UNODC
United Nations Office on Drugs and Crime

Country Office Pakistan

FEMALES BEHIND BARS

Situation and Needs Assessment in Female Prisons and Barracks

Females Behind Bars

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UNODC
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Vision Statement

UNODC aims to counter the sinister trilogy of drugs, crime and terrorism and help strengthen the virtuous triad of peace, security and development. In short, UNODC aspires to be the world's conscience on drugs and crime, reminding States of their commitments and raising awareness about the need for drug control and crime prevention. UNODC provides technical services to assist States and communities in preventing, resisting and reducing these threats.

Due to this comparative advantage within the United Nations system, UNODC has been given the responsibility to lead the UNAIDS response to HIV among injecting drug users and in prison settings. UNODC is mainstreaming HIV/AIDS into its activities globally and at regional and country levels, and is helping countries and civil society organizations to develop and implement comprehensive HIV/AIDS prevention and care programmes. UNODC also has a special mandate for facilitating the development of a United Nations response to HIV for people vulnerable to human trafficking. These most-at-risk marginalized populations are often subject to discrimination and violations of their human rights. Only few have access to HIV prevention, treatment and care services.

Executive Summary

The Joint United Nations Programme on AIDS (UNAIDS) has listed prisoners among the four most 'at risk and neglected populations' in the HIV/AIDS pandemic. The 2006 report states that "Prisons are sites for illicit drug use, unsafe injecting practices, tattooing with contaminated equipment, violence, rape and unprotected sex. Prisons are often overcrowded, have limited access to healthcare, offer poor nutrition and have high rates of airborne and blood borne diseases. Particularly women make up a very small proportion of the prison population in Pakistan and they are faced with much greater challenges than men in accessing healthcare. UNODC Pakistan, through one of its projects initiated HIV prevention services for female prisoners. The project contains significant importance as is only the project targeting female prisoners in the country.

Data was collected in 09 female prisons and barracks across the country, where the project was being implemented. All females who were admitted to a female prison within the study period formed the study population. To be eligible for participation, a woman should be an inmate in one of the targeted prisons, be of 18 years of age or older, irrespective of her drug using status and risk behaviors and was willing to provide an informed consent for participation in the study. A total number of 375 subjects was calculated to be the final sample size for this study. The preliminary data available from the project suggested that a more or less 400 female prisoners existed in the prisons. Owing to the small number of female prisoners reported from these target prisons, no strict inclusion or exclusion criteria were used and all available prisoners who showed a willingness and provided consent to participate, were included in the study. Data collection was preceded by a pre-survey phase, which lasted for a couple of weeks. The supervisory staff in prisons was contacted by the field teams and were explained the objectives of the study to ensure their involvement in the study. This phase focused on answering any concerns of the prison staff and address any of their apprehensions about the study and confidentiality of data. Data collection lasted for a period of 6 weeks. The team members were lead by the project psychologist, who played a key role in data collection. Data were collected on a predesigned format which was developed through a consultative process between the project staff, the UNODC technical team and the research consultant. Data was collected in a secure room (project's counseling room) separate from the prison's main building and provided enough privacy for the interviews to be conducted smoothly without any interference. The questionnaire was of a structured format, developed to gather information on various socio-demographic, prison related information and personal characteristics of the individual herself. After the questionnaire information was collected, the interviewer answered any questions that participants had raised and registered with the project for future followup. After editing, all questionnaires were rechecked using a software designed in MS Access for data entry. Analysis was done using the statistical software package, SPSS version 12.0 (statistical package for social sciences). Since prisons have peculiar characteristics regarding exertion of rights, the numerous ethical issues such as voluntary participation, taking informed consent, and measures to ensure and maintain participants' confidentiality were taken into consideration during the entire length of this study.

A total number of 359 interviews were conducted for this study, within the time allocated for data collection. The average age of prisoners across all prisons was reported to be 35.2 years ± 12.6 (median = 32), with little variability between different prisons. The maximum proportion of prisoners interviewed were illiterate (68%) and more than half of the prisoners interviewed were married with children. Half of the women interviewed shared in the family expenses by providing some sort of financial support. 4% of the women interviewed were non Pakistanis; the maximum numbers of non-Pakistani women interviewed were from Zambia. Of the 359 women prisoners interviewed, an astounding 59% of the women were reported to be under trial. A remaining 31 (8.6%) were detained while the remaining 32.6% (117) were convicted. The maximum proportion of women was imprisoned due to crime such as murders (40%), and drug related offenses. These included using as well as possession of illegal drugs. Another issue of concern is the high number of women who were imprisoned on account of commercial sex work. Upon further inquiry 23.7% of the women stated that they had ever been imprisoned for drug related offenses, while another 15.6% informed that they had been imprisoned for commercial sex work.

A fairly large proportion of women had been tobacco smokers before imprisonment and nearly half of them continued smoking even within prisons. In addition a substantial proportion of the overall female prisoner population indicated use of psychotic drugs before being imprisoned, but did not continue their drug using habit, as drugs were not available

in prisons. Of the 359 women interviewed, only 22 (6.1%) reported that they had ever injected any form of drug. Further inquiry into drug injecting practices revealed that all these injections took place among the women were imprisoned. Forty five (12.5%) of the total women interviewed stated that they had faced some form of sexual harassment while in prison (not rape). Multiple sex partners were notified, with sex between various prisoners being the most common form of consensual sex seen in prisons. 52% of the women interviewed informed that they had heard of HIV and AIDS. Knowledge of sexual intercourse as a mode of transmission of the disease was prevalent among 27.3% of the women interviewed and 42% knew that HIV can be transmitted by sharp instrument/needles and syringes. 49% knew that HIV can spread through blood transfusion, while knowledge of mother to child transmission was found to be 26%. One fifth reported to have experienced an STI in the past 06 months, while 18% received proper treatment for these infections.

An evaluation of the prison environment showed that unlike male prisons, overcrowding is not reported to be an issue in female prisons. The hygiene conditions in all prisons visited were far from ideal. The sanitation facilities available for prisoners varied according to various prisons or barracks. The number of wash rooms ranged from 3 to 4 prisoners per wash room to 60 prisoners per wash room in one of the larger prisons. Only one of the prisons visited had safe drinking water available for the prisoners. All prisons other than two had tap water available for 24 hours, however the water was not purified leading to various water borne diseases. While women prisoners were reported to keep their children with them in prisons, it is also worth mentioning that there were no child care facilities in any of the prison evaluated. Inadequate medical facilities were reported by female prisoners from nearly all prisons. Although doctors are available in all prisons, but the diagnostic and treatment facilities were found to be far from satisfactory. No measures to deal with the mental health issues were reported to be provided by the prison authorities. In all prisons, psychologists were made available through UNODC supported project. The psychological problems reported are depression, stress, mental illness, attention seeking behavior, sleep disorder and generalized anxiety. No recreational facilities are available except television, which was available in only 2 prisons. No indoor games or activities to keep the prisoners involved were seen in any of the prisons visited.

Based upon the results of this study, a series of key principles and actions are recommended, to promote principles of public health, improve the mental state of health of the confined, and prevent the spread of HIV and other communicable diseases in prisons.

These services should include the provision of basic determinants of health such as adequate nutrition, clean drinking water, sanitation facilities, provision of an adequate gender-sensitive and interdisciplinary mental healthcare and provision of drug dependence treatment options for prisoners with problematic drug use.

Comprehensive education and awareness of HIV/AIDS and ways to prevent HIV transmission, with a special reference to the likely risks of transmission within prison environments should be provided to both Prisoners and prison staff. Prison systems should provide easy access to voluntary HIV testing and counseling, which should be easily accessible to all prisoners. While HIV, HCV and HBV testing is continuously done in most prisons under the project supported by UNODC, it is strongly recommended that TB testing should also be initiated in prisons.

Some basic child health services including nutrition, immunization, basic health care needs can be provided by the project as part of the holistic support program. Women should be provided access to legal counseling and provision of legal aid if desired, to access lawyers and follow up their cases in courts. Every effort should be made to develop positive partnerships with the higher prison authorities and the prison staff for every initiative undertaken.

Introduction & Background

1

Chapter 1

1. Introduction and Background

1.1 Prisons and HIV

Data from across the globe suggests that Prisons have become a fertile ground for the HIV epidemic. The Joint United Nations Programme on AIDS (UNAIDS) has listed prisoners as one of the four most 'at risk and neglected populations' in the HIV/AIDS pandemic. The 2006 report states[1] that "Prisons are sites for illicit drug use, unsafe injecting practices, tattooing with contaminated equipment, violence, rape and unprotected sex. They are often overcrowded and offer poor nutrition, limited access to healthcare and high rates of airborne and blood borne diseases".

Worldwide, the levels of HIV infection among prison populations tend to be much higher than in the population outside prisons[2]. This situation is often accompanied and exacerbated by high rates of other infectious diseases such as hepatitis and tuberculosis. Several factors make prisons an ideal breeding ground for onward transmission of HIV infection. Many of those in prisons are there because of drug use or trafficking and they often find ways to continue drug use inside the facilities. Drug injecting with shared, non-sterile equipment is the factor probably accounting for the greatest number of new HIV cases in prisons worldwide. Despite strict regulations against drugs in prisons, intravenous drug use still occurs. Clean needles are almost impossible to find and needles are often shared by inmates[3]. In addition to drugs, many inmates turn to sex to escape the boredom of prison life and in such a situation, safe sex is not even an option for most inmates. Apart from consensual sex, sexual assault and rape is not uncommon in some prisons, which forms potential source of transmission of HIV in correctional facilities[4].

Even though high risk behaviors common to prisons put inmates at a higher risk for HIV infection while incarcerated, most HIV positive prisoners were infected before being sent to prison. Indeed, the populations most vulnerable to the HIV infection are the same communities at high risk for criminalization and incarceration and fear of discrimination deters prisoners from accessing the voluntary HIV testing available in most prisons. Test result confidentiality is a major issue in a prison environment, where even the suspicion of a positive test result can lead to stigmatization, bringing social isolation and violence from other inmates and sometimes even prison staff. The fear of stigmatization also discourages many inmates living with HIV from seeking medical services and treatment. Prison conditions also undermine the dosing schedules that are important for the effectiveness of antiretroviral therapy.

Globally, female prisoners represent about 5% of the total prison population, but this proportion is increasing rapidly, particularly in countries where levels of illicit substance use are high[5]. In 2005, worldwide, on any given date more than half a million women and girls were detained in prisons, either awaiting trial or serving sentences. Women prisoners present specific challenges for correctional authorities despite, or perhaps because of the fact that they constitute a very small proportion of the prison population. The profile and background of women in prison, and the reasons for which they are imprisoned, are different from those of men in the same situation. Prisons and prison regimes are developed with the needs of the majority male prison population in mind. Woman may constitute a small proportion of prisoners worldwide. However, women are vulnerable in prisons, due to their gender and caring responsibilities, and have requirements that are very different to those of men. Separation from their communities, homes and families has a particularly detrimental impact on women prisoners' mental well being. They usually need more psycho-social support than men, both due to the harmful impact of disruption of family links on women, as well as because of their typical background which often involves being victims of domestic violence or other types of abuse. They are often illiterate and unaware of their rights and are lacking in confidence. They need assistance and support to access legal

1. Report on the Global AIDS Epidemic UNAIDS 10th Anniversary Special Edition 2006. Geneva: UNAIDS, 2006.
2. Prisons and AIDS, UNAIDS Best Practice Collection, Geneva: UNAIDS, April 1997
3. Fazel S., Bains P., Doll H. (2006). Substance abuse and dependence in prisoners: a systematic review. Addiction, 101: 181-191.
4. Susan Okie. Sex, Drugs, Prisons, and HIV. N Engl J Med 2007. 356;2; 105-108.
5. International Centre for Prison Studies (2006) World female imprisonment list, www.kcl.ac.uk/depsta/rel/icps/women-prison-list-2006.pdf

counsel and special education and training, including building their life skills. Women also have different and specialized healthcare needs, which need special attention.

HIV prevention, treatment, care and support programmes are not adequately developed and implemented to respond to HIV in prisons[6]. Addressing the problem of HIV and AIDS in prisons requires a multifaceted approach. UNAIDS believes that it is essential that prisoners be allowed access to prevention materials, including condoms, safer-sex supplies, and bleach kits for cleaning needles (HIV/AIDS Prevention). Increasing HIV and AIDS awareness through prisoner health education programs is crucial to decreasing the stigmatization of HIV inside prisons that prevents many inmates from seeking testing or treatment.

1.2 The prison system in Pakistan[7]

The prison system in Pakistan is the legacy of its British colonial past, having been established in the 1850's, the Prison rules also date back to that time though they were revised in 1978. The main laws and rules that directly relate to the administration of prisons and the treatment of prisoners are: The Prison Act, 1894 (Act IX of 1894); The Prisoners' Act, 1900 (Act III of 1900); Good Conduct Prisoners Probational Release Act, 1926 (Act X of 1926) and Prison Rules, 1978. The Prison Act of 1984, which is a federal law, reflects an exclusively punitive approach to imprisonment. It includes "inter alia", the use of fetters and bars, whipping, extended periods of solitary confinement and reduction of diet as punishment. Though the Prison Act does not appear to be consulted by prison authorities any longer, the Prison Rules being considered as the main point of reference, it is still legally in force.

Leading experts in Pakistan are of the opinion that there is an urgent need to reform Pakistan's prison rules and jail manual. Regrettably very few amendments have been made to the Prison Rules to date to bring them in line with the requirements of UN standards and norms.

At the federal level the Ministry of Interior has the responsibility to coordinate prison reforms with provinces and is also responsible for federal level training offered at the Central Jail Staff Training Institute (CJSTI). The prison system in Pakistan is organized on a provincial basis under the overall supervision of the Home Departments in each province. The management of prisons is the responsibility of the Inspector General (IG) of Prisons and each province has a Provincial Minister for Prisons. At the divisional level, the IGs are supported by Deputy Inspectors General of Prisons and Assistant Inspector Generals. Individual prisons are headed by Jail Superintendents.

There are a total of 97 prisons in Pakistan. A particular cause for concern is the exceptionally high level of under-trial prisoners included in these figures. The percentage of the under-trial prison population is approximately 74%, with sentenced prisoners making up only 26% of the total prison population. In the meantime, the conviction rate is said to be somewhere between 12 and 20%[8]. This, in effect, means that a large proportion of those in prison may be innocent, though the low conviction rate is clearly influenced by other factors also including the quality of investigations and corruption levels.

Healthcare provision in Pakistan's prisons is in general the responsibility of the Ministry of Health, though the prison department covers some of the healthcare related expenses from its own budget: in general doctors and paramedics are deputed to the prisons by the Provincial Health Departments of the respective provinces and are employees of Provincial Governments. Each prison has a budget for the procurement of medicines. In case a prisoner requires specialized medical care he or she is referred to government hospital.

1.3 Women prisons in Pakistan[9]

According to the rules women prisoners must be strictly separated from men, either in separate parts of a prison or in a separate prison altogether. There are four prisons exclusively for women located in Multan, Karachi, Larkana and Hyderabad, while a number of prisons have separate barracks for women. In Balochistan, women prisoners are held in

6. Prisons and AIDS. UNAIDS Best Practice Collection, Geneva: UNAIDS, April 1997
7. Assessment of the prison system of Pakistan. UNODC, Country Office Pakistan. 2009
8. According to the Human Rights Commission of Pakistan the conviction rate has declined from 20 to 12%. Other sources referred to a 20% conviction rate figure.
9. Assessment of the prison system of Pakistan. UNODC, Country Office Pakistan. 2009

Central Jail, Gaddani and District Jail Quetta, while all sentenced women and juveniles are held in separate barracks in Peshawar and Haripur prisons in Khyber Pukhtoon Khua province. Under-trial women and juveniles are detained in separate barracks in central and district prisons.

Women make up a very small proportion of the prison population in Pakistan and their numbers have notably declined during the first six months of 2009, from 1518 on 31 December 2008 to the current figure of 1252. This reduction has been achieved, no doubt as a result of the impact of the more active prison visits undertaken by judges, as well as due to changes made to legislation which has favorably affected women's imprisonment. Women prisoners face even greater challenges in accessing the specialist healthcare that they require. Prison authorities report that women receive visits from the district health departments, but that there is a shortage of woman doctors. In some prisons, for example, Karachi and Rawalpindi, NGOs were providing additional healthcare support to women prisoners. There had been 12 HIV positive cases among women prisoners, of which 11 had been released.

Women prisoners are transferred to hospitals for child birth in larger cities. In smaller cities a mid-wife visits prisons and assists with child birth. In smaller towns women prisoners are said to sometimes give birth without any supervision or assistance by medical specialist or mid-wife. Most of the specialist women's healthcare was being provided by organizations of civil society, rather than the Ministry of Health or Prison Department.

It is important to note that in the majority of prisons worldwide mental health among all prisoners is a growing concern. The high rate of mental illness among prisoners is related to many interrelated factors. All prisoners are at risk of developing a range of mental healthcare needs in prisons, irrespective of whether they had particular mental healthcare needs on entry. Currently there are no clinical psychologists available in Pakistan's prisons to respond to the needs of all prisoners and the healthcare assessment on entry does not include a thorough assessment of mental healthcare needs. In some prisons there are temporary or part-time personnel (usually recent graduates) appointed, who do not have the requisite experience.

1.4 Project introduction

Owing to the unavailability of services for prisoners more specifically female prisoners in Pakistan, the United Nations Office on Drugs and Crime in auspices of Ministry of Narcotics Control initiated a project *"HIV/AIDS prevention, treatment and care for Female DUs and female prisoners"* as a precursor to joint programming under the 'One UN" initiative.

This project contains significant importance as is the only project targeting female prisoners in the country. The primary goal of this project is to provide equitable health care and HIV/AIDS treatment and care services as available in the community, which include:

- Providing information on modes of HIV transmission and waves to reduce those risks on testing and treatment
- Providing voluntary counselling and testing services;
- Diagnosing and treating sexually transmitted infections;
- Providing appropriate diet and nutrition supplements;
- Referral for anti-retroviral treatment, other opportunistic infections and other blood borne diseases like Hep B and C;
- Providing reproductive health care.

The project also provides infrastructural support to especially enhance sanitation and hygiene conditions in prisons. The project contributes programmatically to the overall goal of Sub-Programme III, outcome 9 of the Country Programme for Pakistan, 2010-2014 but is not of part of it administratively as yet.

The novelty of this project is multifarious as it is the first effort to address HIV prevention, treatment and care for female IDUs and female prisoners in Pakistan. The project sensitized the policy makers including prison authorities and enhanced the capacity of service providers, peer educators and prison staff. Through the course of this project, service providers will avidly learn important lessons about how service delivery needs to be tailored to the specific needs of women, especially in areas of access, approach as well as addressing broader concerns of female drug users' health and

family issues. Availability of Gender specific baseline drug related HIV data, regular access of female DUs/IDUs to gender-responsive harm reduction services and increased utilization of harm reduction services with the change in risk behaviors being observed will contribute to achieving goals towards success of this project.

The project proves its significance through avid acceptance by the prison authorities and recognition by other stakeholders. Establishment of gender harm reduction services, their linkages with other health services and quality services to female IDUs/DUs and female prisoners played a vital role in its success.

Methodology

2

Chapter 2

2. Methodology

2.1 Study design and sites

Unlike the general population, the prison has peculiar characteristics for the prisoners to claim for their rights. These issues were taken into consideration while designing this study and are mentioned in detail in the section on ethical issues. The study was a descriptive survey where quantitative data was gathered to address the objectives of the study.

Data was collected in 9 prisons across the country, where the project was being implemented. Data was collected in the following prisons through face to face interviews with female prisoners.

- Central prison, Peshawar
- District Jail, Mardan
- Central Jail, Haripur
- District Jail, Mansehra
- Special prison for Women, Karachi
- Special prison for Women, Hyderabad
- Kot Lakh Pat Jail, Lahore
- Ladies Jail, Larkana
- Central Jail, Multan

2.2 Study subjects and sample size

All females who were imprisoned, within the study period, formed the study population. To be eligible for participation, a woman should have been an inmate in one of the targeted prisons, be of 18 years of age or older, irrespective of her drug using status and risk behaviors and was willing to provide an informed consent for participate in the study.

Owing to the small number of female prisoners reported from these target prisons, no strict inclusion or exclusion criteria were used.

The sample size was calculated to capture a difference of at least 15% from the baseline at the end of the project duration. In addition other assumptions used were:

P1 = estimated prevalence at baseline (since information on existing behaviours were not available from any source, varying levels of P1 ranging between 10% to 50% were used. The largest sample size obtained was finalized)

P2 = expected prevalence in future (detect a change of 15%)

P = (P1 + P2) / 2;

$\Delta 2$ = (P2 P1)2

$Z1-\alpha$ = 95% level of significance

$Z1-\beta$ = Power of the study set at 90%

D = Design effect of 2 was used

The following formula was used to determine the sample size for target groups:
Based on the calculations, a total number of 375 interviews were calculated to be the final sample size for this study.

$$n = D\frac{\left[\sqrt{2P(1-P)}Z_{1-\alpha} + \sqrt{P_1(1-P_1)+P_2(1-P_2)}Z_{1-\beta}\right]}{\Delta^2}$$

The preliminary data available from the project, before actual data collection of this study was initiated, suggested that more or less 400 female prisoners existed in the prisons which were selected for this study. Based on this information a "take all" approach was utilized to recruit study subjects. i.e, all subjects who were eligible and willing to participate in the study were recruited in the study.

2.3 Data collection procedures

Data collection was preceded by a pre-survey phase, which lasted for 2 weeks. The supervisory staff in prisons was contacted by the field teams, and was explained the objectives of the study to ensure their involvement in the study, This phase focused on answering any concerns of the prison staff and to address any of their apprehensions about the study and confidentiality of data. During this phase, female prisoners were also explained about the study and an agreement for participation at their own will. At the end of this phase, potential respondents were identified through listing of the prisoners and a sampling frame was developed for the study.

Table 2.3 provides details on the prisons included in the study and also provides information on data collection team.

Table 2.3 Prisons/barracks and data collection team

City	Prison/barracks name	Team numbers
Peshawar	Central prison, Peshawar	01 Psychologist; 01 Health Worker
Mardan	District Jail, Mardan	01 Psychologist; 01 Health Worker
Haripur	Central Jail, Haripur	01 Psychologist; 01 Health Worker
Mansehra	District Jail, Mansehra	01 Psychologist; 01 Health Worker
Karachi	Special prison for women	01 Psychologist; 01 Medical Doctor
Hyderabad	Special prison for women	01 Psychologist; 01 Counselor
Lahore	Kot Lakh Pat Jail, Lahore	01 Psychologist; 01 Counselor
Larkana	Ladies Jail, Larkana	01 Psychologist; 01 Counselor
Multan	Central Jail, Multan	01 Psychologist; 01 Counselor

Data collection was a period for 6 weeks from 01 March to 15 April 2010. All eligible subjects, living in the selected prisons during this time period were asked to participate in a face to face interview with trained female interviewers, after an informed consent was obtained. The team members were lead by the project psychologist, who played a key role in data collection. Data was collected on a pre-designed format which was developed through a consultative process between the project staff, the UNODC technical team and the research consultant.

Data was collected in a secure room (project's counseling room) separate from the prison's main building and provided enough privacy for the interviews to be conducted smoothly without any interference. After selection of the study subjects, interviewer introduced herself and explained the importance of this survey and how its findings will be beneficial. Prior to commencing the interview, informed consent was obtained followed by the administration of the questionnaire. The administration of the questionnaire took 10-15 minutes.

After the information was collected, the interviewer answered any further questions that participants raised and were then registered with the project for the future follow-up .

2.4 Data collection instrument

The questionnaire used was of a structured format, which was developed to gather information on various socio-demographic, prison related information and personal characteristics of the individual. The key variables for which information was collected are as follows:

- *Socio-Demographic variables:* age, education, marital information, profession related information, ethnicity etc*;*
- *Prison related information:* Length of imprisonment, time spent in prison, type of imprisonment;
- *Drug using information:* drugs used, use of drugs in prisons, injection drug use etc;
- *Sexual practices :* Age of initial sexual intercourse, condom use, last sexual intercourse, history of rape etc;
- *HIV Knowledge:* Knowledge of HIV and AIDS, routes of transmission, methods of prevention;
- *Others:* Knowledge of STIs, HIV testing, blood donation;

2.5 Training on data collection

The data collection staff was trained on data collection procedures in a training workshop which focused on issues such as :

- basic interviewing skills
- comfort in interviewing about drug issues and sex
- explaining the rationale and objectives of the study to the subjects
- ethical issues including confidentiality
- acquiring the informed consent
- thorough understanding regarding each question
- debriefing and referral process
- coding and editing
- data management

2.6 Data management and analysis

Data was edited for completeness and consistency of the completed questionnaires. The questionnaires were discarded if gross errors were observed.

After editing, all questionnaires were then analysed by the research consultant, who with the help of a data manager re-checked the data in computer using a software designed in MS Access for data entry. Analysis was done using the statistical software packages, SPSS version 12.0 (statistical package for social sciences).

2.7 Ethical considerations

Unlike the general population, the prison has peculiar characteristics regarding exertion of rights. Thus there are numerous issues attached with conducting studies in prisons and jails, which were taken into consideration while designing this study.

Following were the ethical considerations for conducting the study:

- Participation was entirely voluntary and no coercion was used in the recruitment process. All eligible participants were clearly explained that they had free choice to participate or refuse participation in the study.

- Informed consent was obtained verbally prior to entry into the survey. This was done through a standard consent form at the beginning of the questionnaire and was read out to the participant by the interviewer.

- The following measures were taken to ensure and maintain participants' confidentiality.

    - No identifying information was recorded
    - No written consent was sought
    - Interviews were conducted in a secure place to ensure confidentiality
    - No reports generated from the risk behavior survey contained information that would potentially identify a participant
    - All study-related materials (e.g., completed questionnaires) were kept at a secure place at the field offices and accessible only to the study staff (e.g., interviewers etc)
    - Electronic data files were password protected and accessible to the authorized personnel only

- Interviewers conducted appropriate debriefings with participants at the end of the interview and a proper follow-up plan was developed for each individual.

Results

3

Chapter 3

3. Results

3.1 No of interviews and non response

Table 3.1 provides information on the number of interviews conducted in various prisons and the non response which was reported. The highest non response rate was reported from Lahore, which was due to the fact that 17 foreigner prisoners did not show willingness to participate in the study. A total number of 359 interviews were conducted for this study, within the time allocated for data collection .

Table 3.1 Total number of interviews conducted and non response rate

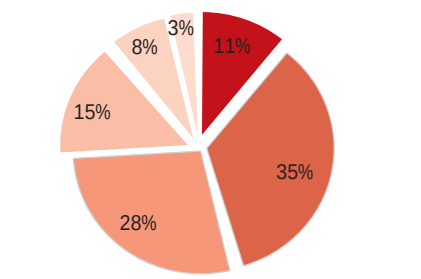
City	Prison name	No of interviews	%	Non response
Peshawar	Central prison, Peshawar	37	10.3	02
Mardan	District Jail, Mardan	12	3.3	None
Haripur	Central Jail, Haripur	30	8.4	None
Mansehra	District Jail, Mansehra	07	1.9	None
Karachi	Special prison for women	73	20.3	04
Hyderabad	Special prison for women	25	7.0	01
Lahore	Kot Lakh Pat Jail, Lahore	82	22.8	17
Larkana	Ladies Jail, Larkana	25	7.0	None
Multan	Central Jail, Multan	68	10.3	04

3.2 Socio-demographic characteristics

3.2.1 Age of the respondents

The average age of prisoners across all prisons was reported to be 35.2 years ± 12.6 (median = 32), with little variability between different prisons. Further analysis reveals that the largest proportion of women fall between 21 to 30 years of age, followed by women who were 31 to 40 yrs. 3% of the women interviewed were more than 60 yrs old.

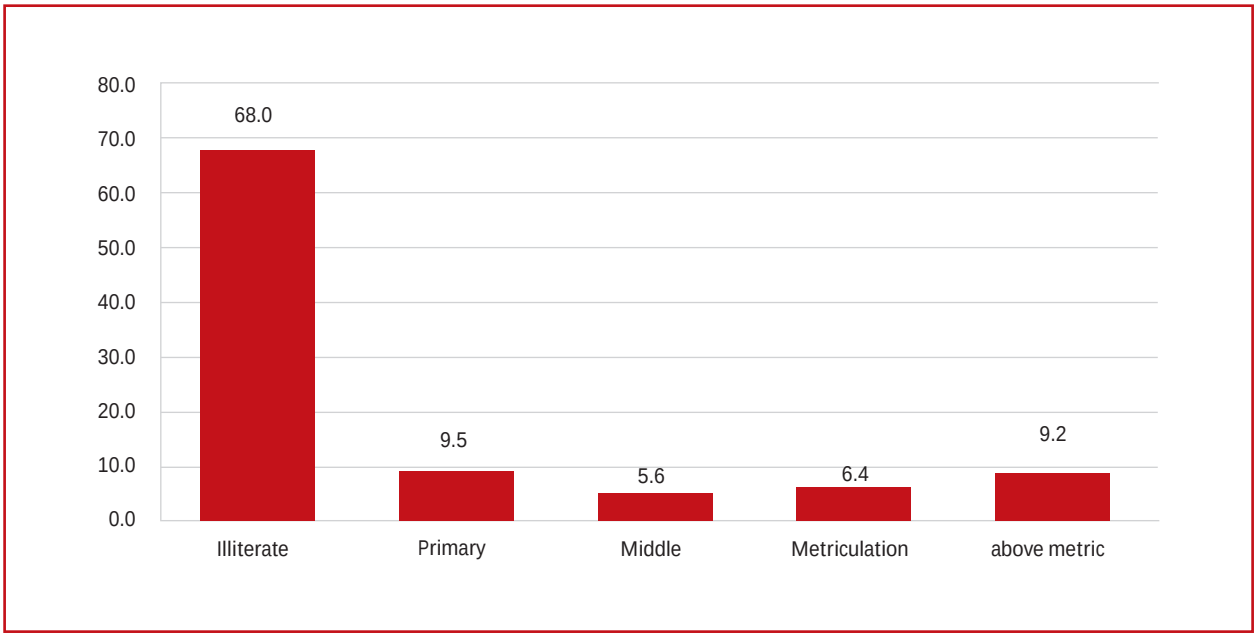
Fig 3.2.1 Age distribution of female prisoners interviewed



3.2.2 Educational status

The maximum proportion of prisoners interviewed were illiterate (68%) as shown in Fig 3.1.2. Nearly 10% of the interviewed women had more than 10 yrs of education.

Fig 3.2.2 Educational status of female prisoners interviewed



3.2.3 Marital status and number of children

More than half of the prisoners interviewed were married having children, while a significant proportion was divorced or separated. (see table 3.2.3)

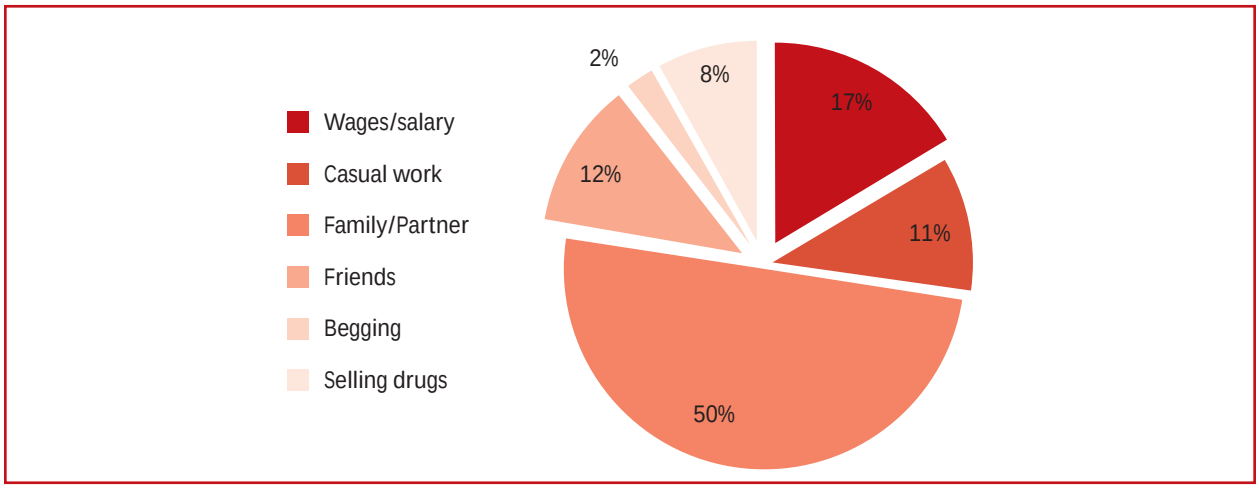
Table 3.2.3 Marital status and children of female prisoners interviewed

Variable	N	%
Marital status		
• Never married	50	14.0
• Married	197	54.9
• Divorced/Sep/Wid	108	30.1
Number of children		
• One	37	10.3
• 02 to 04	121	33.7
• 06 to 08	87	24.2
• > 08	13	3.6

3.2.4 Income source

The various sources of income before imprisonment are shown in Fig 3.2.4. Analysis showed that nearly half of the women interviewed shared in the family expenses by providing some sort of financial support.

Fig 3.2.4 Income source of female prisoners interviewed



3.2.5 Country of origin and language spoken

Nearly 4% of the women interviewed were non Pakistanis. The maximum numbers of non-Pakistani women interviewed were from Zambia.

Table 3.2.5 Country of origin and language spoken by female prisoners interviewed

Variable	N	%
Country of origin		
• Pakistan	456	96.1
• Zambia	8	2.2
• India	1	0.3
• Malaysia	1	0.3
• Philippines	1	0.3
• Afghanistan	1	0.3
• South Africa	1	0.3
• Uganda	1	0.3
Language spoken		
• Urdu	60	19.5
• Punjabi	134	37.3
• Sindhi	38	10.6
• Pushto	76	21.2
• Hindko	17	4.7
• Saraiki	15	4.2
• Foreign Language	13	3.6
• Other Others local dialects	6	1.9

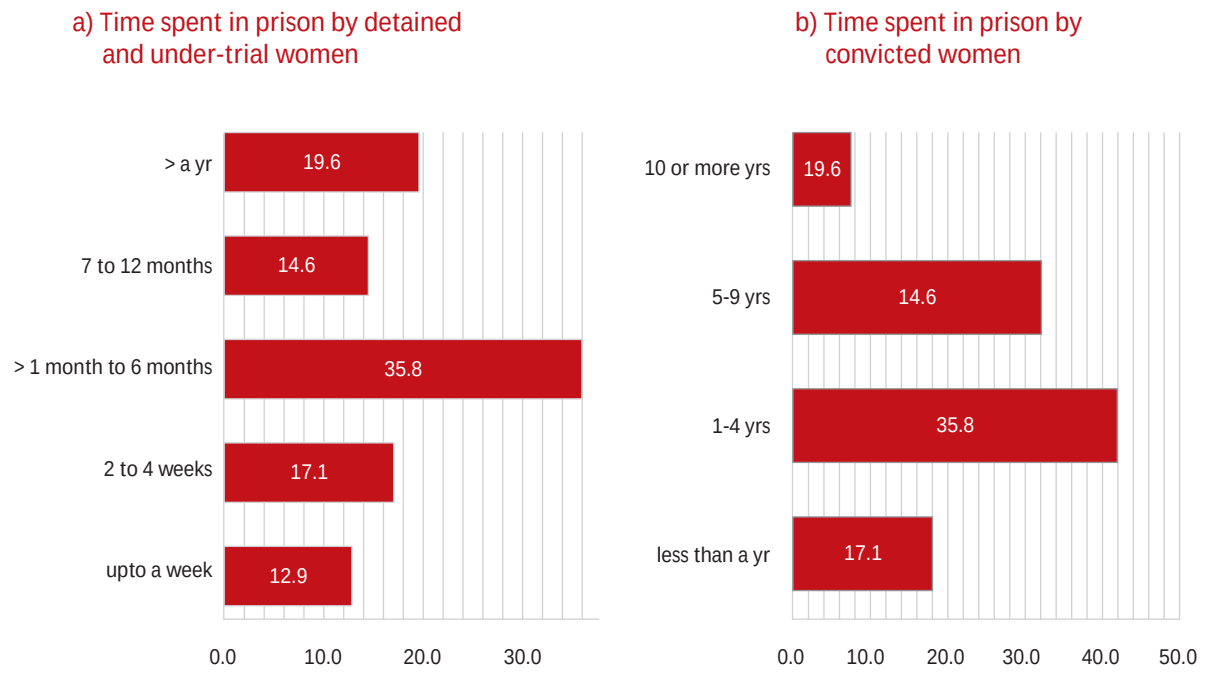
3.3 Imprisonment history

3.3.1 Type of imprisonment and time spent in prison

A large proportion of women in prison worldwide are in pre-trial detention, awaiting their trials, sometimes for years and beyond the sentence matching the offence with which they are charged. Although, as a principle all detainees and under-trials who have not yet been convicted and sentenced, should be considered innocent. However no such practice has been observed which leads to untried women being held with convicted prisoners and being subjected to the same regime as convicted prisoners. A similar situation was seen in Pakistan and out of the 359 women prisoners interviewed, an astounding 59% of the women were reported to be under trial. A remaining 31 (8.6%) were detained while the remaining 32.6% (117) were convicted.

The time period spent in prison by the various categories of imprisonment was inquired. The results are shown in Fig 3.3.1.

Fig 3.3.1 Time spent in prison by detained, under-trial and convicted women



A particular cause for concern is the exceptionally high level of under-trial prisoners included in these figures, while the sentenced prisoners making up only one third of the total prison population. This shows that a large proportion of those in prison may be innocent, and the offense for which they have been imprisoned is still unproven.

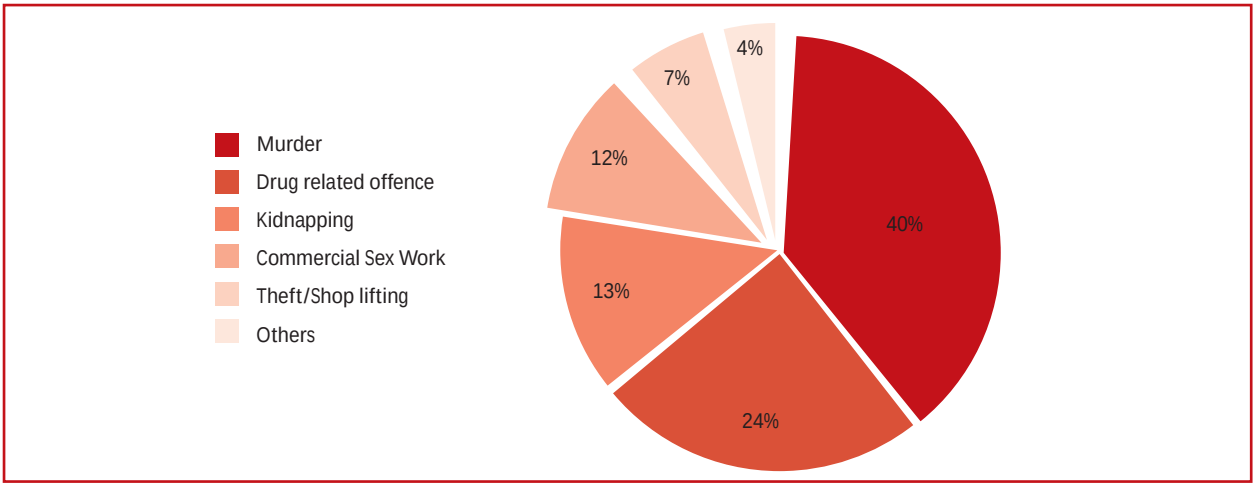
3.3.2 Reason for imprisonment

The maximum proportion of women imprisoned were for committing murders (40%), followed by drug related offenses. These included possession of, as well as using illegal drugs. Another issue of concern is the high number of women who were imprisoned on account of prostitution or selling sex.

Upon further inquiry 23.7% of the women informed that they have ever been imprisoned for drug related offenses, while another 15.6% informed that they have been imprisoned for commercial sex work.

Interestingly, most of the women who were imprisoned on account of commercial sex work were under trial, which shows that sex workers who are raided are kept in prison .

Fig 3.3.2 Reasons for imprisonment of female prisoners interviewed



3.4 Drug use history

3.4.1 Type of drugs ever used & drug use in imprisonment

Further analysis focused on the various types of drugs used by female prisoners. The use of drugs was evaluated as "ever used" and "used during imprisonment". In addition to tobacco smoking/chewing and alcohol, use of Heroin, Hashish (*locally known as Charas),* Afheem, *Opium,* Bhang, *Cannabis* as well as various Pharmaceutical drugs *which included Antihistamines, Benzodiazepines, Antipsychotic and Narcotic analgesics* were inquired. The results are shown in Table 3.4.1

Table 3.4.1 Drug use among female prisoners interviewed

Variable	Ever used N	Ever used %	Used in Prison N	Used in Prison %
• Tobacco	148	41.2	80	22.3
• Alcohol	29	8.1	01	0.3
• Charas (Hash)	16	4.5	02	0.6
• Heroin	07	1.9	02	0.6
• Afheem	08	2.2	01	0.3
• Bhang	04	1.1	01	0.3
• Synthetic (Pharmaceuticals)	46	12.8	32	8.9

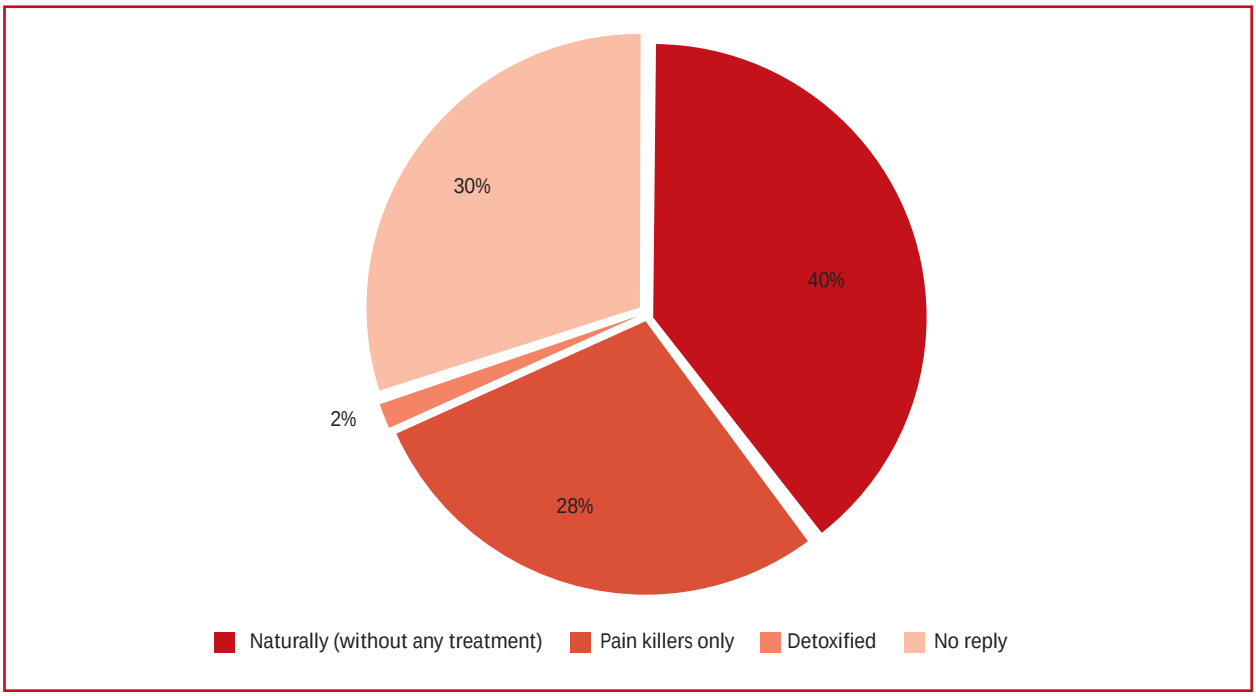
Looking at the analysis, it is seen that a fairly large proportion of women were tobacco smokers before being imprisoned, and nearly half of them continued smoking even within prisons. On the other hand, a substantial proportion of the overall female prisoner population was using any sort of psychotic drugs before being imprisoned, but did not continue their drug using habit, as drugs were not available in prisons. A few cases of drug use in prison are reported on and off, which might be cases on drugs being snuck into the prison occasionally, and the analysis confirms that drug use among women in prisons is not a regular phenomenon.

A moderate use of synthetic/pharmaceutical drugs is reported, however this research is unable to characterize that whether the drugs used were illegal or were used upon prescription from a medical personnel.

3.4.2 Drug use treatment

Twenty eight percent of the women informed that they were regularly using some sort of drugs before they were imprisoned. Since it is not possible for women to continue drug use in prisons; upon further inquiry about drug use treatment and detoxification, it is interesting to note that only one woman admitted to receiving proper detoxification for her drug use. (see Fig 3.4.2)

Fig 3.4.2 In-prison treatment/detoxification of drug using women



3.4.3 Injecting drug use

Of the 359 women interviewed only 22 (6.1%) reported that they had ever injected any form of drug. Further inquiry into drug injecting practices revealed that all these injections took place before the women were admitted to the prison. Twenty women stated that their sex partners inject drugs, which puts these women at a risk of contracting HIV and other infectious diseases such as HCV and HBV.

3.5 Sexual behavior and practices

3.5.1 Sexual history

Out of the total number of 359 women interviewed, 335 reported the mean age of 1st sexual intercourse to be 16.5 ± 3.1 yrs (median 16.5 yrs), irrespective of their marital status. Among these women 275 (76.6%) reported their husband as their first sexual partner. Boyfriends and other male acquaintances were reported as first sexual partners by 11% and 3% of the women, while a few reported of rape as well. Seventy six women (21%) reported to have sold sex for money.

Table 3.5.1 Sexual history of female prisoners interviewed

Variable	N	%
Age at 1st sexual intercourse	16.5 + 3.1 yrs (median = 16.5 yrs)	
1st sexual partner		
• Husband	275	76.6
• Boyfriend	39	10.9
• Male acquaintances	10	2.8
• Raped	21	0.6
• Paid client	3	0.8
Language spoken	76	21.2

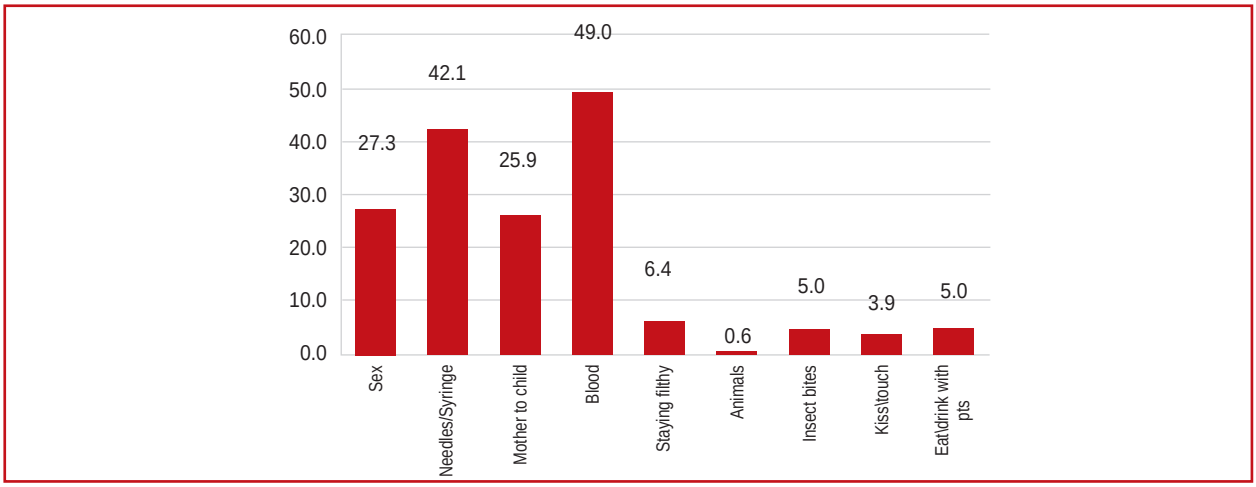
3.6 Knowledge of HIV/AIDS and other STIs

This section presents results related to the knowledge of participating women about HIV and other STIs.

3.6.1 Knowledge of HIV and AIDS

Approximately 52% of the women interviewed informed that they had heard of HIV and AIDS. HIV/AIDS related knowledge was further explored, by inquiring about the modes of transmission of HIV, and the ways how transmission of HIV can be protected.

Fig 3.6.1.a Knowledge about modes of HIV transmission in female prisoners



Knowledge of sexual intercourse as a mode of transmission of the disease was prevalent among 27.3% of the women interviewed and 42% knew that HIV can be transmitted by sharp instrument such as needles and syringes. 49% knew that HIV can spread through blood transfusion, while knowledge of mother to child transmission was found to be 26%. While the correct knowledge of HIV transmission was fairly low, a few misconceptions about transmission of HIV were also reported. Thus eating together with HIV infected people, hugging or touching them were reported to be associated with HIV transmission. A few respondents also believed that one can acquire the virus from staying unclean, and from animals. (Fig 3.6.1.a).

The knowledge about various ways to prevent HIV transmission are shown in Fig 3.6.1.b Interestingly the knowledge of how to prevent HIV was better than the knowledge about the routes of HIV spread. This probably because of the reason that the prevention messages are more focused and directed towards how to prevent the disease rather than how it is spread. The knowledge regarding both the transmission of HIV and its prevention is far less than desired.

3.6.2 HIV/AIDS and HCV/HBV testing

A fairly high proportion of respondents reported that they have been tested for HIV AIDS, as well as other infectious diseases such as Hepatitis B (HBV) and Hepatitis C (HCV). This is probably due to the reason that a large focus of the services provided in prison is on VCT and HIV testing. It is encouraging to note that a large number of the target population utilizes these services. (Fig 3.6.2)

3.6.3 Knowledge of STIs and practices

Slightly more than half of the respondents knew of sexually transmitted infections. One fifth reported to have experienced an STI in the past 06 months, while 18% received proper treatment for these infections. (Fig 3.6.3)

Fig 3.6.1.b Knowledge about ways to prevent HIV transmission in female prisoners

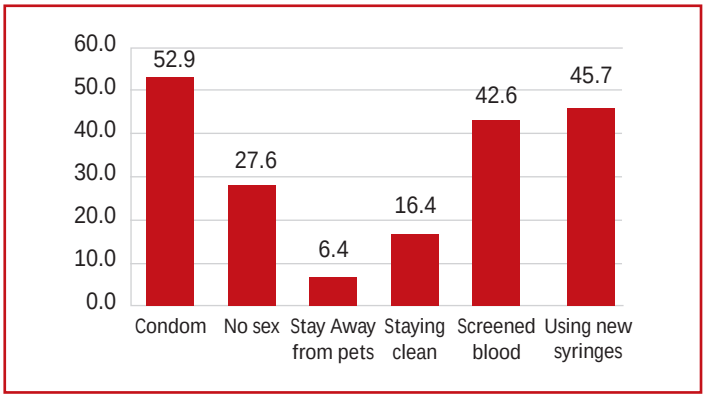


Fig 3.6.2 Proportion of female prisoners tested for HIV, HCV and HBV

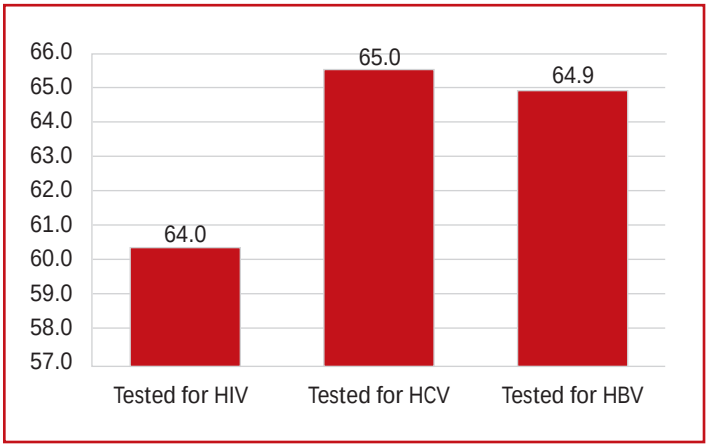
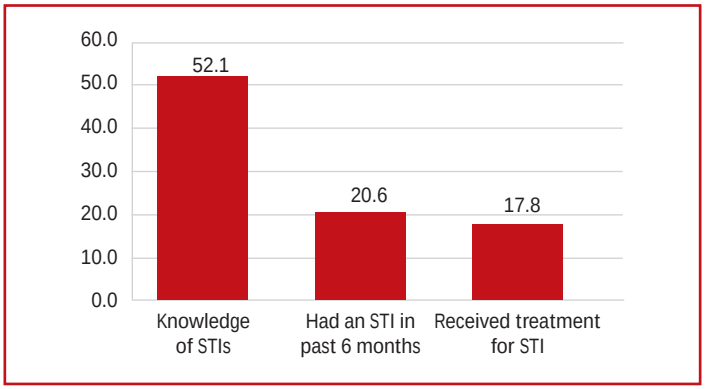


Fig 3.6.3 STIs knowledge and history among female prisoners interviewed



Prison Environment and Challenges

4

Chapter 4

4. Prison Environment and Challenges

Data was collected by the project staff from all 9 prisons which were included in this study on a pre-designed format (annexure II). The following section provides a summary of information collected to provide a snapshot of the living conditions and the facilities available for female prisoners in all the jails from where data were collected.

4.1 Prison capacity and number of prisoners

Unlike male prisons, the issue of overcrowding is not reported to be an issue in female prisons and nearly all jails harbor prisoners within capacity. The highest capacity for keeping prisoners was reported from Kot Lakhpat Jail, and the lowest was at Mardan. In most of the jails no bed or floor mattresses were reported to be available and the prisoners are either supposed to arrange for their own bedding or sleep on the floor. Table 4.1 shows the exact capacity and the number of prisoners in each prison at the time of interviews.

Table 4.1 Capacity and number of prisoners in each prison

Variable	Capacity	No of prisoners
• Karachi	89	77
• Larkana	14	14
• Lahore	165	125
• Mansehra	10	7
• Haripur	26	37
• Mardan	10	12
• Peshawar	45	39
• Multan	84	68
• Hyderabad	33	31

4.2 Health conditions

The maintenance of health and sanitary conditions in prisons is important in preventing illness and disease. Access to sanitary and washing facilities, safe disposal arrangements for bloodstained articles, as well as provision of hygiene items are of particular importance. All detainees and prisoners must have access to facilities which allow them to keep themselves clean. They must be able to bathe or shower as often as is necessary to maintain their personal hygiene. According to this study, the hygienic conditions in all prisons visited were far from ideal. In comparison, hygienic and cleanliness condition was found to be in a better state in Karachi while all other jails were rated as very poor by the data collecting staff. In most of the prisons visited, cleaning staff was available, however cleaning of the barracks and prisons was conducted irregularly.

Sanitation facilities available for prisoners varied according to various prisons. The number of wash rooms ranged from 3 to 4 prisoners per wash room to 60 prisoners per wash room in one of the larger prisons. Three of the prisons where data was collected had no separate wash rooms, and washing and sanitation facilities were within the barracks. In one of the prisons, four wash rooms exist, but were reported to be non functional for months.

Only one of the prisons visited had safe drinking water available for the prisoners. Water was purified through a water filtration plant and was reported to be available around the clock. All remaining prisons other than two had tap water available for 24 hours, however the water was not purified leading to various water borne diseases.

The meals are served 3 times a day except in Mansehra, where it is served 4 times a day. Most of the prisons have poor quality of food especially the bread which is not well cooked. In Karachi, females cook their food by themselves.

4.3 Women in prisons and children

The separation of women from their children due to imprisonment has a traumatic and long term effect on the mothers and their children. Children are likely to suffer from acute emotional and developmental problems, as well as being at risk of inadequate care at home or even in Child care institutions. It is therefore allowed for mothers to keep their children with them in prison, up to the age of 6 years.[10] It was reported to be a usual practice for women having children to live in confinement with children under the age of 12. See Table 4.3.

.

Table 4.3 Prisoners with children living in the prison

Variable	Female with Children	No of Children
• Karachi	7	10
• Larkana	2	2
• Lahore	13	16
• Mansehra	1	1
• Haripur	6	7
• Mardan	3	7
• Peshawar	7	10
• Multan	7	17
• Hyderabad	7	8

While women prisoners were reported to keep their children with them in prisons, it is also worth mentioning that there were no child care facilities in any of the prison evaluated. No recreational or proper educational facilities were reported to be available for children accompanying their mothers in prisons. An educational facility was reported from only one prison where 3 children were provided formal education. In one of the prison, the jail warden voluntarily provides education to the children, which is more of an individual initiative. No recreational facilities were available for children in any of the jail. There is no out door or indoor games available for children, who are reported to hang around aimlessly with their mothers. In addition no health facilities were reported to be available; even no immunization facilities are provided to children.

10. Vide notification No.3/23-SO-Prs-II-HD/87. Dated: 18.07.1988, Government of Punjab.

4.4 Medical services , detoxification and referral facility

A large proportion of female prisoners come from disadvantaged economic backgrounds, and most of them suffer from a variety of health conditions. Therefore female prisoners often have greater primary healthcare needs in comparison to men. Non availability of primary health care facilities, lack of hygiene, inadequate nutrition and medical treatment may worsen their health condition in prisons.

Inadequate medical facilities were reported by female prisoners from nearly all prisons. Apart from project staff, government doctors are available in most of the prisons, but the diagnostic and treatment facilities were found to be far from satisfactory. Female doctors were available only in 3 of the prisons i.e., Karachi, Larkana and Hyderabad, while all other prisons have male doctors, which added to the discomfort of female prisoners.

Women do have reproductive health needs which need to be managed by trained female para-medical staff. This area was found to be extremely deficient in all prisons. At the time of data collection, 2 and 3 pregnant prisoners were reported from Hyderabad and Multan respectively while in Karachi 1 pregnant woman was reported. It was reported that two pregnant women were released in Karachi. Pregnant women are referred out of jail for delivery as no facility is available in jails. Dentists were reported to visit the prisoners in Karachi, Mansehra, Lahore and Hyderabad.

A large number of female prisoners worldwide are imprisoned for drug related offenses and are themselves in need of treatment for substance abuse. Detoxification of drugs is not available in any of the jails.

For patients who need advanced medical treatment, referral is made to Public Sector Hospitals. The process of referral is quite complicated and lengthy and the patients reported to be quiet dissatisfied with the procedures. They reported about the absence of the doctors and their lack of attention to the patients.

HIV testing was available in Kot Lakhpat Jail Lahore, while HBV and HCV testing was available in Karachi, Lahore and Multan only. No STIs testing or diagnostic services were provided in any of the jails, and patients were given Symptomatic treatment for STI's.

4.5 Psychological issues and mental health needs

No measures to deal with the mental health issues were reported to be provided by the prison authorities. In 3 of the prisons visited, psychologists were made available through NGOs. The psychological problems reported are depression, stress, mental adjustment, attention seeking behavior, sleep disease and generalized anxiety.

4.6 Recreational facilities and activities for prisoners

It is important to have various activities designed for prisoners which should keep them busy, while at the same time enable them to live normal lives after release, by increasing their job skills and improving their education. No recreational facilities are available except television, which was available in Peshawar and Hyderabad only. No indoor games or activities to keep the prisoners involved were seen in any of the prisons visited.

There were no efforts undertaken by the prison authorities to provide basic education or any vocational training to the prisoners. Only in Karachi, an NGO was providing skilled trainings to prisoners while some educational support is provided in Multan, while in all remaining prisons no such activity is being conducted.

4.7 Stigma and discrimination

Stigma and discrimination is a unanimous issue reported from all prisons across country. The females are stigmatized on the basis of their crimes e.g., murder, drug trafficking and sex work. Prisoners who are not being visited by any family members and the ones who don't have any money also face harassment from other prisoners as well jail staff. Less stigma is observed in the jails with lesser number of prisoners as compared to the facilities with higher number of female prisoners.

Conclusion and Recommendations

5

Chapter 5

5. Conclusions and Recommendations

Based upon the results of this study, a series of key principles and actions are recommended, to promote principles of public health, improve the mental state of health of the confined, and prevent the spread of HIV and other communicable diseases in prisons.

a) Most women in prisons are young, poor, illiterate and come from disadvantaged economic backgrounds. Most of them suffer from a variety of health conditions, and non availability of primary health care facilities and medical treatment worsens their health condition in prisons. Improving the basic living and health conditions within prisons, will eventually improve the status of prisoners health. Substandard and unhealthy living conditions have a negative impact on the physical health of prisoners, while substandard prison conditions and the consequent stressors can negatively affect the mental health of prisoners, or exacerbate pre-existing mental health problems. Although this project is objectively designed to impact drug use and HIV among prisoners, it is strongly recommended that the project considers functioning from a holistic perspective of health. *The provision of basic determinants of health, such as adequate nutrition, clean drinking water and sanitation facilities* can be the key to protection of the physical and mental well-being of all prisoners.

b) The project should also explore opportunities for sustainability of *provision of basic medical treatment and services to prisoners.* Although regular medical check-ups for prisoners, screening of basic health conditions and proper and timely treatment for any health conditions are already being provided.

c) Due to a high prevalence of various mental issues among female prisoners, *the provision of adequate gender-sensitive and interdisciplinary mental healthcare* should comprise an essential component of the services provided to female prisoners. A comprehensive assessment of the women's mental healthcare and psychological support needs should be conducted by the project staff especially psychologists. This mental health care should be individualized and should aim to improve the self esteem and confidence level of each individual. Reasons that provoke distress or depression should be identified, and all psychiatric problems should be dealt by adopting an integrated approach to counseling, psychosocial support and medication, if necessary. A comprehensive programme aiming to promote mental health in prisons, should include help within the prison in terms of education, vocational training and building self-esteem, a better understanding of human relationships, family contact, physical exercise and treatment of mental illnesses.

d) Current substance use especially injecting drug use was not reported to be commonly prevalent in prisons, however, the element of under reporting on account of strict rules regarding drug use in prisons cannot be over ruled. On the other hand a high number of imprisonments were due to drug related offences, and a fair number of women reported addicted to drugs before being admitted to the prisons. This highlights the need for *provision of drug dependence treatment options for prisoners with problematic drug use.* The provision of drug treatment services in a prison setting requires good support from the prison administration, and warrants a need for strong links between the programme and other aspects of the prison system to ensure and facilitate staff support and encouragement. Various models of service provision for detoxification should be tried, including residential drug treatment units in prison; admission to a prison hospital; out patient treatment with the prisoners remaining in their cells. Upon completion of their sentence, prison authorities should pay attention to the availability of treatment and social support services for prisoners on their release as a comprehensive follow up approach.

e) *Comprehensive education and awareness of HIV/AIDS and ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments* should be provided to both Prisoners and prison staff. As part of the overall HIV education programmes, prisoners should be informed of the dangers of drug use, especially injecting drugs. Drug-dependent prisoners should be encouraged to enroll in drug treatment programmes while in prison, with adequate protection of their confidentiality. Information should be made available to prisoners on the types of sexual behaviour that can lead to HIV transmission. The role of condoms in preventing HIV transmission should also be explained and condoms should be made available.

f) Mandatory HIV testing is unethical and there is evidence suggesting that mandatory HIV testing is inefficient, and can have negative health consequences. Moreover, HIV testing and counseling is not a goal in and of itself, but a means to enable people to access care, treatment, and support if they test HIV-positive, and to take measures to reduce the risk of transmitting infection to others. It is recommended that prison systems should provide *easy access to voluntary HIV testing and counseling,* which should be easily accessible to all prisoners; should always be confidential, and everyone being tested should give informed consent; should be *closely linked to access to care, treatment, and support for those testing positive* and be part of a comprehensive HIV programmes that include access to prevention measures.

g) While *HIV, HCV and HBV testing* is continually done in some prisons, under the project and it is strongly recommended that *TB testing should also be initiated in prisons*. TB has a strong correlation with HIV and the closed environment of prisons, poor health and hygiene conditions and nutritional deficiencies. High prevalence of TB in Pakistan can lead to high infection rates among prison populations, This needs to be evaluated and managed accordingly.

There are a number of ostensible non-health related activities that can be recommended for the project to undertake which would improve the well being and will address the psycho-social support needs of the prisoners. These activities should not be undertaken solely by the project itself, but a collaborative effort with government departments and NGOs which specialize in catering to these specialized needs is deemed appropriate.

h) A large number of women are single parents to minor children and given that a large percentage of women in prison are mothers, this means that the consequences of their imprisonment stretch well beyond the harmful effects on themselves. In addition quite a few children were seen to live with their imprisoned mothers, with no child care facilities available in any of the prison. Some *basic child health services including nutrition, immunization, basic health care needs can be provided by the project as part of the holistic support program.* Organizations and government departments could be mobilized after getting permission from with the prison authorities to provide basic child care services such as recreation and educational activities for the children.

i) It has been seen that most of the women in prisons are from poor and marginalized sectors of communities and do not have the economic means to hire a lawyer and are often illiterate and unaware of their legal rights. This places them in a particularly vulnerable position, at risk of signing statements that have serious legal implications and the lack of legal representation can lead to immense delays in the criminal justice process, and less chances of defendants being considered for bail. A very high number of women seen in prisons therefore are either under trial or pre-trial detainees, waiting for long periods of times for their sentences. It is strongly recommended that such *women should be provided access to legal counseling and provision of legal aid if desired,* to access lawyers and follow up their cases in courts.

j) Recognizing that prisons are important settings for informational and educational programmes for women, the opportunity should be taken to *provide education to women within prisons, which is an important means of helping women gain self-confidence and independence.* Education will not only improve these

women's life and job skills, but will also help them overcome low self-esteem, which is prevalent in many victims of violence, and will help them develop into more productive citizens of society.

k) In addition to providing education to the prisoners, by *providing women with adequate and appropriate opportunities for vocational training in prisons*, and thereby assisting them to gain employment after release, the program can make an immense contribution to the social reintegration of women prisoners.

l) A number of studies have shown that "in-prison" services are less effective if they are not *followed up by appropriate aftercare*. Aftercare programmes play a key role in providing released prisoners with the practical support necessary to help them continue with the changes initiated in prison. Any service delivery designed for prisoners should include a component of assistance to prepare for release starting 1-2 months prior to the release date. The basic objective of this component is to ensure that the social, psychological and medical support needs of the prisoner are met and are continued even after prison. Activities undertaken in prison need to be linked to services outside to ensure continuum of care and monitoring of released prisoners e.g., prisoners who are on treatment for mental health conditions, should be linked up with mental health services outside of prison services. Likewise HIV positive prisoners once released should be linked up with care, treatment and support programs to ensure continuum of care. In most cases it is seen that women prisoners are often rejected by their families due to the offences they have committed. This program should also act as mediator between the prisoners and their families to help women return back to their families after their sentence is over.

m) It is important to recognize that any prison environment is greatly influenced by both prison staff and prisoners. Nothing can be done in a prison facility, unless the prison staff itself is motivated enough to bring about a positive change. Staff has the most important role to play in providing a supportive and healthy environment, which ensures that the harmful effects of imprisonment on the mental wellbeing of female prisoners are minimized.

Every effort should be made to *develop positive partnerships with the higher prison authorities and the prison staff* for every initiative undertaken. Regular meetings with the higher prison authorities on strategic plans, and regular updates provided, can help develop a positive and non threatening relationship between the program and project staff. Regular awareness sessions and trainings provided to staff directly involved in the management of prisons will help develop self awareness among them and will lead to a high level of motivation to work for the improvement of their prison environment. If possible, incentives should be offered for prison staff for their cooperative efforts to have a healthy environment within the prisons.

Annexures

Annexures

Data collection format

Reg No: ☐☐☐

DATE OF INTERVIEW: ☐☐-☐☐-☐☐ (DD/MM/YY)

City: ☐☐☐☐☐☐☐☐ TIME TAKEN FOR THE INTERVIEW: ☐☐ (in mins.)

Prison / District Name : ☐☐☐☐☐☐☐☐

INTERVIEW DETAILS

INTERVIEW ID: ☐☐

INTERVIEWER: (Name)..... Sig: .....

SUPERVISOR: (Name)..... Sig: .....

DATA ENTRY INFORMATION

Form received on : ☐☐- ☐☐ ☐☐ (DD/MM/YY)

DATA ENTERED BY : (Name)..... Sig: .....

DATA SUPERVISOR: (Name)..... Sig: .....

BEFORE STARTING THE INTERVIEW, PLEASE READ THE FOLLOWING TEXT ALOUD:

"This interview is part of a country-wide research study on female prisoners. The interview should not take long to complete. The questions cover various aspects of your drug use history, treatment history, legal involvement, sexual behaviour and other personal information. The interview is confidential and anonymous. Nothing that you tell us can be traced back to you as an individual. It is important that you understand that your participation in this interview is entirely voluntary, there are no risks involved and you are not obliged to answer all or any of the questions if you do not wish to and you may terminate the interview at any point.Before we start, do you have any questions that you would like to ask me?"

SECTION 1. SOCIO-DEMOGRAPHICS

1.1. Age ☐☐ in years **1.2 Education** ☐☐ years

1.3. Current marital status? ***[read all the answers and tick mark (✓)***

1	Single never married	2	Married	3	Divorced	4	Separated
5	Widowed	6	Has a partner		(Specify)		

Number of children ☐☐

Country of origin ☐☐☐☐☐☐☐☐

If Pakistani, city of origin ☐☐☐☐☐☐☐☐

1.4. Please tell me all of the ways in which you have financially supported yourself before coming to prison (*read all the answers and tick mark (✓)*)

1	Wages / salary	2	Casual work	3	Family
4	Friends (partner)	5	Benefits/Pension	6	Begging
7	Selling drugs	8	Thefts	9	Pick pocketing
10	Prostitution / sex for money	11	Other (specify)		

1.5. What language do you mostly speak at home *(read all the answers and tick mark (✓)*)

1	Urdu	2	Punjabi	3	Sindhi
4	Pushto	5	Foreign language		Others (specify)

1.9 What is the profession of your husband? ☐

SECTION 2. PRISON HISTORY

2.1 Type of imprisonment? *[read all the answers and tick mark (✓)*

1	Detainee	2	Under trial	3	Convicted (go to Q 2.3)

2.2 Time spent in prison *(ask this and go to 2.5)*

☐☐ years ☐☐ months ☐☐ days

2.3 Duration of imprisonment ☐☐ yrs ☐☐ months

2.4 Time spent in imprisonment ☐☐ yrs ☐☐ months

2.5 Type of crime *(tick mark (✓)*

1	Possession/Selling of illegal drugs	2	Using drugs	3	Illegal migrant	4	Burglary /Theft/ Shop lifting
5	Prostitution/selling sex	6	Murder	7	Kidnapping	8	Other (specify)

2.6 Have you ever been arrested for a drug-related offence?

1	Yes	2	No	9	Don't remember

2.7 Have you ever been arrested for prostitution?

1	Yes	2	No	9	Don't remember

2.8 Which of the following offences have you ever been arrested for?
INTEREVIEWER: READ ALL OFFENCES AND CHECK ALL APPLICABLE

1	Possession/Selling of illegal drugs	2	Using drugs	3	Illegal migrant	4	Burglary /Theft/ Shop lifting
5	Prostitution/selling sex	6	Murder	7	Kidnapping	8	Other (specify)

SECTION 3. DRUG USE HISTORY

INTERVIEWER – FOR EACH DRUG ASK:
a) Have you ever used [drug]? b) Ever Used in prison?

Drug name	Ever used	Used in prison
3.1 Tobacco (smoking, pan, niswar)		
3.2 Alcohol		
3.3 Charas		
3.4 Heroin		
3.5 Afheem		
3.6 Bhang		
3.7 Synthetic (pharmaceuticals)		
3.7 Solvents/Inhalants		
3.8 Others (specify)		

IF NO DRUG HAS BEEN EVER USED, GO TO SECTION 4

3.9 What was your age when you first used any drug? ____ years

3.10 When was the last time you used any drug?
(Probe after checking the time period in prison)

1	Today	4	More than a week but less than a month
2	Yesterday	5	More than a month ago
3	Last week	9	Don't remember

3.11 Have you ever injected drugs? 1 Yes 2 No
(If NO go to 3.15)

3.12 When was the last time you injected any drug?

1	Today	4	More than a week but less than a month
2	Yesterday	5	More than a month ago
3	Last week	9	Don't remember

3.13 The last time you injected drugs, did you inject with a needle or syringe which someone else had used?

1	Yes	2	No	9	Don't remember

3.14 The last time you injected drugs, did you pass on your needle or syringe to someone else for injecting?

1	Yes	2	No	9	Don't remember

3.15 Does your sex partner inject drugs

1	Yes	2	No	9	Don't know

3.16 When you were admitted to the prison, were you regularly using drugs

1	Yes	2	No	9	Don't know

3.17 If yes, then how did you go through the withdrawl phase

1	Naturally without treatment	3	Was provided proper detoxification services
2	Only Pain killers were given		Others (specify)

3.18 Have you ever received proper treatment (detox, rehab) for a drug problem?

1	Yes	2	No	9	Don't remember

3.19 Have you ever donated blood?

1	Yes	2	No **IF NO go to 4.1**	9	Don't know

3.20 Have you ever donated blood while in prison?

1	Yes	2	No **IF NO go to 4.1**	9	Don't remember

3.21 If yes, was this blood donation voluntary?

1	Yes	2	No **IF NO go to 4.1**	9	Don't remember

SECTION 4. SEXUAL HISTORY

In the previous sections I asked you questions about your injection drug use and sharing. In this section I will ask you some questions regarding your sex lifestyle. As I said in the beginning of the interview, if you do not feel comfortable in answering any of the questions in this section, you may refuse to answer them.

4.1 How old were you the first time you had sex? _____ Years

IF NEVER HAD SEX GO TO NEXT SECTION

4.2. Was this person your… ***(read all the choices and check the appropriate one)***

1	Husband	4	Other specify
2	Boyfriend	9	No reply
3	Acquaintance		

4.3 Have you ever sold sex for money or other benefits e.g., drugs, gifts etc.,

1	Yes	2	No	9	No reply

Now, I would like to ask about your sex activity in prison

4.4 Have you ever been sexually harassed (not raped) while in prison?

1	Yes	2	No ***IF NO go to 4.6***

4.5 If YES, who has harassed you sexually, while in prison? ***(read all the choices & tick)***

1	Jail staff (male)	4	Other specify
2	Jail staff (female)		
3	Other Prisoners	9	No reply

4.6 Have you ever been raped while in prison?

1	Yes	2	No ***IF NO go 4.8***

4.7 If YES, who has raped you while in prison? ***(read all the choices & tick)***

1	Jail staff (male)	4	Other specify
2	Jail staff (female)		
3	Other Prisoners	9	No reply

4.8 While you have been in prison, have you had sex with someone with consent?

1	Yes	2	No ***IF NO go to 4.10***

4.9 If YES, with whom you have had sex while in prison?***(read all the choices)***

1	Jail staff (male)	4	Other specify
2	Jail staff (female)		
3	Other Prisoners	9	No reply

4.10 How many men have you had sex with, while in prison
(If none write 00, if unknown write 99, if refused write 88) ☐

4.11 How many women have you had sex with, while in prison
(If none write 00, if unknown write 99, if refused write 88) ☐

4.12 Of all the times you had sex in prison, how often did you use a condom?

0	Never	1	Rarely	2	Sometimes	3	Often	4	Always	9	DK

4.13 The last time you had sex, did you use a condom?

1	Yes	2	No	9	No reply

SECTION 5. KNOWLEDGE OF HIV/AIDS

5.1 Have you ever heard of HIV or the disease called AIDS?

1	Yes	2	No	9	Don't know

IF 'NO' GO TO 5.5

5.2 Do you know how HIV can be transmitted from one person to another
(Don't read the list, tick the answer which the person knows)

A	Sexual intercourse	
B	Sharp instruments/syringe	
C	Insect bites	
D	Kissing, Touching, Hugging	
E	Eating & drinking with patients	
F	Mother to child	
G	Blood transfusion	
H	Staying filthy	
I	Through Animals	
J		
K		

5.3 Do you know how HIV can be prevented
(Don't read the list, tick the answer which the person knows)

A	Using Condom	
B	Refraining from sex	
C	Staying Away from pts	
D	Staying clean	
E	Transfusing screened blood	
F	Using clean/new syringes	
J		
K		

5.4 Have you ever been tested for HIV/AIDS?

1	Yes	2	No

5.5 Have you ever been tested for Hep C?

1	Yes	2	No

5.6 Have you ever been tested for Hep B?

1	Yes	2	No

5.7 Do you know that there are diseases that can spread through sex?

1	Yes	2	No	***IF 'NO' finish the Interview***

5.8 During the past 6 months did you suffer from any such disease?
(Ask for foul smelling discharge, swelling, ulcer, redness, itching symptoms)

1	Yes	2	No	***IF 'NO' finish the Interview***

5.9 If yes did you get any treatment for that disease?

1	Yes	2	No	***IF 'NO' finish the Interview***

Thank you very much for your kind cooperation and spending your valuable time with me.
Ask participant if s/he has any questions. Provide risk reduction counselling as appropriate. Give referrals/ information re nearby HIV testing and counselling services.

FORMAT for PRISON ASSESSMENT

DATE OF INTERVIEW: ☐☐-☐☐-☐☐ (DD/MM/YY)

City: _____ Prison / District Name : _____

This assessment was conducted by:

_____ _____

(Name) (Signature)

1.	Type of prison	1. Separate prison 2. Female Barracks in a male prison
2.	No of beds available for female prisoners	
3.	Total No of female prisoners	
4.	No of prisoners with Children living with them in prison	
5.	No of Children in the prison	
6.	Water supply *(provide details)*	1. Timings _____. 2. 24 hrs
7.	No of separate wash rooms	
8.	No of functional wash rooms	
9.	No of toilets available	
10.	No of functional toilets	
11.	No of times food is served	
12.	Quality of food	Chose from a Scale of 1(lowest) to 10(highest) and give reasons
13.	Hygiene conditions	Chose from a Scale of 1(lowest) to 10(highest) and give reasons
14.	Recreational facilities available	Give details (what, timings, how many use them, who uses them)

15.	Vocational training facilities	Give details (what, timings, how many use them, who uses them)
16.	Medical facilities available	Doctor M F LHV Basic Medicines available Psychiatrist Dentist
17.	What is the referral procedure for serious patients (mention any issues)	
18.	Facilities for children	(education, diet, recreation, health, vaccination)
19.	How many of the prisoners are pregnant	
20.	What antenatal services are provided to female patients	
21.	No of Child births "in jail" during last yr.	
22.	What treatment services (detoxification, rehab) for drug users are available?	
23.	HIV testing	
24.	Hep C testing	
25.	Hep B testing	
26.	STI testing	
27.	STI treatment	
28.	Psychological assessment	
29.	Staff details (exact number of jail staff)	Diagram
30.	Staff trainings	(number and topics of trainings staff attended in the last 1 yr)
31.	Is there a post-release plan for prisoners? If yes what?	
32.	Stigma & discrimination	(Categories, those who have visits, sex workers, those who don't have money, type of crime)