Chapter Seven

VULNERABILITY & HIV RISK FACTORS OF PRISON INMATES

Comprehensive knowledge about HIV transmission and ways to prevent it are basic requisites for prevention, but translating knowledge into behaviour depends on a number of individual, social and contextual factors. The present chapter highlights the vulnerability of the prison inmates towards HIV/AIDS. The whole chapter is divided into various sections. The first section highlights the high risk behaviour of the prison inmates both before incarceration and during their imprisonment. The second section consists of the details regarding the prison living condition including overcrowding, food/ nutrition, management of stress etc. Explaining the prison medical facilities, the third section highlights the prison medical treatment available inside prison with respect to the care and treatment for HIV and associated diseases. The fourth section covers various aspects relating to the human rights issues like testing, confidentiality, discrimination, segregation of HIV positive patients etc. The next section covers the various measures available inside the prison to tackle the problem of HIV/AIDS in prisons. The last section highlights the inadequacies within the prison administration which renders considerable risk towards health of prisoners in general and those with HIV in particular.

This chapter is based on both quantitative data and qualitative data. The first section on high risk behaviour is based on the quantitative data. The next sections are primarily based on qualitative data obtained through case studies of HIV positive inmates, focus group discussions with the HIV negative prison inmates, the prison administrators including the middle and the lower rung prison staff and prison medical doctors.

7.1 High Risk Behaviour

The prison inmates may indulge into various high risk behaviours prior to their incarceration or during their incarceration which may make them vulnerable to contract HIV. In the present study, an attempt was made to collect information on the high risk behaviour of the prison inmates, if any. To deduce the high risk behaviour of
the respondents, prison inmates were asked if they had any history of drug abuse (except exclusive tobacco use) immediately before incarceration, injecting drug use, history of high risk sex, history of homosexuality before and during incarceration, if any, sexually transmitted infections (STIs), and blood donation.

7.1.1 Drug use immediately before incarceration except exclusive tobacco use

In order to deduce the history of drug abuse of the prison inmates, if any, few questions were asked relating to drug use (except exclusive tobacco use) immediately before incarceration. Questions were confined to drug use only before incarceration as according to prison rules, drugs were not allowed inside prison, but tobacco use was permitted. The following table shows the percentage distribution of the respondents who indulged in drug abuse before incarceration.

Table 7.1: Percentage distribution of respondents’ history of drug abuse before incarceration

<table>
<thead>
<tr>
<th>Items</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever taken drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29.7</td>
<td>89</td>
</tr>
<tr>
<td>No</td>
<td>70.3</td>
<td>211</td>
</tr>
<tr>
<td>Bhang/ Ganja/ Charas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.3</td>
<td>4</td>
</tr>
<tr>
<td>Smack/ Heroin/ Brown sugar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.7</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14.0</td>
<td>42</td>
</tr>
<tr>
<td>Tobacco (Panmasala/ gutkha, cigarette/ bidi/ khaini)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16.0</td>
<td>48</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>300</td>
</tr>
</tbody>
</table>

The above table shows that majority of the respondents (70.3 percent) reported not consuming any drugs except exclusive tobacco use prior to incarceration. However, the percentage of respondents who reported to consume drugs like bhang/ ganja/ charas (1.3 percent), smack/ heroin/ brown sugar (0.7 percent) and alcohol (14 percent) prior to incarceration was very negligible. Also respondents volunteered to say that they had been consuming tobacco in the form of panmasala/ gutkha/ cigarette/ bidi/ khaini (16 percent) and that apart from tobacco use they never indulged into any other type of drug abuse. As the data shows, the percentage of respondents reported to have any history of drug abuse is very negligible. The low
response rate regarding drug abuse may be because of the fact that the respondents didn’t want to reveal their drug abuse history before their imprisonment as they might be fearful of the consequences, if any.

However, some of the prison inmates did mention about their drug abuse prior to incarceration during the interview session and during the FGD with the HIV negative inmates. For example, the following inmate told the researcher how he did drugs by consuming a particular medicine named, “netrovet”.

“Netrovet medicine leta tha nashe ke liye 2-3 bar din mein eek saal tak. 7 mahine se nahi le sakta huun, kyunki jail mein aa gaya, isliye neend nahi aati hai. Jail mein sirf bidi aur cigarette hi milta hai”.

(I used to take Netrovet medicine twice or thrice in a day. Now since I am in prison for the last seven months, I am unable to take the medicine. So I am suffering from insomnia. Only bidi and cigarettes are available in prison.)

Inside jail, consumption of tobacco was allowed in the form of bidi/ cigarette/ pan masala/ gutkha. One respondent reported that 99 percent respondents consumed tobacco inside the jail.

“jail mein to karib nabbai pratishat log tambaku lete honge”

Another inmate who was a Muslim and was part of a robbery gang reported that although there were people inside jail who indulged into smoking and drinking, their group never indulged into such vices, and group members were of the religious sort.

“hamara group tambaku ya sharab nahi peete, sirf namaz padte the”.

Thus, it may be said from the above that although the reported percentage of drug abuse by the prison inmates were very less, indulgence of the prison inmates in drug abuse before their incarceration could be much more than that reported. After incarceration, the prison inmates mostly indulged in tobacco usage in various forms like bidi, cigarette, pan masala, gutka etc. as was available in the jail canteen.

7.1.2 Injecting Drug Users

Injecting drug use is one of the methods of HIV transmission. It was reported by HIV positive inmates that they were infected with HIV due to having unprotected sexual
intercourse and needle-sharing for injection drug use. These behaviours are especially prevalent among imprisoned drug users (Swartz, Lurigio, Weiner, 2004).

In India, the data on drug abuse among prison population in India was virtually absent, though it was widely believed that a significant percentage of population in the prison might be addicted to one or more drugs (Ray, 2002). An Indian study found 4.9 percent of prison inmates were IDUs in 1997 and this declined to 0.8 percent in 2000 (Dolan, 2004). In Manipur Central Jail, 80% of those tested, were HIV positive (UNODC, 2007). Thus, a history of the injecting drug use prior to incarceration and during incarceration can give a clue regarding the vulnerability of the prison inmates to HIV infection.

Table 7.2 History of Injecting Drug Use (IDU)

<table>
<thead>
<tr>
<th>Items</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever heard about Injecting Drug Users (IDUs)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>92.7</td>
<td>278</td>
</tr>
<tr>
<td>No</td>
<td>7.3</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>300</td>
</tr>
<tr>
<td>Have you ever injected drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.4</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>98.6</td>
<td>274</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>278</td>
</tr>
<tr>
<td>Do you think injecting drug use can lead to an incurable dreaded disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>97.5</td>
<td>271</td>
</tr>
<tr>
<td>No</td>
<td>2.5</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>278</td>
</tr>
<tr>
<td>If yes, which disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>67.8</td>
<td>181</td>
</tr>
<tr>
<td>No response/ Don’t know</td>
<td>33.2</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>271</td>
</tr>
</tbody>
</table>

The above table clearly shows that although more than ninety percent of the respondents had heard of injecting drug use (92.7 percent) and that injecting drug use could lead to an incurable dreaded disease (97.5 percent), very negligible percentage respondents (1.4 percent) reported to have ever injected drugs before being incarcerated. Among those who knew that injecting drug use could lead to an incurable dreaded disease (97.5 percent), only less than one third (67.8 percent) knew that the incurable dreaded disease which transmitted through injecting drug use through needle sharing was HIV. Respondents, who reported to have ever injected
drugs before incarceration, said that they were not continuing injecting drug use while inside jail, predominantly because drugs were not available in prison. These respondents also reported that they never cleaned the needle/ syringe the last time they injected and shared with others. Also, only one among the four prison inmates who reported injecting drug use before incarceration had sought help and treatment for drug problem before current imprisonment. All the four respondents shared that they wanted to lead a drug free life and three of them knew where they could get help for drug abuse after release from prison and that those places were De-addiction centre or any NGO working for the de-addiction. All the four inmates also said that they could lead a drug free life after release from prison. All respondents who had heard of injecting drug users were asked about their opinion about the problems faced by drug users in the prison, and majority of them (92 percent) said that there were no drug users inside the prison.

Although the above data on injecting drug users is insufficient for making generalizations on the history of injecting drug use of prison inmates, nevertheless, this negligible data also highlights the fact that there are prison inmates who were injecting drug users while they were outside the jail. The low response rate regarding this topic may be because of the fact that injecting drug use is itself condemned as according to the Narcotic Drugs and Psychotropic Substances Act (NDPS) 1985, which criminalizes and marginalizes IDUs. Nevertheless, IDUs remain a most vulnerable population to contract HIV as sharing injections is one of the most efficient methods of HIV transmission. Also, studies have shown that drinkers acknowledge reduced inhibition and increase in the likelihood of neglecting safety measures after drinking alcohol (Sifunda et. al., 2007). Thus there is a clear association between substance abuse and high risk sex. Thus, it can be said that prison inmates who were substance users before imprisonment could involve in high risk sex and thus contract HIV.

### 7.1.3 High Risk Sex before Imprisonment

Since most HIV infections in India are contracted through heterosexual contact, information on sexual behaviour is important in designing and monitoring intervention programmes to control the spread of the virus. In the context of HIV/AIDS prevention, limiting the number of sexual partners and having protected
sex are crucial for combating the epidemic (International Institute of Population Sciences & Macro International, 2007).

The AIDS virus is primarily transmitted through sexual intercourse. The two scientific key factors responsible for transmission of HIV during sexual intercourse are 1) the likelihood that an infected person will transmit the virus to a partner during sexual intercourse, and 2) the frequency with which an individual acquire new sexual partners. HIV is carried in seminal and vaginal fluids and in cervical secretions, as well as in blood. Any exchange of fluids during intercourse can result in transmission of the virus across the porous membrane of the vagina, penis or anal canal into the blood streams (Bollini & Gunchenko, 2001). It was therefore that a series of questions on sexual risk behaviour were asked to the respondents.

Knowledge of HIV/AIDS and sexual behaviour among youth belonging to the age group of 15-24 are of particular interest because the period between sexual initiation and marriage is for many young people a time of sexual experimentation that may involve high risk behaviours. This issue has special importance in the context of the emerging trends in new HIV cases in India that show that nearly two-fifths of new infections are reported among people below 25 years of age (NACO, 2007).

Table 7.3 Sexual behaviour of respondents

<table>
<thead>
<tr>
<th>Items</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had sex?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>84.3</td>
<td>253</td>
</tr>
<tr>
<td>No</td>
<td>15.7</td>
<td>47</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>300</td>
</tr>
<tr>
<td>First Sexual Partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSW</td>
<td>78.7</td>
<td>199</td>
</tr>
<tr>
<td>Spouse</td>
<td>21.3</td>
<td>54</td>
</tr>
<tr>
<td>Did you use condom during your first sexual intercourse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.4</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>95.6</td>
<td>242</td>
</tr>
<tr>
<td>Apart from your wife / husbands/ regular partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(boyfriend/ girlfriend), have you had sex with anyone else</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13.4</td>
<td>34</td>
</tr>
<tr>
<td>No</td>
<td>86.6</td>
<td>219</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>253</td>
</tr>
</tbody>
</table>

The above table shows that majority of the respondents (84.3 percent) reported to have experienced sexual intercourse in their life and majority (78.7 percent) of them had their first sexual intercourse with a commercial sexual partner, and almost everyone (95.7 percent) didn’t use condom during their first sexual intercourse, although a
negligible of them (13.4 percent) had sex with anyone else apart from their wife / husbands/ regular partner (boyfriend/ girlfriend).

Thus, although the reported data on high risk behaviour is negligible, it is to be noted that the majority of the respondents had their first sexual encounter with commercial sexual workers and that too without a condom. This obviously makes them highly vulnerable to contract HIV/AIDS before their incarceration.

Some of the inmates shared their experience of high risk sex prior to incarceration in the following way:

“...bahut girlfriends the, sabke saath enjoy karta tha, ustime pata nahi tha AIDS ke bare mein...”
(I had many girlfriends with whom I used to enjoy….at that time I was not aware of HIV/AIDS).

“...1982/83 mein dhanda karne wali ke pass jaata tha, tab condom nahi tha, jo acchi thi uske pass hi jaata tha...”
(I used to visit brothel during the year 1982/ 83, at that time there was no condom, and I used to visit only one woman who was good natured...”!)

The above comments show while one inmate expressed his ignorance of HIV/AIDS while he indulged in high risk sex, the other inmate sounded confident of not contracting AIDS as he had a regular sexual partner. However, these two factors, viz. ignorance and misconception, do not reduce the risk of contracting HIV and thus adds to be one of the vulnerability factors.

7.1.4 Homosexuality

Estimates of the proportions of male prison inmates who engage in homosexual intercourse while incarcerated range from 2% to 65% (Krebs, 2002). The fact that much of the sexual contact occurring in male prisons is of the same-sex anal variety does nothing but further increase the risk of HIV transmission behind bars. Anal intercourse is considered to be significantly more risky than either vaginal intercourse or oral sex because the mucosal lining of the rectum is significantly more delicate than both the vaginal and oral linings and therefore more susceptible to rupture, thus making HIV transmission more likely (Schoub, as cited in Krebs, 2002). Although specific estimates of the prevalence of intraprison anal intercourse in particular are
hard to come by, research indicates that it does occur (Davis, Lockwood, Saum et al., as cited in Krebs, 2002).

In the present study, an attempt was made to find out the sexual risk behaviour of the prison inmates during their imprisonment tenure.

Table 7.4 Respondents’ views on homosexuality

<table>
<thead>
<tr>
<th>Items</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you heard of homosexuality?</td>
<td>64.0</td>
<td>192</td>
</tr>
<tr>
<td>Yes</td>
<td>36.0</td>
<td>108</td>
</tr>
<tr>
<td>Have you ever experienced homosexuality?</td>
<td>64.0</td>
<td>192</td>
</tr>
<tr>
<td>No</td>
<td>36.0</td>
<td>108</td>
</tr>
<tr>
<td>In prison, do you think inmates have sex with each other?</td>
<td>83.7</td>
<td>49</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>251</td>
</tr>
<tr>
<td>No</td>
<td>16.3</td>
<td></td>
</tr>
<tr>
<td>Have you ever had sex in the prison?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>91.0</td>
<td>273</td>
</tr>
<tr>
<td>Once or twice</td>
<td>1.0</td>
<td>3</td>
</tr>
<tr>
<td>No answer</td>
<td>8.0</td>
<td>24</td>
</tr>
<tr>
<td>Did anyone ever force you to have sex inside prison?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>94.7</td>
<td>284</td>
</tr>
<tr>
<td>Cannot Say</td>
<td>5.3</td>
<td>16</td>
</tr>
<tr>
<td>Are condoms available in the prison?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.7</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>66.7</td>
<td>200</td>
</tr>
<tr>
<td>Cannot Say</td>
<td>32.6</td>
<td>98</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>300</td>
</tr>
</tbody>
</table>

All respondents were asked if they had heard what homosexuality was and almost two third of the respondents’ (64 percent) knew about homosexuality among whom all of them said that they had never indulged in homosexuality themselves. A high percentage of the respondents (83.7 percent) thought that inmates had sex with each other in prison, although majority (91 percent) denied ever having sex in prison themselves or having being forced to have sex inside prison (94.7 percent).

The above data clearly indicates that majority of the prison inmates acknowledged the prevalence of homosexuality in prisons (83.7 percent) although the data didn’t suggest the exact percentage of prevalence of homosexuality in prisons. Adding to this data, some prison inmates shared some of the intricacies of the prevalence of prison homosexuality during the interview.
Who were the prison inmates who indulged in homosexuality?

Some of inmates viewed that only the life convicts who were languishing in the prison for a longer time indulged in homosexual acts. This was because the undertrials usually were inside the jail for a shorter period of time. Also, all undertrials were kept in a separate barrack supervised by the warder or watchmen, so there was no scope for the inmates to indulge in homosexual acts. So, according to the undertrial prisoners the convict prison inmates who were tied by their bad habit of indulging in homosexuality even before incarceration, continued the same behaviour while they were in the prison.

“…..life saza wale jo 10-15 saal se jail mein hain karte hai…Remand wale to upar ki barrack mein rehte hain. Wo to 1/8 din mein jail se chutke ya phir bail pe chale jaate hain aur warder aur watchman bhi rehta hai daily round bhi hota hai. ....saza wale hi karte hain, jo aadat se majbuur hain aur bahar bhi karte the, aise log hi karte hain…..”

To contradict this view, some inmates felt that homosexuality was mainly practiced by the young inmates who come to the jail at a young age and are lured into homosexual act.

“…Young age mein log andar aate hain, uske bhavna aata hai, chori chupe karte honge.”

“…kishore barrack mein 18-22 years ke log rehte hain…”

However, some of the inmates who knew what homosexuality was, denied the prevalence of homosexuality in the prison, and that they had heard homosexuality happening outside the jail.

“….aadmi aadmi ke sambandh ke bare mein jail ke bahar se suna huun lekin jail mein aisa suna bhi nahi hai…”

Some inmates said that it was only a dirty person who indulges in homosexual acts.

“….Jo gande log hain wo aise karte hain, bahar se aate hain…”

Place where homosexuality happens inside the prison

Homosexuality was mostly happening in the bathroom and toilet when no one was around. Some respondents also pointed out that at night it happened even in the barrack as due to overcrowding inmates were often cramped for spaces.
Respondents guess about the prevalence of homosexuality in jail

While all the prison inmates denied indulging in homosexual acts themselves while inside jail, many of them had some wild guess regarding the percentage of the prison population who were indulging in homosexuality. This data varied between 1% prevalence of homosexuality in jail to 99% prevalence. Some of the comments regarding this are as follows:

“2-4 persons in 1000 people”
“Jail mein 3000 inmates mein 1500 inmates indulges in homosexuality”
“25% homosexuality among 3000 inmates”
“Suna hai 1-2 log hain jo jail mein sambandh rakhte hain”
“Kareeb 4% log honge jo aadmi aadmi ka sambandh rakhte honge”
“...90% may be engaging in homosexuality after coming the prison, 10% may be homosexuals when they were outside the prison...”

Also in the focus group discussion with convict prisoners, almost all the participants agreed to the prevalence of homosexuality and said that the percentage could be as high as 30%.

Homosexuality in the prisons was agreed on by all the participants with the prevalence rate varied between 10-15% to 5-6% (FGD undertrial inmates).

As pointed by the prison staff of one particular jail, HIV/AIDS could spread in prison through homosexuality. Prevalence of homosexuality may be 5%. Some engaged in homosexual acts because of their already homosexual nature, and some to release their sexual tension as they were away from their family for a long time (prison staff).

Adding to the above findings, previous research also indicates that a substantial proportion of prison inmates engage in sexual contact while in prison. Krebs (2002) conducted a literature review and found that more than 65% of 200 inmates in California engaged in consensual homosexual sex while in prison and 30% of 330 inmates in 17 federal prisons engaged in consensual sex while in prison. Thus, it may be said that homosexuality was widely prevalent in the prisons under study.
Causes of homosexuality in prisons

Many inmates had their views on why prison inmates indulged in homosexual behaviour. While some said that it was a youthful tendency to indulge in homosexual acts, others said that whoever did indulge, it was voluntary involvement due to habit and there was no use of force by either of the party.

“...aadat se karte hain, Majbuuri nahi, zabardasti nahi...”
“...habitual bahar se, no zabardasti...”
“...Apne khushi se karte hain...”

However, it was also told that young inmates being forced into homosexual acts as they were mostly scared and couldn’t complain to the jail authority fearing punishment.

“...naye kayedi dare hote hain wo complain nahi karte darr ke mare. Complain nahi karte kyunki phir punishment hota hai...”

Rape is another facet of prison life and occurs involuntary. The taboo nature of rape in society and prison makes it problematic to estimate its prevalence; however, it does occur and is germane to any discussion regarding HIV transmission inside prison (Krebs, 2002).

Among the older convicts, the warders usually indulged in homosexual acts either through persuasion or by force. Majority participated voluntary due to fear or facility and only few indulged by force.

“...Purane kayedi jo hai, warder, pyar se ya kabhi kabhi zabardasti se bhi sambandh karte hain. 35% darr ya phir accha facility ke liye karte hain. 1-2% forced hota hoga...”

Some inmates were lured into homosexual acts for money and good food.

Life saza wale lalach deke karte hain. accha khana, chicken khane ke liye lalach mein aa jaate hain. Aur paisa ka lalach to hai hi

Some life timers who spent a considerable period of time inside jail indulged in homosexuality as an outlet to show their power.

“...Person going for life term goes crazy and reaches certain stage, want to show power...”
According to the participants of the focus group discussion both undertrial and convicted prisoners indulge in homosexuality.

*The various forms of homosexuality varies from sex with consent, forced sexual exploitation, sex in return of cash or kind. Sometimes sexual activity also takes place under the influence of intoxication like charas or ganja* (FGD convict inmates).

Some inmates reported that overcrowding is a major cause of homosexuality in prisons.

*As the barracks are overcrowded, homosexuality is also rampant* (FGD undertrial inmates).

Thus, there is often a spectrum of sexual activity within the prison. Srivastava (1977) notes that physical coercion, victimization and various other subtle tricks were employed to establish homosexual relationships, mostly by the ‘old timers’, who had little or more administrative authority over others. A proportion of prisoners, who were homosexuals while in the community, may choose to participate in consensual homosexual activity while in custody. As the findings in Srivastava (1977) highlights that for some committed homosexuals, the sexually starved life of the prison had nothing to do with their homosexuality, and they were used to this form of sexual behaviour even when they were outside. This apart, prisoners who identify as heterosexual in the community may choose to do the same. Other prisoners may participate in sexual activity, despite preferring not to, either as a form of protection or as currency. At the end of the spectrum is the risk of sexual assault or prison rape within the custodial settings. These prisoners are thus at risk of sexually transmitted infections like HIV (Levi, 2005).

**Terminologies used for people who indulged in homosexuality**

The young inmate who is forced in homosexual act is called “gaadi” (car) and the dominant partner is called the “driver”. Some others said it was called “laundi baaji”; “ghoda gaadi” (horse carriage) and “baldi”, “khajur”.

“...Naye ladke ko Gadi aur jo karta hai usko driver bolte hain...”

“...Kabhi kabhi usko laundi baaji bhi bolte hain...”“Gaadi” bolte hain;

“baldi”, “khajur”
Srivastava (1977) noted that in the Indian context, the prison inmates accepting the female roles were commonly referred to as Laundas and those taking up male roles were known as Laundebaaj. The terminologies typically represent the active and passive sexual roles that the prison inmates take. The term launda is wider in connotation and includes both Punks and Fags, i.e. those who assume ‘passive’ or ‘submissive’ part. Further, Punks are made and situational ‘passives’ whereas Fags are professional ‘male prostitutes’ who are true and habituated to their trade (Sykes as cited in Srivastava, 1977). Some prisoners called fags as jankhas, but ‘jankha’ as a term of colloquial Hindi means a male with feminine mannerisms (Srivastava, 1977).

**Availability of condoms in prison**

The respondents were asked if everyone agreed that homosexuality happened in prisons, should condoms be made available to inmates inside the prisons. All the participants agreed that condoms should not be made available inside the prison as it would increase the activity and inmates would eventually become habituated in the activity. According to the inmates, the only preventive measures that should be taken to reduce the risk of HIV contraction through homosexuality was to keep the potential habitual homosexuals in separate barracks and to make them understand the risks involved in homosexual behaviour (FGD undertrial inmates).

When the issue of availability of condoms inside the prison was raised, the prisoners said that this would increase the occurrence of homosexual acts. (FGD convict inmates).

The prison staff also stressed on the need to distribute condoms inside prisons as homosexuality was anyways prevalent.

“Condom dena chahiye, kyunki ye to hota hi hai” (prison staff).

**Punishment for homosexuality**

If occurrence of homosexuality was reported to the prison authorities, mostly the accused person is shifted to another barrack.

**Homosexuality and transmission of HIV/AIDS**

Almost 8% awareness was reported amongst the inmates regarding the fact that homosexuality is one of the cause of the spread of HIV (FGD convict inmates).
There is less awareness amongst the inmates regarding the link between homosexuality and HIV/AIDS (FGD undertrial inmates).

Thus, it is evident that homosexuality is rampant in the prisons. However, the prison inmates were not in favour of distribution of condoms in prisons. This may be due to the fact that they don’t want to acknowledge the existence of the phenomenon openly due to social stigma attached to the behaviour or because of the available punishment. However, the prison staff agreed that the provision of condoms in prisons was essential. While the prison inmates were not in favour of condom distribution inside prison, it is an integral part of HIV prevention programs in the community. As, homosexuality is legally an offence in India, it is believed that distribution of condoms in the prisons will be equivalent to “encouraging” homosexuality in prisons. However, the fact that homosexuality is widely prevalent in Indian prisons, makes it urgent that condom promotion should be recommended in Indian prisons. Srivastava (1977) offers ‘home leaves’ and ‘conjugal visits’ as two possible solutions to tackle the problem of homosexuality. These methods have been tried with success in several countries throughout the world, especially in Latin America and Sweden and can also be experimented in India.

7.1.5 Reports of Recent Sexually Transmitted Infections (STIs)

Information about the incidence of sexually transmitted infections (STIs) is not only useful as a marker of unprotected sexual intercourse, but also as a co-factor for HIV transmission. In view of the importance of STIs in HIV prevention programmes, since the inception of NACP-1, NACO has been making special efforts to promote early diagnosis and treatment of STIs as part of its family health awareness campaign (International Institute of Population Sciences & Macro International, 2007).

Respondents who had ever had sex were asked whether they were aware of sexually transmitted diseases. Only more than one third (36.3 percent) of the total respondents knew what sexually transmitted infections were. Among the respondents who were aware of sexually transmitted infections, only 24.8 percent knew about Syphilis and only 5.5 percent reported to know about Gonorrhoea. Also, only 11 percent of those who were aware of STIs had sought medical help for STI.
Table 7.5 Sexually transmitted infections (STIs)

<table>
<thead>
<tr>
<th>Items</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of sexually transmitted diseases?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>36.3</td>
<td>109</td>
</tr>
<tr>
<td>No</td>
<td>63.7</td>
<td>191</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>300</td>
</tr>
<tr>
<td>What are the STDs you are aware of?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>5.5</td>
<td>6</td>
</tr>
<tr>
<td>Syphilis</td>
<td>24.8</td>
<td>27</td>
</tr>
<tr>
<td>Don’t know/cant say</td>
<td>69.7</td>
<td>76</td>
</tr>
<tr>
<td>Did you ever have to seek any medical help for STI?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11.0</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>89.0</td>
<td>97</td>
</tr>
<tr>
<td>Do you think STIs can be prevented?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>94.5</td>
<td>103</td>
</tr>
<tr>
<td>No</td>
<td>5.5</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>109</td>
</tr>
</tbody>
</table>

The 11 percent respondents who sought medical treatment for STIs didn’t know the name of the STI they were suffering. Among people who were aware of STIs, majority 94.5 percent respondents believed that STIs could be prevented and an equal number of respondents knew that STIs could be prevented by using condoms during sexual acts.

Thus, although the data on STIs seems to be negligible, however, it may be said that untreated STIs coupled with high risk sexual behaviour can make one vulnerable to contract HIV.

7.1.6 Blood transfusions and Injections

It had been estimated that in the initial stages of the HIV epidemic in India, blood transfusions accounted for 6-8 percent of total infections. However, as a result of concerted efforts and the implementation of a blood safety programme, the share of blood transfusions in transmitting new HIV infection has been considerably reduced (NACO, 2007). Further, injection safety has become part of the Government’s efforts to control the spread of HIV/AIDS with an emphasis on the use of new needles and syringes. Overuse of injections in a health care setting can also contribute to the transmission of blood-borne pathogens, because overuse can amplify the effect of unsafe practices such as the reuse of injection equipment (International Institute of Population Sciences & Macro International, 2007).
The following table presents data on the prevalence of blood transfusions and injections.

Table 7.6 Blood Donation

<table>
<thead>
<tr>
<th>Items</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever donated blood?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26.3</td>
<td>79</td>
</tr>
<tr>
<td>No</td>
<td>73.7</td>
<td>221</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>300</td>
</tr>
<tr>
<td>Before donating blood, did you check the blood for any disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12.6</td>
<td>10</td>
</tr>
<tr>
<td>No</td>
<td>87.4</td>
<td>69</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>79</td>
</tr>
<tr>
<td>Have you or your family members ever needed blood transfusion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5.7</td>
<td>17</td>
</tr>
<tr>
<td>No</td>
<td>94.3</td>
<td>283</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>300</td>
</tr>
<tr>
<td>What was source of getting/acquiring blood?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital authorities provided</td>
<td>11.8</td>
<td>2</td>
</tr>
<tr>
<td>Bought from the blood bank</td>
<td>70.6</td>
<td>12</td>
</tr>
<tr>
<td>Friends/Relatives donated</td>
<td>17.6</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>17</td>
</tr>
<tr>
<td>What do you think should be checked before giving/receiving blood?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>49.6</td>
<td>132</td>
</tr>
<tr>
<td>Blood Group</td>
<td>5.3</td>
<td>14</td>
</tr>
<tr>
<td>Don’t know/ can’t say</td>
<td>45.1</td>
<td>120</td>
</tr>
<tr>
<td>Do you think that needles and syringes should be sterilized/disposable while taking injections?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>95.5</td>
<td>254</td>
</tr>
<tr>
<td>No/Don’t know</td>
<td>4.5</td>
<td>12</td>
</tr>
<tr>
<td>Should a person suffering from HIV/AIDS donate blood?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6.8</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>90.6</td>
<td>241</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2.6</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>266</td>
</tr>
</tbody>
</table>

All respondents were asked if they had ever donated blood and only little more than a quarter of the respondent (26.3 percent) reported to have donated blood. However, among these 26.3 percent respondents, only 12.6 percent respondents had checked the blood for any disease. One of the inmates in the interview mentioned that he had donated blood long back in 1984 and at that time, there was not much awareness regarding HIV/AIDS.
“1984 mein khoon daan kiya tha, tab itna nahi tha HIV/AIDS ka” (HIV negative prison inmate)

Again, all respondents were asked if they or their family member ever needed any blood transfusion and a very less number of 5.7 percent respondents had needed blood transfusion and when asked about the source of acquiring the blood, majority (4 percent) said that they had acquired the blood from the blood bank.

All respondents who had heard of HIV/AIDS (266) were asked what disease they think should be checked before giving/ receiving blood and 49.6 percent of the total respondents (266) knew that HIV/AIDS should be tested before giving/ receiving blood. Majority respondents (95.5 percent) thought that needles and syringes should be sterilized / disposable while taking injections. Also majority respondents (90.6 percent) negated regarding blood donation by a HIV positive person.

Although the above data related to sexually transmitted infections and blood donation does not reveal any concrete vulnerability issues of the prison inmates towards HIV/AIDS, it must be pointed that the inadequacy in the data could be a misrepresentation of what actually the prison inmates felt or practiced. Nevertheless, STI and HIV testing prior to blood donation remains important issues which one has to be aware of as regards to HIV transmission.

7.2 Prison Living Condition

7.2.1 Overcrowding
The problem of space in Indian prisons is a well known and well talked about phenomenon. In a previous study conducted by the researcher, it was observed that in one of the prison, HIV/AIDS patients were usually put into the emergency ward, which was inside the hospital circle. In this ward, many times HIV positive inmates were lodged along with the TB patients. With already weakened immune system, the acquisition of TB is in any way a great risk for those living with HIV, being put with TB patients greatly heightens this risk.

As mentioned by one of the prison inmate, in barracks meant for sixty prison inmates, there are often 160-170 prison inmates staying. As observed by the researcher and as mentioned by the doctor of the prison hospital, Times of India
Vulnerability & HIV Risk Factors

(2005) quoted one of the HIV patient, “I and three of the AIDS patients have been kept along with 22 TB patients in a barrack”. Quoting figures as of February 28, 2006 obtained from the India Centre for Human Rights, its been reported that (Times of India, 2006a) Yerwada in Pune and Mumbai Central Prison are among the most crammed of the Central Prisons.

One of the Superintendent of a Central Prison exclaimed that, “...we cannot stretch the living space...!” Overcrowding has a serious impact on the sanitation and hygiene at the Mumbai Central Prison. Drinking water is available through the respective municipal corporations and is stored in tankers as water is not available twenty-four hours a day. Food is provided as according to the quantity prescribed in Maharashtra Prison Manual. Medical diet is provided to the ill inmates as recommended by the prison doctor.

Thus, it emerges from above that, overcrowded spaces where people having multiple diseases are put together, health condition of a HIV positive inmate may deteriorate. It can impede efforts to deal with HIV/AIDS. It can worsen the health problems of those who are already ill, and may also lead to increased high risk behaviours. Also conditions of overcrowding in prisons is linked to the spread of TB as TB is air borne communicable disease which spreads easily in crammed place and low sanitary standards. As reported by Times of India (2006b), figures compiled by National AIDS Control Organization highlights that over 60% of AIDS patients contract and die of TB. This figure is further substantiated by the fact that, atleast 50 undertrials, mainly affected with HIV have died at Mumbai Central Prison or J.J Hospital over the past two years (TOI, 2006c). Thus, it may be said that overcrowding has a direct bearing on many aspects of a prisoner’s life leading to a deterioration of hygiene, care and supervision. Thus, it may be said that despite the Government’s efforts to construct new jails through the prison modernization scheme, overcrowding has remained a serious problem.

7.2.2 Food/ Nutrition

The food available in the prison was reported to be plain and sometimes without having any salt. In one of the women prison, the researcher tasted the food with the women prison inmates. The food was tasteless and the chapattis were hard and stale. The women inmate had the food by mixing a lot of spicy pickle which she had bought from the prison canteen. Srivastava (1977) also notes that prison inmates grievances
regarding food centre around its lousy preparation and consequential tastelessness and unpalatability. This same problem was reflected during interview with a male prison inmate in another jail.

“Food in the jail is simply plain and without even salt sometimes. Inmates buy some spices or chutney available in the jail canteen with which they can have the food. There are almost 100 prison inmates who are working in the BC\textsuperscript{1}, and they can easily prepare tasty food for 1050 prison inmates. However, this becomes difficult when the total number of prison inmate in the jail is more than 3000. I suggest more people can be employed in the BC. Also, in Bangalore prison, the jail kitchen is run by volunteers from the Hare Rama Hare Krishna group, and the quality of food is much better. The process can be replicated in these jails in Maharashtra” (Prison inmate with MBA background).

Although all the HIV positive inmates were receiving special medical diet, every one of them complained of poor and substandard quality of food, which was not conducive to their digestive system. Food was served three times a day. The lunch and dinner consisted of rice, dal, one vegetable curry and three to four chapattis. Although milk was served as part of the special diet, it was mostly adulterated with water. As everyone said, the food was under cooked. One of the HIV positive inmate complained that he was not subjected to any kind of protein neither in the form of medicine nor in the form of food. He felt that proper nutritious food was the only treatment for HIV positive patients in order to stay healthy. Another HIV positive inmate mentioned the difference in the special diet in two prisons where he was lodged including the current prison. Mentioning that food quality in the previous prison was good, he explained that as part of the special diet, he used to get two eggs, one bread, one apple and two bananas. Whereas in the prison where he was currently lodged, special diet consisted of only bread, banana and milk, and TB patients also received egg apart from bread and milk. Also, some HIV positive inmates complained of corruption inside the prisons where money seemed to play a role in getting better food, space and treatment.

\textsuperscript{1} The prison kitchen is popularly known as BC or the British Canteen since a long time when the British had constructed the prisons.
As specified by the Model Prison Manual, 2003, an average man requires approximately 2,000 to 2,400 calories a day. A person who does heavy work requires not less than 2,800 calories per day. The nutrients required in a person’s daily diet, their quantities and the common sources of nutrients has been specified in the Maharashtra Prisons (Diet for Prisoners) (Second Amendment) Rules, 2005. For hospital prisoners, egg, milk and bread are added as part of the special medical diet. There is no mention of the dietary requirements for the HIV positive inmates, and thus the HIV positive inmates are also recommended the same medical diet. HIV positive inmates who are in ART are advised to take “balanced, high protein diet”, which is practically absent. Consuming milk, banana and bread as special diet will not help if the quality of the main course food is substandard. Thus, poor quality of food and improper nutrition may have a negative impact on health concerns of HIV positive inmates as proper nutrition and vitamins may postpone the development of HIV into AIDS (UPI, as cited in Goyer, 2003).

7.2.3 Stress
Stress may become an important area of concern as all the HIV positive prisoners highlighted that there were no one from outside the prison with whom they could discuss about the disease. One HIV positive inmate shared with the researcher that till date, it was only the researcher who was asking question regarding his illness. One inmate shared that there was no one who comes to meet him in prison.

“Koi milne nahi aata, aap kya kar sakte hain?” (HIV positive inmate)
(No one comes to meet me, what can you do?)

Some HIV positive inmates could talk to other HIV positive inmates inside the prison regarding their problem. Another HIV positive inmate commented that a minor physical problem seemed very troublesome to him as it is always in his mind that he is HIV positive (“...Kya karen abhi dimaag mein hi ye baith gaya hai to kuch bhi ho jaata hai to bahut lagta hai...”). Another inmate expressed his wish of early release so that he could arrange for better medicine and food. Also, the HIV positive inmates who were not required to be prescribed ART often wondered why others were receiving ART medicines and he was not.

“Dusre logon ko goli chalu hai mujhe nahi” (HIV positive inmate)
(Others are getting medicine and I am not!)
As reported in the Times of India (2006d) prison authorities take pains to introduce spiritual and yoga courses for prisoners, but the personal touch was missing when it came to the physical healthcare. It further quotes noted counsellor, Dr Harish Shetty, of the Counsellors Association of India, “Those in the front-line meeting prisoners on a daily basis, have little sensitization towards their condition”.

It emerges from the above that there is no support system available inside the prisons regarding stress related issues of HIV/AIDS. It may be mentioned that being in prison carries with it a number of stresses, including being separated from the family and other support structures, frustration of goals or plans for the future and interruption of family activities. This heavy psychological burden of imprisonment is intensified when the prisoner comes to know that he is HIV positive and further intensifies in the absence of any support system available. The HIV positive inmate thus may become highly stressed, which may further deteriorate the health of the HIV positive inmate. It necessitates the need for *emotional and psychological support as an important part of caring for a HIV positive prisoner’s health and well being*.

### 7.3 Prison Medical Facilities

#### 7.3.1 Facilities provided by medical staff:

According to the Model Prison Manual 2003, all prison inmates are to be subjected for medical check-up during admission to the prison. This procedure of medical check-up during admission was explained by the inmates. The medical examination during check up was mostly limited to noting the weight, height and identification mark of the prison inmates. Apart from these, the new inmates were asked orally if they were suffering from any disease like TB etc. Prisoners, who were aware of their HIV positive status during admission to the prison, didn’t share their status to the medical doctor. People, who revealed of some disease, were prescribed treatment and medical diet, if required, by the medical doctor, if needed, which included egg, bread, milk apart from the normal diet meant for the other prisoners (FGD).

The procedure of medical care in the prison was also revealed during the FGDs with the inmates. Whenever someone fell ill, he would inform about his illness to the circle jailor in the specific circle, whose name was entered in the hospital register and then he was taken to the doctor in the prison hospital.
The procedure was similar in other jails where the ill inmate had to inform the baba (warder) who informed the circle jailor and then made an entry at the hospital register and the inmates case paper was prepared. The inmate would then be taken to the jail hospital to see the doctor. (FGD)

Also, during nights, there were jawabdar and a night watchman in each barrack. A convict prisoner whose behaviour was good during his jail tenure could become night watchman after five years of conviction and any convict could be appointed as jawabdar if his behaviour was good. Both the jawabdar and the night watchmen were paid unskilled wages (Rs 11). During night if someone fell ill, he would tell the jawabdar and night watchman who then informed the night guard of the jail, who called upon the nursing orderly, who in turn informed the doctor who would be in night duty (FGD).

“Patient serious hota hai to inform karte hain CMO ya raat ke doctor ko. Emergency mein raat ko jail guard ko bulana padta hai”. (prison staff).

(If the health condition of the patient is serious, then only the CMO is called for or the doctor in the night shift is informed. If there is an emergency situation, the night jail guard is called for.)

When asked about the kind of medical facilities available inside the prison, the inmates said that they were prescribed similar kind of medicines for every illness. However, according to the circle jailor, there were some common medicines for common diseases like cold, cough, indigestion etc. But while prescribing the medicines, the doctors did not explain the kind of medicines that they gave to the patients (FGD).

The quality of the medical facility inside the prison was described by the prison inmates and staff. As described by one of the women inmate who was a Nigerian national, the treatment inside the prison hospital is quite different from the government hospital.

“The way they treat in private hospital and the way they treat in Government (prison) hospital is completely different. If you have money you are going to get better treatment otherwise not” (Nigerian national came to India in September 2002, caught in airport for carrying Brown Sugar, booked in NDPS).

In cases where a patient was referred by the prison medical doctor for further treatment in the government civil hospital in town, there was often delay in sending
them to the civil hospital. This was primarily because of the non-availability of police guards and even when guards were available, by the time inmates reached the civil hospital, it would already be 12 and the OPD would close. Someone also referred how providing money to the jail authorities often speeded up the process.

“Medical facility achha nahi hai. Check up ke liye daddy ko civil hospital nahi bhej rahe hain, Superintendent ko bola hai per doctor nahi bhej raha hai, paise chahiye usko” (Prison inmate whose aged father is also in the jail).
(Medical facility is not good. They are not sending my father to the civil hospital for check up, I have told the Superintendent but even he is not taking interest, I guess he wants money)

“With 1 prisoner, 4 police guards and 1 amaldar are needed as escort”
(prison staff)

“Bahar treatment ho jaata hai, yahan procedure ka problem hai. Jail mein limited resources hain, sifar paracetamols hi milte hain. Bahut zaruri hui to hi saline dete hain, nahi to agle din usko ***** mein bhej dete hain” (prison staff).
(Outside the jail, accessing medical treatment is easy, here the procedure is little cumbersome. Resources inside jail are limited, only paracetamols are available. If it is too urgent then only, saline is given; otherwise the patient is referred to the civil hospital)

Some other inmate complained about how the drinking water available inside prison was not safe and there were mosquitoes which could carry diseases like malaria. Also, almost 99% of the prison population consumed tobacco which was available in the prison canteen. Most importantly, prison inmates didn’t practice cleanliness inside the prison which could also be a cause for many diseases other than HIV/AIDS.

“Water problem could be contagious. Mosquitoes are lots. People don’t understand what cleanliness is. Consumption of tobacco is 99%. Food problem is there”.

Thus, it can be said from the above that not only the prison medical services are inadequate, facilities inside prison in terms of the basic amenities like food, drinking
water etc and not to mention the scarcity of space, is insufficient. These facts definitely have an impact on the health of HIV positive prison inmate.

7.3.2 Treatment for HIV/AIDS & Associated Disease

There is no treatment available for HIV positive inmates inside the prison. Even for simple blood tests and other check ups, inmates had to be referred to the civil hospital. Also, prisoners were sent to the civil hospital only when their health condition deteriorated. As regards to the HIV positive inmates, it was only when one became sick due to some opportunistic infection like TB or if someone’s CD4 count became lower than 200, then only one was sent to the civil hospital for the Anti Retroviral Treatment. The prison staff also agreed to the fact that there was no adequate specialized service inside the prison, only instruments for checking blood pressure was available.

The HIV positive inmates who developed TB in the prison were treated successfully with the help of DOTS treatment. As mentioned by Lines, & Stover (2005), Tuberculosis (TB) is a common opportunistic infection, which poses a substantial danger to the health of prisoners living with HIV by accelerating the progress of AIDS. HIV infection is the most potent risk factor for converting latent TB into active transmissible TB. TB has been identified as a leading cause of death among HIV positive individuals internationally. Also, many prisoners who may be detected HIV positive inside the prison after a secondary infection like TB may actually have been infected outside the prison (UNAIDS, 1997).

As reported in the Times of India (2006b), every AIDS patient had 15% chance every year of developing TB, which showed that every AIDS patient will develop TB sometime in their life. Thus, in the conditions of overcrowding, poor nutrition, barriers to access and continued medical care, high turnover of population increasing contacts, weak health education and promotion, unhealthy behaviour, prison presents a number of risk factors for dual TB-HIV infection.

The views of the prison doctors and prison staff was quite opposite from those of the prison inmates. The prison doctors and prison staff reiterated that all HIV positive prisoners were getting special medical diet. Whenever, a HIV positive inmate fell sick, the prison doctor attended the patient immediately. An inmate was referred to the civil hospital for the CD4 count, and thereafter the patient was sent for treatment every month. According to the medical doctors, the treatment and facilities
of HIV/AIDS in the prison was better than that available in the community as in prison, the inmate was getting treatment and medicines free of cost apart from the food, which might have been possible if she/he were out in the community. However, the prisoners view was exactly opposite, they were stressing on the basic facilities like improvement in the food quality and medical treatment which remained barely accessible due to the non availability of the guards.

From the above, it may be said that there is no particular treatment facility provided to the HIV positive inmates. There is no voluntary counselling and testing facility available for HIV testing inside the prison. However, most often, inmates are detected with HIV only when they are referred to the civil hospital for diseases like Tuberculosis, lung infection etc. HIV testing is done only when the inmate is diagnosed with a disease where prison medicines don’t work and the inmate is referred for further treatment at the Civil Hospital. If the doctors at the civil hospital feel that a HIV test should be done then the inmate is suggested to go for HIV testing. There are Voluntary Testing and Counselling Centres in the Civil Hospitals where counselling and testing for HIV is conducted. ART treatment is available in Mumbai, Pune, Aurangabad and Amravati Civil hospitals where the HIV positive prisoners are sent. Although all HIV positive inmates are provided with special medical diet consisting mostly of milk and bread, the quality of the food provided is substandard and may not be serving the adequate nutrition required for people living with HIV/AIDS.

7.3.3 Liaison with the local District Aids Control Societies

Among the six prisons where data was collected in Maharashtra state in India, only one prison had some liaison with the District Aids Control Society. Pune District Aids Control Society was conducting voluntary counselling and blood testing in the Yerwada Central Prison at Pune.

“PACS se log aate hain testing ke liye” (prison staff)

(People from PACS i.e. Pune Aids Control Society comes in the jail for blood testing.

“... pichle gurumwar ko ek hafte HIV ka test hua tha. Aids sanstha wale aate hain har Wed/ Thursday ko. pichle 8 mahine main is jail mein huun is dauran 1-2 baar sansthawale ake gayi hai HIV/AIDS ke upar... ”(prison inmate)
(Last Thursday there was HIV testing which continued for a week. People from Pune District Aids Control Society come either every Wednesday or Thursday. I am here in this jail for the last 8 months, during this period once or twice people from various organizations have visited jail and talked about HIV/AIDS).

Despite this, there seemed to be some problem relating to the language by which the communication relating to the HIV/AIDS programmes were conducted, especially this problem was encountered by prison inmates who were from other countries.

*Some people come, but I don’t go to attend those programmes as I don’t understand their language* (Nigerian national).

Some other inmates expressed their non-interest in listening to HIV educative sessions.

*“Batane aate hain, nahi sunne jata huun, interest nahi hai.”* (They come to talk about HIV/AIDS, but I don’t go as I don’t have any interest to hear them).

It seemed that although the Pune District Aids Control Society was working for voluntary counselling and blood testing inside the Yerwada Prison, the work relating to counselling seems to remain inadequate. As some inmates pointed out that although their blood was taken for testing, they never got the report.

*“Khoon leke gaye the lekin phir report nahi mila”*  
“1 mahine pehle khoon leke gaye lekin abhi tak report nahi aaya, once in three months aate hain” (prison inmate)

Inmates were not certain about when the VCTC happened. Some said they came once in last three months and some other said that they came once in the last 4-5 months, still others said that they came 2-3 times in the last 7 months, from the date of interview.

*“4-5 mahine mein eek baar aate hain HIV check up karne ke liye.”*  
“7 mahine mein 2-3 baar aaye the”.
In contrast to this, in all the other prisons, there is no intervention by any District Aids Control Societies inside the prison related to HIV counselling and testing or treatment.

The researcher visited the District AIDS Control Societies in the respective districts where the prisons were situated, i.e. in Aurangabad, Amravati, Yerwada and Amravati township. Although, they had Integrated Counselling and Testing Centres (ICTC), none of them had any liaison with the prison department. Likewise in Aurangabad there are seven ICTC in the city, however, they are only working for the general population. However, during August-September 2006, there was a poster exhibition followed by a detailed question and answer session on HIV/AIDS inside the Aurangabad Central Jail. Situation is same in Thane and Byculla where no preventive activities are being initiated by either the prison authorities or by the Aids Control Societies to involve the prison inmates in terms of knowledge building, voluntary counselling and testing followed by AIDS treatment.

### 7.4 Ethical Issues

#### 7.4.1 Testing

For majority of HIV positive inmates, testing for HIV was conducted only when they developed some opportunistic infections like Tuberculosis, skin disease etc while they were inside the prison. Initially when the treatment inside the prison failed and the medicine provided by the prison doctor proved ineffective, the sick inmates were referred to the civil hospital for further diagnosis and treatment, as inside the prison hospital there were no specialized equipments for testing. The doctor at the civil hospital conducted the necessary check up and testing to identify the particular disease the inmate was suffering from. HIV test was one among such test.

Others didn’t reveal of their HIV positive status during their admission in the prison although they were aware of it. It was when they experienced sudden weight loss inside the jail, that they confided and their CD 4 test was done.

Again some inmates volunteered to get their blood tested during the voluntary blood testing camp organized by the Pune Aids Control Society in Yerwada Central Prison and thus tested positive.

However, limited pre-test counselling was reported by some HIV negative inmate who went for voluntary blood testing at the Yerwada Central Prison.
“...Kuch nahi bataya tha, aisa khoon liya tha aur bola tha ki HIV ki jaanch karwange aur phir report denge...”

The prison staff of one particular jail felt that testing for HIV should be made mandatory.

“...Testing for HIV should be mandatory in prison (prison staff)”

7.4.2 Confidentiality

Often provision of special diet became an ethical issue, as HIV positive prisoners who were receiving such food were easily identifiable by other prisoners. Thus other prisoners could come to know who the HIV positive inmates were in the particular barrack. The nursing orderlies and the police guards who escorted the prisoners also carried the medical records of the HIV positive patients. In one prison, it was observed by the researcher that “HIV positive” was written on the medical files of the inmates who were HIV positive (the researcher had to obtain special permission from the IG prisons in order to get access to the medical records of the respective inmates, on conditions of confidentiality). This made the nursing staff and the police guards easily identify who were the HIV positive prisoners.

“...jail me HIV positive kayedi to hain....pechle saal do logon ko HIV tha...unko special diet milta hai aur ****Hospital mein bhej dete hain ilaaj ke liye...” (prison staff)

(I am aware of HIV disease in the jail, 2 cases of HIV positive inmate was there last year. They are given special diet and are sent to **** hospital for treatment).

“mujhe HIV walon ke baren mein pata chala tha unke medical report se...”(prison staff)

(I am aware of HIV cases in the jail from their medical reports.)

As best described by one inmate, there were one or two HIV positive inmates in the prison. The doctors kept them separate but the other inmates recognized them from the nursing orderlies who worked in the ward where the HIV positive inmate was kept.

“...Jail mein 1 ya 2 cases hain HIV/AIDS ke. Doctor alaag rakhte hain aur nursing orderley se bhi malum ho jaata hai...”
(There are one or two cases of HIV/AIDS in the jail. Doctor keep them separate and people come to know from the nursing orderlies also).

In another jail, the researcher was told by the medical officer that one prison inmate was suspected to have HIV, his blood was sent for testing to the Government Hospital and the blood report was awaited. The researcher requested for interviewing that particular prison inmate and the doctor agreed. The researcher was asked to sit in the office room of the prison hospital ward and the particular prison inmate was called in. However, apart from the researcher, the prison medical doctor and the prison inmate respondent, there were two pharmacists, one prison guard and one prison warder who were also present in the room.

This incident raised serious issue of breach of confidentiality and especially when the prison inmate was suspected to have HIV/AIDS and was confirmed not having HIV. It was also revealed that the particular prison inmate was also kept alone in a separate cell.

7.4.3 Discrimination

As discussed above, segregating a suspected HIV patient may lead them to major discrimination from the fellow prison inmates. In another case, this time a women prison inmate, who was falling ill several times in the prison was suspected to have HIV by the fellow prison inmates. She explains the kind of discrimination she faced from her fellow prison inmates in the following words:

“...ekbaar mujhe bukhar ho gaya tha aur bukhar utar hi nahi raha tha, to sab log mujhe bolne laage ki mujhe HIV hai. Mujhe itna bura lagta tha ki jo log mujhse achhe se baat karte the aaj wo mujhse baat nahi karte hai. Phir mera report accha aaya, to sab baat kar ne laage phirse. Idhar bhed bhav bahut rakte hain (HIV negative prison inmate)

(Once I was falling ill continuously and fever was not going even after having continued medicines. Others started saying that I have HIV. I felt so bad thinking that till now people who used to talk to me so nicely suddenly are not speaking to me properly. Then my blood report came and it was negative. After that the behaviour of others was as before. Here people discriminate as lot.)
From the above, it may be said that HIV positive inmates do face discrimination in terms of behaviour change by their fellow inmates. This was best explained by one of the prison staff as, “They try to keep away and avoid HIV positive people”.

7.4.4 Segregation

As noted earlier, the prison inmate who was suspected to have HIV was kept separate in a cell. When asked about the reason for this, the researcher was told by the medical officer that other prisoners may misbehave with him and so it was better that he was kept separate.

“Prisoners are segregated in the prison only due to their HIV status” (prison staff).

“...HIV positive walon ko alag rakhna chahiye security ke hisaab se nahi to baaki log bure tarah treat karenge aur marenge...” (prison medical staff).

“They are kept separate in separate barracks for security reasons as most inmates in the jail are illiterate and they may discriminate against the HIV positive inmates” (prison staff).

Other prison staff believed that HIV positive inmates should be kept in separate cell as otherwise the disease might spread amongst other inmates if they engaged in homosexual acts (prison staff).

Separate mein rakhna chahiye, kaatke khoon se ya sambandh se phail sakta hai (prison staff).

Some other jail staff believed that HIV positive inmates should not be kept separate only because of their HIV positive status, however, TB and HIV patients should be kept separate.

“HIV positive walon ko alag nahi rakhna chahiye, per is jail mein rakhte hain.
TB aur HIV walon ko alaag rakhna chahiye”. (prison staff).

During interview in one woman prison, a woman prison constable shared with the researcher that one woman prison inmate, Sushma (name changed) whom the researcher had already interviewed, had tested positive. The constable shared her opinion about Sushma. Sushma hailed from Bangladesh and migrated to India. She
worked as a waiter in a beer bar in Maharashtra. The constable came to know this from another prison inmate who was also working with Sushma in the beer bar before imprisonment. Sushma was arrested on charges of not having a valid passport. However during interview with the researcher, Sushma had told the researcher that she worked as a housemaid prior to incarceration and not as a beer bar waiter. The woman constable came to know that Sushma was HIV positive from the prison guard who came to distribute the morning breakfast. During breakfast, Sushma was given special medical diet consisting of milk and two extra chapattis, on the recommendation of the medical doctor. The constable also said the reason of why Sushma was given a special diet

“aise batate hain ki isko HIV ki bimari hai, isliye extra diet diya ja raha hai.”

The constable was not sure if Sushma should be kept in a separate ward and said that she would confirm this with the medical doctor. Later the next day, she told the researcher that the doctor had confirmed that Sushma was not HIV positive and that she should not be kept separate.

This was another incident when the researcher found lack of appropriate knowledge and awareness regarding HIV amongst the prison staff. Although this fact didn’t have any direct consequence to the prison inmate, as often the prison staff acted as they were ordered by their senior staff, without questioning. However, this kind of inadequate behaviour certainly leads to the stigmatization and discrimination of either the HIV positive inmate or anyone whom the prison constable and other prison inmate suspected to have HIV. It has to be mentioned here that the researcher found Sushma ill and was told by the prison constable and the fellow prison inmates that Sushma was not keeping well since her stay in the prison a month back. This led them to suspect Sushma being HIV positive. Also, stigmatization could lead to mental stress for victims like Sushma who had to stay in constant touch with the fellow prison inmates and the prison constables.
7.5 Preventive Measures inside prison

The level of exposure of the prison inmates to intervention regarding HIV/AIDS in prison seemed to be varied. While some prison inmate agreed to be exposed to some kind of HIV/AIDS intervention in prison, the intervention seemed to be irregular. This fact is highlighted by some of the comments by the prison inmates as follows:

“Nagpur jail mein jab mein tha tab HIV/AIDS ke upar bataya tha, 1997 mein, uske baad se to suna nahi hai (inmate who was transferred to one of the jails under study from Nagpur jail).

“Solapur jail mein 18 months tha aur idhar 4 saal se huun. Pichle 4 saal mein eek baar HIV/AIDS ke upar bolne aaye the…yaad nahi kab”.

The following inmates expressed that they had some exposure to HIV/AIDS education through either film screening or though pamphlets by some NGO. However as the following comments indicate, the exposure had been once in a while and not regular.

“2 mahine pehle parde pe dikhaya tha AIDS ke barein mein”
(They showed in screen about AIDS two months back).

“I saal pehle dikhaya tha screen pe”
(They showed in screen one year back)

“TV pe bataya tha 6-7 months pehle”
(They showed in TV 6-7 months back)

“I saal pehle apne circle mein pamphlet mila tha”
(Pamphlets were distributed in our circle about one year back)

“6 months pehle NGO ne jaankari diya tha”
(Information was given by NGO about 6 months back)

“Aaye the 1 der saal pehle batane HIV/AIDS ke barein mein”
(They came to talk about HIV/AIDS about one year back)

“Eek baar parde pe dikhaya tha, isliye suna tha”
(I heard when they showed in screen)

“Freedom foundation wale aaye the 2-3 mahine pehle”
(Some 2-3 months back people from Freedom Foundation came)
As stated by the prison staff, there was a need for the NGOs working in the field of HIV/AIDS to work inside the prison in a consistent manner. NGOs were visiting the jails, but not regularly and only occasionally. It was suggested by the prison staff that NGOs should work in the jail on HIV/AIDS in cooperation with the prison administration for treatment and better care for the HIV positive inmates.

“...2-3 months pehle aaye the jail mein HIV ke baarein mein batane ke liye”
(prison staff)

“….sanstha wale nahi aate hain. Unko aana chahiye aur sabkaa HIV jaanch karna chahiye (prison staff).

“NGO aate hain lekin sif kuch khass dinon mein hi jaise mithai baatne ke liye aur rakhi ke din. Aur koi sanstha to koi bhi issue pe kaam nahi kar rahi hai, HIV/AIDS to duur ki baat hai...NGO ko aana chahiye aur jail walon se milke kaam karna chahiye...”
(prison staff)

“...HIV/AIDS ke baarein mein training aur jaankari chahiye…”

There seemed to be some problem regarding the accessibility of newspaper to all prisoners. As one prison inmate pointed out that newspaper were not available in the barrack in which he was staying and he suggested that reach of newspaper to prison inmate in atleast the vernacular languages should be made to make HIV prevention efforts fruitful.

“... newspaper milta nahin hamare barrack mein, newspaper se bhi thodi jankari mil jaati hai HIV ke baren mein...”

In one of the Central prison, peer educators were trained during a five days HIV/AIDS workshop in the barracks meant for the undertrial prisoners. This training happened in May 2006, since then there were no programs on peer education training. These undertrial prisoners who became the peer educators later started disseminating HIV/AIDS education in the undertrial barracks and thus the convict prison inmates were left out as they were engaged in work in the factories. The convict inmates were also not aware of any HIV intervention in jail.

“...peer educator training hua tha 2006 May mein. Uske baad aisa kuch nahi hua...”
(prison staff)
“HIV/AIDS ke barein mein jaankari to waise kam hi hai...jo under trial hain, unko thoda jaankari mil jaati hai kyunki peer educator ‘nawa jail’ mein batate hain jab superintendent saab ka round rehta hai...”. (FGD)

(The kind of intervention regarding HIV/AIDS inside jail was few. The inmates while being undertrial were given HIV/AIDS exposure in the “new jail” by either peer educators or in some visit by any NGO. These peer educators mostly spread HIV/AIDS education and awareness when there was round by the Superintendent of the prison. These happened in the “new jail” where the undertrial prisoners were housed (FGD).

The undertrial prisoners said that information regarding HIV/AIDS spread through word to mouth. Sometimes in Fridays, when the Superintendent came for a round, information regarding HIV/AIDS was shared which sometimes included photographic illustration (FGD).

Thus it seemed that the peer education programme was not effective and it was happening in a very casual and non-serious way. So the convict prisoners who were engaged in the prison workshop throughout the day were not part of these sessions by the peer educators. Since the peer educators were undertrial prisoners, they were unable in disseminating HIV/AIDS information to all the other prison inmates throughout the jail.

7.6 Inadequacy of Prison Administration

7.6.1 Training of Prison Medical Doctors

All the doctors are appointed by the Directorate of Health Services, Government of Maharashtra. They are deputed for one year from the Health Services Department to the Prison Department. It’s a routine posting. However, there was no special training for the medical doctors on HIV/AIDS in the prisons, before they were appointed as prison doctors.

“...never undergone any training/ refresher course about human rights of prisoners and on HIV/AIDS....no HIV/ AIDS prevention information during initial training and thereafter on a regular basis... ” (Prison medical doctor)
7.6.2 Doctor Prisoner Ratio

There is a dearth of prison medical staff as compared to the total prison population in all the jails. In one Central Prison, the prison medical staff consisted of one medical officer, three pharmacists and a nursing orderly. One of the astonishing aspect of the Amravati prison is that they don’t have a lady doctor despite having a woman prison population of 95 and 9 children below the age of five (as on 02/01/2008). The need for a permanent lady doctor in this jail was voiced by the women prison inmates.

Another Central Prison had one Chief Medical Officer, one medical officer, one lab technician, two pharmacists and three nursing orderlies in a total prison population of 881 among which 23 were women prison inmates (as on 13/02/08). However, overcrowding was not too much of a problem in this jail as the capacity of the male section in this prison was 1049 and that of the ladies prison was 31. However, the ratio of the medical doctors and the prison population was certainly inadequate.

Likewise, another Central Prison had one chief medical doctor, four medical doctors, one psychiatrist, one counsellor, three compounder, six nursing orderlies, one pathologist and one lab technician. This prison had a capacity of 2523 prisoners but housed 3615 prison inmates (as on 14/12/2007). Thus the number of doctors as compared with the total number of prisoners was very less.

Similarly, one Central Prison had a population of 3000 in a prison capacity of 1805 (as on 31/03/08). Thus this prison was also overpopulated.

It may be said that in all the prisons the availability of the medical doctors and the number of prisoners presented a much skewed ratio.

7.6.3 Inadequate equipments in the prison hospital

Inside the prison, only preliminary treatment for the inmates was available. There was no laboratory inside the prison for conducting minor lab tests (e.g. urine test). Basic equipments like ECG machine, more oxygen cylinders were missing. If a laboratory was there inside the prison, the prison doctors themselves could carry on with the tests and start the treatment. Also, there should be a well-equipped district level civil hospital inside the prison. Such hospitals have facilities including X-Ray facility, operation theatre. If such provisions were made inside the prison itself, then the inmates would not be required to be sent to the local Government Hospital. This
would in turn reduce the problem of getting guard. Thus availability of minimum facilities inside the prison hospital would ease the burden on the prison administration in terms of arranging for police escorts. Finally, this would make quality medical services available for the prison inmates (prison medical doctor).

“Treatment jail mein sahi nahi hai. Heart, brain ki bimari ke liye machines nahi hai. Government hospital mein machineries hai, aur doctors bhi acche hain” (prison staff).

(The medical treatment in jail is not good. There are no machines available for heart and brain ailments. In government civil hospital, there are appropriate machines available and the doctors are also good).

7.6.4 Training of Staff on HIV/AIDS

Regarding knowledge and information on HIV/AIDS, the training curriculum for the prison staff didn’t include issues about HIV/AIDS. Some Superintendents said that when they were undergoing training during the 80s, not much was known about the HIV/AIDS and so there were no training curricula on HIV/AIDS. However, even now, there is no training on HIV/AIDS in the curricula that is being imparted to the new batch of people who are joining the Prison Department. He feels that now that HIV/AIDS has emerged as a serious issue and problem worldwide, information related to HIV/AIDS should be incorporated in the training module of the Prison Training Curricula. This information may include knowledge related to HIV care, treatment, prevention and counselling related to the same. The training period for Guard (‘Sipahi’) is 5 months and that of Superintendents and Jailor is for one year.

7.6.5 Corruption

Corruption as a part of prison culture was also revealed by the prison inmates. They revealed that inmates who were rich and powerful could get access to every facility inside jail including better food, space and addictives such as charas. During the personal interview, one of the inmates revealed that there were separate terminologies for various denomination of currency. For example, a note of Rs 100 was called “ear”, a Rs 500 note was called, “baldi” and so on. Inmates who provided money to the guards and subsequently to the higher authority got special amenities (FGD).

Some of the addictives which were available in the canteen by coupon for every prisoner included cigarette and tobacco. However, it came out from the
discussion that addictives such as charas, which were otherwise not allowed inside jail by law, were also smuggled inside through various means adopted by the prisoners (FGD).

It was revealed that the Chief Medical Officer in one particular prison usually asked for bribe of Rs 1000 for referring the inmate to the civil hospital.

“CMO civil hospital mein bhejne ke liye 1000 rupeya paisa mangta hai. Mere jaise garib aadmi kaise paisa de sakta hai”(prison inmate)

(The CMO refers to the civil hospital only when he is given a bribe of Rs 1000. What will poor people like me do who don’t have money to pay a bribe?)

7.6.6 Pre-release
There is the provision of premature release for terminally ill prisoners. Such cases are being referred to the Government for further action, “...we cannot ask for pre-release to the Government. We can just refer the file to the IG regarding pre release and after that it depends on the Government to decide on that”.

Release of prisoners prematurely is a concession or privilege extended by the State and the prisoner cannot claim it as a matter of right. It is based on the reformation philosophy. Premature release is realized through the ‘review of sentences’ undertaken in accordance with the special enactments, rules or orders formulated by the State Governments. The system differs from State to State based on the eligibility criteria of the persons eligible for consideration of premature release, the composition of the Sentence Review Boards and the guidelines governing the question of premature release, but it is observed that more often this system is not being followed (Tiwari, 2002).

7.6.7 Non-availability of police guards
All the prisons face tremendous problem of getting police guards regularly and whenever required. The problem of non-availability of police guards is a major hindrance in the regular accessibility of treatment for the HIV positive inmates. As revealed during discussion with the prison officials, separate guards were provided under the police control for the prisons. However, most often these police guards meant for the prison work were utilized for the police work.
The present chapter highlights the vulnerability risk factors of prison inmates towards HIV/AIDS. Although the vulnerability in terms of high risk behaviour of the prison inmates before incarceration could not be ascertained considering the paucity of the data, it can be strongly said that homosexuality is a persistent phenomenon and very much rampant in the prison. The other factors like improper medical facility and poor prison conditions certainly pose a serious threat to the life of HIV positive prison inmates. Further, it is clearly observed from the data that there is a serious violation of the health rights of the prison inmates as many sensitive issues were not dealt with ethically. Finally, lack of effective preventive mechanism towards HIV/AIDS and inadequacy of the prison administration adds on to the plight of the HIV positive inmates in particular.

It may be said that although the government made various provisions to improve the condition in Indian prisons through various schemes such as the Modernization of Prisons scheme, it seems that things are still not developed in terms of physical infrastructure. A lot of money have been allocated and spent to improve the basic facilities in the prisons, in terms construction of new jails, toilets etc. However, the efficacy and outcome of such scheme is yet not visible. Thus, although efforts are being made by the Government, the results are not visible. Even the existing available resources are either underutilized or utilized in a non-serious way. For example, Maharashtra Government has appointed teachers in all the Central Prisons in Maharashtra state. Although the primary work of these teachers is to provide formal education to the prison inmates, their services could also be utilized in disseminating training and education on various health issues, specifically prevention and care of HIV/AIDS. It appears that the sense of ownership of the prison authorities is missing when it comes to the health of the prison inmates in general and with regards to HIV/AIDS in particular. The ultimate goal of the prison authorities seem to remain limited to the safety and security of the prison inmates and to avoid any incidence of custodial death. Health seems to be the least priority issue and HIV/AIDS seems to be a non-existent phenomenon for the prison authorities. However, despite the government efforts and despite the apathy of the prison authorities, HIV/AIDS is a problem in the prison, especially in terms of access to care and treatment of prison inmates. The various structural problems in the prison, in terms of poor living conditions, poor medical facilities etc, make the prison inmates vulnerable to HIV. Also the fact that homosexuality is a rampant phenomenon in
prisons and the knowledge of prison inmates regarding spread of HIV through homosexuality is low as compared to the other modes of HIV transmission. This, together with the fact that there are no available mechanisms for effective HIV interventions in prisons, makes the prison inmates more vulnerable to HIV.