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Health and human rights in prisons

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Introduction

"Prisoners are sent to prison *AS* punishment, and not *FOR* punishment". This often repeated statement by Alexander Paterson, British Prison Commissioner in the 1930s, implied that the loss of an individual's right to liberty is enforced by containment in a closed environment. Keeping the individual in the custody of the State, should not, however, have deleterious effects on his or her health. This is unfortunately precisely the case – to some degree or another – in many of the world's prisons. Is it possible then to define a "healthy environment" in a prison, let alone talk about prisoners' rights regarding any health services to be provided for them by the detaining authorities? The answer to this question is that prisoners have inalienable rights conferred upon them by international treaties and covenants, they have a right to health care, and they most certainly have a right *not* to contract disease in prison. How these rights apply to the often harmful prison environment and to HIV infection is the subject of this chapter.

Prisons can be bad for public health

Public health policies are meant to ensure the best possible conditions for all members of society, so that everyone can be healthy. Prisoners are often forgotten in this equation. Prisoners enter and leave prisons. They are released if found innocent. They come and go from prison during the investigation and for trial. Furthermore they are often transferred, for a variety of reasons, from one prison to another. Prisoners are in contact with many different people who go in and out of the prison every day. Prison guards, prison staff, medical personnel, delivery and repair persons, not to mention family visitors and lawyers, come and go every day. Prisoners are eventually released from prison when they have served their time, or occasionally when there is an amnesty. This turnover and constant movement in and out of prison makes it all the more important to control any contagious disease within the prison so that it does not spread into the outside community.

Prisoner turnover is variable from country to country. Often the annual turnover of the prisoner population is four to six times the actual number of inmates being held at any given time. For a country like the Russian Federation, with a prisoner population numbering just under one million at the present time, the turnover is closer to some 300 000 per year[3] as many prisoners tend to "overstay", particularly in pre-trial prisons. For

[3] A. Goldfarb, Public Health Research Institute, New York, personalcommunication.

all these reasons, it is not possible to tackle public health issues, such as tuberculosis or HIV, effectively if the prison populations are not taken into account.

Violence: an everyday reality in many prisons

In many countries, violence and coercion between prisoners can lead to serious health risks, either directly or indirectly. Physical assaults – even murder – can occur in remand prisons and sometimes even in colonies. Assaults occur between prisoners and prison guards, and even more so between prisoners themselves. Violence between prisoners – and particularly sexual assault – is vastly underreported, as an internal kind of "omertà" is common in the prison milieu.

Violence in prison settings has many causes. Clashes may have ethnic causes, or rivalries between clans or gangs. The closed, often vastly overcrowded living conditions also lead to hostilities between inmates. The tedious prison environment with its lack of occupation for mind or body, and just plain boredom, lead to accumulated frustrations and tensions. This environment leads the way to high-risk activities, such as use of drugs, sexual activities between men, tattooing and other "blood brotherhood"-style activities (see Chapter 3). Some indulge in these activities to combat boredom. Others, however, are forced to engage in them, in a coercive play for power or monetary gain. Risky lifestyles can lead to the transmission of diseases from prisoner to prisoner and pose a serious public health risk if unchecked. Violence in prisons makes possible unprotected contact with human blood. Fortunately, contamination with HIV through exposure to open wounds has been reported to be extremely low. Unprotected sexual acts with exchanges of potentially contaminated human secretions pose a real risk. Coercive penetrative sex between inmates is not always necessarily forcible rape – on the contrary, the violent prison setting may lead many inmates, particularly "underdogs" or "lowcaste" prisoners to have to accept sexual acts they would otherwise avoid altogether. Intravenous drug use with sharing of needles and syringes obviously poses a specific problem. Coercion can be a relevant factor if some prisoners force others to use injectable drugs and contaminated shared instruments. Both medical and custodial staff have to be informed of the risks of such contacts and the means to avoid contamination. Education on these issues is essential if HIV is to be controlled.

Prisoners have a right to be protected from these dangerous settings in prison and to expect the authorities to protect them from physical and sexual violence. This right goes beyond the right to request incarceration in protected isolation. Prison authorities should be in a position to ensure a safe environment for the general prison population without having to resort to such extreme measures, by having trained staff in sufficient numbers. The problem of violence in the prisons in the newly independent states (NIS) is a reality. The internal prisoner hierarchy, which has been compared to a caste system, has been condoned, encouraged, ignored or even denied by prison authorities. Such a system severely penalizes low-caste prisoners, in extreme cases reducing some of them to becoming sexual objects and victims of abuse. The caste system today is evolving and becoming more complex with the advent of drug gangs and their leaders, who contest the recognized hierarchy. In Western Europe as well, the emergence of drug gangs both inside and outside prisons has considerably complicated the situation.

Contracting any disease in prison is not part of a prisoner's sentence. This fact becomes even more significant when the disease is potentially fatal, as is the case with HIV/AIDS. This leads us to consider the basic rights of the prisoner.

Human rights and prisoners

Instruments and mechanisms

All human beings, and this obviously includes prisoners, have certain inalienable rights which are acknowledged by internationally recognized instruments. Since the Second World War, human rights have been quantified and set down in treaties and conventions. In 1948, the United Nations General Assembly adopted the Universal Declaration of Human Rights. Later, two covenants were adopted, the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). These state that prisoners have rights, even when they are deprived of liberty in custody. The ICCPR specifically provides that "all persons deprived of their liberty should be treated with humanity and with respect for the inherent dignity of the human person".

In 1955, the United Nations, in its Standard Minimum Rules for the Protection of Prisoners (SMR), established standards that included principles for providing health care in custody. The 94 rules in the SMR setting down the minimum requirements for prisoners were approved by the United Nations Economic and Social Council, which in 1977 extended their applicability to persons detained without charge, i.e. in places other than prisons. These standard minimum rules for the protection of people in custody have been supplemented over the years by additional instruments. In 1984, the United Nations adopted the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. In 1985, the United Nations Standard Minimum Rules for the Administration of Juvenile Justice, called the "Beijing Rules", were adopted for the protection of young offenders. In 1988 and 1990, respectively, the United Nations adopted the Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment and the Basic Principles for the Treatment of Prisoners. At a regional level, the Council of Europe developed its European Prison Rules in 1987. Human rights treaties make states accountable for the way they act, or fail to act. United Nations bodies and regional, national and nongovernmental agencies are in charge of monitoring human rights. Prisoners of war are protected by international humanitarian law as set down in the Third Geneva Conventions of 1949.

Respect for even basic human rights has traditionally been a problem in prisons. In Europe particularly, there have been major attempts to protect prisoners from violations of their basic rights, as evidenced for example by the European Convention against Torture. The Council of Europe has created a specific body, the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, known as the CPT, to monitor ill treatment and the conditions of prisoners, including health issues. Many other nongovernmental organizations also monitor prisoners' conditions, in particular all aspects of health within prisons.

The right to health care and a healthy environment in prison

With specific reference to health, the right to conditions “adequate for the health and well-being” of all was recognized in the Universal Declaration of Human Rights. The ICESCR furthermore states that prisoners have a “right to the highest attainable standard of physical and mental health”. The standard minimum rules for prisoners regulate the provision of health care for them. These rules, as well as other instruments regulating the rights and regulations for the treatment of prisoners, have been extensively reviewed and commented on in a comprehensive text by Penal Reform International.

The CPT issued standards for health services in prisons (published in their annual report for 1992). Most recently, in 1998, the Committee of Ministers of the Council of Europe promulgated new recommendations on health care in prisons. Apart from civil and political rights, the so-called “second generation” economic and social human rights, as set down in the ICESCR, also apply to prisoners. The right to the highest attainable standard of health should also apply to prison health conditions and health care. This right to health care and a healthy environment is clearly linked, particularly in the case of HIV, to other “first generation” rights, such as non-discrimination, privacy and confidentiality.

Health care in prison: equivalence versus equity

Prisoners cannot fend for themselves in their situation of detention, and it is the responsibility of the State to provide for health services and a healthy environment. Human rights instruments call for prisoners to receive health care at least equivalent to that available for the outside population. On the one hand, “equivalence” rather than “equity” has been called for because a prison is a closed institution with a custodial role that does not always allow for the same provision of care as is available outside. On the other hand, because prisoners are more likely to be in a bad state of health when they enter prison, and the unfavourable conditions therein make their health situation even worse, the need for health care and treatment will often be greater in a prison than in an outside community. However, providing even basic health care to prisoners has proved extremely difficult in countries where the overall health systems have collapsed or are chronically insufficient. As regards the specific issue of HIV, there are various areas concerned by this provision. The authorities have a duty both to preserve the health of individual prisoners and to promote the public health of the prison – and outside – population.

The above-mentioned treaties and conventions state that prison authorities have a duty to provide:

__ safe and healthy living quarters for all prisoners;
__ protection of individuals from violence and coercion;
__ provision of adequate health care services and medicines, as far as possible free of charge;
__ information and education about preventive health measures and healthy lifestyles;

__ implementation of elementary preventive health measures;
__means for detecting sexually transmitted infections and for treating them, so as to reduce risk of HIV transmission;
__ continuation of medical treatments begun outside (including those for drug users) or the possibility of commencing them inside;
__ provision of specific protection for vulnerable prisoners, such as those who are HIV-positive, from violence from other prisoners, or from those with infectious diseases which could be extremely dangerous for them, such as tuberculosis;
__ where voluntary testing for HIV is available, it should always be provided together with adequate counselling before and after testing

Public health and human rights

Protecting public health while respecting individual rights

The protection of public health in the prison context is concerned with promoting and protecting health, and with reducing morbidity and mortality of prisoners and of the whole community. This includes all prison staff (see Chapter 10), family members of prisoners and staff and visitors, as well as the outside community into which prisoners are eventually released.

As for any infectious disease, ensuring public health may involve collecting information and personal data on the HIV-infected population. It will be necessary to determine risk factors and risky forms of behaviour, so as to know how the infection disseminates. This information is crucial to develop prevention programmes (see Chapter 4). This is done routinely for other diseases, for example tuberculosis and syphilis. In the past, coercive measures such as segregation and quarantine were routinely adopted to control epidemics and public health menaces. Certain measures may indeed constrain individual behaviour for the public good.

In the recent years of the HIV pandemic, such coercive measures were questioned, mainly as a result of civil liberties groups coming forward to protect the rights of individuals. It was claimed that the protection of the public health had to go hand in hand with the respect of human rights. The late Dr Jonathan Mann convincingly demonstrated that respect for the rights of people infected with HIV was essential if the disease were to be dealt with efficiently. If people with HIV were discriminated against or if their right to medical confidentiality was not respected, they would not volunteer to be tested and would be less likely to seek counselling on methods for prevention.

At the beginning of the HIV epidemic, anonymous testing was essentially invoked to avoid the stigma of being identified as HIV positive. In prisons there is often a very real stigma attached to being HIV-positive, even more than outside due to the lack of education on the transmission of HIV infection. Prisoners and prison staff are still very often afraid of anyone identified as HIV-positive out of fear of contagion, out of prejudice against drug addicts or homosexuals, or a combination of these (see also Chapter 10). Prisoners are not generally aware that infection can only occur through high-risk

behaviour (in prisons this means essentially penetrative sex or intravenous injections with contaminated equipment, and also possibly through other practices such as tattooing). The risk of exclusion and even physical harm for such prisoners is clearly a reality in the prison environment.

Despite guidelines issued by WHO stating unequivocally that testing should not be done as a mandatory routine (Annex 1), in the NIS testing has been regularly performed, when it can be afforded, often with little opposition from those concerned. The rationale for thus systematically testing inmates has been at best equivocal. In the prison environment, negative tests may provide a false sense of security for the authorities and subjects alike because of a window period of between three weeks to three months (see Chapter 6). Because of risky behaviour and/or violence inside prisons, there is no guarantee that HIV-negative prisoners will remain negative. Furthermore, single tests can be unreliable, thereby further limiting their usefulness, and repeat testing (even if offered on a voluntary basis) is an expensive option. In some particularly violent prisons, breaches of confidentiality regarding HIV status can be life-threatening. This leads directly to the question of medical confidentiality. In any doctor–patient relationship, the concept of confidentiality is the keystone of medical care. Doctors working with prisoners have a special duty to ensure that the doctor–patient relationship is preserved and that doctors are not seen as merely part of the prison administration. Doctors are responsible for ensuring the confidentiality of prisoners' medical files, which may contain sensitive information. In systems where prison doctors are not realistically in a position to ensure such privacy, they should take care not to write down anything that might compromise their patients with the prison administration.

This question is crucial where HIV is concerned. If a prisoner is not convinced that personal information as sensitive as his HIV status will be protected within the secrecy of the medical file, there will be no trust in the doctor–patient relationship. If there is no trust, doctors will lose any influence they might have to protect prisoners who seek their help. Prisons are unfortunately notorious for not respecting medical confidentiality. Untoward disclosure of HIV status may drive inmates away from the medical services altogether, and make prevention and education even more difficult. Information on a prisoner's HIV status should be divulged by doctors to non-medical authorities only on a limited, accountable and strictly need-to-know basis. A prisoner's right to medical confidentiality should be respected, and not violated – as is most often the case – in the name of control and security.

By putting the accent on education and peer training, it is possible to gain the trust of the general population and obtain cooperation in managing the HIV epidemic. In prisons, there is still an enormous amount of work to be done in the field of health education about HIV and AIDS. There is a great need to educate and convince medical staff, as well as their direct superiors in the prison administration and the prisoners themselves. In many of the NIS even prison medical authorities are still not quite certain about how safe it may be to keep HIV-positive and HIV-negative prisoners together. In the management of HIV it is necessary to convey that any limitations on individual human rights should only be used as a last resort, with a clear purpose and goal in mind. Furthermore, the basic human rights should never be restricted, and restrictions should

not include a majority of prisoners not relevant to the action taken. Any action restricting human rights should be subjected to outside scrutiny and periodically reviewed to assess whether it is effective and still necessary. However, in some cases protective custody (a pragmatic form of segregation) may be justified for the HIV prisoners' own protection, as HIV positive inmates could be assaulted by the others once their HIV status is known. Segregation has been the rule rather than the exception, but this situation might change soon, at least in the Russian Federation.

Public health and human rights must work together

The emphasis of any management programme for HIV infection in prisons should be on education. Prisoners have a right to know about HIV and how to prevent its transmission (education and prevention activities are discussed in Chapter 5). There emerges the apparent contradiction of it being necessary to inform inmates and staff alike about the danger of risky behaviour, and even make available preventive measures to avoid contagion, while not appearing to condone such behaviour.

__ The shared goal of public health policies and human rights is to prevent transmission of HIV and thereby improve health for all in general, while at the same time ensuring the respect of human rights and dignity of those already infected and needing treatment.
__ Prison doctors should be able to work independently, and not as instruments of coercion within the prison system.
__ Consent and confidentiality must be respected so as to ensure that all prisoners will readily seek medical counselling on HIV/AIDS.
__ Adequate counselling before performing any voluntary testing for HIV will ensure trust within the doctor–patient relationship. Counselling should also be available for prisoners **after the result of the testing is known**.
__ HIV test results should be kept confidential or forwarded on a very strict need-to-know basis to any non-medical personnel, as far as possible with the knowledge and consent of the patients concerned.

In prisons, the human environment is often one of violence and highrisk lifestyles, either engaged in voluntarily by those prisoners with positions of power, or forced upon the weaker prisoners. Prisoners have a right to live in conditions where their individual safety is guaranteed. It is paramount for the prison administration to have a thorough knowledge of how HIV is likely to be transmitted in a given prison. If sexual coercion and/or violence are the main issue, better surveillance and active interventions to protect targeted prisoners must be enforced. If drug injection and sharing of injection equipment is the main problem, active education may not be sufficient. It may be necessary to take measures to stop coercion by drug ringleaders, who may seek to force other prisoners to buy and inject drugs, and make available drug treatment programmes and harm reduction measures denied access to recreation, education or normal access to the outside. From a strictly medical point of view, there is no justification for segregation as long as the prisoner is healthy. Solitary confinement of HIV-positive inmates should be forbidden. Any restrictions should be exceptional, such as mandatory testing for

particularly risky situations, such as prisoners working as medical orderlies in hospitals or dental clinics. Prisoners working in other places less obviously posing a risk, such as laundries, kitchens or as cleaners, may also be exposed to injuries and therefore HIV infection (see Chapter 10). The protection of HIV-positive prisoners from other prisoners with contagious diseases such as tuberculosis is discussed in Chapter 7. There may also be considerations of personal security where, for example, prisoners known to be HIV-positive request to be kept in a secure unit as they fear for their own safety.

Both prison reform and penal reform are crucial elements if the many problems affecting the prisons of eastern Europe and the countries of the former Soviet Union are to be resolved. Diminishing the overall prison population will allow improvements in the physical and working conditions in prisons, and help to ensure the security of all individuals in custody. Obviously, financial resources will have to be allotted to the prison systems as well. One effective way to curb the rise in prison populations would be to offer alternatives to imprisonment for non-violent offenders.

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