV. Stigmatization and discrimination may not only obstruct their access to treatment but may also affect their employment, housing, and other rights.
- (c) **Impedes an effective response:** If human rights of vulnerable groups such as injecting drug users, sex workers, and men who have sex with men are not respected, strategies to combat HIV & AIDS epidemic will never yield the expected outcome.

International Mechanisms

The provisions under international mechanisms ensure all the rights of prisoners except the ones they must be deprived of under legal provisions, for the sake of incarceration. There are two general categories of instruments that protect human rights. Each poses different obligations on governments. International human rights law and International rules, standards, and guidelines are the two international instruments that protect the human rights of all groups of people globally, the former being binding on governments (Betteridge 2004).

International Human Rights Laws

The States which ratify these international human rights laws are legally bound to frame laws that ensure respect, protection, and fulfilment of the right of prisoners (life, equality, security, privacy, etc.) and legal provisions for effective measures in case of violation of rights (in case of cruel, inhuman, or degrading treatment) (Betteridge 2004).

International Rules, Standards, and Guidelines

The most important rules, standards, and guidelines in relation to prison inmates are as follows (Betteridge 2004):

1. Basic Principles for the Treatment of Prisoners
2. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment

3. Standard Minimum Rules for the Treatment of Prisoners
4. Recommendation No R (98) 7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison

The other international instruments in the context of HIV & AIDS in prisons are as follows:

1. The World Health Organization (WHO) Guidelines on HIV Infection and AIDS in Prisons, 1993: In 1987, the WHO came up with its first recommendation to address HIV in prison. In 1993, WHO published another guideline which focused on voluntary testing, confidentiality, non-discrimination of HIV-positive inmates, availability of the means of prevention, and access to treatment equivalent to that in the community (UNAIDS 1999).
2. International Guidelines on HIV/AIDS, 1996: The Guideline 4 of the International Guidelines on HIV/AIDS and Human Rights has a section which emphasizes the administrative measures the prison authorities must take to ensure protection of inmates from rape, sexual violence, and coercion. It also recommended provision of information and education on HIV prevention, voluntary testing, and means of prevention (condoms, bleach, and sterile injection equipment), treatment, and care not only to inmates but to prison staff as well. It suggested prohibition of mandatory testing, solitary confinement, and restricting the access to prison facilities. The guidelines included provision for voluntary participation of inmates in clinical trials on HIV and early release of HIV-positive inmates on compassionate grounds (UNAIDS 2006).
3. United Nations General Assembly Special Session on HIV/AIDS (UNGASS), June 2001: The UNGASS Declaration of Commitment identified four areas: prevention of new infections, provision of improved care, support, and treatment for those infected with and affected by HIV/AIDS, reduction of vulnerability, and mitigation of the social and economic impact of HIV/AIDS to reverse the epidemic by 2015. Strengthening of monitoring mechanisms for HIV/AIDS-related human rights violations was acknowledged (UNAIDS 2002).
4. The Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia, 2004: With a broader focus to ensure the rights of prisoners to HIV prevention and treatment, the Irish Penal Reform Trust in collaboration with experts from seven different countries proposed guidelines to deal with HIV in prisons based on best practices to address the issue, scientific evidence, and a human rights perspective. Over 90 NGOs and experts in the field of Criminology and HIV and AIDS endorsed the declaration (The Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia 2005).
5. Global Fund to Fight AIDS, Tuberculosis, and Malaria: The present focus of global efforts to address HIV and AIDS is universal access to comprehensive prevention programmes, treatment, care, and support. Many countries committed themselves towards this end in the 2005 World Summit and 2006 High Level Meeting on AIDS. Global Fund to Fight AIDS, Tuberculosis, and Malaria is one of the major initiatives to ensure funds for extensive response.

National Mechanisms

National AIDS Control Programme

Since the inception of NACP Phase-I (NACP-I), based on the changing trends of the HIV epidemic in India, NACO has been shifting the focus of the National AIDS Control Programme (NACP) in each of its subsequent phases (NACP II, NACP III, etc.). Presently behaviour change has replaced awareness generation. With active engagement and participation of NGOs and Positive (HIV positive) Networks (PLHIV) across the country, NACP has turned into a more decentralized response. NACP-IV, launched in April 2012, aims to accelerate the process of reversal and to further strengthen the epidemic response in India through a cautious and well-defined integration process over 5 years 2012–2017 (National AIDS Control Organisation 2013).

The HIV/AIDS Bill 2007

The Lawyers Collective HIV/AIDS Unit drafted the HIV/AIDS Bill 2007. The Bill proposes provision of and access to risk reduction strategies, counselling, and health-care services for prisoners and detainees services (Lawyers Collective HIV/AIDS Unit 2008).

HIV Jurisprudence in India

A few of the landmark judgements given by the Indian Judiciary in cases involving people living with HIV are (Krishnan 2003):

- In 1990 the Bombay High Court ruled in favour of isolation of AIDS patient, but made it mandatory to ensure the hearing of a person living with HIV who has been detained.
- A very significant public policy ruling was given by the Supreme Court of India in 1996, through which an order was issued for all the state governments, the central government, and NACO to bring about a series of changes.
- The judgement against the discrimination at workplace of the people living with HIV was given by the Bombay High court in 1997 that an employer cannot consider an applicant or an existing employee unfit for the job/position unless the HIV status of the person interferes with her/his job performance.
- The Assam High Court ordered the government agencies working on HIV/AIDS to have more transparency and accountability in their work/programmes.

- The High Court in Kerala directed NACO to release its work and findings on AIDS to the public.
- The Calcutta High Court issued an interim order directing the Indian Navy to pay compensation to a family where the wife of a Naval officer contracted HIV during her blood transfusion in a military hospital.
- In 1998, Sahara House, a centre for Residential Care and Rehabilitation and in 1999 Sankalp Rehabilitation Trust (through Lawyers Collective), filed two separate but similar PILs in the Supreme Court, to ensure that no person living with HIV or is suspected to be HIV positive was denied treatment in the Government-run hospitals. On 1st October, 2008, the Hon'ble Supreme Court passed interim directions and directed the State Governments and NACO to implement the interim directions in a timely fashion (*Sahara House vs. Union of India*, [W.P. (C) No. 535 of 1998]; *Sankalp Rehabilitation Trust vs. Union of India*, [W.P. (C) No. 512 of 1999]).

Initiatives Taken by the National Human Rights Commission

The National Human Rights Commission (NHRC) has taken up various initiatives to protect the Human Rights of people living with HIV/AIDS. NHRC secured proper medical treatment to an AIDS patient at a Government Hospital in Delhi and directed that in medical cases dealing with HIV-positive patients, hospitals should offer proper treatment to the poor patients.

The Commission in partnership with other key agencies (National AIDS Control Organisation, the Lawyers Collective, the UN Children's Fund, and the UN Joint Programme) organized the National Conference on Human Rights and HIV/AIDS in New Delhi in November 2000. The recommendations emerging from the conference were formulated as *action points*. Some of these action points were on consent and testing of HIV, confidentiality, discrimination in health care and employment, women in vulnerable environments, children and young people, people living with HIV/AIDS (PLHA), marginalized populations, etc. These action points respond to the issue of HIV/AIDS both on national and state levels, in reference to all partners, including the international and domestic non-governmental organizations, foreign governments and multilateral agencies, credit institutions, the business community/private sector, employers' and workers' associations, religious associations, and communities. Another purpose of the *action points* is to complement the International Guidelines on HIV/AIDS and Human Rights with practical solutions in the Indian context. Based on the deliberations of the National Conference, systemic recommendations on various aspects of 'Human Rights and HIV/AIDS' were sent to the concerned authorities in the Central Government, State Governments, NGOs, and other key stakeholders (National Human Rights Commission 2006).

The Commission mounted a multimedia campaign to disseminate information on the Human Rights and HIV/AIDS to various target groups. In this direction, the Commission published 'Know Your Rights' series on Human Rights and HIV/

AIDS in collaboration with the National Academy of Legal Studies and Research University (NALSAR), Hyderabad, and produced a short duration film entitled 'HIV/AIDS—Myth and Reality' from a Human Rights perspective in partnership with Doordarshan (National Human Rights Commission 2006).

HIV in Prisons: Ethical Issues

While conducting research involving prison inmates living with HIV, the following ethical issues must be taken into consideration (Williams 2008):

1. **Informed Consent and Voluntary Testing:** Any person who is tested for HIV should be given complete information about the nature of the test and its implications. A policy on voluntary testing has been framed by NACO, which mandates pre- and post-test counselling (National AIDS Control Organisation 2008).
2. **Informed Consent for Research:** Any research which involves people living with HIV should ensure that all the participants are fully informed about all the various aspects of the research (purpose, funding, organization/institution involved, duties and responsibilities of the researcher, method of record keeping, absence of any physical incentive, risks, benefits, etc.) and their consent (based on the information) is taken, before the research is conducted, with a guarantee of confidentiality of each of the participants.
3. **Confidentiality vs. Disclosure:** On one hand, it is the right of the prison inmate living with HIV that his/her HIV status is kept confidential, and on the other hand, it is the moral and legal responsibility of the State, including the prison administration, to ensure that the prison staff, other inmates, and the community (where the inmate will go back after release) are protected from getting infected with HIV. Hence, the priority that should be given to keep the inmate's HIV status confidential in order to protect him/her from threat, stigma, and discrimination is no less than the priority that should be given to ensure preventive measures for others and treatment measures for the inmate living with HIV. Presently, there is no clear directive of the Prison Administration regarding the process that should be followed to ensure both these aspects.
4. **Segregation and Mainstreaming:** There are two aspects favouring segregation—the inmates living with HIV are more prone to other infections compared to the other inmates and it has been observed that some inmates living with HIV engage in reckless behaviour in a deliberate attempt to infect others. On the other hand, a blanket segregation of all inmates living with HIV will lead to exclusion, which will only increase the distress of the already suffering inmate. However, it would be better if the segregation of the prisoner is based on the assessment of each individual cases, considering the medical status, need for protection, and likelihood of engaging in reckless behaviours (Somasundaram & Sundar 1997).

Conclusion

It is evident from the above that there are a good many number of factors which make the study of prison inmates living with HIV not only conclusively significant but also a prerequisite to ensure that the policies and legal provisions are introduced for safeguarding the interests of these inmates in prisons in particular and the community in general. HIV is a very serious and delicate issue inside the prison because of the risk behaviours prison inmates engage in during their term inside the prison as well as after their release to the community. Both prison inmates as well as the prison staff are vulnerable to HIV inside the prison. Although there exist a considerable number of institutional mechanisms in relation to HIV in general and HIV in prisons in particular, the implementation of these mechanisms in the domestic scenario is a matter of investigation. In India, the National AIDS Control Organisation is the only body of the Government of India to address issues relating to HIV and AIDS. Although the HIV/AIDS Bill is the only legislation that has been initiated, there is no particular policy or legislation with regard to HIV in prisons. In this context, it is important to find out the various issues and facets related to HIV and AIDS in prisons giving special emphasis on prisoners' access to healthy conditions, prevention, and treatment.

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