

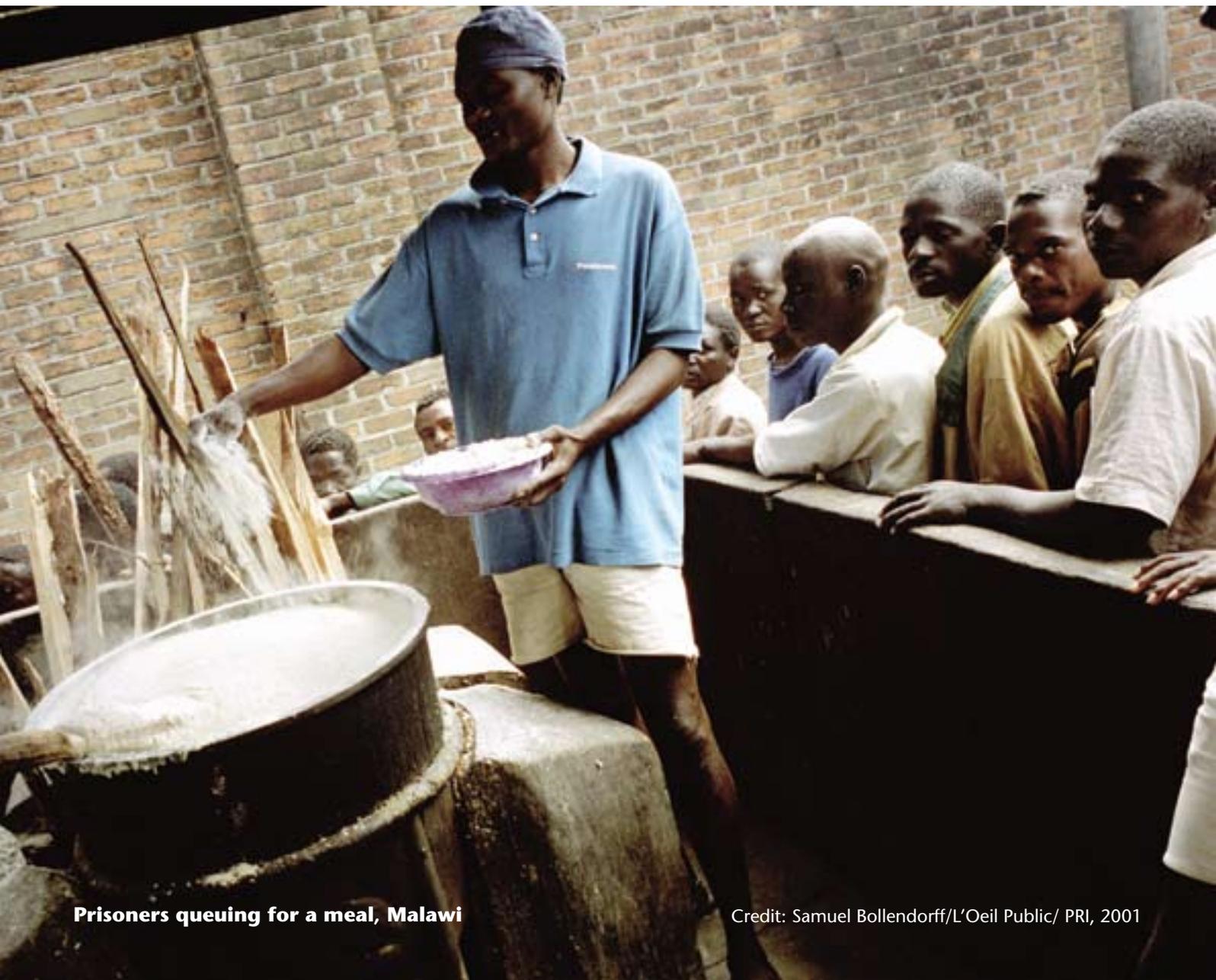
'Prisons can be breeding grounds for infection. Overcrowding, lengthy confinement within closed, poorly lit, badly heated and consequently poorly ventilated and often humid spaces are all conditions frequently associated with imprisonment and which contribute to the spread of disease and ill-health. Where these factors are combined with poor hygiene, inadequate nutrition and limited access to adequate health care, prisons can represent a major public health challenge.'

(World Medical Association, 2000).

'Being in prison is a health hazard: the health status of prisoners is generally lower than the rest of the population.'

(WHO Europe, 2003).

Health in prisons: realising the right to health



Health in prisons

The prevalence of disease, malnutrition, mental illness and general ill health among the global prison population provides overwhelming and incontrovertible evidence that prisons are bad for your health. For many, imprisonment is marked by the deterioration in health and well-being – in some cases it is tantamount to a death sentence. The causes of poor prisoner health are multifarious. Prison populations typically comprise the most disadvantaged and marginalised sections of society who generally have a low health status. However, conditions of detention, combined with the associated problems of prison overcrowding and the high risk behaviours of prisoners in detention, not only increase morbidity and mortality rates, but they also accelerate the rate of transmission and progression of disease. These problems can be compounded by the limited access to appropriate and timely health care and treatment in prison, including the provision of health education and preventative programmes.

Poor prisoner health is exacerbated by the overuse of imprisonment; overcrowded and under-resourced facilities undermine access to health care and the ability of prisoners to lead a healthy life. The exponential rise in penal sanctions, the excessive use of pre-trial detention, and the use of prisons to contain marginalised sections of society are all responsible for this situation. All prisoners and detainees have a right to health, irrespective of their legal status, and states have a positive obligation to ensure this right is protected and fulfilled. The human right to health is related to and dependent upon the realisation of other human rights, such as the right not to be tortured or ill-treated, the right to recognition as a person before the law and to a fair trial, the right to food, and the right to education and training. As such, health interventions must be integrated within a wider agenda of penal and public health reforms that tackle conditions of detention and the underlying determinants of health. They must also recognise the broader public health challenges created within prison.

PRI's practical experience demonstrates that relatively simple steps can have a significant effect in improving prisoners' health.



Juvenile offenders exercising, Pakistan

Credit: PRI, 2003

*'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'*¹

The right to health is a fundamental human right that is indispensable for the exercise of other human rights. It concerns not only the right to timely and appropriate health care but also the underlying determinants of health, such as adequate food and nutrition, access to clean drinking water and sanitation, clothing and housing, as well as fresh air, exercise and mental stimulus.² Whilst the reality faced by many throughout the world is one of health inequality, where the disadvantages of poverty and deprivation combine to deny people a right to health, nowhere is access to health care or the means to live a healthy life more flagrantly neglected than within the confines of the prison environment where 'disease is the most common form of death' (Betteridge, 2004).

HIV/AIDS, tuberculosis and communicable diseases

In most countries, the prevalence of HIV infection in prisons is significantly higher than within the population outside of prison. In Central Asia, an estimated one-third of people living with HIV/AIDS are in prison; in Kyrgyzstan the figure is thought to be as high as 56 per cent (Walcher, 2005b). In Poland, 20 per cent of the country's 7,000 infected people have spent time in prison or pre-trial detention facilities during their lives. Similarly, in Latvia, one-fifth of the HIV cases concern people in prison (UNDP, 2004). In South Africa, it is estimated that as much as 45.2 per cent of the prison population are living with HIV/AIDS; HIV prevalence is thought to be more than twice the rate of prevalence amongst the same age and gender in the general population (Goyer, 2003).

Current indicators suggest that HIV prevalence is increasing at a dramatic rate. The former Soviet states

have experienced a particularly rapid increase in HIV prevalence in prisons. In Russia, the number of prisoners living with HIV increased from seven in 1994 to 36,850 in 2002 – an increase in the prevalence rate from 0.008 per 1,000 inmates to 41.1 per 1,000 inmates (UNDP, 2004). Similarly, in Ukraine, admissions of prisoners with HIV increased from 11 in 1994 to 2,939 in 1997 (WHO Europe, 2001). In Lithuania, an HIV outbreak in Alythus prison in 2002 resulted in 263 prisoners testing positive for HIV within just a few months. Prior to this, there were only 18 known HIV infections within the entire prison system and 300 people living with HIV in the country as a whole (Jurgens, 2002). Between 1995 and 2000, South African prison officials recorded a 584 per cent increase in 'natural deaths' of prisoners – 90 per cent of which were subsequently identified as HIV-related following post-mortem reports (Goyer, 2003).

HIV prevalence is compounded by the high rates of hepatitis C (HCV) and tuberculosis (TB) infections in prisons. TB is the main cause of death for people living with HIV/AIDS and as such presents a serious risk to those infected with the virus. TB infection rates in prison can be between five and ten times the national average (Farmer & Yang, 2004); in some cases, this can increase to as much as 100 times the prevalence rate found outside prison (Reyes, 2007). The prevalence of multi-drug resistant strains of TB (MDR-TB) and extreme drug resistant (XDR) strains are also higher in prisons than the rest of the population, particularly in Eastern Europe and Asia (Reyes, 2007). These trends culminate in high TB mortality rates in prison. In Kazakhstan, TB mortality rates are as much as four times greater in prison than among the general population. In Tajikistan, a 2004 survey found that 78 per cent of those who died from TB were prisoners (Walcher, 2005b). Similarly, in some prisons in Russia, TB accounts for up to 80 per cent of inmate deaths (Farmer & Yang, 2004).

HCV prevalence in prisons tells a similar story. In the US, it has reached epidemic proportions: an estimated 1.4 million HCV-infected people pass through the correctional system each year. In some states, HCV infection rates range from 20 to 40 per cent, compared to a two per cent infection rate among the general population (Herman, 2000).

1 Preamble to the Constitution of the World Health Organisation.

2 The UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No 14 explains that the right to health is related to and dependent upon the realisation of other human rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, prohibition of torture, privacy, access to information and the freedoms of association, assembly and movement (UN Document E/C.12/2004/4).

Protecting the rights of prisoners with mental illness and learning disabilities in Romania

The majority of prisons in Romania do not provide treatment or programmes to guarantee the rights of prisoners with mental illness or learning disabilities. It is estimated that 8,000 of the total prison population of 35,000 in Romania have a diagnosed mental health problem. PRI has therefore been working with local NGOs and the National Prison Administration to ensure that their rights are protected. This has resulted in the development of national prison standards relating to the care and treatment of prisoners and detainees with mental illness or learning disability. Prison staff have received specialist training on the needs and rights of these vulnerable categories of prisoner and the specific risks they face within the prison environment. Systems and procedures have additionally been established to monitor their human rights, along with specific programmes to address their needs whilst in prison.

Further information: www.penalreform.ro

Mental health

Mental health problems and behavioural disorders are much higher among the prison population than in the general population (World Health Organisation/ International Committee for the Red Cross, 2006). The World Health Organisation (WHO) estimate that as many as 40 per cent of prisoners in Europe suffer from some form of mental illness, and are up to seven times more likely to commit suicide than people outside of prisons (WHO Europe, undated). Levels of mental health problems in prisons also appear to be on the rise. Recent US federal statistics revealed that the number of prisoners with mental illnesses quadrupled between 2000 and 2006. More than half of all prison and state inmates now report mental health problems, including symptoms of major depression, mania and psychotic disorders. Rates of reported illness are now five times greater than the general adult population (Bureau of Justice Statistics, 2006).

3 Cited in BBC News, 21 February 2007

Health status, vulnerable prisoners and discrimination

The experience of imprisonment and conditions of detention has a significant impact on the health and well-being of vulnerable categories of prisoner, such as children, women and older people. Children who enter prison are typically already disenfranchised from health care services and have high rates of health problems which deteriorate further upon confinement. Imprisonment not only compromises a child's cognitive, emotional and psychological development, but also results in a high incidence of undiagnosed, misdiagnosed or untreated cases of mental illness. This is particularly so when children are detained in adult prisons, where facilities are not suited to their developmental needs and exposure to abuse and violence is particularly high (Physicians for Human Rights, undated).

Research similarly indicates that imprisonment has a significantly detrimental impact on the health of female prisoners compared to their male counterparts. US federal statistics, for example, report that women in US prisons have higher rates of mental health problems than men – 73 per cent compared to 55 per cent of men (cited in Human Rights Watch, 2006). The Chief Inspector for Prisons in England and Wales recently reported that although women make up five per cent of the prison population, they account for 55 per cent of incidents of self-harm.³ As prison systems have been primarily designed for men, women's health needs are often not addressed by prison policy and procedure. This can result, for instance, in infrequent or absent gynaecological and breast screening services and inadequate health services for pregnant women.

Prisoners may face discrimination and abuse on the grounds of their health status. Prisoners diagnosed with HIV/AIDS, for example, can be subjected to segregation or other discriminatory measures, such as withholding privileges, limitations on work, leisure or other programmes, stigmatisation and violence. Mandatory HIV testing is also applied to prisoners in some countries – as is the case in the US, Moldova, Hungary, Mexico and regions of Russia (Betteridge, 2004). In Kazakhstan, recent amendments to the penal code, introduced on 26 March 2007, have similarly resulted in the reintroduction



Prison overcrowding in Blantyre prison, Malawi

Credit: Joao Silva

of mandatory HIV testing of prisoners and obligatory treatment of TB positive prisoners on release.⁴

The stigma and discrimination surrounding mental health invariably persists within prison. Prison regimes in the US for example routinely criminalise and punish behaviour that is symptomatic of illness, such as self-harm, attempted suicide, being noisy and refusing orders. Prisoners with mental health problems are much more likely to experience harsh treatment and are at greater risk of isolation (Human Rights Watch, 6 September 2006). The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has

recorded numerous accounts of people with mental disabilities being subjected to various human rights abuses in institutional settings, including rape and sexual abuse, violence and torture: 'recent jurisprudence testifies to the vulnerability of persons with mental disabilities in detention to the violation of their human rights' (UN document E/CN.4/2005/51).

In other cases, prisoners can be subject to discrimination on the grounds of their convicted status. In a recent case in Israel, for instance, a Palestinian prisoner was denied a kidney transplant operation because he was convicted of killing an Israeli.⁵

- 4 Testing for HIV without consent infringes on the right to security of the person, the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment, and the right to privacy. World Health Organisation guidelines state that 'compulsory testing of prisoners for HIV is unethical and ineffective and should be prohibited.' (cited in Betheridge, 2004).
- 5 The Israeli Prison Service has said it will not pay for the \$90,000 operation for Ahmed Tamimi, who is currently serving a life sentence for murder. His family have been told that either they or the Palestinian Authority should meet the costs, even though under Israeli law all prisoners are covered by health insurance. The decision has been supported by a judge's ruling following an appeal by the prisoner. In delivering the verdict, the judge said, 'Is someone who came to murder us entitled to get finance for a transplant from the small budget that exists to assist people for this procedure?' (IRIN, 17 April 2007).

The causes of poor prisoner health

'Prison populations contain an over-representation of members of the most marginalised groups in society: people with poor health and chronic, untreated conditions, drug users, the vulnerable and those who engage in risky activities such as injecting drugs and commercial sex work.' (WHO Europe, 2003).

Conditions of detention and prison overcrowding

Although prisoners typically have a low health status prior to their imprisonment, existing health problems are made worse by the confines of the prison environment: poor hygiene and sanitation facilitate the spread of infectious and parasitic diseases; unsafe drinking water can cause chronic diarrhoea, typhoid, amoebic and bacillary dysentery and internal parasites; poor ventilation contributes to the spread of infectious diseases and respiratory problems; and inadequate exercise time and time outdoors can prevent prisoners from maintaining general health and cause skin diseases. Poor conditions of detention are aggravated by prison overcrowding, which can result in prison populations escalating to up to twice or even three times the official prison capacity. At an African conference on prison health in 1999, one doctor described such conditions following a visit to a Malawi prison:

'[Prisoners] share the available space with rats, bats, cockroaches, flies, mosquitoes, and many other visible and invisible things. Very many of them are dreadfully pathogenic. These prisons have overflowing toilets and septic tanks, broken showers, smashed windows and dirty kitchens. The cells are packed in which inmates sleep head to toes and who sweat like pigs in the hot season. This more or less completes the picture...'

(Dr Pandya, cited in PRI, 1999).

In the case of HIV/AIDS, prison conditions not only contribute to the risk of transmission, they also hasten

the progression of HIV and the deterioration in the health of people living with HIV/AIDS. In some cases, it has been estimated that imprisonment can halve the life expectancy of someone who is HIV positive. In the US, research has shown that prisoners with AIDS are dying eight months earlier than AIDS patients in the general population (cited in Goyer, 2003).

A poor and insufficient diet increases the likelihood of contracting a disease and the speed of its progression. It also causes malnutrition. At the Buna Central prison in the Democratic Republic of Congo, it was recently reported that at least ten per cent of inmates showed symptoms of malnutrition, along with associated digestive problems and diarrhoea. In December 2006, three detainees died from illnesses caused by severe malnutrition (IRIN, 2007). Similarly, in the Maison Central prison in Guinea, a study conducted in 2004 estimated that between 10 and 15 per cent of prisoners and detainees were suffering from malnutrition; seven inmates were dying each month as a result of malnutrition and disease (Human Rights Watch, 2006). Prisoners often have to rely on family and friends outside of prison for food assistance to supplement their prison diet (Atabay, 2006).⁶

In addition to the deterioration in prisoners' physical health, the prison environment also negatively impacts on their mental well-being. The decline in prisoners' mental health is the cumulative effect of prison overcrowding, prison violence, enforced solitude – or conversely, lack of privacy – a lack of meaningful activity, isolation from social networks and insecurity about future prospects (WHO/ICRC, 2006). As the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health concludes, 'Prison conditions...tend to exacerbate mental disabilities' (UN document E/CN.4/205/51).

High risk behaviours in detention

Compared to the general population, the prison population typically contains a higher proportion of people whose lifestyles and living conditions already put them at significant risk of infection of blood and airborne diseases. However the impact of imprisonment, and notably prison overcrowding, not only increases

⁶ However, this is not always permissible in prisons. In South Africa, for example, families are unable to supplement prisoners' diets with fresh fruit due to concerns by prison officials that they may be used to secrete drugs (Goyer, 2003). Similarly in Georgia, prisoners have been temporarily forbidden from receiving foodstuffs from their families on the grounds that it presents a security risk (PRI Tbilisi office, through personal communication).

Prison farms in Malawi

PRI established the prison farm programme in 1998 to support the Malawi Prison Service in increasing and diversifying food production inside Malawi's prisons, to improve the prisoners' food rations and support rehabilitation by equipping prisoners with agricultural skills. Since 1998, the prison farms have increased their crop production and extended activities into the areas of horticulture, rabbit and fish production and beekeeping. The focus of the programme has been to increase the prisons self-sufficiency and improve the diet of prisoners at a reduced cost (the cost of producing food in the prison farm is less than the cost of buying the same quantity of food from external suppliers).

An independent evaluation conducted in 2004 found that prisoner food consumption had increased and diversified following the introduction of prison farms. Prisoners themselves reported improvements in their physical and mental health, which was corroborated by medical practitioners who reported lower reported cases of symptoms of malnutrition. Physical health improvements have been attributed to an improved diet, the increased activity of prisoners and greater access to the open air. Improvements in the mental health of prisoners have been attributed to having greater contact with those outside prison and to enjoyment of the farming activities.

In 2005, PRI produced a film on the prison farm programme entitled *Seeds of Freedom*. A convicted prisoner and a former prisoner who were interviewed as part of the film had the following to say:

'One of the advantages of being sent to a prison farm is that you cultivate vegetables that you can consume yourself, rather than beans all the time. It is more diverse. When we cultivate more vegetables, huge amounts are sold and the money is used to buy fish and so we eat fish, vegetables and some beans. Just like you would eat at home. Also, those of us who come out get fresh air, unlike the hot air inside prison, and also our bodies are healthy because they are like being at home where one works, so we are not often sick.'

'When I was imprisoned, I was not sent straight away to the prison farm, I spent six months in prison. When I was sitting inside prison, I felt that due to inactivity, my body was not free and I felt very troubled. But when I was let out in the farms, I really felt good, I felt as if I was still at home doing what I had left there.'

Further information: Kadale (2004) *Impact of Phase 2 of the Prison Farms Program on the Diet and Health of the Prison Population in Malawi*. Available in English.

PRI (2005) *Seeds of Freedom*, DVD (18 minutes). Available in English.

the prevalence of high risk behaviours, but also the risk attached to them. Injection drug use (IDU), for example, is often initiated in prison as a means to cope with an overcrowded and violent environment (Kerr & Jurgens, 2004). Yet the zero tolerance measures adopted by prison administrations to prevent drug use can serve to heighten the risks attached to IDU as prisoners resort to the dangerous practices of sharing needles or manufacturing injecting instruments. The risk of HIV transmission through sexual intercourse is increased by the high prevalence of sexually transmitted diseases in prison (UNDP 2004), a problem that is typically compounded by the unavailability of condoms. Other risk factors include the sharing of razors, tattooing in unsanitary conditions, and violence, including sexual violence, which characteristically increases in overcrowded facilities.

Access to health care services

Poor conditions of detention are compounded by the unavailability of timely or appropriate health care provision, which is generally less efficient than the community-based health services. Prison health care is typically accorded low priority within prison systems, a problem that is not confined to low income countries:

'Even states with adequate resources do not invest in prison health and neglect the public health issues that flourish inside them'

(Reyes 2007:46).

Low investment typically results in insufficient, inadequately trained and unmotivated staff, along with limited resources with which to deliver services. Medical staff in prisons are additionally confronted with divided loyalties between meeting the health needs of their patients and the security needs of the prison

Health in prisons



Yerevan penitentiary centre for tuberculous detainees, Armenia

Credit: ICRC/Clarke, Fred

management. This can present daily practical and ethical challenges for prison doctors as they try to balance the competing interests.

In some countries, such as Tajikistan, prisoners have to pay for their own medication (Halimova, 2004). Corruption and gangs can provide additional barriers to health care, where prisoners are similarly obliged to pay to access services (Reyes, 2007). In other cases, there is simply an unavailability or insufficient supply of appropriate services to meet demand. This is particularly the case with regard to mental health care services. Within the US, for example, only 34 per cent

of state inmates and 24 per cent of federal inmates with a reported mental illness receive treatment in prison (Bureau of Justice Statistics, 2006). The privatisation of prison health care services, particularly in the US, is attributed to the declining quality and availability of health care provision in prisons (Reyes, 2007).⁷

Harm reduction approaches to drug dependency and injection drug use are often seen as incongruous with the security concerns and punitive agenda of prisons. As a result, prisons tend to take a zero tolerance approach to drug dependency and injection drug use, favouring complete abstinence over reduction

⁷ For further information see: Rosenthal, M. 2004a and 2004b; *New York Times*, 'As health care in jails goes private, 10 days can be a death sentence'; *Alternet*, 'Murder incorporated: profits from privatized health care'; Kessler, J. (undated), *The clinic and the prison: priva(tiza)tion*; and Thayer, L. 2004, *Hidden Hell – women in prison*.

measures such as needle exchange programmes, bleach distribution and methadone maintenance treatment (MMT) (Kerr & Jurgens, 2004). Health education and prevention work are also characteristically absent from prison health services. Yet the need for such interventions is acute. Prior to the introduction of an HIV prevention programme in Kyrgyzstan prisons, for example, a survey of inmates revealed that most were unaware of the risks of contracting HIV as a result of drug use; 40 per cent knew nothing about safer sex or safer drug injection (Abdildaeva, 2004).

HIV/AIDS prevention in Russian prisons

In 1999, PRI implemented an 18-month HIV prevention project within the penal establishments of Nizhnii Novgorod. The aims of the project were to raise awareness about HIV infection and prevention among the prison population, improve the living conditions and treatment of HIV positive prisoners and provide materials to aid the prevention of HIV transmission. Activities included the provision of training and relevant educational resources, organising study visits, researching prisoners' attitudes and knowledge about HIV/AIDS and facilitating bleach distribution within the prisons. The project resulted in significant improvements in the living conditions and provision of activities for prisoners with HIV or tuberculosis. This included enabling them to have greater access to their families. Improved awareness of HIV/AIDS among both prison staff and prisoners served to abate fears and reduce the stigma attached to the virus. The project also led to the initiation of a peer learning programme within the prisons.

Further information: Reyes & Bollini (2000) *Evaluation of the implementation of the project of HIV prevention and management activities in the prison system of Nizhnii Novgorod oblast, Russian Federation*. Available in English and Russian.

The effective management of prison health services remains a particular problem. In relation to tuberculosis, poor or non-existent screening on entry into prison, a reluctance to treat short-term prisoners, interruptions in

treatment programmes, and the use of expired drugs, contribute to the increased transmission of TB in prisons, as well as an increase in the prevalence of incurable or multi-drug resistant strains (Reyes, 2007). The separate management of and poor co-ordination between prison health services and the health services provided outside prisons create additional challenges for prisoner and public health. It is estimated that only 25 per cent of prisoners receiving treatment for TB continue to receive it on release; and many of those who do fail to complete their course of treatment.

Containment of public health problems

Mental health and drug use are both illustrative of the overuse of imprisonment, where prisons in essence become a 'law and order solution to public health problems' (Kerr & Jurgens, 2004). In Russia, petty drug offences account for 20 per cent of male prisoners and 75 per cent of female prisoners (Wolfe, 2004). Similarly, in Central Asia, prison sentences are the norm for arrested drug users rather than diversion into drug treatment or rehabilitative programmes (Walcher, 2005a). The consequences of punitive drug policies are high rates of imprisonment and a high concentration of injecting drug users in prison, which in turn drive the HIV epidemic and contribute to prison overcrowding.

In relation to mental health, prisons are being used as a 'default setting for those we do not have the proper resources to look after in the community.'⁸ In the US for example high rates of imprisonment of the mentally ill are attributed to under-funded, disorganised, and fragmented community mental health services (Human Rights Watch, 2006). These trends have led the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health to conclude,

'In many cases, persons with severe mental disabilities who have not committed a crime, or who have committed a minor offence, are misdirected towards prison rather than appropriate mental health care or support services' (UN document E/CN.4/2005/51).

8 Anne Owers, Chief Inspector of Prisons for England and Wales, giving evidence at an inquest of a woman who died in New Hall prison, cited in BBC News 21 February 2007.



'For clean water' – Mordovia women's prison, Russian Federation Credit: Sophie Brandstrom/L'Oeil Public/PRI, 2004

International standards relating to health in prisons

The human right to health is recognised in Article 25.1 of the *Universal Declaration on Human Rights*, which states, 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care...' The *International Covenant on Economic, Social and Cultural Rights* provides a comprehensive elaboration of this right. Article 12 recognises the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and outlines the requirements of state parties to fulfil this right.⁹ The

UN Committee on Economic Social and Cultural Rights interprets the right to the enjoyment of the highest attainable standard of health as one comprising both freedoms and entitlements. Freedoms include the right to control one's health and body and the right to be free from interference, such as torture, non-consensual medical treatment and examination. Health entitlements include the right to a system of health protection which provides equality of opportunity. The Committee also interprets the right to health as an inclusive right:

'extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe

⁹ Article 12.2 states, 'The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: the provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure all medical service and medical attention in the event of sickness.' Similarly, the *Convention on the Rights of the Child* articulates the right to health as it applies to children. Article 25, in particular, recognises, 'the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.'

Health training to prison staff in Burundi

In Burundi, access to health care for prisoners is regularly affected by difficulties in collaboration between the people responsible for prison management: the police chiefs who are in charge of prison security and the prison directors who are in charge of prison administration. Particular difficulties have arisen, for example, when a prisoner has needed to leave the prison and be escorted to hospital for treatment. PRI has therefore been working with those responsible for prison management to improve collaboration between staff and to establish a code of conduct. Training has also been delivered to more than 1,300 penitentiary policemen to sensitise them to health and hygiene standards in detention. They have been taught, among other things, international human rights standards relating to health in prison, the causes and risks relating to disease transmission and what action should be taken in the event of a medical emergency. This is resulting in the improved treatment and care of prisoners.

Further information: prirwanda@penalreform.org

and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information' (UN document E/C.1/2000/4).

There are numerous human rights that are therefore integral to the realisation of the right to health, including the rights to food, housing, work education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. The health rights of prisoners are expressed in the *UN Standard Minimum Rules for the Treatment of Prisoners* which outlines specific standards of care in relation to hygiene, clothing, food, exercise and medical services,

15 Prisoners shall be required to keep their persons clean, and to this end shall be provided with water

and with such toilet articles as are necessary for health and cleanliness.

17 (1) Every prisoner who is not allowed to wear his own clothing shall be provided with an outfit of clothing suitable for the climate and adequate to keep him in good health.

19 Every prisoner shall, in accordance with local or national standards, be provided with a separate bed, and with separate and sufficient bedding which shall be clean when issued, kept in good order and changed often enough to ensure its cleanliness.

20 (1) Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served.

(2) Drinking water shall be available to every prisoner whenever he needs it.¹⁰

The standards relating to prison health care are based on the principle of equivalence, meaning that health services within prisons should be of the same standard as those within the community. Principle 9 of the *UN Basic Principles for the Treatment of Prisoners* states, 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.' Similarly, the *United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* requires that 'health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.'¹¹ Indeed, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health interprets the duty to respect the right to health as one that 'requires the state to refrain from limiting equal access for all persons, including

¹⁰ Rules 82 and 83 additionally address the treatment of 'insane and mentally abnormal' prisoners.

¹¹ The principle of equivalence underpinning prison health care standards is widely debated. Lines (2006), for example, argues that even if prison health care was at an equivalent standard to care provided in the community it would, in some cases, still fall short of meeting human rights obligations and public health needs, therefore presenting the case for standards that achieve equivalent objectives rather than equivalent levels of care.

Health in prisons

prisoners,...to preventive, curative and palliative health services' (UN document A/HRC/4/28:19).¹²

Realising the right to health

'The human rights of prisoners should be safeguarded at all times ... prisoners should retain all rights which are not expressly taken by the fact of their detention' (PRI, 1996).

When a state deprives a person of their liberty, they are obliged to ensure that the human rights of that individual are upheld.¹³ The UN Human Rights Committee articulates this responsibility as one in which states have a 'positive obligation' to protect the rights of those who are vulnerable because of their status as persons deprived of their liberty.¹⁴ Put simply, people are imprisoned as punishment not for punishment; imprisonment should therefore not aggravate the suffering already caused by the loss of liberty.

Prisoners and detainees have a right to health which is articulated in the *International Covenant on Economic, Social and Cultural Rights* and within the specific standards contained in the *UN Standard Minimum Rules for the Treatment of Prisoners* and the *Basic Principles for the Treatment of Prisoners*. It is a right that should be governed by the four principles of availability, accessibility, acceptability and quality. In other words, health facilities, goods and services within prisons should be of sufficient quality and quantity and run by adequately trained personnel. Prison health care should

be accessible to everyone without discrimination, and services should be culturally appropriate and respectful of medical ethics.¹⁵

The deterioration of prisoners' health on incarceration can be a consequence of the overuse of imprisonment, where conditions of detention and the effects of overcrowding cause or aggravate health problems. Medical interventions alone will not ensure that prisoners are able to enjoy their right to the highest attainable standard of living unless they are accompanied by additional measures that address the underlying determinants of ill health in prisons.¹⁶ This requires an approach which integrates prisoner health within a wider human rights framework for prison reform:

'Ensuring that human rights considerations are an integral part of management is not only a requirement of universally accepted standards, but is also the basis of creating an environment that is safe and healthy and a system that works efficiently on the basis of fairness and justice' (Atabay, 2006).

A human rights approach to prisoner health that addresses the overuse of imprisonment should equally address the incarceration of the mentally ill and those with drug addictions. Mental illness and drug addiction are not criminal offences requiring punishment but health problems requiring treatment. As PRI's *10-point plan to reduce overcrowding in prisons in Africa highlights*,

- 12 The Council of Europe Recommendation No. R(98)7 concerning the ethical and organisational aspects of health care in prison additionally outlines key principles and recommendations for member states in relation to the following: accessing health care; the equivalence of care; patient's consent and confidentiality; and professional independence. Furthermore, the Council of Europe Recommendations (2003)23 on the management by prison administrations of life sentence and other long term prisoners includes explicit recommendations for the treatment of elderly and terminally ill prisoners.
- 13 As paragraph five of the *Basic Principles for the Treatment of Prisoners* states, 'Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights ...'
- 14 The Human Rights Committee's *General Comment No. 21 concerning humane treatment of persons deprived of their liberty (article 10 of the International Covenant on Civil and Political Rights)* (1992) notes that this positive obligation means that, 'not only may persons deprived of their liberty not be subjected to treatment that is contrary to article 7, including medical or scientific experimentation, but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a closed environment.'
- 15 This principles are outlined in the *UN Economic Social and Cultural Rights Committee's General Comment No. 14 on the right to the highest attainable standard of health* (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2000).
- 16 As the World Medical Association's *Edinburgh Declaration on Prison Conditions and the Spread of Tuberculosis and other communicable diseases* states, 'The most effective and efficient way of reducing disease transmission is to improve the prison environment targeting overcrowding for the most urgent action' (2000).



A prisoner exercising in Palmasola prison, Bolivia

Credit: Stéphane Remael/L'Oeil Public/PRI, 2002

'Prison is not a suitable institution for mentally ill people' (cited in PRI, 2005). Prisons should therefore not be used for the purpose of containing society's 'ills' in the absence of appropriate treatment and care within the community.

Above all, a human rights approach to health in prisons must recognise that prisoner health is a public health issue. Prisoners come from the community and the large majority will eventually return to the community, taking with them the health problems and infectious diseases they have picked up whilst in detention. The public health hazard this presents should not be underestimated. Although it is estimated that there are between eight and ten million prisoners worldwide on any one day, there are thought to be

between four to six times as many people passing through prisons worldwide in the course of the year (Duda, 2007). The closer integration of prison health care within the broader public health system will not only enable greater equivalence in health care provision inside and outside of prison, it will also improve the continuity of health care when prisoners are released.¹⁷ This will ultimately help to minimise the health impact of imprisonment – for prisoners themselves and the community as a whole. If international commitments to improve public health, as enshrined in the UN Millennium Development Goals (MDGs),¹⁸ are to be met, prisoner health must not be treated in isolation from the broader public health agenda.

17 As the WHO *Europe Declaration on Prison Health as part of Public Health* states, 'Penitentiary health must be an integral part of the public health system of any country...it is necessary for both prison health and public health to bear equal responsibility for health in prisons' (2003).

18 Targets relating to health include: reduce by half the proportion of people who suffer from hunger; halt and begin to reverse the spread of HIV/AIDS; halt and begin to reverse the incidence of malaria and other major diseases; reduce by half the proportion of people without sustainable access to safe drinking water; provide access to affordable essential drugs in developing countries. Further information: www.un.org/millenniumgoals/index.html

Bibliography

- Abdildaeva, R. (2004) 'Pioneering HIV prevention in Prisons', in *Harm Reduction News*, Vol. 5, Issue 3. Open Society Institute.
- Alternet, *Murder incorporated: profits from privatized health care*, published 6 November, 2001.
- Atabay, T et al. (2006) *Human Rights and Health in Prisons; a review of strategy and Practice*. The Netherlands: Penal Reform International/Royal Netherlands Tuberculosis Foundation (KNCV).
- BBC News, *Prison chief speaks at inquest*, published 21 February, 2007.
- Betteridge, G. (2004) *Prisoners' Health and Human Rights in the HIV/AIDS Epidemic*. Canada: Canadian HIV/AIDS Legal Network.
- Bureau of Justice Statistics (2006) *Mental Health Problems of Prison and Jail Inmates*. USA: US Department of Justice.
- Council of Europe (1998) *Recommendation No. R(98)7 of the committee of ministers to member states concerning the ethical and organisational aspects of health care in prison*.
- Council of Europe (2003) *Recommendations (2003)23 on the management by prison administrations of life sentence and other long term prisoners*.
- Duda, J (2007) *The tuberculosis epidemic breaks through prison walls*, published on 23 March, 2007
- Economic and Social Council (2006) *Combating the spread of HIV/AIDS in criminal justice pre-trial and correctional facilities*. Report of the Secretary General. UN Document E/CN.15/2006/1.
- Farmer, P. & Yang, A (2004) 'Tuberculosis and HIV in prison' in *Harm Reduction News*, Vol. 5, Issue 3. Open Society Institute.
- Goyer, K.C. (2003) 'HIV/AIDS in Prisons: problems, policies and potential' in *Monograph No 79*, February 2003.
- Halimova, Z. (2004) 'Women prisoners no better off than men', in *Harm Reduction News*, Vol. 5, Issue 3. Open Society Institute.
- Herman, A. (2000) *Hepatitis C and incarcerated populations: the next wave for correctional health initiatives*. USA: Association of State and Territorial Health Officials.
- Human Rights Watch (2006) *The perverse side of things: torture, inadequate detention conditions and excessive use of force by Guinean Security Forces*. Vol 18 No 7 (A).
- Human Rights Watch, *US: Number of Mentally Ill in Prisons Quadrupled*, press release, 6 September 2006.
- Human Rights Watch, *New Data on the Prevalence of Mental Illness in US Prison*. Article, 10 January 2007
- ICPS/PRI (undated) *Improving Prison Healthcare in Eastern Europe and Central Asia*. Guidance Document 1.
- IRIN *DRC: prisoners endure appalling conditions*, published 14 February 2007.
- IRIN *ISRAEL/OPT: 'Poor medical treatment' for prisoners in Israel*, published 17 April, 2007.
- Jurgens, R. (2002) 'HIV/AIDS in Prisons: Recent Developments' in *Canadian HIV/AIDS Policy and Law Review* 7:2/3.
- Kadale (2004) *Impact of Phase 2 of the Prison Farms Program on the Diet and Health of the Prison Population in Malawi*.
- Kessler, J. (undated) 'The clinic and the prison: priva(tiza)tion', published in the *Hippolytic*
- Kerr, T. & Jurgens, R. (2004) 'Harm reduction in prisons: an obligation to act', in *Harm Reduction News*, Vol. 5, Issue 3. Open Society Institute.
- Lines, R. (2006) 'From equivalence of standards to equivalence of objectives: the entitlement of prisoners to health care standards higher than those outside prisons', in *International Journal of Prisoner Health*, December 2006; 2(4): 269-280.
- New York Times*, 'As health care in jails goes private, 10 days can be a death sentence', published 27 February, 2005
- Physicians for Human Rights (undated) *Youth in the adult criminal justice system: health and human rights risks*. PHRUSA.
- Physicians for Human Rights (undated) *Health and human rights in juvenile justice*. PHRUSA.
- PRI (1999) *Health in African Prisons*. Malawi: PRI.
- PRI (2005) *Reducing Pre-trial Detention: an index of good practices developed in Africa and elsewhere*. Malawi: PRI.
- Reyes, H. & Bollini, P. (2000) *Evaluation of the implementation of the project of HIV prevention and management activities in the prison system of Nizhnii Novgorod oblast, Russian Federation*. Moscow: Penal Reform International.
- Reyes, H. (2007) 'Pitfall of TB management in prisons, revisited' in *International Journal of Prisoner Health*, March 2007; 3(1): 43-67.

- Rosenthal, M. (2004a) *Prescription for Disaster: Commercializing Prison Health Care in South Carolina*. USA: Grassroots Leadership and South Carolina Fairshare
- Rosenthal, M. (2004b) *Prescription for Recovery: keeping South Carolina's Prison Health Care Public and Making it Better*. USA: Grassroots Leadership and South Carolina Fairshare.
- Thayer, L. (2004) 'Hidden Hell – women in prison', published in *Amnesty International USA magazine*, Fall 2004.
- UN Commission on Human Rights (2005) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (Mr. Paul Hunt). UN Document E/CN.4/2005/51.
- UN Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14: the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*. UN Document E/C.12/2000/4.
- UN Human Rights Council (2007) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Paul Hunt. UN Document A/HRC/4/28.
- UN Human Rights Committee (1992) *General Comment No. 21 concerning humane treatment of persons deprived of their liberty (article 10 of the International Covenant on Civil and Political Rights)*. UN Document A/47/40.
- Walcher, G. (2005a) 'Prisons as regional drivers of HIV/AIDS and tuberculosis in some Central Asian countries: a matter of 'least eligibility'?' in *International Journal of Prisoner Health*, June-December 2005 1(204) pp 103-115.
- Walcher, G. (2005b) 'Prisons – the disease pump' in *Transitions Online*, 5 December 2005.
- Wolfe, D. (2004) 'Policy reform is key to harm reduction', in *Harm Reduction News*, Vol. 5, Issue 3. Open Society Institute.
- World Health Organization/International Committee for the Red Cross (2006) *Mental Health and Prisons Information Sheet*.
- World Health Organization Europe (undated) *Prison health factsheet*.
- World Health Organization Europe (2003a) *Health in Prisons Update: WHO Regional Office for Europe Newsletter No 1*, 2003.
- World Health Organization Europe (2003b) *Prison Health as part of Public Health, Moscow Declaration*, 24 October 2003.
- World Health Organization/International Committee of the Red Cross (2006) *Information Sheet: Mental Health and Prisons*.
- World Medical Association (2000) *Edinburgh Declaration on Prison Conditions and the Spread of Tuberculosis and other communicable diseases*.

PRI publications and resources on health in prisons

Human Rights and Health in Prisons: a review of Strategy and Practice

(PRI/KNCV, 2006) Available in English and Russian.

Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia

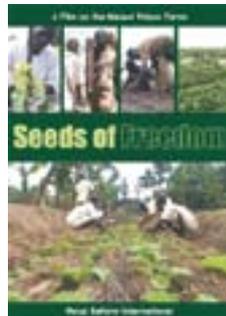
(Irish Penal Reform Trust, PRI and others, 2004) Available in English.



Soigner en Prison

(PRI, 2005)

Available in French.



Seeds of Freedom

(film)

(PRI, 2005)

Available in English.

HIV in prisons: a reader with particular reference to newly independent states

(WHO Europe with PRI, 2001)

Available in English.

HIV/AIDS in Malawi Prisons

(PRI, 1999) Available in English and Russian.

Kampala Declaration on Prison Health in Africa

(PRI, 1999) Available in English and French.

To download PRI publications, visit our website www.penalreform.org

To order hard copies of PRI publications, please email publications@penalreform.org

Where the mind is without fear and the head is held high: mental health and care of women and children in prison in Andhra Pradesh.

(PRI/PRAJA, 2001) Available in English.

Health in African Prisons

(PRI, 1999) Available in French and English.

PRI BOARD MEMBERS

Hans Henrik Brydensholt, Denmark

David Daubney, Vice-Chairperson, Canada

Olawale Fapohunda, Nigeria

Paddington Garwe, Zimbabwe

Maria Eugenia Hofer Denecken, Chile

Juliet Lyon, UK

Amin Mekki Medani, Sudan

Angela Melo, Mozambique

Simone Othmani-Lellouche, France

Bruno Schoen, Treasurer, Germany

Livingstone Sewanyana, Deputy Secretary General, Uganda

Rani Shankardass, Chairperson, India

Anthony Tang, HKSAR, China

HONORARY BOARD MEMBERS

Al Bronstein, Honorary President, USA

Vivien Stern, Honorary President, UK

Hans Tulkens, Honorary President, The Netherlands

PRI Offices

Head Office

Unit 450, The Bon Marche Centre, 241–251 Ferndale Road, London SW9 8BJ, United Kingdom
Tel: +44 (0) 20 7924 9575
Fax: +44 (0)20 7924 9697
Email: headofsecretariat@penalreform.org

Regional Offices

Central Asia

Office 40. 153, Abai Avenue, Almaty 050009, Kazakhstan
Tel/Fax: +73272 506476
Email: prialmaty@penalreform.org

Middle East & North Africa

Alkadery Building, 2nd Floor, Office No 4, Ali Nassouh Al Taher Street, Sweifieh off the 6th Roundabout, Abdoun Post Office, PO Box 852 122, 11185 Amman, Jordan
Tel: +962 6 582 6017
Fax: +962 6 582 6078
Email: priamman@penalreform.org

Great Lakes

Parcel No. 1253, Kimihurura, Kigali Ville
PO Box 370, Kigali, Rwanda
Tel: +250 518 664
Fax: +250 518 641
Email: prirwanda@penalreform.org

Russia, Ukraine & Belarus

Uglovoy Pereulok Dom 2, PO Box 62, Moscow 127055, Russia
Tel/Fax: +7 495 250 6464
Email: primosc@orc.ru

South Caucasus

16 Kikodze Street, Tbilisi 0105, Georgia
Tel: +995 32 20 57 75
Tel/Fax: +995 32 98 35 60
Email: prtbilisi@penalreform.org

USA

1025 Vermont Avenue N.W., 3rd Floor
Washington, D.C. 20005, United States of America
Tel: +1 202 580 6940
Fax: +1 202 580 6938
Email: priwashington@penalreform.org

PRI Mandate

Penal Reform International seeks to achieve penal reform, whilst recognising diverse cultural contexts, by promoting:

- the development and implementation of international human rights instruments with regard to law enforcement, prison conditions and standards;
- the elimination of unfair and unethical discrimination in all penal measures;
- the abolition of the death penalty;
- the reduction in the use of imprisonment throughout the world;
- the use of constructive non-custodial sanctions which encourage social reintegration whilst taking account of the interests of victims.