HEALTH IN AFRICAN PRISONS

Workshop
12-13 December 1999
Kampala, Uganda

Organised by
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This workshop was held with backing from the African Commission on Human and People's Rights. Special thanks are also extended to Pr. Dankwa, Chairman of the African Commission on Human and People's Rights and Special Rapporteur on Prisons and Conditions of Detention in Africa who despite a heavy schedule was able to make it to Kampala and to contribute in an invaluable way to the discussion.

Staff and managers from the Fairway Hotel who hosted the workshop are commended for their dedication, understanding and help. Last but not least, the interpreters who have voluntarily interpreted the workshop deserve congratulations for their excellent work and thanks for their dedication.

INTRODUCTION

In December 1999 the Kampala workshop on 'Health in African Prisons' gathered together about 80 people from all over Africa and the world to share their experiences. Practitioners, Heads of Prison Services, researchers and NGOs have worked together to gather information and suggest new directions in this field. Together the 80 delegates elaborated and adopted the Kampala Declaration on Prison Health in Africa, as well as a series of recommendations for governments, NGOs and donors.

The Kampala workshop was part of the process preparing the Pan African conference on Prison Health that the Ugandan Prisons Service is currently working on. The workshop aimed to set the ground for debate and highlight some of the most pressing issues. Group work allowed the detailed discussion of various subjects and the development of suggested plans for action.

Beyond the texts of the workshop, the present document contains information about African experiences that the participants wished to share with their colleagues. It aims at supporting reflection and action and at inviting all those in charge to take a different look at the question. Above all, it aims at inviting Africans to adopt a shared instrument to promote a better respect of the fundamental right to health in prisons.

Most African States desperately lack resources, a situation that exasperates the problems of African penal systems. However, participants at Kampala were well aware that lack of resources could not continuously be invoked to justify disastrous situations. Some simple and cost effective measures - such as information and consciousness raising - are likely to contribute to an improvement. Civil society and the community are also to be actively involved in the process of providing better health care for prisoners. It has been recalled on several occasions that prisoner's health concerned the whole population. Those in jail will eventually be released; those who work in the prisons go back to their friends and families every day. These are factors in the transmission of disease that can have dire consequences on whole communities.

Health in prison is everybody's concern. We hope that this meeting, and the publication of its work will contribute to the debate and raise new ideas to progress towards more humane prisons.

KAMPALA DECLARATION ON PRISON HEALTH IN AFRICA

Considering the poor records in the field of prison health in Africa,

Considering good health care management and practices that should be promoted and implemented,

The participants to the Kampala Workshop on Prison Health, 12-13 December 1999, recommended measures to be taken by Non-Governmental Organisations, Donors, Governments and Inter-Governmental Organisations to reform and improve prison health in Africa.

Inventory of prison health in Africa

Conditions in African prisons are life threatening and a potential health hazard to the prison population and society at large; morbidity and mortality rates are high; health status is worse in prison than in the general community.

Structural Problems

Few resources are dedicated by the Governments to prisons for health and adequately trained personnel is lacking.

Recruitment policy is inadequate and there are no incentives to attract doctors to work in prisons.

Access to health care is difficult, drugs and equipment are lacking. Access to facilities in the communities is not easy where prison facilities are not adequate.

Record keeping is inadequate.

Confidentiality and privacy are lacking.

The system lacks transparency.

Poor attention is paid to prisoners' complaints.

The community is not interested in the fate of prisoners.

General conditions of detention - Impact on health

Excessive recourse to pre-trial detention entails overcrowding which facilitates the spread of disease inside and outside prisons. In many countries, awaiting trial prisoners amounts to 70% or more of prison population.

Living conditions are precarious: dilapidated infrastructure, lack of ventilation, of bedding, clothing and exercise.

Proliferation of vectors such as mosquitoes goes uncontrolled.

There are high incidences of drug abuse as well as violence in some places.

The well being of prisoners is undermined by the lack of work and recreational activities as well as the lack of moral and spiritual support.

Extra/special care is needed for vulnerable groups (children born in prison, drug addicts, juveniles, foreigners, elderly people, women, alcoholics). However, the penitentiary system is not adapted to their needs.

Specific health issues

Sanitation and water facilities are poor.

Food is insufficient in quality and quantity.

There is high incidence/prevalence of infectious and contagious diseases such as TB and HIV/AIDS; facilities for the terminally ill are lacking and screening process is unsatisfactory.

Prison population is poorly informed about health care, infectious and sexually transmitted diseases. There is hardly any prevention and treatment. Information on the right to health is lacking as well as health education for prisoners.

Psychological and social support is inadequate and there is no specific approach to mental health.

Recommendations

All efforts possible should be made by NGOs, Governments and Donors to have the following recommendations implemented:

Governments should make sure that general good management practices are enforced

Norms and standards should be respected.
Governments should make sure that they fulfil obligations to international and regional standards pertaining to human rights, health and prison conditions. They should in particular implement World Health Organisation's directives and develop standards of health care - legislative and policy directives as well as a prisoner's manual on procedures and complaints.

Governments should commit themselves to less punitive criminal justice.
Imprisonment should remain the exception. Criminal justice systems should be improved to expedite awaiting trial prisoners. Legislative reform in line with international standards, notably in the field of non-custodial sentence, should be carried out and alternatives to imprisonment such as community service, diversion and mediation should be implemented. As many releases as possible should be ordered. Health should be considered when deciding upon an early release measure.

Equality of access to health care should be ensured.
The Ministry of Health should take over the responsibility of health in prison and prisons should be included in public health programmes. Adequate finance should be made available and budgeting for prison health care should be a separate line item. There should be transparency and accountability regarding health care. This should be achieved by having a state department responsible for health care and training of officials (including human rights training).

Prisons should be more open to the outside.
Prisons should be open to relevant external actors providing specific assistance as well as independent inspectors who should report to a high authority. Access to prisons by the public should be facilitated to enhance transparency. Open door visits could be organised on a regular basis to sensitise and educate the community about prison.

Production activities should be developed.
Governments should see to it that production activities are developed to increase prison administrations' and prisons self-sufficiency. Any labouring activities should benefit prisoners.

Sharing experiences and on-site training should be supported.
Regular exchanges should be facilitated between health professionals. Prison officials should be properly trained and progressive attitudes encouraged. Governments should participate fully in the Conference on Health to be convened by the Uganda Prisons Service.

Governments should make sure that some basic good practices are enforced at the level of each prison

Primary health care should be a priority. Prisoners should be allowed to take responsibility for their health.

Each prisoner must have a confidential clinical health record giving all essential details of the individuals health profile. It should record all incidences of illness and treatment. It should contain a fitness certificate on discharge.

Health examinations and treatment should be conducted in privacy.

Discipline regarding maintenance of hygiene and sanitation in institutional environment must be enforced.

Professionally trained personnel, diagnostic facilities and drugs should be available in adequate quantities at all times.

Health education and counselling should form an integral part of the treatment for all health care management.

There should be a public health programme for staff and prisoners alike to prevent disease rather than cure it later. It should be a continuing process.

Preventive health care programmes should focus on decongestion.

A holistic approach should be adopted to include paramedics and social welfare.

NGOs/civil society groups should

Assist in health awareness and education including AIDS and STDs.

Develop networks within the NGOs working in this field to co-ordinate their work, exchange and build synergies.

Engage constructively by including prisons in the planning of their activities whenever possible, by getting more involved in educating donors, by demonstrating ethical accountability and transparency.

Donors should

Make sure that their assistance benefits the recipient/targeted persons.

Encourage developmental programmes in the field of prison health in recipient countries.

Support NGOs doing work in the area of prison health.

Support prison administrations and justice systems for the improvement of health.

Kampala, 13 December 1999

OPENING

Communication

Rosemary Wool[1]

I regret very much that I am unable to attend this very important workshop but I am delighted that the Ugandan Prison Service has taken the initiative to prepare for and to host a conference on prison health-care. I am also delighted that the Vice-President of the International Council of Prison Medical Services is chairing the Organising Committee.

If I understand rightly, this conference will be about reform. Before reform can take place, the following criteria must be established:

- A clear need for reform
- The political will for reform
- Agreed principles on which the reformed service should be based
- Leadership
- A strategic plan of action

There must surely be an agreement by even those who take an extreme punitive stance, that the prisons in all African countries, as in most other countries of the world, are in need of reform in those areas which impinge on the health of prisoners. Overcrowding is common everywhere, hygiene is often of a poor standard, fresh air and exercise are limited, and work, education and purposeful activity are not accessible.

Furthermore, the morbidity of prison populations is always correspondingly higher than the general populations of countries. The main problems differ from country to country, for example in some it is HIV/AIDS, in some tuberculosis, in some drug misuse. But in all prison populations there are sick populations. Sadly they are seldom recognised as such, and because of this, their health problems are not adequately addressed.

The second criteria for reform to take place is the political will. All too often, politicians get more votes if they are seen to be tough on prisoners, and improving conditions is regarded as soft. But one way to gain political attention is to show that the health of prisoners has a direct impact not only on the health of the general population but also on the economy of the country.

The third criteria is agreed principles on which the service must be based. The ethical principles are clearly set out in international legislation, for example the Standards Minimum Rules for the Treatment of Prisoners under any form of Detention or Imprisonment, the Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment. But other principles need to be established. Since prisoners come from, and return to, the general population, it is important that the Ministry of Health shares responsibility for prisoners' health care with the Ministry of Justice or the Ministry of Law and Order. All secondary care, including medical and psychiatric care of a specialist nature, should be the responsibility of the Health Authority.

The fourth criteria is strong leadership. The leaders of the reform process must be identified early in the process and given the necessary authority to take the work forward.

And finally, strategic planning. Any prison service embarking on reform must have a plan of action, and a strategy. I am pleased to see that in the workshop you have allowed space for countries to analyse their own situations. Analysis of the total environment, i.e. both inside prisons and in the outside community, must take place in order to identify and assess the areas in need of reform. Then follows planning of the future direction of the service, planning of the strategy, and planning of the implementation process.

1. Secretary General, International Council of Prison Medical Services.

Maybe when I attend the conference in June, you will let me expand on this theme!

I do wish you all a most fruitful workshop, and I look forward to reading the report of your deliberations.

OPENING ADDRESS

Ahmed Othmani[2]

Professor Dankwa, Chairman of the African Commission on Human and Peoples' Rights; Mr. Etima, Commissioner General of Uganda Prisons Service; Dr. Nyabwana, Director of Uganda Prisons Medical Services; Mr. Fedeli, Representative of the Italian Embassy; Mr. the Regional Vice-President of the ICPMS,

Distinguished Guests

Dear Colleagues

Ladies and Gentlemen

It is always a great pleasure to come back to Uganda to be among friends and colleagues and meet new ones. It is also a great honour to be here with you all. As Chairperson of Penal Reform International, I am very proud that PRI is contributing to this important workshop, under the auspices of the African Commission on Human and Peoples Rights.

It seems that every time we meet in Kampala, something happens. Is it your weather? There was the Kampala Declaration on Prison Conditions in Africa in 1996, which in 1997 was adopted by the United Nations and is increasingly cited authoritatively throughout our continent and beyond. In response to the recommendation tabled here, the ACHPR nominated Professor Dankwa as Special Rapporteur on Prisons and Conditions of Detention a month later.

In March this year, further to the agenda set in Kampala in 1996 and with the assistance of DFID, PRI and FHRI, representatives from eight countries were invited here to discuss new approaches to criminal justice and to consider the exciting developments going on in certain countries in the region. Countries that have recognised that the problems facing their criminal justice systems are not going to go away unless a new perspective is brought to bear. A perspective that takes into account the economic, social and cultural realities of their people.

The resolutions tabled at that meeting contributed to an international meeting of penal reformers in England one month later, which called for a new agenda for penal reform for this new century we are waiting and hoping to see in - inshallah.

Perhaps the air of Kampala is especially creative - whatever the reason: the warmth of the welcome and hospitality of our hosts does much to bring us together - to enable us to focus on our common aims and - most importantly - to work together to achieve them.

Many of you know about Penal Reform International and its work: in brief we try to improve conditions for everyone living and working in prisons through the development and implementation of international human rights instruments with regard to law enforcement, prison conditions and standards. We work with others to reduce the use of imprisonment throughout the world by advocating the use of constructive, non custodial sanctions which encourage social reintegration while taking into account the interests of victims; and, last but not least, the abolition of the death penalty. I am sure you would agree with me that all these objectives, especially the first ones are very relevant to the topic we are here for.

Our approach is deliberately practical, cost effective and inclusive: we set out to work with governments and show them ways of saving money and improving conditions at the same time. We work with NGO partners in many countries and assist them to set up networks to promote penal reform and find funding. We share information through our newsletters and publish studies, reports and commentaries to facilitate the application of these international standards.

I say as a matter of pride that I think we have a highly privileged relationship with Ugandan institutions. We have been working closely with the judiciary, prison service and NGO community here. We follow

2. Chairperson, Penal Reform International

the interaction between governmental and non-governmental agencies with a watchful eye and observe the benefits that accrue to all parties when the political will exists and when NGOs are prepared to engage constructively with governmental agencies.

The importance of our meeting here cannot be over-emphasised nor the drama of the situation. There is a remarkable congruence regarding prison health problems between countries, but responses to them vary a great deal. National approaches, structures, policies and practices seldom reflect what could be termed a common, possibly African, approach. But, first of all, we have to identify the major issues in prison health and thereby set an African agenda for future work in this area.

One of the principal long-term objectives to keep in mind in the course of this workshop is to find ways of increasing African co-operation in the area of prison health. The need for continuous exchange of information and experience is clearly evident. The need for wider diffusion of successful models, policies and practices should be strongly emphasised. This is based on the fact that most prison health problems are shared by most, if not all, prison administrations in Africa, and introducing changes could be greatly facilitated by replicating, or adapting, improvements which proved successful elsewhere. Therefore, the need to elaborate a set of common African standards could be a theme of this workshop. One of its main purposes could be to provide the background and incentive to start such a process.

We are not at the beginning of a process. Much has been done and is being done. Last year in Dakar, Senegal, we had the International Conference on "HIV/AIDS in African Prisons" which culminated in the "Dakar Declaration". This Declaration made it clear that the health of prisoners is a public health issue and that it is the responsibility of government to provide for the health of detainees as for any other citizen.

The Special Rapporteur on Prisons and Conditions of Detention in Africa consistently stresses the health of prisoners in his recommendations following country visits.

Research studies are emphatic that the situation of prisoners' health is not just a human rights issue but a public health hazard that - for example in the former Soviet Union the prevalence of TB in prisons - has become a cause of major concern.

We are all here to share our different experiences, to exchange ideas. Every one of us will learn what is happening elsewhere and how others deal with the question of health in African prisons. Every one of us could describe how it is in his or her country. This will contribute to our deliberations in the forthcoming international conference on Health in Prisons provisionally set for June in the year 2000.

Just two days ago, December the 10th, was the 51st anniversary of the Universal Declaration of Human Rights. Let us remember and be clear that in talking of health in prison, we are talking about the right to life. Nothing more, nor less. Poor conditions that contribute to a breakdown in a person's health breach that right. We know the problems and we need - together - to work towards the solutions. As a philosopher once said: "It is not what is, but what could or should be which needs us". Thank you.

PLENARY

Overview of prison health in Africa

Dr. Pandya[3]

The situation

The situation in prisons is the same all over Africa. I will present you an overview of the situation of health in Malawi prisons, which I am sure reflects the general situation of prison health elsewhere in Africa.

Contagious and infectious diseases are rampant amongst the prison population in Malawi. Overcrowding is the single most important factor which makes contagious diseases spread like wildfire. Lack of reliable running water, poor hygiene and sanitation and poor vector control provide suitable environs for the spread of infectious illnesses.

There is also a high turn over of the prison population. This makes the import and export of contagion and infection across the secure walls of prisons very easy and at the same time very alarming.

In this sense, the prisons in Malawi are a reservoir of various infections and the prisoners are the "vectors" who spread the disease to the unsuspecting general public. This is in addition to the common vectors like mosquitoes and flies who have no respect for the limitation imposed by the high walls of the prisons.

An experienced surgeon at Zomba Central Hospital commented that "if you enter Zomba Central Prison today, you will come out HIV positive tomorrow". This is obviously an exaggeration but very aptly reflects the risk the prisoners face about contracting HIV infection, sexually transmitted infections and HIV related diseases.

A prisoner who contracts HIV infection in the prison and then goes out either because he is released after serving his sentence or acquitted, will probably spread HIV infection to a dozen or so individuals in a three months period. More alarmingly, a prisoner who goes out while incubating tuberculosis will spread the disease to hundreds if not thousands within three months before he seeks medical attention. It is needless to emphasise the urgent need to contain this disease which has reached epidemic proportions already.

Malaria, diarrhoeal diseases, typhoid, cholera and a host of other infective diseases are either common or occur in a mini epidemic form within the prisons. Regrettably, only in an epidemic situation, public health authorities divert their attention to institutions like prisons. At other times, they are neglected and forgotten places. The spread of these infections by mosquitoes and flies can be controlled by adequate attention to sanitation and personal hygiene.

Briefly, the prisons in Malawi are a serious health hazard to those who are confined and to those who work there. Moreover, the prisons are also a major reservoir of a variety of these infections that can then spread to the general public. Unhappily, this fact is little realised or appreciated by the public health authorities.

HIV infection and related illnesses like tuberculosis occur and spread within the prison population at a high rate. This is largely due to the failure to recognise the existence of homosexuality amongst the prisoners. Homosexuality is illegal in Malawi and admitting its presence is beyond the moral courage of the highest authorities of the country let alone that of the prison authorities. A blind eye is turned to the problem of homosexuality amongst the prisoners and resultant consequences. Acute shortage of medical manpower as well as prison wardens, poor terms and conditions of service, limited budgetary provision for food, clothing and above all drugs and medicines means that the prisoners are deprived of a reasonable diet, adequate clothing, bedding and basic health care.

3. A.H.I. Clinic, Malawi

The male inmates on the other hand are irresponsible at looking after themselves. The attitude of the prisoners regarding personal hygiene and sanitation, proper use of available facilities like showers and toilets and maintaining a reasonable standard of cleanliness varies from "could not care less" to "total despair". The prisoners are there in the prisons because they have broken the laws governing an organised society. They continue to show similar behaviour within the prisons while using the communal facilities. In other words, vandalism is a major factor in destroying the limited facilities that are provided. Perhaps this is a show of defiance towards the authorities.

Long delays in dispensation of justice and unreasonably long sentences for minor offences aggravate the overcrowding not to mention the inability of police to prevent crime rather than detect and punish crime. We now have a scenario of the prisons in Malawi. They are the institutions where confined Homo-sapiens share the available space with rats, bats, cockroaches, flies, mosquitoes and many other visible and invisible living things. Very many of them are dreadfully pathogenic. These prisons have overflowing toilets and sceptic 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. It is a picture that is depressing and infuriating both at the same time.

What is being done?

A start has to be made somewhere and it has been made. Under the auspicious of GOM/EU Rule of Law and Penal Reform International, several steps are being taken to redress the situation. I will briefly mention some of the problems that are being tackled and leave the details for other contributors.

A prison management group has been formed which meets regularly to discuss various problems and attempts to solve them.

A health assessment in the Malawi prison has been carried out and comprehensive recommendations have been made with regard to hygiene, sanitation, food, procurement and distribution of drugs, establishment of dispensaries in the prisons, training courses and guidelines for a public health programme in the Malawi prisons.

Health committees are being established consisting of the prisoners and the staff in each prison.

Repairs of broken sewage pipes and emptying of the sceptic tanks is under way and is about to be completed.

Essential drugs are being provided on an "ad hoc" basis, pending a detailed assessment of the requirements.

The prison farms and the accounting systems are being brought under the supervision of separate competent authorities within the prison establishment.

It is a good start and deserves commendation.

What can be done?

The cells, showers and toilets of the female prisoners are generally clean and of acceptable standards. The same standard can be maintained in the cells of the male prisoners despite the obvious handicap of overcrowding, by the provision of adequate water storage facilities and a strict disciplined supervision of the use of the facilities.

Group and individual health education for members of staff and prisoners is a must and should be fully implemented. Leaflets, posters, lectures, demonstrations, videos, etc. are tools that can be used. It should be a continuing process.

A provision of "in house" laboratory facilities, mandatory medical examinations and testing of the inmates, new arrivals and discharges and isolating or treatment of those who are found to have contagious or infectious disease will go all long way to reduce the incidence of disease to a manageable level.

A well planned schedule of routine maintenance of electrical, plumbing and building facilities is absolutely essential and this need cannot be over emphasised.

All well documented research and well planned activities will remain on paper but nothing will come out of it, if adequate resources are not made available in the national budget or resources are not forthcoming from other agencies.

As long as crime exists, prisons are a necessary part of public life in an organised society. Their neglect has serious consequences to the public at large health wise, manpower wise and money wise.

In the words of the US Ambassador to the United Nations Mr. Richard Hallbrooke "In Africa, HIV infection and related illnesses are spreading faster than the awareness about them. This is reducing productive manpower which these countries can ill afford". Let us do something about it. The prisons will be a good starting point. After all, prisons are meant for the correction of offending members of society. Let the prisons set an example to the public at large, to show what can be done by meaningful co-operation and disciplined behaviour.

Let us not sit back and say, "Oh but what can we do, we are so poor" : Ignorance is the enemy, not poverty.

Thank you

NB: Since the workshop, Dr. Pandya communicated that there had been a few improvements in the health care of prisoners at Zomba prison:

Seriously ill prisoners are referred to the local hospital instead of a central place in Zomba. This cuts down the long delays and saves money in the form of transport and staff allowances;

Zomba prison has also noticed some improvement in water supply and the food situation has improved in the sense that the prisoners get enough to eat at least once a day;

Dr. Pandya's report on health needs assessment in Malawi prisons should be out beginning of the year 2000, now that the prison authorities have approved the draft.

International standards and instruments pertaining to prison health

Elio Corvaja[4]

Illustrious President, Eminent Colleagues,

I am honoured by your invitation and by the opportunity you have given me to stay in this beautiful country.

I will subdivide my presentation in three parts:

- In the first part I shall introduce the most important international instruments on Human Rights and the various Declarations (Recommendations, Covenants, etc.) that confirm these rights for imprisoned citizens as well.
- In the second part I shall analyse the Standard Minimum Rules for the Treatment of Prisoners and the Resolution (73) 5 of the Committee of Ministers of the Council of Europe, which I consider to be the most relevant documents on social and health rights of imprisoned citizens.
- And in the conclusive part I shall take the liberty of proposing two operative protocols to be implemented, if possible, in order to establish the Standard Minimum Rules for the Treatment of Prisoners in Africa.

International human rights standards and their application to persons deprived of their liberty

I will first give a short account of how Human Rights have been progressively recognised, first in individual countries and then internationally. These rights, except the right to liberty, should apply to prisoners without discrimination.

Recognition of human rights

- Declaration of the Rights of Man and the Citizen, adopted by the Constituent Assembly of the French Revolution on 26 August 1789.
- Atlantic Charter of 14 August 1941 signed by Roosevelt and Churchill.
- United Nations Declaration of 1 October 1942. It reproduces the content of the Atlantic Charter and extends it to cover all the United Nations.
- The Universal Declaration of Human Rights adopted by the General Assembly of the United Nations on 10 December 1948, Resolution 217 A (III), Article n° 10 "the treatment of persons deprived of their liberty".
- 1st United Nations Congress on Prevention of Crime and Treatment of Offenders, 30 August 1955.
- Standard Minimum Rules for the Treatment of Prisoners and Relevant Recommendation.
- Resolution 663 (XXIV) published 31 July 1957 and adopted by the United Nations.
- Two International Covenants adopted by the General Assembly of the United Nations on 16 December 1966.
- African Charter on Human and Peoples' Rights, adopted June 27, 1981; OAU Doc. CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982).

European Conventions on Human Rights

In Europe the international human rights are analysed and adapted to social, political and legislative continental requirements.

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4. University of Messina - Italy, Scientific Secretary of INTERCENTER (International Center for Social, Penal and Penitentiary Studies)

- Convention for the Protection of Human Rights and Fundamental Freedoms, Yearbook 5 (p.126) - Decision in Application n°1270/61.
- Recommendations of the Committee of Ministers being of particular interest to prison administrations (Directorate of Legal Affairs; November 1981), Council of Europe publication.
- The International Dimension of Human Rights, Unesco handbook, "Working party" of The European Committee on Crime Problems, organised by the Council of Europe in 1968.
- Resolution (73) 5 on Standard Minimum Rules for the Treatment of Prisoners, Adopted on 19 February 1973 by the Council of Europe's Committee of Ministers - Part I° n° 1 - 94.
- The history of the Standard Minimum Rules, Doc. DPC/CDAP (74) 1 of 12 November 1974, by the Directorate of Legal Affairs for the 2nd Conference of Directors of Prison Administrations (revised in 1985).

International rules on health rights that can be applied to prisoners

The Universal Declaration of Human Rights contains three articles that we must consider fundamental for all peoples, including the imprisoned people:

> Art. 3: Everyone has the right to life, liberty and security of person.
>
> Art. 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
>
> Art. 25: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care…

These articles are repeated and are conceptually the same in all the other very important international instruments and we think it would be right to cite, for example, Art. 16 of the African Charter on Human and People' s Rights, which is the same as Art. 25 of the Council of Europe Recommendations (73) 5:

> "Every individual shall have the right to enjoy the best attainable state of physical and mental health. States parties to present Charter, shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick".

The first Covenant (Economic, Social and Cultural Rights)

The International Covenant on Economic, Social and Cultural Rights (ICESCR) enumerates the following rights: to work; to an adequate standard of living; not to be hungry; to physical and mental health; to education; to participate in cultural life and to benefit from scientific progress and its applications.

The second Covenant (Civil and Political Rights)

The International Covenant on Civil and Political Rights (ICCPR) enumerates the following rights: to life; to freedom and security of the person; to prohibition of torture and slavery; to take part in politics; to ownership; to marriage; to fundamental freedom of ethical values of opinion, religion, expression, thought and conscience, etc.

Additional protocols

In addition to the Law, the respect for human rights in prison can be defined and guaranteed by Additional Protocols subsequently added to the official covenants and containing the rules of procedure for individual complaints. The protocols intend:

- To protect the individual: e.g. the International Convention on the Suppression and Punishment of the Crime of Apartheid, adopted by Council of Europe on 30 December 1973.
- To protect a category or group of persons: e. g. the Declaration on the Rights of the Child adopted by the United Nations General Assembly, on 20 November 1959.
- To protect the ill inmate: e.g. Resolution (73) 5 of the Committee of Ministers of the Council of Europe, adopted on 10 March 1973.

But NGOs must also guarantee the respect of human rights in prisons by dedicating more attention to ensuring that individuals', minority groups' and health rights are respected.

It is very important to remember that the respect for Human Rights "intra and extramoenia" is the first fundamental right in a State that believes in the Law; this respect must be assured by Governmental and Non Governmental Organisations.

In collaboration with Governmental and Inter-Governmental Organisations, NGOs should:

- Make proposals,
- Control and monitor prison conditions through visits and inspections,
- Carry out studies,
- Organise meetings, conferences and debates,
- Be a permanent "stimulus" to reform and improvements.

Minimum Standards for the Treatment of Prisoners

It must be said as a preliminary observation of general application that the minimum standards for the treatment of prisoners are those that are generally accepted as being "good principles and practices" for the treatment of prisoners and the organization and management of penal administrations.

Various bodies have endorsed such rules:

- the United Nation Congress on the Prevention of the Crime and the Treatment of Offenders (30 August 1955 - published 31 July 1957 - Resolution 663 CXXIV and following updating)
- the European Committee on Crime Problems in 1968
- Council of Europe on 19 January 1973 (revised version) and following updating.

The rules deal with almost all aspects of prison live, from the arrest and remand. They tackle the prison regime; contact with family and friends; accommodation; clothing and bedding; Contacts with the outside world; food; classification; discipline and punishment; environment; exercise and sport; hygiene (personal and environmental); management (staffs, internal organization); registration; re-education; treatment (community and medical); staff (information and training).

The application of the minimum standards for the treatment of prisoners are not the exclusive competence of the Director of the jail because some of them fall within the competence of the prison's Medical Officer, who is responsible for controlling hygiene (as regards people and premises), food and the mental and physical health of prisoners.

The Medical Officer of the prison must analyse all these institutional and professional problems and organize the medical service taking into due account the type of prison and the type of prisoners.

It is very important to remember that each rule must be adapted to each prisoner and that treatment must vary accordingly to the different types of prisoners. The rules recommend that the special categories in which prisoners fall be taken into account and that specific rules be applied to some categories in order to allow personalisation of the treatment.

Various Resolutions (particularly Resolution R (73) 5 n° 21-26 and Resolution (73) 5 n° 68-71) by the Council of Europe give definitions of the concept of health in prisons and the working field of prison medical practitioners.

They recommend the following:

- At every institution there shall be available one general medical and psychiatric service (qualified dental officer and necessary staff for the treatment of pregnant women with nursery service);
- The Medical Service should be organised in close relation with the National Health Service;
- Sick prisoners who require specialist treatment shall be transferred to specialised institutions;

- The first visit for incoming inmates is a right and is very important; the medical officer should examine every prisoner to discover physical or mental diseases and take all necessary measures;
- The medical officer is responsible for the care of the physical and mental health of prisoners;
- Prisoners are entitled medical attention of a quality equivalent to that provided to the general population;
- The medical officer shall report to the Director upon the health condition of infectious and/or ill prisoners and the sanitary conditions of the premise.

These Resolutions also recommend that the Doctor shall ensure that all requirements regarding prisoners' health and hygiene are met, particularly exercise, clothing and work. The medical practitioner shall not limit his attention to the physical health of prisoners. He needs also pay attention to their psychological health and well-being. The concept of personalized treatment includes the institutional and the psycho-socio-sanitary treatment for each prisoner.

As regards social treatment, it is recommended:

- To separate those prisoners who exercise a bad influence;
- To organize separate sections for the treatment of different types of prisoners;
- To define the treatment's program;
- To allow for the participation of some prisoners in activities of the Institution;
- To encourage the assumption of responsibilities in certain sectors of the Institution activities.

As regards, health care, Resolution (73) 5 n° 21-26 recommends that:

- Sick prisoner who require specialist treatment shall be transferred to civil hospitals;
- The Medical Officer shall have the care of the physical and mental health of prisoners.

Before presenting a health care program for the prisoner's treatment it's very important to analyse the very concept of health. Health is the capacity and possibility to keep the psychophysical equilibrium (OMS 1974). The prison changes and troubles the psychophysical equilibrium. It causes problems and diseases to the psychophysical equilibrium and produces multi-pathogen factors of sickness (clinical diseases and mental illness). Prison is sickness. (E. Corvaja - 1984).

The pathogen factors that can trouble the psychophysical equilibrium of people and prisoners can be psychophysical, somatic or clinical. The causes of alteration of psychophysical equilibrium in prison are many: limited space, limited activities, hygiene problems, poor food, limited contacts with the outside world, etc.

Proposition for an African instrument for the treatment of prisoners

Classification of the Rules proposed:

1. Institutional Rules
2. Health Rules
3. Ethical Rules

1. Institutional rules shall deal with:

Registration, accommodation, quality of staff, security, re-education (discipline), punishment, work, community treatment.

2. Rules pertaining to health and health care shall deal with and guarantee

Good conditions as far as the following are concerned: environment, hygiene, clothing, bedding, diet, exercise and sport, recreation, nursing, health care. Special needs of drug addict prisoners, prisoners with AIDS, infectious diseases (Hepatitis, TBC, etc.), chronic diseases (Diabetes, Glaucoma, Cold), as well as aggressive prisoners, insane and mentally ill prisoners need to be taken into account.

3. Ethical rules shall deal with:

Contact with the outside world, familial links, promiscuity, religious and moral support, right to vote, civil and social rights, rehabilitation (preparation for release), psychosocial treatment.

Conclusion

There is a need to:

1. Identify what changes are needed
2. Implement necessary measures
3. Adopt an operative additional protocol to the African Charter.

The African Commission on Human and Peoples' Rights shall consider the creation of an additional more binding protocol to complement the African Charter of Human Rights. It can draw inspiration from international law on human rights, particularly from the provisions of instruments on human and peoples' rights: the Charter of the United Nations, the Charter of the Organisation of African Unity, the Universal Declaration of Human Rights, the Resolution (73) 5 of the Committee of Ministers of the Council of Europe on Standard Minimum Rules for the Treatment of Prisoners and other instruments adopted by the United Nations, by the Council of Europe and by the African Countries in the field of human and people's rights in prison (See Art. 60 of African Charter on Human and People's Rights).

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Prison health in Burkina Faso

Médard Voho[5]

Health in prisons is a matter of constant concern for African States. These States are aware of their duty to protect the health of inmates by allowing them access to health services in accordance with national standards.

But despite their goodwill, the state of health in prisons remains very poor.

The state of prisons in Burkina Faso

Burkina Faso has 11 penal institutions, including ten (10) prisons (maisons d'arrêt et de correction) and one prison farm (centre pénitentiaire agricole - CPAB). The average number of inmates per day is 2,500, for a theoretical total prison capacity of 1,660.

The budget for the care of inmates in 1999 was 88,300 CFA francs.

Overpopulation, overcrowding, poor hygiene and malnutrition all contribute to the poor state of health among inmates.

Health condition in penal institutions

Health services

The regulations require that all penal institutions should have a clinic capable of dispensing day-to-day health care and first aid.

But in reality only Ouagadougou, Bobo-Dioulasso, Uahiguya, Kudugu and Baporo have dispensaries, these being poorly equipped and usually lacking in medicines. The lack of hospital beds and test laboratories should also be noted.

The medical staff consists of five State-qualified nurses under the provincial health department.

Health figures

1998 figures show that the most widespread illnesses are the following:

- digestive diseases 26%
- skin diseases 25%
- genito-urinary diseases 16%
- respiratory and ENT diseases 16%
- malaria 10%
- others 7%

A study by the Regional Health Department of Ouagadougou has shown that the incidence of HIV infection is 9.1% and that of syphilis, 7.3%.

The above figures show that the most widespread diseases in our prisons are the result of malnutrition, poor hygiene and unprotected sexual activity.

Thus, to improve the health of inmates, the Department of Prison Administration and Social Rehabilitation has set itself two goals:

- to establish hygienic conditions in penal institutions;
- to prevent the spread of STD/AIDS in penal institutions.

To this end, an action plan has been devised, comprising of distinct activities.

5. Judge, Director of Prisons and Social Rehabilitation in Burkina Faso.

Current activities aimed at improving prison health conditions

The main activities designed to improve prison hygiene are:

- supplies of drinking water for inmates, via the construction of a water tower able to supply each cell at Ouagadougou and the construction and equipment of wells at five penal institutions;
- fitting showers and latrines for inmates in the yards of three penal institutions;
- discussion groups on the subject of bodily hygiene and the maintenance of sanitation facilities, led by social workers.

The main activities undertaken to halt the spread of STD/AIDS in penal institutions are:

- discussion groups on STD/AIDS led by social workers and by voluntary bodies and NGOs;
- training for prison staff on STD/AIDS in order to raise the awareness of inmates.

This training is part of a project carried out by the African Penal Association (in partnership with other organizations including the Department of Prison Administration and Social Rehabilitation. Its name is the " Project to raise awareness of STD/AIDS in Burkina Faso's prisons ".

The project to raise awareness of STD/Aids in Burkina Faso's prisons

Most inmates are young adults. They are therefore sexually active. Thus homosexuality and rape are widespread in penal institutions. Such behaviour creates conditions that increase the spread of STD/AIDS in the prison environment. A study carried out in May 1998 by the regional health office in the compound of Ouagadougou prison showed that the rate of HIV infection was 9,1% and that of syphilis was 7,3%, compared with an earlier study in 1987, which produced figures of 2% and 4% respectively.

These are significant figures which show how urgent it is to halt the spread of STD/AIDS in our prisons. In pursuance of this aim, awareness raising is the only available method given the very low budget allocated to the care of inmates.

The aims of the project

- to help improve the knowledge of STD/AIDS by prison staff;
- to improve inmates' knowledge on how to use condoms to prevent the spread of disease;
- to encourage inmates to call on the health services for STD/AIDS care;
- to educate inmates so that they adopt lower-risk sexual behaviour.

Strategies

Awareness raising on STD/AIDS in prisons involves two phases:

1- Training for all prison staff

An initial group of 189 prison officers have been trained.

Following this first group, 2 officers in each institution have been selected to receive more advanced training. These are to become the " link communicators ", also responsible for organizing the awareness-raising sessions at their own penal institutions.

They have been selected according to the following criteria:

- their teaching ability;
- their ability to speak several local languages;
- their availability.

Following this second training phase, the 4 most successful officers have been asked to make up the " basic awareness cell ". It is planned that this " cell " will tour the country's 11 institutions (4 per year), in order to support the " link communicators " already working in each institution.

2 - Raising awareness in prisons

This task is carried out by the link communicators and by the basic awareness cell.

Training module

The proposed training module comprises the following:

1 - STDs

- Definitions, symptoms and examples;
- Consequences;
- Prevention and recommended behaviour by sufferers.

2 - AIDS

- Definition/epidemiology;
- Transmission modes;
- Preventive measures;
- Demonstration and negotiations on the use of condoms;
- Care of patients.

Results and problems encountered

The training part of the project can be regarded as successful in that all prison staff have been trained. The awareness-raising part has been 70% completed. The officers chosen as link communicators have each organized discussion sessions in their own penal institutions. The awareness-raising visits to prisons by the basic cell have not yet taken place due to the budget not having been made totally available.

Note that the link communicators were found to lack the educational skills and teaching materials they needed for their awareness-raising task. As a result, inmates have gradually lost interest in the discussion sessions on STD/AIDS.

It is therefore necessary to rethink the strategic approach by involving IEC professionals for a few years and by taking measures to deal with opportunistic AIDS and conventional-STD infections.

This completes my presentation on the thinking behind the IEC project on STD/AIDS in Burkina Faso's prisons.

Before I finish, I would like to thank the organizers of the present workshop and also take this opportunity to call on donors to fund projects aimed at improving the health of inmates.

The transmission of HIV: report on a study carried out in some prisons in Malawi

Dr. DeGabriele[6]

Early in 1998 a conference on HIV / AIDS in African Prisons was held in Dakar, Senegal. One of the observations made by the delegates was that although it is known that the issue of HIV / AIDS in prisons is a very serious one, little is known of the actual situation. In the same year, Penal Reform International (PRI) in Malawi initiated a study of the local situation. As far as we know it is the first study of its kind in Africa. The details of this study are published in a report called "HIV / AIDS in Malawi Prisons".

This report looks at how HIV is transmitted within the prisons, and how prisoners with HIV / AIDS are cared for. Research was carried out at three of the largest prisons in Malawi: Zomba with a prison population of nearly 1,900; Chichiri in Blantyre with 1,400 prisoners, and Maula in Lilongwe, with 1,100 inmates. All sectors of those involved in the prison system were included: prison service staff, pastors, health workers, and of course the prisoners themselves.

Homosexual Transmission of HIV

Although many prisoners enter prison already infected with HIV, some prisoners are infected during their stay in prison, mainly through homosexual activities, what is sometimes called sodomy. Although it is difficult to come up with exact figures, many inmates reported that it was common in their cells; some prisoners even put up curtains in order to get some privacy. These relationships usually involve the better off, often older prisoners, and the younger prisoners or juveniles who have no outside support. There are also many partners, as an older man can have many "wives" and the younger men or boys are passed around.

Bad Conditions

Although it is true that a few of the male prisoners are anyway inclined to homosexuality, or else resort to other men in the absence of women, most prisoners, especially juveniles, resort to homosexuality because of the very poor conditions in the prisons. In order to understand what happens, one has to understand that the conditions in which the prisoners live and most of the prison staff work are extremely bad. Perhaps some readers will think that they too are poor and cannot afford to pity these prisoners, but they would be wrong. Although many people in Malawi eat only one meal a day during the hunger months, many eat an adequate diet during the other months of the year. All the prisoners eat is one small meal of nsima and beans or nandolo, every day of the year. A few prisoners are literally naked, and many wear only rags. Apart from inadequate food, most prisoners have few clothes, many have no blankets, no soap, and nothing to do and nobody to care for them. It is in such a situation that some prisoners turn to other, better off prisoners, to exchange sex for some food, a blanket or a piece of soap. It is no different from the relationship of a poor prostitute to a rich client.

Juveniles

Most vulnerable are the juveniles. Often they have no friends or relatives on the outside to support them. This is because either they come from broken families, have run away from home, their families live too far away, or are too ashamed to visit their disgraced offspring. Being so needy makes them easy prey to adults on the prowl. Sometimes juveniles are smuggled from the juvenile wings to the adult wings by junior officers in exchange for a small bribe. Juveniles have been reported to stay many months with the adult prisoners. In order for juveniles to be protected, they should be totally separated from the adult prisoners.

6. Researcher, Malawi

The Care of prisoners with HIV / AIDS

How serious is the situation of HIV / AIDS in our prisons? Of all the 8,400 cases treated in Zomba Central Prison Clinic during 1997, 25% of these cases were HIV positive. During the same year, 40% of the 167 deaths were due to AIDS.

Prisoners quickly become sick

Inadequate diet, poor hygiene and sanitation, lack of blankets and the insect infestation found in most of our prisons contribute to the quick decline in health of even the strongest prisoners, let alone those who are vulnerable, such as the very old, the young, those who are HIV positive and those who come into prison already sick.

Overcrowding is another contributing factor to the spread of communicable diseases such as TB, diarrhoea and scabies. Overcrowding means that it is difficult to obtain an adequate supply of water for keeping the body and the environment clean. It also means that waste water and excreta are difficult to dispose of properly. Overcrowding is also directly linked to the high rate of homosexuality because in some cells the men sleep very close to each other.

Of particular concern is the plight of those prisoners who are close to death. Common decency would allow that somebody who does not have much longer to live should be allowed to die at home, if possible surrounded by family and friends, at least to make peace with them. Moreover, as prisons cannot afford to transport the bodies, or even give a decent burial, many are put into a mass grave without any ceremony.

Inadequate Medical Care

If being sick in prison is not bad enough, the medical attention given to those who have chronic diseases, especially AIDS related, is pitiful. The prison medical staff try their best, but they are overworked, underpaid, and under-trained for the responsibilities they have to carry. It also seems that the health care of prisoners is not a priority. As one prisoner said "to be with AIDS in prison is to be in hell".

One issue that does not help matters is lack of co-operation between various departments - the prisons, the police and at District Health level. The care of sick remandees is the responsibility of the police who usually refer the patient to a hospital, while the care of convicted inmates is the responsibility of the prison, with Central Hospital staff reluctant to provide any treatment to patients referred to them.

A way forward

If this makes very depressing reading, it is because the prison situation is depressing. However, as with most things in life, if we want to we can improve the situation. Many of the problems are not caused by lack of money, but by lack of will and the reluctance to make decisions. So what can be done?

By far the most important considerations are that all prisoners should be provided with adequate food, clothes, blankets and soap. This would not only reduce the number of prisoners exchanging sexual favours in order to obtain these goods, it will go a long way in delaying the onset of sickness of HIV infected people, and assist those prisoners with AIDS. Already, the prisons have resumed food and cash crop production on the prison farms, and everybody is benefiting.

As overcrowding is also a direct cause of HIV transmission and the transmission of contagious diseases, it is an issue that needs to be addressed. There are various options here: build more prisons, or to provide alternative sentencing (such as community service) to those who are not guilty of serious crimes and are not a threat to the public. This latter solution has been adopted in many countries and has proved to be cheaper, more humane, and with less likelihood of the person committing another crime.

Many NGOs are putting in a lot of money, and although some have the courage to make their help conditional on institutional reforms and proper monitoring, other NGOs do not, rendering their assistance ineffectual.

Relatives and friends need to be sensitised as to the rights of those on remand and those who are convicted prisoners. They also need to know their rights as visitors to the prison. Regular visiting of

prisoners is essential, not only to provide some material support, but to provide emotional support which is important in maintaining health and well being.

Finally, juveniles need to be kept away from adult prisoners. The Government has already undertaken to do this.

So, although we have a long way to go, we have started changing things.

A specialized centre for the detention and rehabilitation of women and minors in Mali

Céline Rousselin[7]

Introduction to the health situation in Malian prisons

The health system in Malian prisons is very poor, if not almost non-existent. Poor access to healthcare by inmates and a lack of basic health cover (e.g. hygiene, primary care for common ailments) are the two main causes of morbidity and mortality in Malian prisons.

The most frequently encountered medical conditions are skin diseases associated with poor hygiene, endemic levels of malaria, and diarrhoea epidemics due to poor food hygiene.

But there are some positive examples, though these are insufficient to claim that there is true health cover in these prisons.

At the central prison in Bamako, there is a clinic able to dispense first aid medicines (1,500,000 CFA francs/quarter, financed by the Prison Administration - Direction nationale de l'administration pénitentiaire et de l'éducation surveillée - DNAPES); one nurse and one healthcare assistant are seconded by the Ministry to provide care; the local doctor provides consultations once a week.

At Sikasso, a clinic has been established by an NGO (Mali Santé Suisse) and a doctor offers consultations on a weekly basis.

At Koutiala, a clinic has been established by the Italian Sisters and weekly consultations are available from the medical-assistance doctor.

There is no health cover in the other prisons located in remoter areas and at the four prison farms. Inmates are only able to receive care if their families pay both for the care and their medicines.

The lack of prison officers makes it difficult to transport inmates to hospitals, since the prison service is responsible in the event of escapes and other such incidents.

The CSDR at Bollé

The CSDR (Specialized centre for the detention and rehabilitation of women and minors) at Bollé is a new type of venture undertaken by the Malian Ministry of Justice. In most African prisons, women and minors are housed in separate quarters from the men, but in the same compounds; in this instance a special training package has been designed to improve the possibility of reintegrating these groups, considered the most vulnerable, into society.

The CSDR offers new premises equipped with exemplary sanitation facilities (showers, toilets...), well-ventilated cells each containing 6 to 8 beds with mosquito nets, a training building, a school, a common room/exhibition room, all located in a 72-hectare site in which agricultural and pastoral activities can take place.

A new team of female prison officers has been trained to supervise the women prisoners.

This is therefore an " ideal setting " in which to introduce a new project on health in custody.

Presentation of current activities designed to improve the health of inmates at the Bollé CSDR

The programme of activities began when women and minors were transferred out of the central prison (October 1998 for women and June 1999 for all non-adult males). From then on, these categories of inmates are sent directly from police stations to the CSDR.

The programme comprises different types of activities.

7. Association Balemaya

Training

Theoretical training for health staff at the Bollé CSDR
The staff consists of 2 nurses, one coordinating nurse and one healthcare assistant. An overseas doctor provides the theoretical training for the health staff during two, two-hour sessions each week.

Practical training for the healthcare staff
The nurse in charge of the Baleyama programmes carries this out, systematically and informally as the need arises.

Computer training of the coordinating nurse
The Balemaya coordinator has organized training in the use of a computer for the nurse in charge of the pharmacy. The purpose is to manage stocks of medicines and to send simple letters using WORD. There is a plan to purchase a computer in the future.

Training in the management of stocks of medicines
Training in stock management has been provided by the Balemaya coordinator, the purpose being to monitor pharmaceutical stocks, consumption, donations and purchases, to plan orders, monitor any abnormal consumption and produce a yearly pharmaceutical budget.

Training on organizing a crèche/nursery
A Malian nurse has been trained to fill a need for a crèche within the prison. The training covers functional organization, practices to support the mother/child relationship while helping provide health education for mothers and mothers-to-be. This project was initiated by the Balemaya coordinator and continued by a voluntary worker from overseas.

Training on health education
The coordinator at Balemaya, following a traditional Malian method and a participatory method, introduced this training. The aim is for the target population to take control of its own health and for people to become mediators in the health of others, also to help the healthcare team become aware of the "snowball effect" that such a method can produce.

Training towards an approach to inmates based on psychology and sensitivity to human relations
Following difficulties experienced by the healthcare team in managing the stress of working in prison and due to the lack of objectivity of healthcare provision, which varies according to the nature of offences committed, this form of training was initiated by the coordinator at Balemaya, with the support of an Malian educational psychologist.

First-aid training for supervisory staff, social workers and community workers
This training session has been developed at Balemaya and will be carried out early in 2000 by a voluntary partner (the Red Cross of Mali) for prison administrators and staff at Bollé, the aim being to provide better first-aid care and to make the staff more aware of the need to ensure multi-disciplinary healthcare (accident prevention, early warning, first aid while awaiting the arrival of the medical team, and encouraging human relations between staff and inmates).

Bollé as a training ground
The dispensary at the Bollé CSDR provides the location for a course to train healthcare assistants from the Training Centre for Social-Health Workers, directed in Bamako by Dr. Seydou Traore. Four student healthcare assistants come to Bollé on a 1-month placement where they are trained by the medical team. It is planned that Bollé may become, in future, a location for international courses aimed at student nurses and medical housemen.

Heath care

Medical consultations
An overseas doctor, working on a voluntary basis, carries these out twice a week. Patients are followed by means of individual files. The decision to transfer a patient or to provide specialist consultations is taken after discussion with the coordinator at Balemaya. These transfers are carried out by ambulance (a Ford truck donated by the charity "Les Amis du Monde"). Emergencies are covered by means of a nurses' duty system.

Nursing care
This is prescribed by the doctor and carried out by a nurse. The healthcare staff consists of a Malian coordinator in charge of the pharmacy and her healthcare team, plus a nurse experienced in gynaecology and obstetrics who is in charge of mother/baby care, a retired male nurse responsible for monitoring vaccinations and for the care of the boys and a healthcare assistant responsible for hygiene at the dispensary and the incineration of waste.

All those in charge of a particular sector take their turn in providing nursing care.

Vaccination schedules
Inmates' vaccination histories are taken at reception. Anti-tetanus vaccinations are systematically performed on inmates by the local community health centre. Babies have also been routinely vaccinated since 1998: a vaccination booklet is kept up to date and returned to inmates on release.

Hospital care at the dispensary
In the event of the doctor or health team deciding that an inmate needs hospital treatment, two beds are available in one ward and an isolation ward also exists for the treatment of contagious diseases or for special psychological needs. The nursing staff monitors patients around the clock and a monitoring sheet is kept up to date.

Pre- and post-natal care
The responsible doctor or nurse monitors pregnancies. Foetal scans are carried out at a health centre in town. Deliveries are performed outside in a health centre, as the prison is not equipped for this purpose, though this situation should change in 2000. The mother remains in the ward for 10 days following her baby's delivery to rest and for her condition to be monitored.

Routine medical care for Bollé staff
The doctor, who maintains staff health files, performs this. Staff are housed close to the prison. They are present around the clock: it seemed important to the Balemaya association that they should be medically covered as far as possible.

AIDS care
The purpose is to strengthen incentives to screen for HIV within the prison while offering a coherent medical cover, i.e. appropriate follow-up. Among other requirements, this presupposes that inmates subject themselves to voluntary testing, subject to the principle of medical confidentiality between patient and doctor. The medical team will insist on AIDS prevention as part of health education. This is a key incentive to screening and lower risk after release. Training for administrative staff and prison officers will be carried out in January 2000. An action programme will be developed in cooperation with the prison administration. Screening, psychological follow-up and possible treatment will be performed in cooperation with the CESAC.

Medical team meetings
These take place once a week at the dispensary. The Balemaya coordinator drafts the agenda. It includes organizational issues (concerning the various activities), human problems (experiences, problems faced by the team) and financial matters cash accounts, financial priorities, etc.).

Team meeting with all sectors at Bollé
These take place at the prison and are chaired by the governor who sets the agenda.

Health education

The AIDS game
This project arose due to the interest shown by young male inmates in the problem of AIDS. The proposal to play this game was made in November 1998 and its basic structure was developed in December 1998 by the health team, led by the Belamaya coordinator. It is based on a similar game marketed in France and distributed, among other places, at Nanterre prison. The aim of the game is to raise awareness of AIDS among young people, taking into account their anxieties, their ideas about the disease and their responses to it. The idea is that they become agents in their own health education,

working to improve their self-image, become more creative and spread a positive image of inmates in the outside world. Following a feasibility phase, the game will be marketed in Malian schools, communities, etc. and in France too, as an example of a health-education tool.

"Constructive theatre"
The health team has had to face health-education problems that are difficult to solve using traditional methods applied to young people and children. It therefore seemed useful and timely to use drama as a means of raising their awareness of matters such as violence, drugs, alcoholism, homosexuality as sexual deviance, etc. This enables children to speak more freely and to reflect about these problems. The purpose of this activity is to provide a vehicle for these children and young people to express their pain, to educate them through creativity and to improve their self-image after release. At the end of 1999 and early in 2000 there will be shows at the prison and a video film will be made. The Balemaya coordinator and the prison administration will evaluate the approach at the end of 2000.

Discussion on topics chosen by inmates
Traditionally in Mali, health education is carried out through talks with supporting posters, or using videocassettes. The topics can encompass the problems of everyday life such as violence, excision, etc. or sanitation problems (water, latrines, etc.), primary health care (family planning, vaccination, etc.), nutrition, endemics (malaria, bihardizia, etc.). These topics are prepared week by week, depending on the interest of inmates.

At the crèche, the health education programme is mainly focussed on subjects associated with the infant care, with practical instruction (e.g. preparing enriched baby porridge, bottle feeding, washing the baby hygienically and monitoring its skin condition, eyes, nose, etc.).

Assessment of knowledge and actions
The assessment of inmates' knowledge of specific topics is carried out each week, at the beginning of each course. Activities are to be assessed in December 1999 by the administration of the CSDR and its parent institutions. These assessments will then be presented to the general meeting.

Equipment

Completing the renovation of the women's dispensary
The dispensary was equipped by Balemaya in 1998 with furniture, permanent work surfaces, mattresses, sheets, mosquito nets, etc., medicines and medical equipment. The young inmates made all the furniture during training sessions (woodwork, metalwork). Some items of medical equipment are still needed to complete the dispensary.

Renovating a clinic room for young inmates
In 1998, boys' consultations were held in the women's dispensary. Due to the close contact between different groups, this presented security problems for the prison staff. In 1999, the Ministry of Justice began a programme to renovate the children and young persons' quarters (100 metres behind that of the women), which had been in existence since 1960. A room has been reserved for the clinic, which is due to be equipped by Belamaya early in 2000.

Completing the crèche
Located in the wing reserved for mothers and babies, the crèche needs to be equipped. This task is shared with the Bollé prison administration. Games are being collected in France for this purpose, while some games made of foam or fabric are produced in the fabrics workshop by women inmates; other wooden games are made by juveniles in their workshop. The prison administration will be undertaking the production of traditional dolls in the sewing workshop. Exterior renovation is due to take place early in January 2000 in order to increase the outside space available to children (games, manual work, cooking). Every day, a nurse is seconded to the crèche and helped by an overseas volunteer.

Completing the library
There are libraries in the compound of every centre. The Ministry of Justice has provided the necessary furniture and human resources. Balemaya is developing in France a system to collect books and magazines, sorted according to their suitability for Mali and for a population of women prisoners (most

are illiterate) and young people or children (the boys attend school). The voluntary bodies, via the support unit, have undertaken to collect Malian books and magazines

Aims of Balemaya / expected impact

The establishment of the Balemaya Association and its involvement in the support project at Bollé prison arose out of the aim to launch a variety of activities to improve standards of physical and mental health in prisons. It's a dynamic search process carried out jointly with local and international partners.

Problems encountered

Lack of understanding by prison governors and officers faced with diffuse projects whose purpose may be difficult to grasp immediately, and which only bear fruit in the long term (health education, therapeutic drama).

No real discussion with prisons about health programmes.

Undoubted lack of training for the prison staff in the field of health and education.

Proposals

To provide training for prison administrators and officers in managing the general state of health in institutions (AIDS training in January 2000, first-aid training in February 2000, increasing the participation of officers and community workers in activities associated with health education and drama therapy).

Introducing health strategies with DNAPES and the CSDR management, targeting AIDS, the role of the medical team in managing violence in prison and the issue of punishment (solitary confinement, etc.).

Increasing the involvement of DNAPES in the development and evaluation of health programmes and in future plans.

Introducing a strategy to support the costs of DNAPES and the prison administration by using human resources from the Health Ministry, by introducing a mutual system for prison staff, by reserving part of the solidarity fund (arising out of professional activities) to contribute towards the cost of medicines, by using the income from health-education activities (theatre performances, sale of AIDS game, etc.) and by encouraging support from the Malian voluntary sector (ASFOM-Balemaya Mali).

Reasons to promote health in prisons

To improve the dignity of prisoners

The individual stress associated with imprisonment can lead to deterioration in inmates' physical and mental health. To protect the human dignity of inmates, a minimum requirement is that they should be granted health care of equivalent quality to that provided outside.

An essential factor in improving prison conditions

The prison administration can improve some aspects of prison life, such as buildings, sanitation, food, training, social and cultural activities, etc., but as long as health cover is inadequate, many inmates cannot gain access to these improvements.

A factor in reducing the social disruption caused by prison life

Specific measures to care for the physical and mental health of inmates provide a way of treating them in the same way as the general population; the introduction of special facilities such as the crèche is an attempt to correct the fact that prison is a socially abnormal environment in which to be born and spend one's early life (lack of a father, etc.); the introduction of social and cultural activities (games, sport, theatre, dance, percussion, etc.) is an attempt to reproduce the rhythms of social life, pleasure, etc.

A factor in post-release rehabilitation

Post release preparation should not be limited to schooling and practical-training programmes since health education is a vital factor in the social reintegration of inmates: the situation of women imprisoned for infanticide, child abandonment or abortion is closely linked to their social exclusion and poor education in family planning. Health education can thus contribute to reducing recidivism and improving the social and family environment of former inmates.

The drama-therapy theatre can help young people reflect on their behaviour in relation to alcohol, drugs, violence, sexual deviance, etc.

The AIDS game, as a method based on activity, can introduce behavioural change and a sense of self-worth in the target population as it learns to take charge of its own health.

The role of NGOs in prison health in Nigeria

Dr. Anthony Okwuosah[8]

That prison conditions in Nigeria are very bad is not news. What maybe news is the openness of the new improved prison service. This we owe perhaps to the fact that our dear President was a guest of the Nigeria Prison Service and became President only a few months after. The openness can also be attributable to the activities of NGOs both local and international, especially the Nigerian Institute of Advanced Legal Studies, the Civil Liberties Organisation, Hurilaws, PRAWA, MRCTV and of course certain religious bodies. NGOs that have had tremendous impact on prisons in Nigeria include PRI and the ICRC. Lastly, the advent of democracy is clearing the veil of fear and secrecy that had pervaded prisons in Nigeria.

Prison situation in Nigeria

The reports on the situation of health and medical conditions in Nigeria Prisons though largely anecdotal have painted a rather dismal picture of congestion and inhumane and degrading conditions. These reports show an official death rate of about 4,500 inmates (1992) and a total lock up of about 50,000 in 147 prisons. These deaths are thought to be due to largely preventable causes such as malnutrition, tuberculosis, diarrhoeal diseases, malaria, etc.

Awaiting trial persons (ATPs) constitute about 70-80% of the total prison population in Nigeria and in some prisons up to 90% especially in the major urban areas. The criminal justice system in Nigeria is largely to be blamed for this situation. And the prison service without the power to say "no more guests, we are full" finds itself overwhelmed.

Deaths in Nigeria prisons are largely amongst the ATPs accounting for over 95% of the total number of deaths.

To worsen the situation of the ATPs, when released or acquitted they come back to a society that lacks the sophistication to distinguish between the acquitted prisoner and the convict. They therefore acquire the stigma of the ex-convict with its attendant social problems.

NGO Activities in Nigerian Prisons

Over the years, Nigeria has witnessed a rapid increase in the number of NGOs supporting a wide range of activities in such areas as health, education, child welfare, environmental awareness, HIV/AIDS awareness, human rights and of course prisons and penal reform.

Before 1987, NGOs' involvement had been only token and uncoordinated especially among religious groups whose main interest was saving the souls of the so-called "dregs" of society.

The downturn in the Nigerian economy in the late eighties resulted in a rapid deterioration in prison conditions leading to an increase in morbidity and mortality. The churches again were the first on the scene. Credit must however be given to Civil Liberties Organisations in Nigeria for bringing prison issues into common discourse by their "Behind the Wall" supported by PRI. This unfortunately alienated them from the prison service. This also led to a renewed interest in prison welfare activities by other groups such as churches and NGOs.

These activities were uncoordinated, wasteful (duplicated) and at times contradictory. This situation led to the formation of the National NGO coalition on Penal Reform in August 1997 during National Conference on Prison, which was supported by the British Council. The initiative to organise the conference and to set up a coalition was championed by Mrs. Uju Agomoh and Mr. Wale Fapohunda.

The Coalition at present is made up of 85 NGOs and religious bodies working on prisons and penal reform. The aims include:

8. Medical Director, Medical Rehabilitation Centre for Torture Victims (MRCTV) Lagos, Nigeria

- Promoting exchange of information, expertise and experiences,
- Improve scope, quality and coverage of penal reform work,
- Facilitate training and development of the capacity of its members,
- Facilitate better co-operation between the Coalition and related government agencies,
- Deliver practical support to prisoners, ex-prisoners and their families,

Since then, there has been better co-ordination and co-operation amongst NGOs with organisations concentrating more on areas of specialisation and competence.

Medical Rehabilitation Centre for Torture Victims (MRCTV)

I work as the medical director (part-time and pro bono) for the MRCTV in Lagos. The MRCTV is an independent, non-profit organisation providing specialised and direct medical, physical and psychological assistance to victims of human rights abuses and we also try to involve health professionals in human rights work.

We are perhaps the first NGO to offer a carefully articulated comprehensive health care programme for inmates.

Our Prison Programme embraces three concepts namely:

- Through care concept, which takes into account the fact that from arrest through incarceration to release several factors interplay to influence the survival of the inmate and his rehabilitation and integration into the society on release as a gainfully employed and well adjusted citizen. Therefore intervention should best start inside the prison.
- Healthy prison concept, which evaluates the prison as a community or setting to promote health, its potential to have positive effect on the health and lifestyles of inmates and the role of health and non health professional prison staff in promoting and ensuring health in the prisons.
- Primary health care concept (PHC), which uses affordable and culturally acceptable means, with participation of the concerned community, to achieve health. The PHC concept involves health education, provision of water and sanitation, wholesome and adequate food, essential drugs in the clinics, prevention and treatment of injuries, immunisation against common diseases, promotion of healthy habits and lifestyles and prevention of drug misuse.

By embracing these three concepts and targeting all inmates in need without discrimination, we ensure equity and access to vulnerable groups such as detainees, ATPs and other inmates. Treatment continues even after release at our centre when necessary.

We also believe that outside contact with the prisoners is one of the most important safeguards against abuse. Most abuses occur because prisons are removed from public scrutiny where even government may not be aware of the extent of erosion and abuse of rights of the prisoner and the deplorable and inhumane conditions prevalent.

However, this access comes at a price, which often includes a stated or unstated injunction against disclosure, the risk of being co-opted and of becoming tolerant to otherwise unacceptable prison conditions and laws through familiarity and acculturation. We ran the project for about six months and during the period attended to over 600 inmates including women and children. We also provided care for staff and their family.

Attendance suggests the following prevalence of diseases in prison in order of prevalence:

- Malaria (173 cases)
- Dermatoses (80)
- Tuberculoses (73)
- Acute Respiratory Infections (73)

- Orthopaedic conditions (45)
- Diarrhoeal disease (29)
- Eye problems (20)
- Surgical conditions (hernia hydrocoels) (18)
- Urinary Tract Infections (18)
- Psychological disorders (17)

Other conditions we saw include diabetes mellitus, epilepsy, asthma, cancer, pregnancy and pelvic inflammatory disease.

Despite the laudable goals and achievements of the programme, we had to stop the intra-mural prison work because we could not publicise our activities or even take potential donors into prisons to view our work and support us.

However, with the opening of the prisons now, we hope to resume work in this field according to lessons learnt. These include avoiding general outpatient clinics but focus on special issues such as:

- Health education programmes to address issues such as HIV/AIDS, personal hygiene, unhealthy lifestyle, etc.
- WATSAN (Water and Sanitation) programmes to strengthen existing sources and provide new ones.
- Communicable Disease Control Programmes.
- Immunisation Campaigns.
- De-worming.
- Surgical programmes.
- Mental health and drug abuse programmes.
- Post release treatment and rehabilitation at our centre outside the prisons.

We are also addressing the issue of lack of reliable data to use in planning health interventions in prisons in Nigeria. In response to this need and with the support of PRI and in co-operation with the Nigeria Prison Service, we are presently carrying out a full access, ethical, scientific and affectively neutral study to determine the health conditions and health needs in Nigeria Prisons. The report of the study is expected to provide a valuable insight into the magnitude of the health problems and needs and assist in planning governmental and non-governmental interventions. It will also provide a basis for international comparative analysis and for advocating for improvements in the health of inmates and contribute to the global campaign for non-custodial sentences and for better conditions for those in custody. The study will cover 20 of the 147 prisons in Nigeria.

Recommendations for improved health in prison:

Our recommendations for improving health in the prison are:

- Poverty alleviation and economic reforms that will prevent crimes of need and also increase resource allocation to prisons and better salaries and welfare packages for staff and also relations of inmates which will ensure continued support and visits.
- Decongest the prison by speedy trials, non-custodial sentences, avoiding mandatory sentencing policies in our legislation, avoidance of pre-trial detention whenever possible. If used, pre-trial detention should be limited by law and should count as time served and should not exceed the maximum sentence for the offence. Terminally ill prisoners should be released.
- Decent basic conditions of sanitation, ventilation and temperature control, lighting, clothing, bedding etc. should be ensured in prisons.

- Widespread health education and provision of medical care equivalent in standard to that available outside. As a minimum, every prison should have a primary health care centre manned by appropriate personnel with adequate referral system including agreed workable arrangements to pay for referral care where necessary.
- Provision of a wide range of purposeful actions, constructive work opportunities to improve physical and emotional life for inmates including conjugal visits, community links are important means of encouraging health and preventing abuses.
- Media access will also prevent abuses and encourage empathy and support from the community.
- Every extra-judicial prison death should be a subject of an inquest and detailed report of the findings should be mandatory.
- Time outdoors for exercise, sunning and fresh air is very important for health and should be mandatory.
- Cases of people with communicable diseases should not just be isolated but vigorously treated with contact tracing and treatment as imperatives.
- The problem with AIDS in the prison should be specifically addressed and risks and practices such as use and reuse of unsanitary barbing implements, reuse of poorly sterilised needles and syringes and equipment by de-motivated and disillusioned prison health care staff, injecting drug use, needle sharing and homosexuality should be curbed.
- Special problems of female prisoners should be addressed including psychological and social problems. Newborn babies should be allowed to stay with their mothers and the babies should have the usual post-natal care available.
- Proper nutrition should be ensured and inspection of prison food is extremely important. The quantity, quality and preparation should be closely monitored.
- The police and other detaining authorities should be made to apply the SMR to people they hold to avoid their dumping battered, tortured, brutalised and very ill detainees on the prison service. The prison insisting on police signing medical reports of very ill patients can ensure this.

Concluding remark

In summary, the openness of the Nigerian Prison Service is already yielding considerable fruits. We have improved more in the last one-year in excess of all improvements in the last 10 years preceding this period. And we can only but appeal to the Nigeria Prison Service and all the other prison services present here to open to and embrace NGOs in making prisons in Africa healthy.

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WRITTEN COMMUNICATIONS

Nigeria Prison Service ongoing projects and initiatives in Nigeria to reform prison health

The situation

There are 147 prisons, 9 prisons farms, 2 borstal institutions and 1 staff college in the Nigerian Prison Service manned by a staff strength of 22,000. Most of these prisons were built during the British colonial era. They therefore served the purpose for which the colonial government built them. During that period and shortly after then, inmates were very few and most of them were political detainees, revolutionists and people caught taking part in insurgencies. The Nigerian population then was mainly agrarian and there were relatively few urban centres and the crime rate was very low.

The pattern of morbidity and mortality in the prison up to the late 1970s was not different from the general population. Most Nigerians were not aware of what went on in the prisons. In actual fact, deaths in Nigerian prisons were rare events. In those days, the health care delivery in the prisons consisted of rudimentary curative services in the clinics located within the various prisons and manned by nurses or auxiliary health workers.

However, by 1985, the living conditions in the prisons had started to degenerate dangerously. Deaths that hitherto had been unknown or at worst were very rare became daily occurrences in most of the major prisons. The years 1986 to 1990 were really horrible years with regards to the health of inmates in Nigerian prisons. More than 4,000 inmates died between 1988 and 1989 in all of the prisons. The reasons among others could be traced to the conditions of the old colonial prison structures, which could no longer serve the teaming population of inmates.

These old prisons no longer register relevance to our present professed goals - reformation and rehabilitation of the criminal offenders. The majority of these buildings have low inmate capacity and are dilapidated. They are characterised by cracked floors, leaking roofs and defective ventilation. The environment is also marked by poor drainage and leaking sewage. The outlawed pail system of sewage disposal is still in use in some of these prisons, the water and electricity supply are erratic and pathetic.

All these contribute to the high morbidity and mortality, which we see in prisons. The gross disparity between the teaming, awaiting trial (A.T.) persons resulting from lapses in our police and judiciary institution and low capacity of these prisons resulted to congestion in most of our prisons.

Although most people have heard about congestion in our prisons, what may not be known to them are the consequences and the health implications of this unfortunate phenomenon. Admittedly, congestion in our prisons consist largely (95%) of those charged with serious offences such as armed robbery, murder, rape, drug peddling, etc. These A.T. persons live under the most imaginable horrible conditions and have the following characteristics:

- The offences for which they are charged are not bailable;
- They cannot be transferred in a decongestion bid or effort because they must be close to the court of trial as much as possible;
- They are usually in custody for several years before completion of their trials; this period ranges between 2-10 years;
- They are likely to lose contact with relatives in the course of their trial;
- They constitute the majority of those who become seriously ill and die in prison.

As part of the complications, congestion has resulted in diversion of attention of prison authorities from their traditional role of reformation and rehabilitation. It has also created chaos within the system, and sharp practices by prison officers, which further compound the problems, have become difficult to curb.

Proper supervision of feeding, essential supplies, and attendance in court have become almost impossible.

The morbidity and mortality patterns are highly influenced and in most cases caused by congestion. Overcrowding leads to faeceo-oral diseases resulting from lack or inadequacy of portable water and poor sewage disposal system. Diarrhoeal diseases such as gastro-enteritis, salmonella infections, other dysentery diseases and infective hepatitis are common.

Congestion is responsible for the high incidence of severe droplet infections such as tuberculosis and other contagious disease such as scabies, ringworm etc. In some prisons as many as 10% of the inmates suffer from tuberculosis alone, while more than 40% suffer from skin diseases. Most of the deaths recorded in our prisons are due to tuberculosis alone or combined with other diseases. Congestion also leads to high tendencies to practice homosexuality resulting to HIV/AIDS.

Diseases emanating from malnutritional disorders are quite visible in the prisons also. Some of these diseases are due to Kwashiorkor and rickets, beriberi, scurvy and other vitamin deficiency diseases. Other problems like psychological disorder, hypertension etc. are always present in the prisons.

The high morbidity militates against effective prison administration as it escalates the cost of correctional care both in personnel and logistics. It also has its health tolls on prison staff as most of them become frustrated and stressed. Complaints of insomnia, abdominal pains, and headaches are common among the prison officers.

Practical solutions

Vis-à-vis paucity of resources at our disposal and the enormity of the problem, it would be counter-productive if we have to continue with wholesome curative services. In line with the National Policy on Health, the Nigeria Prison Service embraced the Primary Health Care (PHC) scheme. The PHC scheme shifts emphasis to preventive services, health promotion and protection. Our plan of action involves:

- Provision of adequate and safe water supply
  At the inception of this policy, most prisons lacked potable water. Deliberate efforts have been made and a lot achieved to connect all our prisons with pipe borne water - where available. These have been complimented by sinking boreholes.
- Improvement of general sanitation and provision of appropriate sewage disposal system
  The bucket / pail system is still in use on some of our prisons, although they are gradually being phased out, and replaced with the water closet system. This is being complimented with the ventilated, improved pit (VIP) latrines. These VIP latrines have reduced the spread of faeceo-oral diseases. Additionally sewage-dislodging trucks have been procured for prompt evacuation of human wastes.
- Health education
  Public and Community Health workers were massively recruited and posted to all prisons to ensure proper sanitation of the prison environment. Within the limits of resources available, they have been mobilised with logistical inputs for effective performance.
- Proper supervision of nutritive food
  This is now being addressed by increased funding for inmates feeding. The health officers in the prison are mandated to ensure that the food served to inmates is supervised on a daily basis - to ascertain both quantity and quality.
- Improving the supply mechanism of basic amenities
  Clothes, bedding, soaps are supplied on regular basis, but our effort is not enough owing to ever increasing number of inmates who need them.
- Immunisation against communicable diseases
  This is organised periodically by nurses and community health workers against such diseases as tetanus, meningitis and yellow fever. The Federal Ministry of Health had been very helpful.

- Supply of essential drugs and other health items
  Only essential drugs are procured on a quarterly basis for all the prisons. Recently the Petroleum (Special) Trust Fund (PTF) had been extending generosity to the prisons by donating drugs and medical equipment.
- Fumigation of the cells.

To implement the PHC scheme various health committees were put in place and personnel for these committees were drawn from all the division of the service. It is therefore the concern of everybody working in the prisons to supervise and monitor this programme.

Referral Hospitals

These are hospitals located in each prison administrative zone to take care of serious medical problems of inmates and staff of the prison service. Prior to the establishment of these hospitals, the prison clinics and infirmaries were not adequately equipped to handle most specialised cases; hence ill inmates were referred to nearby government hospitals, which had often resulted to escape from prison custody. Most times, these inmates were discriminated and at times refused treatment for lack of funds, though there are government circulars that entitle prisoners to free-medical care in all government hospitals.

Saddled with the above problems it became imperative to build the Referral Hospitals. At present four out of the eight planned have already been completed, equipped and are functional.

Other ongoing projects include:

- Renovation and expansion of old prison clinics and infirmaries,
- Construction 43 new prisons nation-wide, out of which 15 are in use,
- Procurement of more ambulances and sewage dislodgement trucks,
- Training and re-training programmes for health workers, residency programmes for doctors specialising in different fields. Meanwhile, in-house seminars and medical conferences are constantly organised to update the knowledge of health personnel.

Conclusion

In concluding this paper, it is pertinent to mention the role played by the government of Nigeria in releasing huge sums of money for the renovation and expansion of all old prisons in the country. One hundred and ten millions USD was released just a year ago and another sixty five million USD is expected now. This is in line with government desires to give a face lift to the prison to conform to the United Nations Minimum Standards for prisons.

To decongest the prison the Federal government of Nigeria set up Judiciary Committees to release long awaiting trial inmates whose offences are not serious. Presidential prerogative of Mercy Committee liberally grants amnesty to inmates on health grounds. More than 3,000 inmates were recently set free. There is also a Policy to release all Awaiting Trial Persons that have stayed in prison upwards of ten years, exempting all those with serious offences like rape, robbery, drug peddling, etc.

This paper would not be complete without commending the role of Non-Governmental Organisations (NGOs) and religious bodies in complementing the efforts of the government in reforming prison health. These organisations have helped in donating drugs, medical equipment, food, clothing etc. and have also organised several health education programmes to enlighten prison officers and inmates.

It is hoped that with the ongoing prison reform projects, a new environment would be created for proper supervision of inmates so that the desired goals of rehabilitation and reformation would be achieved.

Thank you.

Situational paper on HIV/AIDS as observed and experienced in Namibian prisons

Mr. Nyoka[9]

Global view of HIV/AIDS in Prisons

Prisoners with HIV face medical, social, economic and political problems that are compounded by their incarceration. A current controversial issue is whether prisoners should be provided with condoms so as to allow them practise safe sex in prisons. This is considered as one way by which the Namibian Prisons Service can also control the spread of HIV/AIDS in this country.

This rather unique proposition is advanced after noting that other countries have provided their inmates with condoms. In particular South Africa's Correctional Services are already issuing condoms to its prisoners.

Most of the countries which are issuing condoms to inmates have done preliminary studies and were able to get inflow of information which prompted them to make a "careful decision of providing condoms" to inmates. However, no such studies have been carried out in Namibia.

In Africa, two countries are known to have endorsed the usage of condoms to prisoners. These are South Africa and Mozambique. It is not clear how the authorities in Mozambique have reached this decision, but in the case of South Africa, it is a known fact that homosexuality is legally practised.

In Mozambique a cross-sectional study was carried among 1,284 male and female prisoners to assess the prevalence of and risk factors for sexually transmitted diseases (STD) in four correctional institutions in Maputo. It is interesting to note that seventy (5.5%) men reported having had sexual intercourse while in prison, in all but one instance this involved sex with another man. This may be one of the reasons why the decision was taken to provide condoms.

In Malawi, Penal Reform International conducted research earlier this year in three large prisons. The research dwelt on the Transmission of HIV in Prison, Care of Prisoners with HIV/AIDS and Monitoring and Evaluation. The research did not address the issue of provision of condoms to inmates, despite the acknowledged existence of HIV/AIDS and the transmission of the disease through homosexual behaviour in Malawi prisons.

Transmission of HIV/AIDS in Prisons

Developed countries like Britain have also conducted research into HIV/AIDS in prison. 452 released prisoners were interviewed about their activities before, during and after prison stays. The study found that persons engaged in few incidents of HIV-risk behaviour in prison but increased their risk when they continued engaging in HIV-risk behaviour outside prisons.

Those who reported engaging in penetrative sex whilst in prison also did so with greater frequency outside, although they used condoms only outside. The survey also confirmed the practice of sharing syringes whilst in prison and also noted that the methods of syringe cleaning are less efficient in prisons.

Other potential factors of infection in prisons include shared razors. Before measures where taken to prevent the spread of HIV, it was a common policy to distribute one single razor to groups of inmates. Because blades are potential weapons, inmates were told that if the common blade was not returned after its use, all prisoners' visit would be cancelled. Thus the guard did not bother to observe every shaver and the blade would not be lost.

Prisoners may also share toothbrushes. Tattooing is widely practised in prisons and usually performed without fresh or sterile instruments. Tattooing involves multiple skin punctures. Assault and fighting amongst prisoners may cause open wounds and so could lead to the transmission of HIV/AIDS as well as biting, spitting or spilling blood during confrontations with either guards or fellow inmates.

9. Commissioner General of Prisons, Namibian Prisons Service, Namibia

Provision of condoms to inmates

Provision of condoms within the prisons for prevention of HIV and other sexually transmitted infections has been a matter of debate in the UK and internationally from as early as 1987 when a World Health Organisation (WHO) expert called for "careful consideration" of condom availability for disease prevention in prisons. During 1988 the British Medical Association adopted the policy that condoms and health education on the risk of HIV infection should be freely available in prisons and the Prisons Reform Trust took a similar view.

Progress in England and Wales has been slow. In 1991 HM Prison Service initially began to encourage prison governors to introduce schemes whereby prisoners being released from prison could have access to condoms.

A thorough review by the Services' AIDS Advisory Committee recommended in 1995 that all prison establishment should be required to introduce such schemes and confirmed "an unanswerable public health case" for condoms to be made available to male prisoners during sentence, despite the lack of hard evidence on the extent to which penetrative anal sex occurs.

Prevention of HIV/AIDS

The Home Secretary accepted all the Committee's recommendations except the one relating to making condoms available to male prisoners during sentence, and consequently HM Prison Service has not been able to implement this recommendation. This means that there is no scheme for general availability to condoms in the Service although governors are not prevented from distributing condoms within their prisons.

Given the lack of general availability of condoms, there are concerns about potential legal liability of prison medical staff if a prisoner contracted HIV or other infection sexually whilst in prison. A doctor may be under the legal risk of breaching his or her duty of care for not providing condoms when circumstances warrant.

Therefore, when circumstances warrant, doctors are encouraged to prescribe condoms and lubricants to individual prisoners, when in the clinical doctors' judgement, there is a known risk of HIV infection through sexual behaviour.

The availability of condoms in prison is one of the many issues over which legal and public health interests conflict. Most correctional administrators have not permitted the distribution of condoms to inmates. Although homosexual activity is known to occur, statutes in many jurisdictions make sexual activity in prison a punishable crime. It is correctly argued that condoms distribution would condone and promote this behaviour.

In Britain, where homosexual acts in private place are not an offence if both parties have consented and are 18 years or older, objections to the provision of condoms are based on the reason that prison cells are not regarded as places of privacy, therefore sex between prisoners is illegal.

So under what circumstances might a Prison Medical Officer be able to prescribe condoms? As indicated earlier, when in the clinical doctors' judgement there is known risk of HIV infection through sexual behaviour. This is when a prisoner is going on a weekend out, or has a conjugal visit, is going for parole or is released from prison.

However, in the United States where they have different Prisons administrations, only six prisons systems provide condoms to the inmates. In New York City jail on Riker's Island, homosexuals in a known dormitory are offered condoms. In other prisons (State of Vermont, San Francisco, Philadelphia and Mississippi), condoms are distributed on arrival or sold from vending machines in institutional canteens.

The Correctional Service of Canada (CSC) started to provide condoms to inmates in 1992. Eleven of 17 European countries are reported to provide condoms to their inmates.

The general experience of those countries that have opted to distribute condoms to their inmates is that the issuing of such condoms should be done in a discreet and accessible way, i.e. in boxes in washrooms,

or the detention blocks. If condoms are issued in the open, the programme does not work.

The problem remains that distributing condoms often sends a mixed message to inmates as sexual activity in some institutions is illegal and a punishable offence. Correctional medical staff may advocate condom availability while administration, security staff and even prisoners oppose it. There was a serious riot in the Jamaican Prisons Service in 1998 when condoms were issued to inmates. The riots caused the deaths of some inmates and the loss of jobs for some high-ranking officials.

In Israel, where there are about 6,000 inmates in prisons, HIV screening is voluntary and most of inmates are willingly to undergo testing. Inmates are not segregated during the day, but at night inmates are separated when certain behaviour such as covert drug use and sexual encounter could occur despite the monitoring system. The Israel Prison Service does not distribute either condoms or syringes in order to avoid legitimising homosexuality or drug misuse.

The Namibian Prison Service experience

Namibia Prisons Service started to experience prisoners admitted with HIV/AIDS late in 1994. The number grew constantly until 1997 when the breakdown was as follows:

	1997	1998
Patients by January 1	75	80
New patients	48	148
Death caused by HIV/AIDS	5	10
Released on Medical grounds	8	7
Released on normal discharge	30	116
Remaining on December 31	80	95

Medical examination for HIV/AIDS is not mandatory, therefore inmates are not screened when they are admitted in prison. Only those prisoners who display general weakness and are constantly sick may be referred for HIV/AIDS antibody tests.

So far there is no proven evidence that prisoners currently living with HIV/AIDS in prisons acquired the disease during their incarcerations, taking into consideration the long period of incubation between HIV/AIDS infection and symptomatic illness.

Where HIV/AIDS has been contracted whilst the individual is in prison, it is important to examine all the possible causes of infection. HIV/AIDS could be contracted in a number of ways in prison, including through sodomy, the use of shared syringes in hospital or for drug injection, the use of shared razor blades, the use of shared toothbrushes and tattooing. Any violent incidents, including fighting and rioting, may also carry the risk of infection where blood and open wounds may occur.

Namibian Prisons Services - especially Windhoek Central prison - has doubled its population in the past few years. Overcrowding and understaffing is widespread in the prison administration system. Inmates are admitted and released more frequently, increasing the number of active participants in the general population. As more pass in and out of prison, so the problems and disease associated with incarceration like T.B and HIV/AIDS increase.

Providing inmates with condoms should not be seen as the only way of preventing infection and the spread of HIV/AIDS. There is a need to improve significantly overall hygiene and health facilities within prisons. Considering the current overcrowding and the levels of cleanliness, hygiene is a weakness exasperating the incubation periods of HIV/AIDS.

It is very probable that situational homosexual behaviour may occur as a consequence of heterosexual deprivation, characteristic of prison conditions. Prison Officials have a special responsibility to inform all prisoners of the risk of HIV/AIDS infection from such behaviour. Prisons provide an opportunity to inform and educate large numbers of persons who may have engaged or may be likely to engage in

HIV/AIDS high-risk behaviour. Many of these people are unlikely to have received such education in the general community.

Provision of condoms is a generally acceptable way of controlling the spread of HIV/AIDS. But this is only if the infection is transmitted through unsafe sex. In prisons, officially sex whether safe or unsafe is prohibited but it is not guaranteed that sex is not being practised.

Furthermore homosexuality, aside from being illegal in some countries, is culturally and religiously controversial. The church globally has had very strong resistance against condom use. Many African cultures are intolerant of homosexuality.

The following African countries have the highest figures of HIV/AIDS infection per 100,000 people. These same countries hesitate to provide condoms in their prisons to preserve their nations' moral standards.

Countries	Rate for 100 000
Zimbabwe	564,4
Zambia	530,1
Malawi	505,4
Namibia	420,6
R.D. Congo	372,4
Botswana	351,6
Tanzania	281,4
Swaziland	270,3

Source: United Nations Human Development Program

These countries have different National Programmes of HIV/AIDS campaigns and uphold that:

- Homosexuality is still regarded as a criminal offence and is punishable severely, in some countries it carries life sentence.
- Prison officials are there to control prisoners' activities i.e. illicit sex, drug use etc.
- HIV/AIDS in prisons does not necessarily originate from unsafe sex.

Perhaps it is worthy to note the British view on why they are still resistant in issuing condoms to prisoners. They agree that prisons contain individuals at high risk of HIV infection, notably through intravenous drug use. For complex political, social and legal reasons penal institutions in the UK are unable to provide condoms and clean needles. They compare current data about risk behaviour and seroprevalance with experience in other countries. Intravenous drug use in prison appears to be common and the majority who inject in prison share syringes. Sexual activity does occur between men in prison in the United Kingdom but may incur a smaller risk of infection.

Conclusion

Various jurisdictions have differing approaches to HIV/AIDS prevention and control. Whether testing should be mandatory or voluntary, whether victims should be segregated or mixed and whether condoms, bleach, or clean needles should be made available to prisoners, are questions hotly debated by public health and correctional officials. Even accurate assessment of risk-taking within the institutions leads to controversy, as asking questions could imply acceptance of the very behaviours correctional officials are trying to prevent.

Education and risk-reduction counselling are the least controversial and mostly widely employed modes of prevention. The guidance as to whether condoms are to be provided to inmates should be based on political, cultural social and legal reasons.

References:

HIV/AID in Malawi prisons Research paper for Penal Reform International

HIV prevention in prisons and jails : obstacles and opportunities Public : Mec. Query.

HIV in UK prisons : a review of seroprevalance, transmission and patterns of risk.

AIDS and HIV infection in prisoners : The AIDS knowledge base.

Prescribing of condoms in prison : survey report BMA Foundation for AIDS

Appeal from the Catholic chaplains of the Madagascar prisons

Prison should be a place for rehabilitation, but practically never is.

The greatest criminals and delinquents are not necessarily in prison.

Often, prisoners are incarcerated for acts that they were forced to commit because of their great poverty.

There are still many people in prison who have not been judged and are there because of a lack of resources and of the means to look after and feed themselves properly.

In Madagascar, there is no way a sentence can be reduced during detention.

In the year 2000, we should be capable of pardon, not by words but rather by deeds.

Consequently we appeal to the authorities to do everything possible to free prisoners, shorten long sentences and grant amnesties.

We ask the population and families to take in freed prisoners and give them a helping hand.

We will continue to work with prisoners to prepare them for such possible liberation.

We particularly ask Heads of Prison Administrations to press their governments to listen to this appeal, so that Africa may become an example and open the millennium with acts of generosity to people who are normally among the most rejected.

Monique Clouzeau

Medical Practitioner

Catholic Prison Chaplaincy

GROUP WORKSHOPS

Knowledge of the standards

The group established that:

- Standards pertaining to health are hardly known, including by people or institutions concerned (NGOs or administrations).
- There is no instrument gathering all international standards pertaining to health in prison.
- Not all states have specific laws and rules pertaining to health in prison.
- Poor hygiene and lack of food contribute to international standards pertaining to health in prison not being respected.
- African countries do not have shared specific instruments pertaining to health in prison.
- Seldom are international standards included in national legislation.
- International standards and minimum rules pertaining to hygiene and health in prison are not adequately spread.

Recommendations

1. A specific text gathering all international standards and setting forth rules pertaining to health in prison should be established.
2. All States should have specific laws and rules pertaining to health in prison.
3. All States should commit themselves to respecting international standards pertaining to health. Experience shows that it is easier to put pressure on States once they have formally committed themselves to respect rules and standards. African countries should ratify international conventions.
4. African countries should have shared rules and standards, and a text or declaration pertaining to health in prison.
5. No effort should be spared to improve knowledge and spreading of international standards pertaining to health in prison. NGOs have an important role to play in this respect in sensitising the public, the media, the States and all stakeholders.
6. International rules and standards pertaining to health need to be distributed in prisons, administrations and other relevant institutions.
7. Hygiene rules need to be spread as widely as possible insofar as any slight improvement in hygiene contributes to the fight against diseases and mortality.

Practical use of these standards

Statement

The group noted that African Nations, though not participants in the formulation of the Universal Declaration on Human Rights, have accepted the Universal Declaration on Human Rights, the Charter on Human and People's Rights, the United Nations Standard Minimum Rules for the Treatment of Prisoners, the Convention Against Torture and other Cruel Inhuman or Degrading Treatment or Punishment, etc., and have not challenged them.

It concluded that it was therefore important that these standards be implemented by African governments and that the standards, should, if anything, be improved upon but never undermined in any way as doing so would imply that they do not give the same value to African lives as other governments who implement these standards give to the lives of their citizens. Further arguments for the modification of these standards can only constitute a red herring. Implementation of these standards was not merely a matter of resources, but that of political will.

The group therefore made the following proposals on ensuring implementation of the standards:

Recommendations

1. Sensitise governments to develop the political will for improving prison health conditions.
2. Lobby governments to review their constitutional provisions to reflect fundamental rights, such as the right to life, the right to health, where they do not exist.
3. Lobby governments to translate the standards into country legislations or statutes where they have not been adopted.
4. Take actions to influence government constitutional or statutory processes for improved access to prisons.
5. Draw public attention to the problems arising from the relationship between closed prisons and health.
6. Where necessary, take legislative measures to challenge government to open up closed prison systems for visit, inspection, assessment and monitoring of implementation of standards.
7. Call on governments to show enough political will in getting the relevant authorities - the police, the judiciary, etc., to decongest prisons through speedy trials, discharges, etc., as this alone would reduce the pressure on resources and free needed resources for improvement of health services and feeding of prisoners.
8. Educate the public to show concern and make enquiries about the health of their relatives in prison.
9. Encourage civil organisations to pressure governments to improve prison conditions and also to provide assistance in various forms for the improvement of the welfare of prisoners.
10. Work with the press to give publicity to issues in prisons so as to inform the public and pressure governments to implement standards.
11. Lobby governments to comply with requests from the African Commission on Human and People's Rights for regular reports on country activities. Such reports should be collated and widely circulated.
12. While acknowledging the problems of increasing crime rates and the need for effective criminal justice system, also highlight the neglects and shortcomings in the health of prisoners and call for the implementation of standards and penal reforms. In doing this, solicit the support of highly visible role models, e.g. Heads of State and other leaders who may have suffered incarceration in prisons.

13. Encourage international agencies to persuade or put pressure on national Governments to allow visits to prisons, inspection of facilities and implementation of standards.
14. Use prisoners as potent resource for contributing to their welfare through participation in agriculture to grow their food. Food and other materials produced by prisoners should be used exclusively to improve the feeding of prisoners.

What measures could be taken in practice by governments or international inspecting bodies if these standards where not upheld?

Governments

Incorporate standards in their domestic legislation and set up procedures for reinforcing them to ensure that these standards are complied with.

Publicize standards via the mass media in order to make public opinion aware of them, realize their importance and support them.

Promote, encourage and support research into prisoners' living conditions so that the general public is informed about the conditions that currently prevail in prisons, and thus demonstrate that some of these conditions could be improved without increasing costs.

Many influential people in the judicial systems of various countries are strangely ignorant about the existence of standards and consequently could benefit from the measures mentioned in points above.

The special training of prison staff should include teaching about the rights of man, so that in their day-to-day contact with prisoners they treat them humanely and encourage their rehabilitation and integration in society as responsible persons and citizens who obey the law.

International institutions

These should avoid confrontation with governments and institutions that are involved in their activities, as such confrontation is counter-productive.

They should adopt and encourage good practice and advise against bad practice.

They should appoint and select key persons both within governments and in civil society in order to make the opinions they express more effective.

In general, the international institutions should set up education programmes in order to make as many people as possible aware of the importance of minimum standards for prisoners, and thus create increasing interest in improving the living conditions and well-being of prison staff, without whose support it is very often difficult to set up standards in any prison.

Areas of prison life affecting health

The group recalled that besides the right to circulate, prisoners retain all other rights granted to fellow citizens.

Factors influential on prisoners' health

- Overcrowding / promiscuity
- Malnutrition
- Idleness
- Inadequate living space

Other factors influence the mental health of prisoners

- The very situation of imprisonment
- The type of offence committed and hence the relation to the sentence
- Children being imprisoned with their mothers.

The particular case of mentally ill prisoners

Two cases occur

- Prisoners mentally ill previous to their imprisonment
- Prisoners becoming mentally ill due to or during their imprisonment.

Different approaches have been proposed by the group, taking in consideration experiences led in various countries:

- The mentally ill prisoners is referred to a specialised institution when crisis arise, after which he is sent back to the prison;
- In Senegal, prisons may have a separate unit where all mentally ill prisoners are kept together and benefit from specific attention;
- In Benin, mentally ill prisoners are sent directly, without an escort, to psychiatric hospital despite the risks of escape;
- Participants agreed on the fact that in case of pre-trial detention, the instructing judge should stamp the decision to refer the prisoner to a specialised institution.

General Recommendations

- Fight overcrowding and promiscuity
- Develop alternatives to imprisonment
- Improve the judicial process
- Limit use of prison by using imprisonment as a last recourse, sentencing and making greater use of conditional release when possible or necessary
- Ensure strict segregation of prisoners (particularly women and juveniles) in order to prevent sexual abuses
- Fight malnutrition, improve quality and quantity of food (with supervising mechanisms)
- Develop activities within prisons
- Develop prison farms and production units within the prisons
- Ensure that leisure time is granted to prisoners.

Recommendations pertaining to health

1. Improve access to health care
2. Include prisons in the plans and policies of the Ministry of Public Health
3. Sensitisation on STD/HIV/AIDS
4. Develop programs of sanitary education including by opening the doors to NGOs and all those wishing to get involved in the field.

Availability and access to health care

The group identified problems and proposed solutions.

- Lack of resources

Lobby governments to encourage them to provide the necessary resources.

- Health Services in prisons are under the Prison Administration

All maters pertaining to health should be monitored by the Ministry of Public Health.

- Overcrowding

Reduce overcrowding in prison by referring seriously ill prisoners to hospitals or sending them back home, ensure that good coordination exists between the various institutions and make sure the clinics and hospitals are ready to handle these prisoners.

- Dilapidated and outdated premises

Up-keeping programmes for existing premises.

- Need for specialised health services

Nothing is provided for women, pre- or postnatal women, or for the mentally ill. Private clinics and hospitals should be encouraged to provide free consultation and care for prisoners.

- Right to health

Sensitise the public to the fact that prisoners have the same right to health than other people in the community. Supervising mechanisms need to be revised in order to ensure equality of treatment and non-discrimination.

- Poor management of files

Sound management of files ensures that each and everyone has access to health care.

- Prevention

Prevention measures should include the use of condoms.

- Training and sensitisation

Training of prison staff and prisoners

Vulnerable prisoners' health

Definitions

Who is vulnerable? What makes a person vulnerable? Why are they vulnerable? Vulnerable prisoners include: women, juveniles, the mentally ill, individuals with HIV/Aids, refugees in detention, foreigners in detention, poor prisoners and older persons.

There is a need to consider health care in terms of two different categories, that is preventative and promotive health care measures (PP). PP is better than curative measures.

Recommended treatments per category

Women

- Access to services for preventative means such as mobile health services both private and public for pregnant mothers.
- Compulsory antenatal services for pregnant mothers.
- Non-custodial services for pregnant mothers e.g. some West Africa countries.
- Segregation: women prison warders in charge of women prisoners.
- Special health needs of women e.g. sanitary pads supplied regularly.
- Special care for women imprisoned with their children e.g. special diet for their children.
- Research on psychological impact of children serving sentences on behalf of their mothers.

Juveniles

- Sex education.
- Visual audio, drama/awareness campaigns on adolescence and prevention of diseases.
- Separation of juveniles from adults in detention.
- Formal and informal education for all categories, convicts, remands, and civil debtors.

Mentally ill/HIV- Aids

- Recommend them for release: it is the duty of doctors working with prisoners, psychologists and social workers to recommend for their release to governments, e.g. in Malawi and Uganda (presidential prerogative of mercy).
- Involve or encourage NGOs, churches and other stakeholders in civil society to assist with better health diet and hygienic services for prisoners with HIV/aids.
- A greater need for micro nutrition in their diet.

Refugees

These are categorically not known in prisons but classified either as convicts, remand or civil debtors. The problems faced by refugees include:

- No outside visits by relatives.
- No supplementary basic necessities supplied from outside.
- Delayed access to justice.
- No sureties.
- Less information on legal aid availability.

Therefore: information should flow between prison authorities and organisations and institutions working with refugees.

- Inform UNHCR and government departments in refugee areas.
- More involvement of civil society.
- Resettlement after sentence, within or outside the country.

Foreigners

- Information flow to their embassies and in particular countries.

General recommendations

- Every effort should be made for introducing non-custodial measures for the most wanting of these categories of vulnerable people (see Uganda example for women).
- Rehabilitation and reconciliation of these individuals, that is, prepare them for release, through sensitisation and contact with their relatives, friends and institutions concerned with their welfare.

CLOSING CEREMONY

Address by Ahmed Othmani

I would like first of all to thank you here for your participation in this workshop.

Two documents will be prepared and sent out:

- The recommendations
- The full report

This workshop was only a new step, a contribution to the preparation of the All Africa Conference to take place in 2000. A new step as well in the implementation of the Kampala Declaration. The workshop was indeed a contribution to the momentum created in Kampala in 1996 towards penal and prison reform, more efforts to make prisons more humane, to ensure better crime prevention and rehabilitation.

The workshop was also a contribution to networking across positions, nations, functions and responsibilities (officials, professional of health, NGOs). This workshop was characterised by dialogue, convergence and a non-confrontational approach that is the manner best suited to addressing these problems.

We will meet again.

Thanks to the team of interpreters who worked on a voluntary basis.

Thanks and gratefulness to Uganda Prison Service, Mr. Etima and his team. We have been together for a long time and will continue to help each other face the problems, find solutions, make evil less evil, prison less of a prison, open them to scrutiny and to help. Push the walls of darkness towards more humanity. PRI is grateful for the continuous collaboration and support. We will meet again.

Thanks to Prof. Dankwa. He needs support and we need his work and efforts. Congratulations for his nomination as Chairperson of the African Commission on Human and Peoples' Rights and thanks for support and active presence during the workshop.

Thanks to all of you. Safe journey back. I hope that this has been useful to you and helpful to your work.

Address by Prof. Dankwa[10]

I would like to express the gratitude of the African Commission to Mr. Etima for securing the venue and assisting to make it a success. The workshop would not have been possible without Mr. Etima. We are all engaged in trying to make effective the protection of human rights in Africa.

My prayer is that we go away strengthened and resolved to achieve better conditions of detention.

Congratulations to Mali for the exhaustive report on the situation of human rights presented in Kigali on the occasion of the session of the African Commission in November 1999.

It is a pity that I cannot extend these congratulations to Uganda. It is therefore difficult for the African Commission to say what is the state of Human rights in Uganda despite all of the good things that are going on.

All Uganda must put maximum pressure on the government so that before June when we meet in Kampala for the Conference on Prison health, a report is submitted.

10. Chairperson, Special Rapporteur on Prisons and Conditions of Detention in Africa, African Commission on Human and Peoples' Rights

Address by Joseph Etima[11]

All good things and bad things come to an end. Many people do not understand prison, why prisoners need treatment. This is the closing of the preparatory meeting. English, French and Portuguese speaking persons have sat together to discuss matters of law and social control.

Thanks to you all.

You did not see the other side of the city, this is to ensure that you will come back again.

The meeting was blessed by the presence of Prof. Dankwa. He is occupying the highest position in Africa in the field of human rights and he was here. This shows the importance of the workshop. He is Special Rapporteur as well and we were able to learn from him.

Uganda failed to submit its human rights report. The report was submitted by Parliament to the Ugandan human rights commission and it will be consulted by the Ministry of Justice. The report will be at Prof. Dankwa's desk before he comes to Uganda.

Thanks to PRI for choosing Uganda. Some people must be thinking that I am bribing the chairman of PRI. Uganda is just the Pearl of Africa and it is easy to reach.

UPS commitment to PRI will never be removed. UPS will continue to struggle to speak out without being challenged by anybody. We work on issues where changes are needed.

Thanks to the organisers, the press and interpreters.

We will continue to be apostles and ambassadors of change on issues related to imprisonment.

I wish I could keep you longer but we shall meet again in June.

The workshop is closed.

11. Commissioner General of Prisons, Uganda Prison Service.

PROGRAMME

12 December 1999		Speakers
09.00	*Registration*	
10.00	*Plenary:* Welcome address	Presentation of songs by prisoners Representative of ICPMS Mr. Othmani, Chairperson, Penal Reform International Prof. Dankwa, Chairperson, Commissioner, African Commission on Human and Peoples' Rights, Guest Speaker Mr. Etima, Commissioner General of Prisons, Uganda, Guest Speaker
10.45	*Plenary:* Overview of the situation	Dr Pandya, Malawi
11.15	*Break*	
11.30	*Plenary*: International standards and instruments pertaining to health care	Dr. Elio Corvaja, Inter Center, Italy
12.00	*Group discussions:* 1) Knowledge of the standards 2) Practical use of these standards 3) What measures could be taken in practice by governments, or international inspecting bodies, if these standards were not upheld?	
13.00	*Lunch*	
14.00	*Plenary*: Country presentations - examples of specific initiatives to improve health in prisons, practical steps and actual outcomes.	
14.00	*Plenary*: Country experience - Nigeria	M. Kalu, Deputy Controller General of Prisons and Dr. Briggs, Deputy controller general in charge of health, Nigeria Dr Okwuosah, Deputy Controller General of Prisons
14.40	*Plenary:* Country experience - Burkina Faso (HIV/AIDS related activities)	Mr. Médard Voho, Director, Prison Administration, Burkina Faso
15.00	*Plenary:* Country experience - Malawi	Dr. Jolofani, Malawi
15.30	*Break*	
15.45	*Group discussions:* discuss the themes and identify good practice to be taken to face the problems. Areas of prison life affecting health (including food, nutrition, exercise, physical conditions, etc.)	

	Availability of and access to health care Vulnerable prisoners' health (women, juveniles, mentally ill, HIV/ AIDS)	
16.45	*Break*	
17.00	*Plenary*: report back and presentation of examples of good practice from each group	
17.45	Preparation of the International Conference on Health in African Prisons (date to be confirmed)	Chairperson: M. Etima Commissioner General of Prisons Secretaries : Nalwanga Sarah, Dr. Arinaitwe, Muhumuza Eli, Florence Nabatanzi
19.15	*End of the first day*	
13 December 1999		**Intervenants**
09.00	*Plenary:* Country presentations to give examples of specific initiatives to improve health in prisons. Practical steps and actual outcomes.	
09.00	*Plenary:* Country experience - Uganda	Dr Nyabwana, Deputy Commissioner of Prisons in charge of health, Uganda
09.30	*Plenary:* Country experience - Mali (juvenile and women prisoner's health)	Céline Rousselin, Balemaya, Mali
10.00	*Plenary:* Discussion	
10.30	*Group Discussions*: Recommandations	
	Group 1: to NGOs Group 2: to donors Group 3: to governments and inter-governmental organisations	
11.15	*Break*	
11.30	*Plenary:* Reporting	
12.30	*Lunch*	
14.00	Short Declaration by Dr. Clouzeaux, Madagascar	
14.15	*Presentation of the afternoon work* (overview, good practices, recommendations)	
14.45	*Group work*	
16.15	*Break*	
16.30	*Reporting back in plenary*	
17.00	*Evaluation*	
18.00	*Closing ceremony*	

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N° 4726-5 journada il 1420 (16.9.99)

Section 2 - The duties of prison doctors

Article 129

The prison doctor responsible for the physical and mental health of prisoners must examine:

- New prisoners on their arrival
- Prisoners reported as sick or who declare themselves sick
- Prisoners in punishment cells or in solitary confinement
- Prisoners to be transferred
- Prisoners admitted to the clinic
- Prisoners who apply for health reasons to be excused from any work or sporting activity or for a change of duties.

If the doctor considers that the physical or mental heath of a prisoner is likely to be seriously compromised by the form of his or her detention he must notify the prison governor in writing, who must take the necessary provisional measures, inform the head of the prison administration and, if the person concerned is a remand prisoner, the competent judicial authority.

Article 130

The doctor must also:

- Ensure that the prison food and hygiene facilities are inspected
- Ensure that the rules concerning the separation of bedridden, contagious and mental patients are complied with and if appropriate prescribe their admission into the clinic or their transfer to a specialized medical unit in another prison establishment or their hospitalisation
- Suggest hospitalisation for freed prisoners who cannot return to their homes
- Prescribe consultations with specialist doctors
- Decide what to do with drugs found in prisoners' possession or sent to them from outside
- Draw up death certificates when a prisoner dies inside the prison
- Deliver the certificates required under current legislation in the event of work accidents, illnesses during work or criminal acts
- Deliver medical certificates to prisoners and subject to their express agreement to their families or lawyers
- Deliver certificates concerning the health of prisoners containing information necessary for their handling and treatment in the prison and after release whenever the prison administration or judicial authority requests them.

Article 131

In the event of a hunger strike, the director of the prison administration and the family of the prisoner or the judicial authority in the case of a remand prisoner must be informed.

The prisoner may be subjected to forced feeding if his life is in danger in accordance with the instructions and under the control of the doctor.

Article 132

It is forbidden to submit prisoners to medical or scientific experimentation.

Article 133

Prisoners may only donate blood within the prison and with approval by the director of the prison administration.

Article 134

The doctor shall set up medical files on prisoners and give a professional opinion for their classification and duties.

Article 135

The doctor's prescriptions are to be recorded in a special register kept in the clinic.

This register must be checked by the medical inspectors when they inspect the establishment.

Treatment prescribed must be given by medical auxiliaries under the doctor's control.

Section 3 - Hospitalisation

Article 136

If the prison doctor considers that the necessary treatment cannot be given in the prison or the infection is of an epidemic nature, sick prisoners must be admitted into the nearest hospital.

The medical head of department must under his own responsibility examine the prisoner to satisfy himself that the prisoner must be kept in hospital. He may at any time order that the prisoner be returned to the prison if he finds that he can be treated there.

Prisoners may only be admitted to a private hospital with the approval of the Minister for Justice.

The requirements of paragraph 2 above apply to the Medical Director of the private clinic concerned.

Article 137

Hospitalisation is only on medical prescription. Notice of this must be provided before the sick prisoner is moved, to the prison administration and also to the competent judicial authority in respect of remand prisoners.

In an emergency, these authorities must be notified after hospitalisation.

The Governor of the prison must also give all the appropriate information to the authority concerned to enable it to arrange with the police for an escort and guard, and in general to take whatever measures may be necessary to avoid any incident arising from the personality of the prisoner.

Hospitalised prisoners are considered as continuing to serve their time or their period on remand; the same detention regime applies to hospitalised prisoners.

If the sentence expires during hospitalisation, the prisoner shall be considered as no longer confined.

Section 4 - Birth during detention and admission of young children

Article 138

All births within the prison must be declared to the registrar of births by the Governor of the prison or the head of the social services.

The birth certificate must give the address of the establishment without mentioning its name or stating that the mother was a prisoner.

When a prisoner is on the point of giving birth she may be given special leave in accordance with article 46 above.

Article 139

Young children may only be accepted with their mothers with a written order from the competent judicial authority.

Children may be left with their mothers up to the age of three years. However this period may be extended up to the age of five years on request by the mother and authorization by the Minister of Justice.

The social services must arrange for fostering of the child in the latter's interest before separation from the mother and with the agreement of the person appointed as foster parent.

Project for medical assistance to prisoners in Burundi

Place

The project concerns all sick prisoners in prisons of high population density such as Mpimba central prison, Gitega prison and Ngozi prison.

Name of the body responsible for the project

The Burundese Association for the Defence of Prisoners' Rights (ABDP) will plan and execute the project.

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Name and address of the person responsible for the project in ABDP

Laurent Gahungu, Member of Parliament, Secretary General of ABDP, responsible for co-ordinating the activities of the Association.

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Objectives

Defence of prisoners' infringed rights, including legal aid to prisoners, their moral, intellectual and physical welfare, regular follow-up of the files of prisoners in difficulty.

Previous activities

Among the many tasks carried out by ABDP on a day-to-day basis are:

- Distributing drugs in the prisons of Mpimba (4 times), Gitega (twice), Ngozi (once) with the help of the Civil Volunteers Group and the Joseph Ntanyotora family, and the participation of young members of the Kamenge youth centre.
- Distributing footballs, handballs and volley balls.
- Provision of musical equipment for the Mpimba choir.
- A bladder operation on the prisoner Mrs. Stéphanie Rurahinda with the help of the Co-operation Section of the Belgian Embassy.
- Purchase of drugs for certain prisoners for a total value of 124,075 BuF.
- Distributing blankets to Gitega prisoners during the cholera epidemic.
- Setting up a library in Mpimba central prison with about 520 books.
- Follow-up of prisoners' files in various jurisdictions and
- Legal aid with Burundese lawyers.

Competencies

In view of the actions already performed by its executives, ABDP is very confident of the success of the project. Care must be taken, especially in the follow-up and evaluation of stocks in collaboration with the various medical departments in the prisons with which we work regularly.

Beneficiaries

The project concerns all sick prisoners in prisons regularly served by ABDP and others for which the costs involved are too big for the prison services to cope with, such as for example morbid cases that require specialist treatment or special tests.

Justification

In initiating this project, ABDP has justified it as coming under the general objectives of the Association, including social assistance to prisoners.

In our contacts with the prisons we have found that prisoners encounter serious difficulties in obtaining drugs or the resources to pay for medical treatment and special medical examinations. Very recently, the Prison Administration informed the various departments in the prisons of the difficulties it was experiencing in covering the costs of providing medical treatment to prisoners.

It is for this reason that ABDP conceived this project to permit prisoners to enjoy their health rights.

Expected results

One of the duties of prisons is to prepare inmates for their release and reinsertion in society and their place of origin. It is thus clear that during this period their health must be protected, especially in situations of high health risk.

The provision of drugs is a fundamental aspect of this. During 1998, ABDP provided two consignments of drugs to Mpimba central prison and the specialized prison for women at Ngozi. The death rate in the three big prisons shows us how important it is for drugs and access to medical treatment to be available. For, at Bujumbura about 36 deaths were recorded, compared with 199 at Gitega and 379 at Ngozi.

ABDP wishes to help reduce these deplorable figures.

Description of the operation

After obtaining funds, the Association will purchase drugs and pay for treatment and examinations that the prisons cannot afford. The drugs purchased will be made available to the infirmaries within the hospitals, while the funds for special examinations will be directly administered by the Association.

Participation of the operator, the beneficiaries and other persons

As for its other projects, ABDP will collaborate with the Prison Administration to ensure optimum follow-up of the activities. It will also be responsible for ensuring that the drugs are properly used and that they are not misappropriated, and that prisoners cannot sell drugs provided to them. A system will be worked out for following up cases selected for assistance in conjunction with the Prison Administration and the persons concerned.

Detailed budget

A. Pharmaceutical products

Order	Designation	Quantity	Total cost
01	Folic acid	10 000 tablets	54 127fbu
02	Nalidixic acid	2 000 tablets	761 062 fbu
03	Antacid	3 000 tablets	27 285 fbu
04	Aspirin 100mg	50 000 tablets	130 090 fbu
05	Aspirin 500mg	30 000 tablets	193 145 fbu
06	Chloroquinine 100mg	45 000 tablets	244 9220 fbu
07	Erythromycin 500mg	3 000 tablets	251 203 fbu
08	Iron-Folic acid	3 000 tablets	27 322 fbu
09	Ferrous fumarate	3 000 tablets	17 580 fbu
10	Indomethacin	3 000 tablets	12 470 fbu
11	Mebedazol	90 000 tablets	854 020 fbu
12	Metronidazol	90 000 tablets	796 420 fbu
13	Onatrimoxasol	3 000 tablets	22 626 fbu
14	Papaverin 30mg	6 000 tablets	72 044 fbu
15	Paracetamol 100mg	10 000 tablets	26 836 fbu
16	Paracetamol 500mg	100 000 tablets	693 450 fbu
17	Promethazin	3 000 tablets	19 298 fbu
18	Quinine 100mg	15 000 tablets	200 718 fbu
19	Quinine 500mg	15 000 tablets	896 018 fbu
20	Amoxycillin 500mg	6 000 capsules	238 833 fbu
21	Ampicillin 500mg	6 000 capsules	199 440 fbu
22	Tetracyclin 250mg	15 000 capsules	219 545 fbu
23	Cloxacillin 500 mg	1 000 capsules	303 473 fbu
24	Methylated spirits 70%	6 liters	34 844 fbu
25	Benzyl benzoate 25%	12 liters	86 182 fbu
26	Methylene blue 1%	6 liters	39 490 fbu
27	Eosin alcohol solution	6 liters	35 061 fbu
28	Maalox	72 bottles	589 090 fbu
	1) Total pharmaceuticals		**9 262 022 fbu**

B. Operating costs

Order	Designation	Quantity	Total cost
1	Rental of storage room (6 months)	12 000	720 000 fbu
2	Transport of drugs	Lump sum	500 000 fbu
3	Guard	30 000	180 000 fbu
4	Follow up and checking	600 000	3 600 000 fbu
5	Communications	1 800 000	1 800 000 fbu
	2) Total operating costs		**6 600 000 fbu**
	Total 1) + 2)		**17 862 022 fbu**

Seminar on increasing awareness of STD/AIDS in African prisons[12]

The international seminar on increasing awareness and training held at Ouagadougou from November 26th to December 9th 1998 on the theme "STD/AIDS and African prisons" marked the beginning of execution of a pilot project initiated by APA (African Prison Association), consisting of a campaign to increase awareness of STDs and AIDS in the prisons of Burkina Faso and other African countries. In view of the pandemic nature of AIDS, which is a question of public health, no one should be excluded from information on this scourge.

If only because of its objectives, which include improving detention conditions in African prisons, APA could not remain inactive in the prisons on this subject.

Starting from the idea that in all the African countries there have been, since the appearance of HIV/AIDS, national committees for combating AIDS, companies or institutions that market contraceptives, and NGOs and associations that are fighting AIDS, it seemed possible to create synergy among the structures mentioned above, the prison administrations and prison staff with the object of increasing awareness of AIDS in prisons and generally, since it is clear to APA that while the free population is at risk in contracting the AIDS virus this risk is greater for those in prison, due to the very nature of the prisons in our different countries.

The project initiated by APA for increasing awareness of STDs and AIDS in prisons is in four phases:

A first phase, aimed at increasing awareness among and training all prison staff as members of society in order to create a snowball effect spreading information in family, professional and sporting circles, etc.

In the second phase the object was to give additional training to the staff considered most effective in the first phase, especially in communication techniques. This training was provided by the specialist doctors of the National Committee against STD/AIDS.

In a third phase, it is planned that the staff thus trained should organize awareness sessions for prisoners in the establishments where they work. The principle of two persons per establishment has been accepted. These trained staff will receive technical support from the regional health-education committees (CRESA) of the Health Ministry, with whom they had a day of discussions during their training.

There will be a fourth phase during which a team of staff (4) and volunteer doctors will organize follow-up and also awareness-increasing visits in order to assess progress in information activities for prisoners, difficulties encountered, loopholes in training, success...

APA is aware that this strategy, now being implemented, has its limits, but considers it as a pilot experiment; for this reason the project does not exclude direct participation by prisoners themselves at a later date in the awareness process. It is APA's experience that certain messages get through better from prisoners to prisoners rather than from warders to prisoners. To this end, APA has considered creating, for example, troupes of prisoner actors who will present sketches for increasing awareness of STDs and AIDS...

But for the moment APA believes that the human and intellectual capital thus composed (prison staff) will be available for increasing awareness in prisons. APA thus intends to make an effective contribution to the general campaign against STDs and AIDS. APA considers that, with modifications, this experiment can be taken up in other African countries, and for this reason the presence of participants from certain countries in the sub-region has been very beneficial and thinks of it as an outline for a project to be set up in this field.

12. Text extracted from: APA Bulletin, June 1999 Seminar for increasing awareness of STD/AIDS in African prisons, by Issa Traore, member of APA and volunteer co-ordinator of the project.

Do prisoners in Uganda have reasons to celebrate the anniversary of the Universal Declaration of Human Rights?

Doreen Nakasaga Lwanga[13]

Will the celebration of the fifty-first anniversary of the Universal Declaration of Human Rights on Friday 10 December have any practical significance to those who inhabit our prisons in Uganda? What about those who are detained in places not disclosed, such as those referred to as 'safe houses' in Uganda? What about those in Kigo Prison where, according to Stella Amabilis, Co-ordinator for the Public Defenders Association, even lawyers are not allowed to visit?

The composition of Uganda's prison populations has changed quite a bit this year. Business men and politicians have joined farmers, 'idlers', 'defilers', and tax evaders. When I visit the prisons, people often exclaim: 'Whoever thought I would share a cell with a manager of the famous white and green bank or that big man from the North who worked in the Office of the Prime Minister?' What more proof do we need that 'justice' in Uganda is for both the rich as well as the poor?

I am afraid that prisoners still need more proof. Let us begin with the 'Standard Minimum Rules for the Treatment of Prisoners'. We can buy arms for wars in other people's countries, but our government does not have enough funds to allow the Prisons Department to ensure these minimum rules are enjoyed by prisoners in terms of personal hygiene, clothing, bedding, food, exercise, sport, medical care, and accommodation. For example, inmates in Luzira Prisons eat one meal a day at 4 p.m. and it comprises posho and beans - no vegetables, no fruits.

Only those prisoners who go out to work (or whose relatives supply food) have a hope of an adequate diet. We prison visitors find it not exceptional to hear of prisoners who have collapsed and died on the field where they were working because of malnutrition (See also Hudson Apunyo, 'Eight prisoners escape in Lira', The Monitor, 18 October 1999).

The aim of a prison sentence is rehabilitation; once an offender has served a sentence (which is a punishment in itself) s/he should be prepared to rejoin society as useful citizen. Ill-treatment of inmates by prison staff, allegedly all too common in Uganda, hardly contributes to rehabilitation. Recently, we saw a concerted effort by the Commissioner-General of Prisons, Mr. Joseph Etima to bring to justice all prison staff who torture inmates. In at least one case, the offender was brought to book (see 'Prisoner Complains of Torture', The Monitor, 16 September 1999; and Sylvia Jjuko, 'Etima orders for the arrest of officer', The Monitor, 20 September 1999). I fear, however, that 'justice' was only done in this case because the condition of the brutalised prisoner, Alphonse Kiggundu, was so serious he required hospitalisation.

While it is unlawful to treat anybody in detention in a cruel, inhuman and or degrading manner, very few inmates are so bold as to speak out against such treatment. They also dare not tell even human rights activists who visit the prison for fear that they might be tortured again.

The 'Minimum Rules for the Treatment of Prisoners' also require states to ensure the separation of categories of prisoners, that is, civil offenders from criminal offenders, youths from adults, untried remand prisoners from convicts. These standards do not operate in Uganda's prisons and make our prisons 'schools for crime' with idlers graduating from prisons as highway robbers or worse.

The double standards that operate in the granting bail in Uganda must also make many poor prisoners who have only committed petty crimes wonder what they have to celebrate this Friday (see 'Matembe hits at unjust judiciary' The New Vision, 14 October 1999). On the other hand, perhaps the hundreds who have recently been released after serving years on remand as treason suspects and other charges have some reason to celebrate. But will Mr. Paddy Kalenzi, a person who had served 12 years in the Upper Prison without having ever been convicted feel like celebrating? I suspect many of these men who have

13. HURIPEC Prisons Project, Kampala, Uganda

been released will be more preoccupied with the impact of wasted years and separation from family on their futures. Will any be compensated for their losses? What about the families of those who died while on remand?

Foreigners in prison, for whatever reason, will have even less reason to celebrate the anniversary of the Universal Declaration of Human Rights. They have even greater problems accessing lawyers to defend them and no relatives to visit. Sometimes their embassies, for example if there are British, intervene, but if they are refugees, they almost cease to exist as human beings.

If they have been charged with a criminal or civil offence, even where the charge is frivolous, experience shows that the international body vested with the responsibility of protecting refugees, United Nations High Commission for Refugees (UNHCR) does not involve itself in such a case. It argues that unless the crime committed is related to a refugee issue, any asylum seeker or refugee is meant to face criminal charges as any national. But in Uganda, refugees are not issued identification cards, which is their right, so officials may not even know (or accept the fact) that a person is a refugee.

Few refugees know that they could have access to free legal aid through FIDA, LAP, or the Public Defenders Association, nor would they have means to contact these organisations. When refugees ask for bail in court they are refused because there is no one to stand 'surety' and because they are believed to have 'no fixed address'.

In the case of foreigners in detention, and all refugees are wrongly classified by our prison authorities as foreigners, they are to be deported after serving their sentence, and magistrates indicate this on the court charge sheet and copy it to the prison authorities. They are then handed over to the Criminal Investigation Department (CID) to be deported to their country of origin. CID officers then detain them until they can be deported. Lack of funds again creates delays and there are times when such ex-prisoners have spent more than a year in CID detention. Even offers to meet these expenses have been made by family or friends, CID officials have refused on the grounds that it is the government's obligation to deport.

If a refugee is in this situation, once s/he has served a sentence, he should be returned to his settlement or other place of abode. Only if the GoU decides such a person can legitimately be defined as a security risk, can it legally in terms of its national and international obligations refuse to follow these procedures. Then UNHCR does have a duty to protect such a refugee by finding another country. On rare occasions, because UNHCR has failed to get involved, the International Committee of the Red Cross has been instrumental in resettling those foreigners who are refugees who have finished serving their sentences. Deportation of such refugees to their country of origin where they fear persecution is in violation of the principle of non-refoulement.

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* HM Prison Service *Suicide awareness strategy pack*.

Liebling, Alison, (ed.) *Deaths of Offenders: The hidden side of justice* 1998, Waterside Press, UK. Particularly Leibling, A. 'Prison suicide and the nature of imprisonment' and Wadham, J. 'The right to life and the European Convention on Human Rights'.

Liebling, *Alison, Suicides in Prison* 1992, Routledge, ISBN 0415075599.

Liebling, Alison, *Suicide attempts and self-injury in male prisons*: a report commissioned by the Home Office Research and Planning Unit for the Prison Service (now out of print).

Lockwood, Daniel Prison *Sexual Violence* 1980, NY, Elsevier (now out of print).

Maden, Taylor, Brooke and Gunn *Mental disorder in remand prisoners* 1996, Home Office, UK.

Minnesota Lawyers International Human Rights Committee (now the Minnesota Advocates for Human Rights) *Hidden from View: Human Rights Conditions in the Krome Detention Center* 1991, ISBN 0-929293-10-X.
Summary: A joint legal-medical team investigated the conditions of confinement at the Immigration and

Naturalization Service (INS) Krome Avenue Detention Center in South Dade County, Florida. They evaluated compliance with internal INS standards as well as United Nations principles on the protection of persons in prison or detention. In this report, the team evaluates such issues as health care, sanitation, nutrition, recreational facilities, detention of minors, physical and sexual abuse, access to outside investigators, grievance and disciplinary procedures, and attitudes of detention officers.

Physicians for Human Rights *Health Conditions in Haiti's Prisons* 1992, USA.

Physicians for Human Rights *Health Conditions in Cambodia's Prisons* 1995, USA. ISBN 1-879707-18-7.

Summary: In the first half of 1994, a medical team assembled by PHR, the American Refugee Committee, and the Columbia College of Physicians and Surgeons studied health conditions in thirteen prisons throughout Cambodia. Through on-site visits and structured interviews with prison officials and randomly-selected prisoners, the medical investigators found evidence of conditions that threatened the health and well-being of the inmates. One investigator called the Police Judiciaire prison in Phnom Penh "a public health disaster waiting to happen." When PHR released its preliminary findings, the Cambodian government took measures to ease the overcrowding and rehabilitate that prison. The report recommends measures to improve health conditions and urges national assistance to help the Cambodian government fulfil its pledge to protect the human rights of all prisoners and detainees.

Scacco, Anthony M. Jr., (Editor) *Male Rape: A Casebook of Sexual Aggressions* 1982, NY: AMS ISBN: 0 4046 1622 4.

* Stern, Vivien (ed.) *Sentenced to Die? The problem of TB in prisons in Eastern Europe and Central Asia* 1999, International Centre for Prison Studies, UK. ISBN 0 9535221 1 3.

* Toebes, Brigit C. A., *The Right to Health as a Human Right in International Law* School of Human Rights Research Series, Volume 1, Intersentia-Hart, The Netherlands.

Journal Articles

Title: *The AIDS Litigation Project - a national review of court and human rights commission decisions, part I: the social impact of AIDS.*
Authors: Lawrence O.Gostin,
Source: JAMA. 1990 Apr 11; 263(14): 1961-1970.
Abstract: The Aids Litigation Project, which monitors the legal repercussions of the AIDS epidemic in the United States, is operated by the American Society of Law and Medicine and the Department of Health Policy and Management, Harvard School of Public Health, and supported by the National AIDS Program Office of the U.S. Public Health Service. Gostin's article is the first in a two-part series reviewing case law and human rights commission rulings tracked by the Project since 1981. The series covers 469 AIDS cases decided, settled, pending, or filed at local, state, and federal levels. Part I discusses civil and criminal cases involving issues ranging from AIDS education to AIDS and the prison system. Accompanying the article are tables of cases broken down by court system and by subject matter, and a subject compilation of 320 case citations. (KIE abstract)

Title: *Prison health law*.
Authors: Tomasevski, Katarina
Source: European Journal of Health Law. 1994; 1(4): 327-341.

Title: *Section 1983 civil liability of prison officials for denying and delaying medication and drugs to prison inmates*.
Authors: Vaughn, Michael S.
Source: Issues in Law and Medicine. 1995 Summer; 11(1): 47-76.

Title: *European guidelines on prison health*. [Commentary].
Authors: Bertrand, Dominique; Harding, Timothy
Source: Lancet. 1993 Jul 31; 342(8866): 253-254.

Title: *Long-term contraceptives in the criminal justice system*.
Authors: Dresser, Rebecca
Source: Hastings Center Report. 1995 Jan-Feb; 25(1): S15-S18.
Abstract: ...Contraceptive Sentencing: A Proposal -- One way to reconcile the competing concerns about potential abuses and possible benefits of contraceptive sentencing would be to adopt the following principle: whenever long-acting contraceptives are proposed as a probation condition, judges must also present to the defendant at least one non-incarcerative alternative sentence. If the defendant was convicted of an offence that would not ordinarily call for a prison term, then she should be given two alternatives: one including contraceptives as a probation condition and one including a set of non-contraceptive probation conditions customarily applied to defendants in her situation. If individuals convicted of the offence are eligible for a prison term, and the judge believes that probation with contraceptive use would be an appropriate alternative, the judge would be obligated to make three proposals: probation with contraceptive use, an alternative set of probation conditions, and the prison term the defendant would normally have to serve. Adherence to this principle would remove some of the pressure a defendant might feel to compromise her medical or reproductive preferences for the sake of avoiding confinement in a correctional institution.

Title: *Apartheid medicine: health and human rights in South Africa*.
Authors: Nightingale, Elena O.; Hannibal, Kari; Geiger, Jack; Hartmann, Lawrence; Lawrence, Robert; Spurlock, Jeanne
Corporate name: American Association for the Advancement of Science. Science and Human Rights Program
Source: JAMA. 1990 Oct 24/31; 264(16): 2097-2102.
Abstract: In April 1989, the authors visited South Africa under the auspices of the American Association for the Advancement of Science, the National Academy of Sciences' Institute of Medicine, the American Psychiatric Association, and the American Public Health Association. The purpose of the trip was "to assess the effects of apartheid on the delivery of health care and to examine the roles South African health professionals have played in helping and hindering the promotion of health care rights." This summary of the group's full report covers: 1) health care under apartheid; 2) medical education; 3) human rights violations and health professionals (including torture, hunger strikes and restrictions, harassment of health professionals, the physician and the prison system, and the impact of detention on children); 4) the response of the medical community to human rights violations; and 5) concluding observations.
Note: Copies of the full report are available from the AAAS Science and Human Rights Program, 1333 H St., NW, Washington, D.C. 20005.

Title: *The AIDS crisis in prison: a need for change*.
Authors: Easley, Peter Rhodes
Source: Journal of Contemporary Health Law and Policy.1990 Spring; 6: 221-238.

Title: *High prevalence of sexually transmitted and blood-borne infections amongst the inmates of a district jail in Northern India*.
Authors: Singh S; Prasad R; Mohanty A
Author affiliation: Clinical Microbiology Division, Department of Laboratory Medicine, All India Institute of Medical Sciences, New Delhi. ssingh@medinst.ernet.in
Source: Int. J STD AIDS. 1999 Jul;10(7):475-8.
Abstract: Two hundred and forty male and 9 female jail inmates confined for various crimes in a district jail near Delhi were screened for sexually transmitted and blood-borne diseases including HIV, syphilis and hepatitis B and C viral infections, skin diseases etc. The inmates were aged 15-50 years with a mean of 24.8+/-0.11. Their alleged criminal background, period of stay in the jail, drug addiction, education, birth place, marital status, sexual activity, and clinical complaints were recorded by an anonymous questionnaire. Serum samples were tested for antibodies against HIV (1+2), hepatitis C (HCV), Treponema pallidum and for hepatitis B surface antigen (HBsAg). Sputum examination was done for acid-fast bacilli. Out of the 240 men, 115 were married and 125 unmarried. One hundred and eighty-four (76.6%) men gave history of penetrative sex. Of the 184, 53 (28.8%) were homosexuals or bisexuals and

131 (71.2%) had sex with women only. Sixty of the 131 (45.8%) were faithful to their partners while 124 gave a history of having multiple sexual partners and 100 of them (80.6%) had unprotected sex. Eighty-three of these 100 also had had sex with commercial sex workers (CSWs). One hundred and twenty-six were addicted for alcohol, 44 for smack/charas and 8 had a history of intravenous drug abuse. One hundred and seventy-four were not aware of AIDS. On examination 28 of the 240 (11.6%) had active hepatitis with or without a history of jaundice in the last 2 years, 25 (10.4%) active pulmonary tuberculosis (TB) and 11 (4.6%) had syphilitic ulcers on the penis. Four-fifths of the teenagers confined to a particular barrack had moderate to severe scabies. Three males (1.3%) were found to be Western blot confirmed HIV-1 positive while 28 (11.1%) men and 2 (22.2%) women were positive for HBsAg. Twelve (5.0%) men but no women, were found to be positive for anti-HCV antibodies. Out of the 3 HIV-positive persons, one was an intravenous drug user (IVDU), second was a drug addict and frequent CSW visitor while the third was a homosexual. This pilot study gives an indication that sexually transmitted and blood-borne infections are highly prevalent in jail premises and pose a threat of rapid spread of these infections through IVDU and homosexuality.

Title: *Survey of risk behaviour and HIV prevalence in an English prison*.
Authors: Edwards A; Curtis S; Sherrard J
Author affiliation: Department of Genitourinary Medicine, The Radcliffe Infirmary NHS Trust, Oxford, UK.
Source: Int. J STD AIDS. 1999 Jul;10(7):464-6.
Abstract: An anonymous, voluntary, linked cohort study was undertaken to determine the prevalence of HIV infection and identify risk factors for the spread of infection in an English prison. Three hundred and seventy-eight (68%) of the inmates participated. The HIV point prevalence was 0.26%. Injecting drug use (IDU) was the most significant HIV risk factor within 20% admitting IDU at any time, of whom 58% injected whilst in prison. Of those injecting in prison 73% shared needles. Two inmates admitted having sex with a male partner in prison. This study demonstrates that the potential exists in this setting for an outbreak of blood-borne virus infection; hepatitis B virus (HBV), hepatitis C virus (HCV) and HIV infection. Injecting drug use and needle sharing represent the greatest risk.

Title: *Seroprevalence of HIV, HCV and syphilis in Brazilian prisoners: preponderance of parenteral transmission*.
Authors: Massad E; Rozman M; Azevedo RS; Silveira AS; Takey K; Yamamoto YI; Strazza L; Ferreira MM; Burattini MN; Burattini MN
Author Affiliation: NUPAIDS, The University of Sao Paulo, Brazil.
Source: Eur J Epidemiol. 1999 May;15(5):439-45.
Abstract: Between November 1993 and April 1994, our physicians' team interviewed and took blood samples of 631 prisoners randomly drawn from the largest prison of South America, which counted about 4700 inmates at that time. The interview consisted of questions related to risk behaviour for HIV infection, and the subjects were asked to provide blood for serological tests for HIV, hepatitis C and syphilis. Our main purpose was to investigate the relationship between HCV and injecting drug use as related to HIV seropositivity. Participation in the study was voluntary and confidentiality was guaranteed. Overall prevalences found were as follows: HIV: 16% (95% confidence interval (CI): 13-19%); HCV: 34% (95% CI: 30-38%), and syphilis: 18% (95% CI: 15-21%). Acknowledged use of ever injecting drug was 22% and no other parenteral risk was reported. Our results, as compared with other studies in the same prison, suggest that HIV prevalence has been stable in recent years, and that the major risk factor for HIV infection in this population is parenteral exposure by injecting drug use.

Title: *Prison legal matters: is prison neglect creating super HIV?*
Authors: Rodrigues T
Source: PWA Newsline. 1998 Oct-Nov;:34-5.
Abstract: Prisoners from the California Department of Corrections (CDoC) system have complained that they are unable to adhere to their anti-HIV treatments because medical personnel are not helping them receive the necessary medications. The prison system appears to be ignoring the need for continuous treatment, which has public health officials concerned that the prison system is breeding a virus that may

be too potent for current anti-HIV drugs. In addition to lawsuits filed by inmates, a resolution by the San Francisco Board of Supervisors urges the City Attorney to investigate the CDoC for unacceptable care in managing HIV-infected inmates. Also, inmates that are released from prison are not given any guidance on how to obtain medical treatment or follow-up care outside of prison.

Title: *Australian prisons are still health risks* [editorial; comment]
Authors: Levy MH
Source: Med J Aust. 1999 Jul 5;171(1):7-8.
Comment: Med J Aust 1999 Jul 5;171(1):14-7
Med J Aust 1999 Jul 5;171(1):18-21
Med J Aust 1999 Jul 5;171(1):31-3

Title: *HIV prevalence at reception into Australian prisons, 1991-1997* [comment]
Authors: McDonald AM; Ryan JW; Brown PR; Manners CJ; Falconer AD; Kinnear RC; Harvey WJ; Hearne PR; Banaszczyk M; Kaldor JM
Author Affiliation: National Centre in HIV Epidemiology and Clinical Research, Sydney, NSW. amcdonald@nchecr.unsw.edu.au
Source: Med J Aust. 1999 Jul 5;171(1):18-21.
Comment: Med J Aust 1999 Jul 5;171(1):7-8
Abstract: Objective: To measure the extent and outcome of HIV antibody testing at reception into Australian prisons.

Design: Cross-sectional survey at reception into prison.

Participants and setting: People received into Australian prisons from 1991 to 1997.

Main outcome measures: Number of people tested for HIV infection and prevalence of diagnosed HIV infection.

Results: In 1991-1997, HIV antibody testing was carried out for 72% of prison entrants in Australia; the percentage tested declined significantly from 76% in 1991 to 67% in 1997 ($P < 0.001$). In New South Wales, the percentage of entrants tested at reception into prison dropped from almost 100% in 1991-1994 to 45% in 1997, whereas in the Northern Territory, South Australia and Western Australia the extent of testing increased significantly ($P < 0.001$). HIV prevalence was 0.2% among people received into Australian prisons in 1991-1997, and did not differ by sex. Most people with HIV infection (242/378; 64%) received into prison in 1991-1997 had been diagnosed at a previous entry; 136 people (36% of the total number of diagnoses) were newly diagnosed at reception into prison.

Conclusions: A national monitoring system in place from 1991 indicates generally high rates of HIV antibody testing and a low prevalence of HIV infection among people entering Australian prisons. In each year, people not previously known to the prison health service to have HIV infection were received into prison, indicating continuing HIV infection in the population entering Australian prisons.

Title: *Transsexual orientation in HIV risk behaviours in an adult male prison*.
Authors: Stephens T; Cozza S; Braithwaite RL
Author Affiliation: Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University, Atlanta, Georgia 30322, USA. tstephe@emory.edu
Source: Int J STD AIDS. 1999 Jan;10(1):28-31.
Abstract: The present study examined the consequences of being a self-reported transsexual male and HIV risk behaviours in a state penal system. The specific research question was whether or not sexual orientation of inmates influences the level to which they evidence HIV risk behaviours. A total of 153 participants volunteered to participate in the study of which 31 described themselves as being transsexual. Based on risk ratios and using transsexual inmates (TIs) as the reference group, they were 13.7 times more likely to have a main sex partner while in prison [95% CI=5.28, 35.58]. Moreover, TIs were 5.8 times more likely than non-transsexual inmates (NTIs) to report having more than one sex partner while in prison [95% CI=2.18, 15.54]. It is obvious from these findings that TIs require more preventive support than their NTI confederates. In addition to TIs being protected from assault and battery by NTIs, they need social support and carefully developed preventive informational materials.

Title: *Crisis or opportunity? The privatisation of behavioural health services in the criminal justice system*
Authors: Clarke B
Source: Behav. Health Tomorrow 1998 Apr;7(2):21-4, 57

Title: *Opportunities for AIDS prevention in a rural state in criminal justice and drug treatment settings*.
Authors: Farabee D; Leukefeld CG
Author Affiliation: Center on Drug and Alcohol Research, University of Kentucky, Lexington 40504, USA.
Source: Subst Use Misuse. 1999 Mar-Apr;34(4-5):617-31.
Abstract: This study examined the likelihood that drug users would receive HIV/ AIDS prevention information and supplies (e.g., condoms and bleach) in the rural state of Kentucky. Despite evidence of high HIV risk among criminal justice and substance-using populations, incarceration and substance-user treatment were only minimally associated with prior HIV prevention exposure or HIV testing. These data strongly support the use of criminal justice and treatment settings to provide AIDS prevention interventions for the high-risk drug-using populations they serve, and to target HIV prevention services in rural as well as urban areas.

Title: *Prisoners' views about the drugs problem in prisons, and the new Prison Service drug strategy*.
Authors: Gore SM; Bird AG; Cassidy J
Author Affiliation: MRC Biostatistics Unit, Institute of Public Health, University Forvie Site. sheila.gore@mrc-bsu.cam.ac.uk
Source: Commun Dis Public Health. 1999 Sep;2(3):196-7.
Abstract: Three hundred and seventy-five out of 575 prisoners (222/299 drug users and 153/267 non-users) who responded to a self-completion health care questionnaire at two prisons in 1997 commented on drugs in prisons. One hundred and forty-eight out of 176 responses expressed negative opinions about mandatory drugs testing (MDT), and 107 said that MDT promoted switching to or increased use of heroin/hard drugs'. Sixty-two prisoners suggested that more help/counselling was needed for drug users, 52 segregation of drug users/drug-free wings, and 50 more security on visits/in corridors after medication. The new Prison Service drug strategy has revised random MDT. It targets those who supply drugs, and supports those who want to stop using drugs, and accords with prisoners' views about the heroin problem in prisons.

Title: *Birth in prison. The rights of the baby*.
Authors: Kitzinger S
Source: Pract Midwife. 1999 Jan;2(1):16-8.

Title: *The impact of primary mental health care in a prison system in Brazil*.
Authors: Taborda JG; Bertolote JM; Cardoso RG; Blank P
Author Affiliation: WHO Collaborating Centre for Research and Training in Mental Health, Porto Alegre, Rio Grande do Sul, Brazil. taborda@conex.com.br
Source: Can J Psychiatry. 1999 Mar;44(2):180-2.
Abstract. Objective: To analyse the impact of a psychiatric service in a prison general hospital that refers prisoners with mental disorders to a separate forensic psychiatric hospital (FPH).

Method: Analysis of data on prison population and referrals to the FPH.

Results: Despite a 10.9% increase in the overall prison system population over 3 years, referrals from the prison general hospital with the new psychiatric service to the FPH were reduced by 36.5%, whereas referrals from other prisons increased by 120.4%.

Conclusion: Our results demonstrate the efficiency of the new primary health care approach.

Title: *Unmet need among disturbed female offenders*.
Authors: Nikki Gorsuch
Institution: Enfield Community Care Trust, Hadley Lodge Regional Secure Unit, Enfield, England UK.
Source: Journal of Forensic Psychiatry. Vol 9(3), Dec 1998, 556-570.
ISSN: 0958-5184

Abstract: Explored characteristics of women who remain in the penal system despite psychological disturbance. The case-note study describes 44 women (average age 30 yrs) on a prison health care unit psychiatric wing, referred to NHS psychiatric services by prison medical officers. Half the women were difficult to place, being refused a bed at least once. The other half (comparison group), obtained beds without difficulty. Data studied included current charge and legal status, history (personal, psychiatric, offending), deliberate self-harm, diagnoses and medication, and referral outcome. The difficult to place women were significantly more likely than the comparison group to have suffered childhood physical and/or sexual abuse; to have committed a variety of offences, violent crimes or arson; to have been in a secure psychiatric facility; to be considered a danger to themselves and a management problem in prison; to have a personality disorder diagnosis; and to receive a prison sentence or community disposal rather than a hospital order. Treatability and lack of service provision are discussed as related to the failure of these women to obtain psychiatric referral. ((c) 1999 APA/PsycINFO, all rights reserved)
Population location: England UK
Publication Year: 1998

Title: *Prison health: A neglected subject in correctional psychology*.
Author: Thomas J. Young
Institution: Washburn U, Beatrice, NE, USA.
Source: Journal of Prison & Jail Health. Vol 11(1), Sum 1992, 51-54.
ISSN 0731-8332
Abstract: Argues that the criminal justice and correctional psychology literature has devoted insufficient attention to the subject of prisoners' health. Of 12 correctional psychology textbooks (published 1980-2990) reviewed, only 4 briefly mentioned the topic of prison health and medical treatment. ((c) 1998 APA/Correctn, all rights reserved)
Publication Year: 1992

*** Title:** *Prisoners: an end to second class health care?*
Author: Richard Smith
Source: BMJ 1999;318:954-955 (10 April) Editorial

*** Title:** *Point prevalence of mental disorder in unconvicted male prisoners in England and Wales*
Author: Deborah Brooke, Caeilia Taylor, John Gunn & Anthony Maden.
Source: BMJ 1996;313:1524-1527 (14 December)

*** Title:** *HIV/AIDS and human rights in prison. The Costa Rican experience*
Author: Valerio Monge CJ
Source: Med Law 1998;17(2):197-210

*** Title:** *Molecular investigation into outbreak of HIV in a Scottish prison*
Author: DL Yirrell, P Robertson, DJ Goldberg, J McMenamin, S Cameron, AJ Leigh Brown
Source: BMJ 1997;314:1446 (17 May)

*** Title:** *Spread of blood borne viruses among Australian prison entrants*
Author: Nick Crofts, Tony Stewart, Peter Hearne, Xin Yi Ping, Alan M Breschkin & Stephen A Locarnini
Source: BMJ 1995;310:285-288 (4 February)

*** Title:** *Outbreak of HIV infection in a Scottish prison*
Author: Avril Taylor, David Goldberg, John Emslie, John Wrench, Laurence Gruer, Sheila Cameron, James Black, Barbara Davies, James McGregor, Edward Fllett, Janina Harvey, John Basson and James McGavin
Source: BMJ 1995;310:289-292 (4 February)

*** Title:** *Prevalence of mental disorder in remand prisoners: consecutive case study*
Author: Luke Birmingham, Debbie Mason and Don Grubin
Source: BMJ 1996;313:1521-1524 (14 December)

* **TITLE:** *Drug injection and HIV prevalence in inmates of Glenochil prison*
Author: Sheila M Gore, A Graham Bird, Sheila M Burns, David J Goldberg, Amanda J Ross and James McGregor
Source: BMJ 1995;310:293-296 (4 February)

* **Title:** *Substance use in remand prisoners: a consecutive study case*
Author: Debbie Mason, Luke Birmingham and Don Grubin
Source: BMJ 1997;315:18-21 (5 July)

* **Title:** *Mortality from overdose among injecting drug users recently released from prison: database linkage study*
Author: SR Seaman, RP Brettle and SM Gore
Source: BMJ 1998;316:426-428 (7 February)

* **Title:** *Health and human rights*
Author: Jonathan M Mann
Source: BMJ 1996;312:924-925 (13 April) Editorial

* **Title:** *Shackling prisoners in hospital*
Author: Luisa Dillner
Source: BMJ 1996;312:200 (27 January)

* **Title:** *Prison rights: mandatory drugs tests and performance indicators for prisons*
Author: Sheila M Gore, A Graham Bird and Amanda J Ross
Source: BMJ 1996;312:1411-1413 (1 June)

* **Title:** *Harm reduction measures and injecting inside prison versus mandatory drugs testing: results of a cross sectional anonymous questionnaire survey*
Author: A Graham Bird, Sheila M Gore, Sharon J Hutchinson, Stephanie C Lewis, Sheila Cameron and Sheila Burns
Source: BMJ 1997;315:21-24 (5 July)

* **Title:** *Shared ethical principles for everybody in health care: a working draft from the Tavistock Group*
Author: Tavistock Group
Source: BMJ 1999;318:248-251 (23 January)
Abstract: Proposes that "health care is a human right" and proved controversial in this view - see letters (included). Members of the group are listed at the end of the article.

Other relevant documentation

Universal Declaration of Human Rights published in the British Medical Journal. BMJ 1997;315:1455-1456 (29 November).

Universal Declaration on Human Rights - particularly Article 5 and Article 25.

International Covenant on Economic, Social and Cultural Rights - particularly Article 11 and Article 12.

Convention on the Rights of the Child - Article 24 in particular.

Regional human rights mechanisms, particularly the *African Charter* - see Article 16 (concerning right to adequate standard of living).

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Composition and lay-out
PRI Paris - October 2000