CHAPTER-VIII

Conclusion
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CONCLUSION

This chapter is divided into two parts. The first part discusses the findings of the study whereas the second part proposes suggestions to increase the visibility of prison system so that it could be more efficient to ensure better health and health care facilities to women in prison. When women enter prison, they are doubly deviant, doubly damned. Woman prisoners carry a baggage with her of a life that ended up in her offending against the law which society/state has made for social order and security, and which we all subscribe to. Women prisoners are fewer in number than men and are not just violators of the criminal code, but also at the same time violators of particular social mores (Shankardass, 2012b). Historically, both control over women and the nature of their crimes had a gendered character, i.e., gendered in the sense that certain acts that were considered crime for women were not for men, for example, bigamy. Inequity could be seen also in the punishments meted out to them, men and women were punished differently even for similar offences. The historical definitions of crime and punishment indicate that offending women violating against the legal system were also the violators of certain social mores. Like all other modern institutions, the criminal justice system in India has evolved in the process of reconciling a series of diverse, often contradictory imperatives and roles. Since, man's interests are best protected in the social life of society, therefore every member of society owes certain duties towards the other members and also has certain rights and privileges, which he insures for him from others. It is the obligation on the state to maintain normalcy in society through crime control machineries. A criminal justice system is a set of legal and social institutions for enforcing the criminal law in accordance with a defined set of procedural rules and limitations. Fair and effective administration of justice is the corner stone of a free society and this builds up the essential component of public confidence in the institutions of government (http://shodhganga.inflibnet.ac.in/bitstream/10603/9696/8/08chapter%202.pdf). In the administration of justice there are two major systems for the dispensation of justice, the adversarial and the inquisitorial system. India follows the adversarial system. Under such a system two advocates presents their parties position before an impartial jury or judge who attempts to determine the truth of the case. Justice is done when the most effective adversary is able to convince the judge or jury that his or her
perspective on the case is the correct one. Thus, the prosecution and the defense under such a system stand opposed to each other. As such in this system lawyers play a vital role in deciding the fate and destiny of undertrial prisoner who though presumed to be innocent languish in prison for several years (Sadiq, 2013). Further, the criminal justice system is slow, cumbersome, expensive and cumulatively disastrous. The poor can never reach the temple of justice because of heavy costs involved in gaining access. The hierarchy of courts with appeals after appeals ends legal justice beyond the reach of the poor. By making the legal process costlier, there is more denial of justice to the people. In fact the legal system has lost its credibility for the weaker section of the community (http://shodhganga.inflibnet.ac.in/bitstream/10603/9696/8/08_chapter%202.pdf).

Findings
The findings of the study are the outcome of the experiences shared by women prisoners and prison staffs of three District jails (Aligarh, Bulandshahar & Meerut) of Uttar Pradesh, India. Women’s experiences with crime and criminal justice system are shaped by social-structural constraint, caste-class inequalities, societal gender ideologies, self-esteem and identity problems.

Profile of Women in Prisons
In the present study the profile of women prisoners illuminate that women prisoners may be broadly categorized into two groups in terms of their age, i.e., reproductive (younger) age group and non-reproductive (older) age group. Sixty percent of women prisoners belonged to reproductive age group while, forty percent of women prisoners belonged to non-reproductive age group. Women experience problems in accessing appropriate health care and the particular challenges of securing women specific care during incarceration. Prison infringes on women’s human rights to reproductive health care and decision making. For biological and social reasons women are more directly affected than men by decisions with respect to reproduction i.e., decisions which in turn are shaped by issues related to gender equality, stereotypical gender roles and the role of women in society more broadly. Reproductive rights matters are crucially important to women as they affect women’s psychological and physical integrity, their health and sexual autonomy, their ability to enter and end relationships, their education and job training, and their ability to negotiate work-family conflicts in institutions organized on the basis of traditional sex-role assumptions. Further,
incarceration creates unique stresses for older women because of anxiety about ageing and dying in prison, and because daily prison life can be especially challenging as women grow older and become frailer. Older women are also more likely to confront a range of serious medical conditions i.e., menopause, osteoporosis, cardiovascular disease etc. Women face discrimination in all spheres of life that directly or indirectly lead to their contact with, and extreme vulnerability in the criminal justice system. These include discrimination in areas such as education, marriage, employment, divorce, reproductive rights and mobility among many others.

Majority of the women prisoners were married. Married women are more prone to domestic violence and abuse. Women in prison are more likely than men to suffer from physical and psychological disabilities often as a result of domestic violence, physical and sexual abuse. Most of the women in prison have children both in prison and left outside. They are usually the primary and sole carer for their children. Both allowing children to live in prison and separating children from their mothers pose difficult problems and dilemmas. Children are a life-sustaining force for many prisoners, and breaking up the bond between the mother and child is often punishment of the worst kind for the mother and strongly affects her physical and psychological health. Women who were divorced and separated were also worried about their future. Most of the older women were widow and economically dependent on their children or other family members. They were more vulnerable and experienced more health problems. They face additional discrimination and barriers in accessing adequate healthcare due to their status in society. Their condition may become worse in prison due to the absence of adequate medical care, lack of hygiene, and overcrowding.

Majority of the women prisoners were illiterate and economically marginalized. Due to lack of legal awareness and inadequate financial and physical resources they fail to get justice. Women are deprived of their right to education because of the mindset that views education for women as unlikely to reap any returns and ascribes to the view that investing in the education of the male child is like an investment as the son is likely to be responsible for caring of aging parents, and women with largely a reproductive role in society have little need for education. Gender inequities determine much about the health risks a woman faces in her life, her knowledge, her vulnerability, personal resilience, capacity, self confidence and
access to social support systems which help her to deal with health problems as they arise. For example, inadequate access to education for women leads to diminished social and economic opportunities, and as a result women’s access to cash income is limited and women’s economic activity rate is low, as compared to that of men.

Findings show that majority of the women prisoners were housewives. The works they do at home are uncountable. Women produce children, they are mothers and wives, they do the cooking, sewing and washing, they take care of men and are subordinate to male authority, and are largely excluded from high status occupations and from positions of power. Their workplace largely remains within the household boundary and is not considered economically valuable because it is not paid. This lack of recognition of women’s labour fails to get them their due value in the family. Wife is considered as the possession of husband. He has full right of her.

It was found during the study that 77.2 percent of women prisoners belonged to Hindu community, while 22.8 percent belonged to Muslim community. According to 2011 census, 78.35 percent population of India practice Hinduism and 14.28 percent practice Islam. Therefore, the percentage of Muslim women was higher in the prison population than the share in the national population. Thus, Muslim women tend to suffer not just the disabilities attached to the female status, but also to the Muslim community’s impoverished minority status in the country. They are educationally most backward, economically poor and politically a powerless community in India. They are generally deprived of the benefits of developmental schemes and are underrepresented in governmental services and decision making bodies. Surprisingly, majority of Muslim women were accused for dowry offences. Historically, dowry has been a Hindu practice. Its existence in the Muslim community indicates the prevalence and acceptance of this system in other communities irrespective of religious considerations. Further, majority of women prisoners belonged to lower caste. Most women belonging to the so-called lower caste also belonged to the lowest economic strata. Casteism, sexism and economic deprivation often throw women outside their conventional roles. They get caught in this vicious cycle of multiple marginalization or triple jeopardy of caste, gender and class. Thus a large majority of women who are detained not only do not have the economic means to hire a lawyer, but they are very often unaware of their legal rights. This places them in a particularly vulnerable position, at risk of signing statements that have serious legal implications.
and of being open to coercion. Further, lack of legal representation can lead to immense delays in the criminal justice process, and less chances of defendants being considered for bail, for example, taking into account women’s caring responsibilities for their children and others.

Majority of the women prisoners belonged to lower income group. There is a close relationship between gender, caste, class, and income because majority of the poor women come from lower castes. Studies illuminate that poor households include more wage earning women yet their status remains low. An adequate income is an important factor in being able to access health care services. Women’s lack of education often leads them to undertake poorly paid work. Accordingly, resulting economic benefits are fewer for women and the lack of economic independence for women has implications for both their social status and their health. Further, number of family members and household income also cumulatively affect health status of women.

Findings reveal that majority of women were having five or six members in the family. Moreover, the number of people living in a rural household is more compared to the urban counterparts. Low income and large number of family members negatively affect the overall well-being of family especially female members of the family. Women are the main carers in families. Women’s health is often neglected or subordinated to the family’s health and this may result in the worsening of situations as a result of significant delays in seeking treatment. This is not surprising since women are one who handle all the activities of households but once we talk about decision making their participation is very less. Actually, typically they have little autonomy living under the control of first their fathers, then their husbands, and finally their sons.

Majority of the women belonged to joint family and rural background. The Indian family is by and large patriarchal in structure. In a patriarchal family set up, all male members i.e., husband, brother and father, perform duties like decision making for the rest of the family, and their physical and moral protection. Feminist sociologists believe that family is a patriarchal and hierarchical institution through which men dominate and exploit women. Further, the cultural and socioeconomic environment affect women’s exposure to disease and injury, their diet, access to
and use of health services, and the manifestations and consequences of diseases. Women in rural areas have no, or limited access to healthcare facilities. Their lack of information and knowledge of health issues and the inability to recognize symptoms of disease also exacerbate the problem. Restrictions placed on female mobility and a lack of female health care workers also result in negative health outcomes for women.

Moreover, an attempt was made to find out the types of crime committed by women. It was found that majority of the women prisoners were alleged for crimes i.e., dowry death & murder, followed by theft, abduction, cheating, drug trafficking etc. Majority of the women involved in serious offences were alleged for dowry death and spousal murder. A keen insight into the fact reveals that women who have awful early experiences are more likely to enact violence than others because of the difficulties which they have experienced in integrating their murderous feelings: first, their aggression is projected into others, their violent partners and when this becomes unbearable they retaliate through violent action themselves. There are important social and psychological factors to consider in exploring the circumstances of domestic violence and revenge. Once involved in a relationship these women find it difficult to leave, even in the face of physiological or emotional abuse, because of their lack of self esteem, scarce financial resources, fear of letting others know about the abuse, worries about the future of their children, and dependence on their partner. Women who kill have often been severely physically beaten and/or sexually abused over long periods of time by their male victims. As far as dowry death is concerned the likelihood of the participation of female members in the murder cannot necessarily be ruled out. However, in view of the power relations within the family and the fact that dowry benefits men more than it does women, it can well be mentioned that their participation in the act is not on equal terms and the returns of such participation are questionable. The dowry question is critical not only because it brings in women into prison but also it places unmarried sister-in-law and elderly mothers-in-law behind bars. The stigma of jail-bird reduces all the chances of a decent marriage for the sister-in-law. The mother-in-law is generally illiterate, elderly, economically dependent and marked with physical disabilities and diseases peculiar of her age.
Health of Women prior to Imprisonment

During the study it was found that a large number of women experienced health problems when they enter prison. They were experiencing diseases like hypertension, arthritis, diabetes, cataract, tuberculosis and so on. The socio cultural factors cumulatively affect the overall well-being of women in society. Women’s health is socially constructed through their occupancy of gender specific status and the enactment of gender related social roles. It was found during the study that women experiencing chronic health problems did not get proper regular treatment in society. Most of the time their health problems are not considered worthy enough to pay heed towards them. Women’s institutionalized incapacity owing to low level of literacy, limited exposure to outside world, access to money and restricted mobility reflect in their inferior health status and access to health care. The receiving of care as well as access to familial resources can be highly gendered, favoring the males.

Findings reveal that in most cases it was attitude of the family that precluded women from seeking treatment. Moreover most of the time family members thought that the illness did not require medical attention. It was observed that the culture of silence prevented care seeking in problems related to sexual health. Some reproductive health problems went untreated because they were considered normal. All the decisions regarding care, treatment and consultation of doctor at the time of diseases or illness of women are taking by the male members of the family. Patriarchy is the root of oppression for women and the biological body is the primary site of women’s oppression. Throughout history patriarchal ideology has constructed women’s illness as inherent biological weakness. Women become associated with the irrational body and men with the rational mind. Expressed as hierarchical power relations, mind body dualism and all the accompanied it sanctioned patriarchy by permitting men to associate themselves with the positive and socially valued.

It was found during the study that family members often tend to neglect the health of women and women themselves were also found to be inattentive towards their health issues. This is primarily because of their great importance attached to their role as caregiver. Further, they have little information about issues that affect their health. Women’s health is profoundly affected by the ways in which they are treated.
and the status they are given by society as a whole. Gender beliefs held by both men and women have a major impact on women’s health. Generally, both sexes believe that women should work hard and be deprived of good food and care. It was reported that their health problems pay heed only under extreme circumstances. When poor women are ill, they tend to delay seeking modern treatment until their symptoms are too severe to ignore, meanwhile perhaps visiting a general practitioner or local pharmacy. Thus, they take longer to recover and often return to work before they have completely recuperated. Women often substitute for their husbands in agricultural work when they are ill but husbands rarely substitute for their wives, and only essential duties are assumed by other family members. When women recover, they are faced with many pending tasks, in addition to their normal work. Those who are sole carer of their family lose necessary income for daily survival, and many have to use their scarce resources for medicines and other health-related costs. The fact that women are often paid less for the same jobs as men also means that they have fewer resources to fall back on when they become ill, and their control over their own earnings is often limited. The power relations and unequal status between men and women in society are a root cause for gender inequality, as they determine a person’s ability to take control over their life and health. While gender norms are broadly reinforced culturally and institutionally, it is within the household that children first learn about gender roles, equating maleness with power and authority and femaleness with inferiority and subservience. Boys learn how to exercise their authority over girls, whereas girls learn to submit.

In India, household is a primary site in which male privilege and control over women are expressed. From an early age, Indian girls are told that their proper place is in the home, fulfilling domestic duties and attending to the needs of men, whereas men learn that they are superior to women and must exercise authority over them. Where women continue to be discriminated against or subjected to violence, their health suffers. At its most extreme, social or cultural gender bias can lead to violent death or female infanticide. Many of the main causes of women’s morbidity and mortality in both rich and poor countries have their origins in societies’ attitudes to women, which are reflected in the structures and systems that set policies, determine services and create opportunities. Where they are excluded by law from the ownership of land or property or from the right to divorce, their social and physical vulnerability
is increased. Further, a lack of equity in women’s pay, single parenting, lower education levels and unemployment means that women are particularly susceptible to socioeconomic disadvantage and poverty. Many health issues and diseases experienced by women are closely tied to disadvantage. Women from low socioeconomic backgrounds have a much higher exposure to risk factors for poor health. Overweight/obesity, tobacco smoking, poor diet, nutrition and insufficient physical activity are much more prevalent in low socioeconomic status groups. This can lead to higher prevalence of chronic disease including heart disease, cancer, liver disease, respiratory disease and diabetes. Women are also more susceptible to poor health literacy, which is integral to women being able to take control of their health, make informed decisions, effectively navigate the health care system and receive appropriate and timely care. In woman’s lifetime her health status during any phase of life impinges the next phase. The life cycle approach includes the health of the girl child right from birth, adolescent group through the reproductive years and into menopause and geriatric health.

As far as maternal health is concerned findings of the study suggest that majority of the respondents throughout the life are at risk of sexual, physical violence and abuse, forced or early marriage, poor obstetric care during pregnancy and childbirth, and the rigors of child care, household chores, and physical labor, all of which can present health risks. These stresses contribute to women’s psychological and physical problems, especially during their childbearing years. Further, gender discrimination results in malnutrition of women. They are worse off than men in terms of food intake and quality care of health during pregnancy.

Majority of the respondents had experienced pain of miscarriages and/or abortions, and were largely deprived to the access of institutional delivery. They were not even benefited from proper ante-natal and post-natal care. Health is affected not only by their biological differences from men, but also by gender-based social, cultural, and economic inequities. Gender inequities begin at birth when a preference for sons puts some baby girls at risk of infanticide. Girls in some societies receive less and worse food than boys, and less health care disparities in nutrition and health care often continue into adulthood. Although both men and women expressed interest in family planning methods, the burden is often placed on the woman to obtain a method, and the responsibility for raising children belongs entirely to the woman.
Majority of the respondents got married before attaining the legal age prescribed in the constitution of India. Gender differentials in the age at marriage have important implications for woman’s well being. Gender differences in decision making about marriage are influenced both by preferences for marriage and the constraint structure that bounds decision making. A combination of factors both economic and cultural, may lead to the differences in the age at marriage between men and women. Historically, in India, early marriage and child marriage were recognized as social problems and social reformers were involved in campaigns to increase male and female marriage age. Firstly, in 1872, the Civil Marriage Act was passed, than the Infant Marriage Prevention Regulation Act was passed in 1894, prohibiting the marriage of girls below 8 years and boys below 14 years. It was later in British India that the Sarda Act of 1929, fixed the legal marriage age for men at 18 and for women at 14. Further, in independent India, the Child Marriage Restraint Act was passed in 1978, fixed the legal age at marriage for women at 18 years and for men at 21 years. However, in India the median age at first marriage for women aged 20-49 is 16.7 years, still well below the legal age. There are many economic and social factors which may alter both individuals’ preferences and the constraint structure that influence age at marriage and women’s participation in decision making. In India, dowry-related violence, sometimes leading to deaths by murder or suicide, is increasingly being documented. Dowry, a Hindu tradition, was originally a way for parents to share their inheritance with their daughters who were not allowed to inherit property. This practice has become a crucial marital transaction and a way to get rich quick. Bridal abuse is a way of putting pressure on her family to give them more of their assets, and when a wife is unable to provide them, she may resort to suicide or be killed. Women rarely seek medical help, mainly because of shame. They remain silent about their experience, because of culturally-endorsed acceptance of violence or fear of stigma and greater harm. Further, lack of economic autonomy is an important reason that women stayed in abusive relationships. Their worth and social acceptance is found in marriage and children, making separation or divorce almost impossible.

Women’s responsibility for household work and role of caregiver, and their lack of decision-making power tend to experience more negative stress. The feeling of lack of control over one’s life sometimes experienced by women, due to a range of
socially determined gender roles, can lead to feelings of depression and helplessness. Mental health issues are major causes of disability for women of all ages, and they suffer higher rates of depression and anxiety compared to men. Findings of the study reveal that the respondents are more vulnerable in terms of psychological well-being. They experienced more stress and anxiety when they enter prison. Women as such are accorded lower status in their families and society. Low socio-economic status and the challenges associated with it increase the distress and the chances of women being depressed. They are at greater risk than men of depression and anxiety disorders. Battered women often suffer from substance abuse, depression, and other problems.

During the study it was found that older respondents were experiencing age specific health problems like arthritis, cataract diabetes, and hypertension. Their problems largely remains unattended in the family however this condition becomes worse in prison due to structural constraints in prison. Women have a longer life, marked by many chronic non-life-threatening disabilities that can greatly affect the quality of their lives. Osteoporosis, for example, due to a natural decline in bone density after menopause, affects mainly women. Older women are more likely to live alone than men and isolation can severely affect the health of older women and given the lower economic status of women, they are less likely to be able to seek help. For women, living in rural areas is associated with having large families and a tendency to rely on untrained personnel or general practitioner for births and medical needs. They are, thus, more exposed to poor medical care for reproductive healthcare and, consequently, more at risk of infection. They also have less access to medicines to treat morbid conditions. Further, family members pay no attention towards their health problems and their needs are taken for granted.

Findings of this part of the study are in accordance with the idea contained in the feminist theory of health that the way in which the individuals are socialized into masculine and feminine social roles will have a determining effect on their health and illness. In many cases the diagnoses and treatment of women as diseased are not more than thinly disguised social norms of women’s appropriate social roles, especially their role as mother.

In developing countries, like India women who are totally dependent for economic livelihood upon their husbands are particularly affected when they suffer
domestic abuse. Those who are unable, for economic reasons, to leave their husbands are the worst-off and least able to escape the situation. The economic dependency sometimes leads women to commit petty and non violent crimes in order to fulfill their basic needs. Women who are repeatedly exposed to painful events over which they have no control and who have no obvious means of escape may develop the classic symptoms of learned helplessness i.e., they become passive, lose their motivation to respond, and come to accept that they cannot take action which would allow them to escape from the painful stimuli, even when situations are introduced in which action could be taken to avoid them. The experiences of being mistreated further reinforce their low sense of self esteem and the belief that they are powerless to alter their situation or take effective action. The vulnerability of women in terms of their background or lack of family and social support does not only cause them to be accused but it can play a role in increasing the likelihood that they will be victimized and also makes it more likely that they will be disadvantaged in terms of escape routes. The dynamics of abuse create a vicious cycle in which the victim becomes increasingly more passive and frightened and the abuser more able to control and terrorize, the more she gives up her external sources of support, the easier it becomes for the abuser to dominate her. This dynamic is clearly evident in the battered women who become the sponge for her partner’s feelings of inadequacy and self contempt. She absorbs these feelings, becomes increasingly depressed, while in turn loses touch with her own feelings of vulnerability, finding her aggressive and sadistic feelings more acceptable and less frightening to acknowledge. The moment where the victim becomes aggressor, where the battered women becomes the killer or criminal, can be seen as the moment of rebellion, of challenging the polarized and distorted roles that have been created. However, women are still much more likely than their male partners to be victims of fatal assault within the family.

**Health of Women during Imprisonment**

Health is one of the key indicators of well-being of a society and prisons serve as mirrors of society. The World Health Organization (WHO)’s definition of health encompasses physical, mental and social dimensions. This definition clearly emphasises two commonly neglected aspects namely mental and social well-being, apart from physical health as being integral components of health. The prison environment is not really conducive to good health. Prison environment is
increasingly being recognized as setting in which society’s diseases are concentrated. Prisons are plagued with problems of overcrowding, violations of human rights, abuse and violence amongst inmates themselves and with authorities, lack of medical care, structural and physical deficiencies and shortage of staff. Prisons are environment that are likely to contain a high number of socially disadvantaged people. However, prisoners do not exist in a vacuum as they have lives before imprisonment, and return to these lives on release.

An insight into the profile of women prisoners and an analysis of their health conditions prior to imprisonment unfolds that majority of the women prisoners come from the underprivileged sections of society with the common experiences of violence, abuse and poor health conditions. The sole purpose of the existence of prisons is that society, which expresses its wishes through the means of courts, finds it necessary to separate and isolate some people who have broken the law. Traditionally, prisons have been used for punitive purposes only. However, in modern time prison institution is a means to reform and rehabilitate the inmates. In spite of the fact that prison system has, during the past decades, undergone a massive change both in its objective and in its physical structure, the basic character of prisons as closed institutions with little public scrutiny continues to the present time.

For Michael Foucault, prison is a tool of control in modern society. He further, adds that the prison does not merely control the criminal but control the working class by creating the criminal and that this is ‘the unspoken rationale for its persistence’. Therefore, prisons have various effects on its inmates inside, and that these effects change the way people on the outside understand the social significance of prison. Prison and its population are no longer seen as isolated from other aspects of society. Hence, increase in the number of female prisoners can be interpreted both as a product of shifting social forces as well as a provocation of social change. As offenders women have constituted much smaller percentage than their proportion in the population. Further, most arrested women are usually first time offenders. Prisons are a reflection of the societies within which they are located. Thus it is unsurprising that this discrimination is made manifest within the penal institutions whose facilities were historically built and run to cope with the needs of the male majority. Consequently, some of the most neglected, misunderstood and unseen women in our society are those in prisons. While women’s rate of incarceration has increased
dramatically, prisons have not kept pace with the growth of the number of women in prison, nor has the criminal justice system been redesigned to meet women’s needs, which are often quite different from the needs of men. Historically, treatment research and recovery have been based on the male experience, often neglecting women’s needs. While this neglect has a serious impact on women and treatment programs in the free world, the problem is magnified for women in the criminal justice population. Gender is thus fundamental but largely ignored issue in criminal justice system because women offenders are different from men with different pathways to crime, different life circumstances and different rehabilitative needs.

Findings of the study reveal that majority of the women prisoners were undertrial. Undertrials are those prisoners, who in the eyes of law, are yet to be convicted by the absolute final judgement. Generally, the trial process is slow and costly and the undertrial prisoners pass their days with suspense and expectations. Every hour reinforces their disillusionment and bitterness towards the system. Lack of family support, legal unawareness and inability to fight the legal battle make the experience of imprisonment more difficult for undertrial women. Further, the plight of the undertrial is that though nothing has been proved against her/him but she/he is bound to suffer the hardships of prison life. The reformative and rehabilitative effects of imprisonment are insignificant for them. Yet, the costs of imprisonment to the state, to prisoners themselves and their families are great. Women prisoners experience helplessness as they receive far less support from their partners and family than do the male prisoners. They are unable to defend themselves and ignorant of the ways and means of securing legal help and thus totally at the mercy of jail officials, who often fail to show any understanding of their problems. The prolonged and uncertain wait for their charges to be processed through court accompanied with lack of contact with loved ones often make them prone to psychological stress, suicide and self harm. High health risks coupled with the already well known risks of physical abuse and violence that are prevalent in prison amounts to additional punishment over and above the years of restraint that the guilty are paying with and the innocent must put up with. Further, because of short sentences that women often serve, there is a high turnover rate in women’s prisons which means that there is an intensive interaction between the prison, the community and wider society. Prison health is integral to good public health, effective health care in prison ultimately reduces the
health risks to people in the community. The prison health care programs and screening not only identify and help correct medical disorders, but encourage the inmates to continue a healthier path for themselves and any dependents they may have once released. This raises self esteem to a degree and helps aid in the avoidance of future criminal activity.

Findings of the study also reveal that for many of the women prisoners health screening at the time of admission to prison (known as Mulaizha) may be the first time they have ever undergone a physical examination, dental care and other basic health care routines. It was learnt during the study that some of the respondents were diagnosed for diseases through Mulaizha. Developing countries like India face challenges of both communicable diseases (especially tuberculosis, HIV, malaria, diarrhea, cholera & sexually transmitted diseases) as well as non communicable diseases (commonly, hypertension, diabetes, obesity, cancer & mental disorder). Both communicable and non-communicable diseases add not only to mortality but also morbidity in society. These issues are more prevalent in prison population than in the general population. Prison population consists of an over representation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions. Majority of the respondents suffer from diseases such as, hypertension, tuberculosis, diabetes, arthritis, cataract and psychological ill-being. During imprisonment majority of the women inmates reported waterborne diseases and skin disease. Within prisons, the risk of spread of infectious diseases (e.g., tuberculosis, skin diseases etc.) is heightened by poor and overcrowded prison conditions. Germ theory of health which is descendant of contagion theory, currently dominates thinking about disease causality. The remarkable discoveries of science and the apparent ability to control infectious disease through scientific methods have led to germ theory’s dominant role in the realms of health and disease. Germ theory like contagion theory, posits a specific, potentially controllable cause of infectious diseases. Women prisoners are characterized by their pre-incarceration health risks such as trauma, abuse and maternal health problems. In prison, pre-incarceration health risks interacts with the characteristics of the prison, the access and quality of health services, and the experience of being detained, contributing to a wide variety of health outcomes.
Further, majority of the respondents reported problems of emotional and psychological ill-being. Symptoms of emotional ill-being provide a baseline indication of psychological ill-being among women prisoners rather than a clinical diagnosis of psychological illness. Stress, anxiety, sense of insecurity and uncertainty of release covered a range of feelings and behaviors, such as persistent sadness, loss of interest in activities, insomnia and anger or irritability were common among women inmates. Separation from family and children, uncertainty of release and acceptance by the family and society were the major source of anxiety. Human rights and mental illness are closely related. Persons with mental illness are most vulnerable to violation of their rights in the society as well as in prison. They are stigmatized, isolated and discriminated. A mentally ill prisoner has a double disadvantage as both a mentally ill person and a criminal. Many times, a person with mental illness may not receive proper treatment and remains in the custody for years. This may be on account of being unfit to stand trial, lack of support, or because the family is able but unwilling to bail out the person because of the illness. The UN Special Rapporteur on Violence against Women has noted that mentally ill women are at high risk of sexual abuse in custodial settings. Gender is conceptualized as a structural determinant of psychological and physical health and illness that runs like a fault line, interconnecting with and deepening the disparities associated with other important socioeconomic determinants such as income, employment and social position. Gender differentially affects the power and control men and women have over these socioeconomic determinants, their access to resources, and their status, roles, options and treatment in society. Gender has significant explanatory power regarding differential susceptibility and exposure to psychological health risks and differences in psychological health outcomes. Gender differences in patterns of help-seeking and gender stereotyping in diagnosis compound difficulties with identification and treatment. Gender acquired risks are multiple and interconnected women are more prone to panic disorder, depression and post traumatic stress disorder, many arise from women’s greater exposure to poverty, discrimination and socioeconomic disadvantage. Low status is a powerful predictor of depression. Traditional gender roles further increase susceptibility by stressing passivity, submission and dependence and impose a duty to take on the unremitting care of others and unpaid domestic and agriculture labour. Violence-related psychological and physical health problems are poorly identified, victimization histories are not routinely taken and women are
reluctant to disclose a history of violent victimization unless physician asks about it directly. Sylvia Tesh (1988) remarks that fundamental cause of poor health is unjust social system, concluding whatever makes life better in general also makes it healthier. Similarly, Turshen (1989) describes a new theory of disease called the social production of health and illness. The way in which society is organized determines health and disease, and while specific etiologies are involved in specific disease, the vulnerability of a particular group of people is a socially determined historical phenomenon.

As the number of women increased, so have the number of older women in prisons. These older women present unique problems for prison institution trying to meet their health care needs. Ageing in general brings with it new physical, psychological and social challenges. Prisons are typically designed for younger prisoners. For older prisoners, this introduces additional challenges to safety, functional ability and health. It was found that older women were suffering from age specific health problems such as menopause, arthritis, cataract and hypertension.

In addition to the physiological and psychological well-being environmental issues also affect the health of women prisoners. Indeed the issue of healthy and unhealthy living conditions has particular meaning in considering the issue of prisoners’ health, as overcrowding, inadequate sanitary conditions and poor food and water standards are common in prisons. The findings of the study show that women prisoners are living in overcrowded cells with poor hygiene and sanitation, lack of clean water, inadequate quality and quantity of food, and insufficient toiletries for the cleaning and grooming. Women are incarcerated in overcrowded, unsanitary and stressful conditions, alongside others who share the same increased health vulnerabilities. As a result the prison environment is one marked by disease transmission, environmentally exacerbated health decline and death, and heightened risk of mental illness. World Health Organization says that ill health thrives in settings of poverty, conflict discrimination and disinterest. Prison is an environment that concentrates precisely these issues. Human Rights Watch also documented consistent problems with environmental health in prisons, including overcrowding, poor sanitary conditions, inadequate ventilation and insufficient personal hygiene supplies. Further, inadequate diet and unhygienic living conditions contribute to an extremely high rate of disease and illness. The right to healthy living environment is also engaged under
civil and political rights mechanisms. Additional, the right to life inherently includes a requirement to provide the necessary elements for survival such as food, water and shelter. Moreover, the problem of poor prison health is not one limited to prisoners and prison authorities. Indeed, health experts and international organizations have consistently emphasised 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 prisoners is not only a matter of pressing concern for prisoners, it is also integrally linked to state obligations to fulfill the right to health within the population as a whole. It endorses the idea of contagion theory which put responsibility for population health on governments and other political entities, which are expected to protect their populations through appropriate measures. In crowded, noisy, unhygienic environments, human beings tend to treat each other terribly. The prison atmosphere, with its undercurrents of violence, tension, bitterness and distrust, made an adverse, psychological impact on the children who were staying with their mothers. The claustrophobic conditions drastically curtailed their natural instincts to frolic and romp around and indulge in playful activities.

Findings of the study show that in the overcrowded prisons, there was lack of proper recreational facilities and physical activities. There were no gymnasiums in women jails. Women inmates spent most of the time watching television, gossiping or quarrelling. They were significantly less satisfied with regard to access to sports and entertainment facilities. The general lack of nutrition and physical exercise, the excessive lock-up hours due to lack of staff, widespread anxiety, unhygienic living conditions all take a heavy toll on the physiological and psychological health of the women prisoners.

Specific standards that recognize the special needs and circumstances of female prisoners are included in the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment such as the need for specific measures to protect the right and special status of women, especially pregnant women and nursing mothers. Several UN agreements define parameters relating to marriage and reproduction, including establishing a minimum allowable marriage age. Age at marriage is likely to shape women’s empowerment and
agency within households and their status in the broader community. Hence, norms and behaviors relating to expected (unequal) social roles and status are deeply rooted in local culture, which in part also shapes individual identity. For girls, social roles are likely to be restricted to the domestic sphere, to being a daughter, wife, home-maker, and mother. For young mothers, the fulfillment of these diverse domestic roles often implies physical and social isolation from the maternal household, peers, and wider society, which may have knock-on effects on their mental health (e.g., susceptibility to depression), nutritional status, and their children’s health outcomes. There is likely to be a two-way association between early marriage and poor mental health, and together, these factors have knock-on effects on a range of adverse maternal health and child outcomes. Women have equal rights to men to freely choose a spouse and to enter into marriage with their free and full consent. Women also have the right to good reproductive and sexual health. This includes a satisfying and safe consensual sexual experience, the capability to reproduce, and the freedom to decide if, and when, to bear a child. Access to timely and adequate health care for women and their children is also essential.

It was found during the study, that majority of the women inmates did not participate in decision making of marriage, child-bearing and use of contraceptives. The health care provided to them was limited to maternal health in terms of ensuring their role as mother and wife. Women’s health is usually the last priority, however for example, in case of resolving problem of infertility, women’s health gains utmost importance. Further, recognition of problem also depends upon several psycho-socio-cultural factors besides the biological evidence of a medical condition and which in turn determines the decision to seek treatment. Since marriage entails adult responsibilities and also understanding of its consequences, setting a minimum age is a legal guarantee that adult responsibilities are not assigned to children prematurely.

The findings of the study show that majority of the women prisoners got married before the legal age and most of them have children before attaining the age of 20 years. According to UN statements, under-age marriage constrains
overall well-being by denying girls their childhood. However, marriage not only accelerates the transition to womanhood, it also reduces opportunities for personal, emotional, and psychosocial development during the critical middle phase of adolescence. During adolescence one’s identity, selfhood, and sense of place in society are developed, often in relation to the broader culture and customs. Critical knowledge about reproductive and sexual health is also gained during these years, either through school or peer groups. Marriage age also plays a very important role in lowering fertility levels from the biological maximum. The availability of reliable contraception offers the chance to thwart this relationship by stopping at a particular desired number of children or by increasing the spacing between births. Additional plausible explanations for faster childbearing include poorer contraceptive knowledge, access to other birth control methods and less control over family planning decisions. In patriarchal societies male child preference is also largely responsible for the large number of children.

It was found during the study that majority of the women inmates were deprived of proper pre-natal and post-natal care outside as well as in prison because of which they experienced problem of anemia and malnourishment. The high rate of malnutrition among young mothers is a critical public health concern because adolescence is a period of nutritional vulnerability due to rapid growth and development. Poor maternal nutritional status is in turn associated with a poor start in life for children who are more likely to experience other social and health penalties. Thus, Women in prisons have more specific health issues, the most prominent are related to maternal health such as, pregnancy, childbirth, lactation, menstruation and menopause. It was found that some women suffer maternal health issues i.e., miscarriage or abortion prior to arriving in prison. These women are required more care and facility. Pregnant women require specialized resources and attention with respect to diet, exercise, clothing, medication and medical care. However, it was found during the study that pregnant women have little or no access to adequate facilities that can meet their accommodation or health needs in poor infrastructure facilities of prisons. Prison environment is incompatible to the needs and care of a pregnant body. It is more difficult to catch up on missed sleep and
missed meals due to the inflexibility of the prison regime while alerting staff to a medical problem may be difficult, particularly at night.

It was found that special diet of milk, fruits and multivitamin tablets were provided to the pregnant and lactating women. However, few complained that it was not sufficient. There was no separate living space for pregnant and nursing women and they had to adjust in the overcrowding. Pregnant women face challenges in terms of consistency in the standards and quality of maternity care due to limited access to gynecologist or midwives and poor continuity of care. There are also difficulties in securing transportation from prison to health care facility as well as gaining access to any education in birthing techniques to help prepare them for the birth. Findings show that there are several responsible factors that affect overall well-being of women. Therefore, current theories of health are more often multi-causal, based on multiple factors that contribute to health both independently and through action. It posits that the occurrence of disease at both the individual and population level results from a dynamic interplay between exposure and susceptibility within a historical and social environment.

As far as impact of imprisonment is concerned findings reveal that some women, such as those who begin incarceration with a more debilitated health status are victims of abuse and violence and neglected in terms of health in the family and belong to impoverished background find prison to be a place for recovery rather than disease. The positive changes are largely due to behavioral changes such as minimum level of care, abandonment of risky behaviors and abuse. Further, most of the older women who were deprived minimum level of care in family or society reported that in prison they had better access to care. In terms of maternal health prisons provide a facility of institutional delivery which many did not have access to before coming to prison. Inmates without any previous pathology did not report a positive influence of prison on their physical and psychological well-being. Women play a prominent role in family routines, when they are imprisoned, they see themselves forced to leave their families, which results in high levels of anguish and suffering and enhance the deterioration of their psychological well-being.

As far as health care services in prison are concerned Model Prison Manual provides for women inmates gynecologist as well as sufficient nursing and other
supporting staff. Modern facilities like X-ray, ECG, ultrasound and sonography should be available to women in prisons. Women prisoners suffering from mental disorders, anxiety, and drug addiction should get proper medical treatment and psychotherapy. It has been seen that there is always a wide gap between theory and practice, findings of the study reveal that in all the district jails there was lack of gender specific health care facilities. All the available infrastructure facilities were common for both male and female prisoners. In the three district jails there was no full time female doctor or gynecologist to take care of female inmates. A female doctor from the District Hospital visited the inmates once a week. Further, there were no separate hospitals for women inmates in the prisons. However, there were dispensaries in women enclosures which are useful to provide first aid care at the time of emergency. There is absence of medical personnel, which not only includes specialists but also laboratory technicians. Further, insufficient police escorts make it difficult to refer ill prisoners to outside hospitals. This eventually makes timely medical treatment often an exception rather than the rule. Lack of sufficient vehicles to transport prisoners to hospitals during exigencies is not unusual.

It was found that women prisoners access to doctors is far less than that of male prisoners. Except in cases of emergencies, when they are taken to the prison clinic with sufficient staff, women in most of the prisons have to wait for doctors to visit them. Moreover, in many cases, besides lack of resources, it is the existence of a dehumanized system in the prison which contributes to the problem. Further, there was strong demand of trained counselors and psychiatrists in prisons. However, the absence of counselors speaks volumes of the negligent attitude towards the psychological well-being of prisoners. Health care services need to be able to respond to the needs of a constantly changing prison population. A comprehensive package of health care needs to be provided for each new reception, and this is particularly challenging given the severity of the problems women prisoners have. Trying to make follow-up arrangements for women upon release is often also a challenge. Thus, prisons needs to be managed within ethical framework, guided by international standards developed to protect the human rights of women prisoners and to ensure that prisoners treatment aims to facilitate their social reintegration, as a priority.

Thus, findings of the study indicate that women’s health and well-being is a neglected issue in patriarchal society because of gender identity through which
women are put at the lower ladder in society. Indian society has deeply entrenched patriarchal norms and values. Patriarchy manifests itself in both the public and private spheres of women’s lives in the country, determining their ‘life chances’ and resulting in their qualitatively inferior status in the various socio-economic spheres. There are similarities in women’s lived experiences due to such gendered existences. Women’s lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. Health is socially determined to a considerable extent. Access to healthcare, is almost fully so. This being so, the ‘lived experiences’ of women in India are replete with potential risk factors that have implications for their lives and well-being. The multiple roles of household work, child rearing and unpaid work that women carry out has implications for their physical and mental health. However, their health is considered as a matter of concern when they are unable to perform the role of mother or wife. In general, women in India are restricted in matters of decision making, freedom of mobility, access to money and so on. Certain periods in a woman’s life like early childhood, adolescence and old age may be especially vulnerable to discrimination and neglect.

The status of women in India is depressed on many socio-economic indices with low literacy rates, poor participation in political processes, concentration in low skilled and low paying economic activities and a culture that values motherhood and care giving roles in women. Feminist sociologists argue that medicine plays a vital role in enforcing conformity to these social roles, and is especially targeted at women. This is because controlling women’s ability to reproduce is central to patriarchal society. Further, almost all the medical attention paid to women is around their reproductive organs and their life cycle, as it relates to their ability to have children. In many cases the diagnoses and treatment of women as diseased are no more than thinly disguised social norms of women’s appropriate social roles, especially their role as mother. For example, with the active productive life of a person being over and the second filial generation having made its entry in the family, the position of the individual undergoes a change.

In India, crimes and violations take women (especially poor and lower caste women) from one imprisoned life, under the patriarchal control, to a more visibly
disciplinarian and incarcerated life of the prison. An analysis of power relations is central to the feminist project of understanding the nature and causes of women's subordination. Drawing on the traditional model of power as repression, many types of feminist theory have assumed that the oppression of women can be explained by patriarchal social structures which secure the power of men over women. Foucault, claims, that in pre-modern societies power was centralized and coordinated by a sovereign authority who exercised absolute control over the population through the threat or open display of violence. From the seventeenth century onwards, however, as the growth and care of populations increasingly became the primary concerns of the state, new mechanisms of power emerged which centred around the administration and management of life. Foucault tells that this new form of 'bio-power' coalesced around two poles. One pole is concerned with the efficient government of the population as a whole and focuses on the management of the life processes of the social body. It involves the regulation of phenomena such as birth, death, sickness, disease, health, sexual relations and so on. The other pole, which Foucault labels 'disciplinary power', targets the human body as an object to be manipulated and trained. In *Discipline and Punish* Foucault studies the practices of discipline and training associated with disciplinary power. He suggests that these practices were first cultivated in isolated institutional settings such as prisons, military establishments, hospitals, factories and schools but were gradually applied more broadly as techniques of social regulation and control. The key feature of disciplinary power is that it is exercised directly on the body. Disciplinary practices subject bodily activities to a process of constant surveillance and examination that enables a continuous and pervasive control of individual conduct. The human body was entering a machinery of power that explores it, breaks it down and rearranges it. Thus, discipline produces subjected and practiced bodies, 'docile bodies'.

Foucault's notion that power is constitutive of that upon which it acts has enabled feminists to explore the often complicated ways in which women's experiences, self-understandings, comportment and capacities are constructed in and by the power relations which they are seeking to transform. The idea that modern power is involved in producing rather than simply repressing individuals has also played a part in a controversial move within feminism away from traditional liberationist political orientations. Foucault argues that, since modern power operates
in a capillary fashion throughout the social body, it is best grasped in its concrete and local effects and in the everyday practices which sustain and reproduce power relations. This emphasis on the everyday practices through which power relations are reproduced has converged with the feminist project of analyzing the politics of personal relations and altering gendered power relations at the most intimate levels of experience 'in the institutions of marriage, motherhood and compulsory heterosexuality, in the ‘private’ relations between the sexes and in the everyday rituals and regimens that govern women's relationships to themselves and their bodies. One of Foucault's most fertile insights into the workings of power at the micro-political level is his identification of the body and sexuality as the direct focus of social control. Foucault insists on the historical specificity of the body. At a fundamental level, a notion of the body is central to the feminist analysis of the oppression of women because biological differences between the sexes are the foundation that has served to ground and legitimize gender inequality. By means of an appeal to ahistorical biological characteristics, the idea that women are inferior to men is naturalized and legitimized. This involves two related conceptual moves. Firstly, women's bodies are judged inferior with reference to norms and ideals based on men's physical capacities and, secondly, biological functions are collapsed into social characteristics. While traditionally men have been thought to be capable of transcending the level of the biological through the use of their rational faculties, women have tended to be defined entirely in terms of their physical capacities for reproduction and motherhood.

Prison is the miniature of society. It reflects the existing value pattern of society. At the most general level feminist theories of health, illness and health care have the same task in common, the attempt to show that women's experience of health is socially constructed rather than built directly upon biology or the materiality of the body. Liberal feminists argue that there is no intrinsic relationship between sex/biology and gender. Radical feminism takes a contrasting approach which endorses a strong connection between sex and gender. It attempts to undermine patriarchal privilege by positively valuing what is distinctive about the female, rather than the male body. The body is central to, and for some radical feminists effectively determinate of, women's experience. Control over the body is also central to marxist feminism, although many writers in this tradition are critical of what is seen as radical
feminism's essentialism, arguing that while the 'biological base' is important, it is modified in different social contexts according to women's historical relationship to the means of production under patriarchy. Women’s ill health is because of their subordinate position in society. Indian women in prison are a very specific group of individuals.

Majority of women prisoners in India are uneducated, poor and belong to marginalized or socially disadvantaged groups and have limited knowledge about health and practice unhealthy lifestyles. Thus, they represent a distinct and vulnerable health group needing priority attention. They carry a much greater burden of illness than other members of the society; they harbor diseases that are determined both by the environment out of which they come and by the prison in which they live. Women’s ill health in prison is not essentially because of the prison environment. On the other hand imprisonment proves to be beneficial for many of the women as it protects them from abusive relationship and deprivation of minimum standard of health care. Incarceration offers a unique opportunity to identify and address the destabilizing stresses in an inmate’s environment that led to her entry into the correctional system, and many women express interest in seizing this opportunity to make life changes.

Prison environment however is increasingly being recognized as settings in which society’s diseases are concentrated. In India overcrowding has aggravated the problem of hygiene. Prisoners, who enter prison with history of violence and abuse or other health related problem often leave without having received proper medical attention. In fact, their problems may often escalate in prison. If the inmates are not treated adequately in jails they will return to the community further burdening the existing health care facilities of the country. The diseases with which women suffer prior and during imprisonment are also experienced post release which spreads to the wider community. Thus, there is a cycle of disease impacting the behaviour of women which proves to be the pathway to prison and which continues even after release. Structured support is crucial in preventing released inmates from returning to poor health and unsafe living situations that results in high rates of recidivism and high rate of prevalence of diseases.
Prisons Staff

The state has a special duty of care for those in places of detention which should cover safety, basic needs and recognition of human rights, including the right to health. Prisons staff explained that caring of sick prisoners is challenging. Penal institutions were not designed for the purpose of providing health care. Their environment, regimentation, physical plant, and lifestyle are anything but therapeutic. Prisons staff were of the view that women enter prison with more physiological and psychological ill-being as compared to men. Further, a number of health problems and needs are specific to women in prison. Chronic physiological illness is generally uncommon in young age group, however, many women inmates have temperamental, emotional and behavioral problems that manifest as self-harm and suicidal behaviour. Women are more affected by the anxiety relating to children whom they bring along and those left outside. Moreover, the prison environment can be overcrowded and may be violent, prisoners suffer emotional deprivation and may develop mental health problems while incarcerated. Other health care needs may be made more complicated by imprisonment such as the management of chronic diseases like diabetes or hypertension. Further, certain health care needs are requirements of the prison system itself, for example, health screening on arrival at prison and assessments carried out to determine a prisoner’s fitness to appear in court.

Most health care in prisons is primary care. However, health care delivery in prisons faces a significant number of challenges not experienced by primary care in the wider community. There are particular challenges in maintaining a health care ethos to thrive in an environment where the highest priorities are maintaining order, control and discipline. Moreover, the prison infrastructure and culture hinder providers from offering quality medical care to women prisoners. The health care providers (especially male) in prisons frequently fail to meet women’s needs, specifically with regard to communication and sensitivity. Lack of counselor or psychiatrist is an obstacle to provide proper counselling and guidance to reduce stress. Prisons staff emphasized women’s capacity to use self-and community advocacy skills to meet their health care needs and cope with the challenges created by the prison infrastructure and culture. The prison environment presents unique challenges to those providing health care. The specific needs of women are often not met by prison systems, which have been largely designed by and for men. Women in
prison need free access to a full range of gender-specific health services. There should be explicit recognition that women and men are different and that equal treatment of men and women does not result in equal outcomes.

Since prison administration has a direct bearing on the improvement of the quality of life of those who deviate from the accepted social norms, the development of prisons shall be pursued as an integral part of the National Development Plans. Investment on prisons shall lead not only to the reformation and rehabilitation of offenders as law abiding citizens, but also to safeguarding the life of those adversely affected by crime. The governments at the centre and in the States shall endeavour to provide adequate resources for the development of prisons and other allied services. Providing health care for prisoners has historically been the responsibility of the prison service. Prison is a part of society and prison health ensures the health of society to large extent. The success of the prison system depends less on the governing rules than on the manner and spirit in which those rules are interpreted and applied by the staff in prison. A staff suited to the needs of the establishment becomes, therefore, the foremost task of a prison administration.

Prison system is based on bureaucratic organizational structure. Prison is a symbol of modern society based on the idea of rationality. Here, it is significant to mention Weber’s idea of bureaucracy. According to Weber, bureaucracy might be seen as institutions that closely control and direct human behaviour or social actions. He believed that bureaucracies consisted of individuals carrying out rational social actions designed to achieve the goals of bureaucracies. Weber says that in legal authority, legitimacy is based on a belief in reason, and laws are obeyed because they have been enacted by proper procedures. Thus, it is believed that persons exercising authority are acting in accordance with their duties as established by a code of rules and regulations. He saw the whole development of modern societies in terms of a move towards rational social action. He referred to the increasing dominance of rational action as the process of rationalization. Bureaucracy is a system of control. It involves a hierarchical organization in which superior strictly control and discipline the activities of subordinates. Obedience constitutes deference to an impersonal order, not an individual, and even the giving of a command represents obedience to an organizational norm rather than the arbitrary act of the person giving order. Thus, the official does not exercise power in his own right, he is only a trustee of an impersonal
compulsory institution. The organization of the administrative staff under legal authority is bureaucratic in form.

Although Weber admires the rationality and efficiency of bureaucratic organizations and respect the concept of justice embodied therein, he also associate bureaucracy with an oppressive routine that is adverse to personal freedom. Indeed, Weber recognized the possibility that bureaucracy could become mankind’s iron cage, whose rigidity would easily snuff out human feelings and values. He views that bureaucracy might be seen as institutions that closely controlled and direct human behaviour or social action. The bureaucratic organizations produce an ‘iron cage’ which imprisons and restricts people. According to Weber, bureaucracy has the controlling power which hinders human’s greater capabilities of sensitivity, innovations and creativities. People are being forced to do whatever ‘the process of rationality’ suggests to do in a bureaucratic organization. The more we become rational, the more we find our self as ‘spiritless specialist’ trapped in ‘iron cage of rationality’. Max Weber coined the term ‘iron cage’ for the increasing rationalization in social life. Weber thought of the ‘iron cage’ as a trap and in some ways as a prison. He realized that the social actions of individuals became more based on rationality instead of being based on their values and tradition.

Prisons staff perform their duties in accordance to the procedures established by the Centre/State Government. Prison is an institution which is designed to achieve the goal of reformation and rehabilitation of prisoners in order to make them better citizens when they return to the community. In a bureaucratic hierarchal structure prison staffs are bothered to discharge their duties within certain framework. They are not free to show their humanity towards prison inmates. Discipline, security and sense of accountability awaken them to follow certain guidelines. However, prison structure like scientific medicine is not neutral it also represent societal norms. The prevailing notion of gender discrimination in society and the subordinate health care of women are also reflected in the concrete structure of prison management. For example, available health care infrastructure facilities are largely male centered. There is lack of gender sensitive care and facilities for women prisoners. The hidden gender perspective is lying in the management of abstract soul of prison administration. Moreover, in the fulfillment of the requirements of a bureaucratic structure prison staffs pose to rise above the stark gender disparity existing in the society outside. This
subjective gender panorama becomes invisible in the discharge of duties and it appears that prison administration is gender neutral. While working in an iron cage they willingly ignore the gender difference and opt to function as dutiful citizens of the state. However, the fact that prisons are designed by men and for men is well manifested in the unequal distribution of health care infrastructure.

Besides, availability of health care services to women in prisons with due attention to maternal health and complete ignorance of psychological well-being is reflective of the idea of Foucault that prison is a form of social and political control for wider society and not just an institution which controls crime and criminal behaviour. Foucault remarks that motive for reform of offender is simply a reflection of class power and an ambitious attempt at changing the offender character. Further, the development of scientific medicine and the internalization of norms of hygiene as well as the development of a state administrative structure to enforce and coordinate prison health are all aspects of Weber’s iron Cage. Modern society for Foucault is a highly disciplined society, a society in which social controls have grown and continue to grow, not arbitrarily but through the spread and knowledge of technology and the rationale and relationships that underpin and promote them.

**Suggestions**

The Indian justice system is one of the most important pillars of the Indian democracy. However, for all its power, it remains erratic, under-staffed and above all slow. That old saying, justice delayed is justice denied, sadly holds true for India. The Indian Judicial System follows a three-tier system, the lower courts, the state High Courts and the Supreme Court i.e., India’s highest constitutional court. All three systems currently face many challenges. Securing justice is riddled with difficulties from the very start for the ordinary Indian. The procedural difficulties one face in getting their case heard is a big contributor to the chaos in the system. From getting an FIR registered to going to a lower court which takes its own time to decide cases and maybe even the High Court or Supreme Court in case of dissatisfaction, means a case can take years to decide. In addition, the huge number of vacancies existing in the courts, and the situation gets truly distressing. According to official figures, there are more than 27 million legal cases pending in various courts in India, 6 million of which have been stuck in courts for five years or more. To manage this caseload, India has only 16,000 courtrooms and barely enough judges to preside over and carry out
hearings. There is one judge for every 73,000 people in India, seven times worse than the United States. This gaping hole in the vacancies not only creates inordinate delays in getting justice but has brought the entire system to the brink of collapse and repeatedly contributed to what can be rightfully called ‘miscarriage of justice’. The lack of manpower in the lower judiciary, known as the session court, is particularly problematic since a major chunk of pending cases is lying in the subordinate courts. The deeper depression, lies not just because of the corruption in the system or the quality of workforce but the amount of resources the government earmarks for spending on judiciary (https://www.youthkiawaaz.com/2017/02/indian-judiciary-failure-and-solutions/).

The very pendency of criminal proceedings for long periods by itself operates as an engine of oppression. Owing to the prolonged pendency of a case prisoners suffer in many and different ways. Especially harmed is the defendant who has criminal charges and a thread of a prison sentence hanging over his head. He is subject to psychological anxiety and deprivations, social stigma and economic impairment. The stereotype regarding Indian jails is known to all. Jails busting at the seams, inmates languishing for years awaiting trial and committee after committee set up to bring about jail reform coming with recommendations that are conveniently ignored. Although imprisonment affects men and women both but it tends to affect women more adversely than men. It is because women have different physical and psychological needs and majority of them are primary carers of their dependent children. Women have the right to good reproductive and sexual health. This includes a satisfying and safe consensual sexual experience, the capability to reproduce and the freedom to decide if, and when, to bear a child. The ideal age, physically, for a woman to have a baby is under the age of 30 years. Fertility peaks from age 20 to 25 years and begins to decrease at age 30 years, generally women at this age are healthy, without chronic medical conditions, and have lots of energy. The risk of giving birth to a child with a birth defect does increase as the mother’s age increases. Further, with increasing age women are also more likely to face medical complications. They include a greater risk of miscarriage, stillbirth, multiple pregnancy, cancer, and needing a caesarean or assisted delivery (https://www.theguardian.com/society/2010/dec/31/pregnancy-mothers-fertility-children). Findings show that majority of the women belonged to reproductive age group. Their prolonged stay in prison often
deprives them of their opportunity to marry and to have children. Also, most of the women inmates are mothers. Motherhood is a feeling of satisfaction and source of happiness for the women. Separation from children proves crucial to women and their overall well-being. Women with children left outside feel enormous guilt about being absent from their children’s lives and worry about children. Imprisonment generates new psychological health problems or exacerbates existing ones. In society women generally play the role of carers of their families and children and the sudden change of their role from caregiver to offender and isolation from loved ones has an adverse effect on their psychological well-being. In view of all this, the clear message is that women should sent to prison only when there is absolutely no alternative. Nothing could be more unjust than detaining women in prison.

The profile and background of women in prison and the reasons for which they are imprisoned are different from those of men. Existing prison facilities and programmes for women inmates have all been developed initially for men who have historically accounted for the larger proportion of the prison population. It is therefore asserted that a gender perspective must be considered while catering to the needs of women in criminal justice system in general and prison in particular. It is clear that the needs of women prisoners are often overlooked by penal institutions, by governmental policy makers, and by the international community and that consideration needs to be given to every aspect of women’s prison regimes as well as to the reasons for the increasing female prison population to ensure that their rights, as defined in international law, are met. Virtually, all women in prisons have been battered in an adult relationship, affecting their physical well-being and self-esteem. Psychologically these women suffer from chronic fear and stress. One of the most frequent psychological consequences of violence against women is post traumatic stress disorder. This is an anxiety disorder occurring in the lives of people who have experienced extreme trauma, be it a single occurrence or a continuous period in the life of the victim. Anxiety disorders are the most prevalent mental disorders among incarcerated population (Braithwaite, Arriola & Newkirk, 2006). It is very important that these disorders be recognized and treated, and the women are educated about the psychological well-being.

A woman’s psychological well-being can have a profound effect on her interaction with the court and her chances for long term sobriety. Female offenders
thus need treatment that is gender specific, culturally specific and empowering. The prison must be the one place without doubt where the value and need for counselling needs little justification. This relates to several features of the subjects, women and prisons, and it also requires handling of the several strands that form the picture called ‘women and the prison’. Supplemented with the utter neglect in the area of mental health generally and women’s mental health particularly, the space for several interventions is unquestionable. While the wider agendas and processes of restoring social and economic balances that are more just and equitable towards the vulnerable (women, children, elderly, poor and powerless) are being worked out in society, any postponement of immediate remedial measures at various levels would spell disaster for those already damaged at the starting line. The trapped cannot be expected to wait while society and its principal actor-agency, the state, sorts out any long term agendas on these issues. Immediate steps that would enable these vulnerable groups to cope better with present difficulties and complications would be needed and counselling is one such immediate step especially in case of conflict and confinement in which women are at a total loss. Down the ages, in most societies, viewing women’s mental disorders (from the simplest such as distress and anxiety to the most complex) as figments of the imagination, sexual/biological aberration, or diabolical possession, little was ever done to address the causes and symptoms of women’s mental conditions. Despite the two principles that are supposedly the corner-stone of modern democracies and should affect women positively today i.e., equality and freedom, in the South Asian context, older traditional perceptions of women have a strong presence and live side by side with modern ideas. They are still adhered to the practices in the personal and social lives of women and subconsciously internalized by women themselves when they perceive their roles in the family, community or society at large. Therapeutic intervention is not an alternative to justice for the injured, violated and betrayed, nor is it a recommended soft option for those who feel or are unable to contest or claim. It can be a method of equipping women to envisage or start a journey that empowers them to take on the machinery, any machinery, whether familial, societal or state, to claim what is rightfully theirs. A therapeutic intervention is that point in the continuum of redress where the state of mind of a woman is addressed with the object of restoring enough of her lost self-esteem and self-confidence for her to be able to exercise her own choices. Counselling thus emerges as essentially a therapeutic process. It is guided by theoretical and practical
rules strongly rooted in principles that have their bases in different disciplines such as philosophy, including ethics, morality, psychology, law and jurisprudence, sociology and anthropology.

Most people in difficult life situations need counselling at some time or another and the more vulnerable groups in society need it more than others do. Choosing counselors to work with women locked up either at police stations or in prisons is not to be taken lightly. The location, subject, atmosphere and routine all convey the same message of tension and apprehension and while all of these are adequate reasons for justifying the pressing need for counselling here, there is no easy way to set about doing it. There is no other place that is comparable to the prison in modern society where so many strangers are compelled to live together and that too in a cage. Prisoners have no choices in prisons and cannot leave the four walls of the prison when they wish, not even for short spells, unless the machinery that sent them there deems it fit to allow them. Those who wish to counsel prisoners need to be quite familiar with some basic features about prisons. The model that the counselor therefore needs to build for this specific purpose is essentially a therapeutic model. It is a model that is at the same time wider and yet perhaps more limited in its reach than a straightforward problem-solving model, so that while it does solve a lot of problems for the client, its primary target is not a specific problem. Therapeutic counselling for women locked inside a prison is aimed at their personal selves and at features that relate to the prison experience. The purpose is to lighten their personal load at each level. The focus at the personal level is an attempt to see just what the client is experiencing as a result of being plucked from her habitat and brought to the most alien of places i.e., a prison. Some of these experiences relate to happenings prior to coming in prison and are aggravated by the strange and unfamiliar surroundings. At the prison level, the attempt is to determine just what features of prison life have the kinds of negative results that necessitate the need of counselling and therapy inside (Shankardass, 2012b). Therefore, it is suggested that counselors should be appointed in each jail in order to dispense duties relating to the welfare of the prisoners. Further, counselling would alleviate the stress of being imprisoned and provide a sense of support and empowerment which would also be helpful to reintegrate in society after release.
Model Prison Manual (2003) of India mandates that the welfare personnel will primarily be concerned with the well-being of prisoners, undertaking individualized care for those needing institutional adjustment and responsiveness through correctional Programmes. Welfare officer plays a very important role in coordinating the work of the welfare unit and helps inmates in overcoming problems of institutional adjustment. He assists inmates in dealing with problems faced by their families and dependents, connecting correctional needs of prisoners with the resources available within and outside the prison. He participates in the orientation, classification and reclassification of programme, facilitates understanding between the inmates and administration, assists prison authorities in maintaining prison security discipline, participates in the pre-release programme and helps the inmates establish contacts useful to them after release, and identifies the resources for rehabilitation of prisoners (BPRD, 2003). It is, thus, suggested that every jail should have a welfare officer in order to dispense duties relating to the welfare of the women inmates.

Cultural and recreational activities should be organized in all prisons for maintaining the psychological and physiological well-being of prisoners. These activities are the basic elements of rehabilitation programmes for prisoners. Yoga and meditation should be daily practiced for which the hours should be fixed. Permanent centers of meditation could be opened inside the prison. The services of NGOs could be availed in this regard. There should be a play ground for outdoor games and a community hall for cultural programmes in every prison. Therefore, present study suggests likely above activities in every jail for maintaining the overall well-being of women inmates.

As far as prison management is concerned it requires an ethos that differs from that of the police or the civil service and yet the top jobs in the department are reserved for police and civil service persons in the hope that the department would then be highly regarded in the general criminal justice structure. The officers at management level, majority of them are on deputation from the police service, consider this as a punishment posting and are generally too demoralized to contribute significantly to the building up of the department. Most of them are merely time servers. The supervisory level consisting of staff belonging to the prison service, too is demoralized because of poor conditions, lack of career opportunities and low public esteem. At the grassroots level, the department has people who remain inside the
prison walls, interacting with prisoners most of the time. This factor, combined with their pathetic service conditions, has the effect of dehumanizing them (Shankardass, 2012a). In some countries the management of the prison system was, and in some cases such as India remains even today, the responsibility of the police force. A posting to take charge of a prison often came about as an informal sanction as a result of some failing elsewhere. Bright police officers made sure that they completed their spell as a prison manager as quickly as possible before being transferred back to mainstream police duties. Central to the prison administration is the problem of demoralization and lack of motivation of the prison staff. A common aspect of prison culture is that prison officers see themselves as part of an unvalued, unappreciated occupational group. This often includes a perception that managers are bureaucrats who do not understand the nature of the operational work, the dangers and difficulties involved, and that prison management does not properly support officers. Trust, legitimacy and fairness are as important for prison officers as they are for prisoners. Professional leadership by senior managers is therefore of key importance. Prison officers frequently have a strong *esprit de corps*, which emphasizes solidarity with fellow officers. There can be significant peer pressure from prison officers as a group about the way things are done, and officers who do not confirm may suffer (http://www.prisonstudies.org/sites/default/files/resources/downloads/managing_prisons_0.pdf). Therefore, it is suggested that managing prisons must have its own philosophy and importing senior staff from other services cannot be a substitute for the culture that needs to be in place to guide the department.

Further, the State Governments should not downgrade the posts of the prison department by prescribing lower pay scales for them as compared to the posts of the other department particularly when the recruitment to these posts is done by the State Public Service Commission on the basis of a combined recruitment test. Prison staff training and addressing their needs should focus on improving work conditions, improving staff morale and cohesion, better communication with prisoners and greater sensitivity to their needs. 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 prison staffs so that the latter are sensitized to the needs of the prisoners and regard themselves as the caretakers of the inmates. Special training in human rights and
psychological health issues is required. Such training is also required for other personnel not directly manning the prison, including the judiciary, lawyers and police. Ensuring a good prison environment conducive to correction and rehabilitation thus becomes a joint responsibility of the prison department, legal services authorities, human rights commissions, governments, non government organizations as well as society. Most prisons suffer from severe under staffing. Therefore, it is suggested in the light of the findings of the study that the State Government should periodically review the requirements of different types of staff required, including medical and take steps to remove the shortage. Moreover, a conscious policy towards the induction of more women in the prison administration is necessary to bring about gender balance and sensitivity within the system. This could create a more tolerant culture towards marginal and weaker sections within prison walls. In order to ensure that gender sensitivity becomes an integral element of the management of women’s prisons, the responsibility for research, evaluation, policy formulation and implementation of policies relating to female prisoners should be the responsibility of a central department responsible for women’s prisons, with female senior staff.

Thus, it is concluded that rehabilitation of inmates is one of the most important goals of incarceration and the correctional system may well be the female inmate’s last best chance. While in prison, they are completely at the mercy of the state for their basic needs and medical care. The period of incarceration no matter how long or short, provides a window of opportunity to improve the health care of these women. All health and behavioral problems need to be assessed and intervened before discharge from the prison, so that they do not recur in the community. Rehabilitation and reformation of the prisoners should occur at multi-dimensional levels, from physiological, psychological, spiritual, vocational and social perspectives. Prisons can provide a corrective, rehabilitative role only if these concerns are adequately addressed.