

B4 Prisoners

More than thirty years ago, a young black medical student named Steven Bantu Biko spearheaded the formation of the Black Consciousness movement in South Africa, an important contribution to the eventual downfall of apartheid. In the years that followed, he was kept under surveillance by South Africa's security police, subjected to repeated interrogations and detention, and banned from making public speeches. On 12 September 1977 Biko died of a severe head injury in Pretoria Central Prison following an interrogation during which he was beaten, chained to a window grille and left to lie in his own urine. Biko was one of more than seventy detainees in South Africa who died in detention between 1960 and 1990. In 1997 South Africa's Truth and Reconciliation Commission heard how two doctors serving Pretoria Prison at the time had failed to render adequate medical assistance to Biko following the assault he had been subjected to. The dereliction of duty of these doctors had been raised in 1978. At the time, however, the Medical Association of South Africa defended the prison doctors, demonstrating the apathy and complicity of the medical profession towards the systematic abuse and killing of many prisoners. Torture and death form the extreme end of a spectrum of public health problems that concern people who are imprisoned or held in detention.

This chapter discusses the health-care needs and living conditions of prisoners and detainees deprived of their freedom by the state, and for whom the state is thus responsible. Although the words 'prison' and 'jail' are often used interchangeably in many countries, 'jail' often refers to a place used to hold persons awaiting trial or serving sentences of less than one year, whereas prisons are usually used to hold those serving longer sentences. 'Detention centre', on the other hand, describes a facility used

TABLE B4.1 **Prison population rate**

Country	prisoners/100,000 population
United States	738
Russia	611
St Kitts & Nevis	547
US Virgin Islands	521
Turkmenistan	489
Belize	487
Cuba	487
Palau	478
British Virgin Islands	464
Bermuda	463
Bahamas	462
Iceland	40
Nigeria	30
India	30
Nepal	26
Mauritiana	26
Central African Republic	24
Congo	22
Faroe Islands	15

Source: Wamsley 2007.

to confine persons detained without charge or awaiting trial, those facing immigration issues, refugees and minors. Where the word ‘penal institution’ is used in the context of this chapter, it refers to both prisons and jails.

At the end of 2006 over 9 million people were being held in penal institutions worldwide. The United States incarcerates the greatest number of people (2.19 million in 2006), nearly a quarter of the world’s prison population. This is followed by China (1.55 million) and Russia (0.87 million) (Wamsley 2007).

Many prisoners around the world are victims of unsafe convictions, imperfect judicial systems and poor living conditions in prisons. The majority come from the poorest and most marginalised sections of society with limited or no access to health care. Shockingly, a large number of those

held in prisons and detention facilities are children. A significant proportion of prisoners suffer from mental illnesses, making prisons the new 'mental asylums' of our time (Fellner 2007). Ritual humiliation and sexual abuse by prison guards and other prisoners pose further threats to a prisoner's physical and mental well-being.

Prisons and health

Information on the state of prison health around the world is incomplete and largely inadequate. In 1993, Human Rights Watch (HRW) conducted a major review of prison conditions worldwide and found that the great majority of prisoners were 'confined in conditions of filth and corruption, without adequate food or medical care, with little or nothing to do, and in circumstances in which violence from other inmates, their keepers or both is a constant threat'. HRW also noted that incidences of cruelty frequently occur because 'prisons, by their nature, are out of sight; and because prisoners, by definition, are outcasts'.

Eight years later, another international review noted that living conditions in prisons 'have certainly not improved uniformly in the past decade, and in many countries, overcrowding has made these conditions even worse' (Van Zyl Smit and Dunkel 2001).

In 2007, a prison health brief found that 'the prevalence of disease, malnutrition, mental illness and general ill health among the global prison population provides overwhelming and incontrovertible evidence that prisons are bad for your health. For many, imprisonment is marked by the deterioration in health and well-being – in some cases it is tantamount to a death sentence' (Penal Reform International 2007).

Prison health in the context of public health and policy

In many countries, prison health care falls under the remit of the Ministry of Justice rather than the Ministry of Health, often resulting in the exclusion of prison health from wider public health policy development. This is particularly short-sighted as the majority of prisoners will eventually re-enter the civilian population and custodial personnel, health staff, visitors, delivery personnel, repairmen and lawyers act as 'bridge populations' between prisoners and the outside world (Reyes 2007).

Communicable diseases: HIV and tuberculosis

The prevalence of HIV and other sexually transmitted infections (STIs) tends to be higher among prison populations compared to the general population (UN Office on Drugs and Crime et al. 2006). In South Africa,

BOX B4.1 The campaign to gain access to anti-retroviral treatment (ART) in South African prisons

In August 2005, a South African NGO, the AIDS Law Project (ALP), became aware of the plight of HIV-positive prisoners at Westville Prison who were being denied access to ART. The ALP initiated legal proceedings on behalf of the prisoners and in June 2006 the High Court ruled that the South African government should ensure that all HIV-positive prisoners are assessed for treatment. However, by August 2006, prisoners with AIDS had still not received treatment, forcing the courts to order the government to provide ART to sick prisoners with immediate effect. This and the ensuing media coverage eventually forced the government to make a vital policy shift.

Source: Hassim 2006.

HIV prevalence in prison is twice that in the general population (Goyer 2003). In Central Asia, one-third of people living with HIV are in prison; in Krygstan this figure is as high as 56 per cent (Walcher 2005). High rates of HIV prevalence in prison settings are due to an over-representation of three high-risk groups: intravenous drug users, commercial sex workers, and men who have sex with men (WHO 2007). In spite of this, HIV/STI programmes in prisons have not been implemented in many countries (see Box B4.1).

In many countries, tuberculosis (TB) is a leading cause of mortality in prisons, where the rate of infection may be 100 times higher than the rest of the population (Reyes 2007). In the Ukraine in 2003, about 30 per cent of TB patients resided within the penitentiary service, with the disease accounting for about 40 per cent of all prison mortality. In Russia in 2002, 42 per cent of all known TB cases were estimated to be prisoners (Prison Healthcare Project n.d.). Between 10,000 and 30,000 of prisoners released each year in Russia are believed to have active TB.

However, with sufficient political will and appropriate policies, progress can be made. In Azerbaijan, the treatment of about 7,000 prisoners with TB reduced mortality rates from 14 per cent in 1995 to 3 per cent in 2004. In Georgia, TB treatment programmes resulted in prevalence falling from 6.5 per cent in 1998 to 0.6 per cent in 2005 (ICRC 2006).

In cases of prisoners on antiretrovirals (ARVs), there is often no cohesive follow-up or support system upon release from prison. In countries where health care is largely privatised, prisoners struggle to keep up with their



IMAGE B4.1 **Overcrowded remand cell in Malawi**

treatment regimens, even if they were compliant in prison. This not only impacts on the health of ex-prisoners and their ability to seek and maintain employment (helping break the cycle of reincarceration), but also fuels wider disease transmission and the development of drug resistance, particularly multi-drug-resistant TB.

Sanitation and living conditions

Many prisons are overcrowded and unfit for habitation. In 2006, the UN Office on Drugs and Crime found that ‘overcrowding, violence, inadequate natural lighting and ventilation, and lack of protection from extreme climatic conditions are common in many prisons of the world’, often combined with ‘inadequate means for personal hygiene, inadequate nutrition, lack of access to clean drinking water, and inadequate medical services’.

On average, prisons in Europe run at 130 per cent of official capacity. In the US, prisons are at 107 per cent capacity. Prisons in Bangladesh currently hold 288 per cent of their official capacity. However, the country with the highest level of prison overcrowding is Kenya: 337 per cent of official capacity (Penal Reform International 2007).

According to the European Committee for the Prevention of Torture, cells intended for single occupancy should be about 7 square metres.

However, in May 2006, Georgia's Tbilisi Prison No. 5 held 3,559 prisoners in a facility originally designed for 1,800 prisoners, resulting in 1 square metre or less per prisoner (HRW 2006a). One cell was found to contain 75 prisoners with only 25 beds, non-private toilet facilities and piles of uncollected refuse.

The excessive use of pre-trial detention and slow, bureaucratic criminal justice systems are major contributing factors to prison overcrowding. In India, for example, seven out of ten people held in penal institutions are pre-trial detainees, while in Nigeria over 25,000 prisoners are awaiting trial (Penal Reform International 2007).

Mental health issues

The criminalisation and incarceration of people with mental illness is a human rights issue in need of urgent attention. People with mental illnesses often end up being 'misdirected towards prison rather than appropriate mental health care or support services' (Commission on Human Rights 2005).

A systematic review of surveys from twelve different countries estimated the prevalence of psychiatric disorders in a total population of 22,790 prisoners. It found that among male prisoners included in the review, 3.7 per cent had a psychotic illness, 10 per cent major depression and 65 per cent a personality disorder. Among women prisoners surveyed, 4 per cent had a psychotic illness, 12 per cent major depression and 42 per cent a personality disorder (Fazel and Danesh 2002).

Prisons in the US are now host to three times more adults with serious mental health disorders than the general population. In 2005, it was estimated that around 50 per cent of prison inmates were suffering from a mental health problem – over 1 million men and women. Many have ended up in prison because 'community mental health systems are in a shambles – fragmented, under-funded and unable to serve the poor, the homeless and those who are substance-addicted as well as mentally ill' (Fellner 2007). Furthermore, around a half of prisoners with mental health problems were imprisoned for non-violent offences.

Prison mental health services are frequently lacking in funding, resources and adequately trained medical personnel. In many areas of the world, prison mental health services are non-existent, with prison staff often receiving little or no training in managing prisoners with mental health problems. Common practices such as solitary confinement only serve to further fuel mental illness.

BOX B4.2 Human rights abuses at Guantánamo Bay

Since January 2002, more than 750 individuals of some 45 nationalities have been detained at the US's offshore prison camp at Guantánamo Bay, Cuba. Among the detainees were children as young as 13. Amnesty International (2007) has found that 'their dignity, humanity and fundamental rights have been denied', including the right to due legal process. Five years since the start of the 'war on terror', hundreds of individuals remain in detention without having been formally charged or brought to trial.

In 2005, in spite of having condemned the practice of binding and shackling of prisoners' limbs in China, Eritrea, Iraq, Israel, Libya and Pakistan, the US government allowed the use of 'stress positions' and the shackling of prisoners in painful positions for extended periods of time in Afghanistan. The US also condemned forced nudity when used by regimes in North Korea, Egypt, Syria and Turkey but used it as a tactic in detention camps in Afghanistan and Iraq. Solitary confinement and isolation in China, Jordan, Pakistan, Tunisia, Jordan, Iran, North Korea and pre-war Iraq had also been condemned, but later approved for use by the US military (Malinowski 2005). The CIA is also believed to have used 'water-boarding', a tactic that simulates drowning, during interrogation sessions. The UN Working Group (UN Economic and Social Council 2006) on the situation of detainees at Guantánamo Bay found that although thirty days was the maximum time permissible for detainees to be held in isolation, detainees were put back in isolation after very short breaks, resulting in quasi-isolation for up to eighteen months.

Torture and abuse

In 1984 the UN Convention Against Torture was adopted by the United Nations General Assembly. To date, over 140 countries have ratified it. In spite of this, in 1998 the UN Special Rapporteur on Torture reported that 'systematic torture was still being practised in over 70 countries' (BBC News 1998). According to HRW, the US, China, Iran, Egypt, North Korea, Pakistan, Brazil, Libya, Burma, Zimbabwe and Tunisia are among the worst offenders (HRW 2005). In 2006, the Medical Foundation for the Care of Torture Victims (a UK-based NGO) received 2,145 new referrals from 86 different countries. The top ten countries that produced the most referrals were Iran (235), DRC (193), Eritrea (150), Turkey (142), Somalia (118), Cameroon (104), Afghanistan (101), Sri Lanka (80), Sudan (80) and Iraq (74).

Judicial caning

Judicial caning continues to be used as a form of punishment in a number of countries including Malaysia, Singapore, Brunei and Hong Kong. In 2007, Malaysia came under criticism following the release of a video showing a naked and screaming prisoner strapped to a wooden frame whilst being beaten with a rattan stick by a prison guard (CNN 2007). Amnesty International and various other human rights advocates have spoken out against this form of cruel and degrading punishment on a number of occasions, to no avail.

The complicity of medical professionals in torture and abuse

The complicity of medical professionals in the conduct of torture includes disclosing confidential medical details to those committing torture; providing clinical support for the initiation and continuation of torture; or simply remaining silent about such abuse.

In his book which details how physicians at Abu Ghraib and Guantánamo Bay prisons violated codes of good medical practice, Stephen Miles (2006) concludes that 'the US military medical system failed to protect detainees' human rights, sometimes collaborated with interrogators or abusive guards, and failed to properly report injuries or deaths caused by beatings.' This also involved delays in issuing and falsifying death certificates. Doctors are also known to have broken detainee hunger strikes through forced feeding via the insertion of nasogastric tubes (Rose 2006).

Evidence of medical complicity from other countries also exists. Amnesty International (2001) has reported the widespread use of torture and cruel treatment within Brazilian prisons and places of detention. In some instances, doctors examining torture victims were alleged to have omitted documenting evidence of torture in medical case notes and failed to carry out thorough medical examinations, including examining prisoners fully clothed. Under the regime of Saddam Hussein in Iraq, doctors are known to have been involved in torture (for example, amputating ears of dissidents), although in many instances doctors are thought to have been forced to act under extreme duress (Reis et al. 2004).

HRW (2004) has produced a report highlighting the persecution and torture of men who have sex with men in Egypt. Between 2001 and 2004, at least 179 men were charged with the 'crime' of homosexuality. Many were forced to undergo cruel and degrading physical examinations in order to 'prove' their sexual orientation, which included the use of rectal sonograms and manometry. Although doctors claim to have obtained consent prior to these examinations, HRW found documentation of this in only one of the hundred case notes it examined.

Counterculture

Turkey is one example of a country where the practice of torture is being overturned (Worden 2005). There have been multiple accounts of students, intellectuals and government critics being subjected to brutal torture. However, when Turkey ratified the European Torture Convention in 1998, it was forced to open itself up to greater international scrutiny. This included granting the European Committee for the Prevention of Torture access to police stations for unscheduled visits. In 2003, *immunicado* detention was officially abolished. The medical profession and other civil society groups within Turkey began speaking out against torture, and evidence on the practising of torture was presented to parliament. Since 2000 there have been no further recorded deaths in police custody. In 2005, HRW reported a reduction in the number and severity of torture cases.

Children

According to the United Nations Children's Fund (UNICEF) (2006) there are over 1 million children held in detention worldwide, the majority of whom are held for minor offences or petty crimes such as truancy, vagrancy, begging or alcohol use. Many of these offences are 'status' dependent, meaning that such actions would fail to be a 'crime' if carried out by adults. Many legal systems do not take into account a child's age when handing out sentences.

Child detention: some examples

HRW has reported that an estimated 400 children between the ages of 13 and 18 are incarcerated in state prisons in Burundi, three-quarters of whom are held under pre-trial detention. Many of the children had been awaiting trial for months, and in some cases years. Many were also being held in communal holding cells and police lock-ups, awaiting transfer to state prison facilities. In some cases children were tortured to obtain confessions and most of the children had no access to legal counsel (HRW 2007). Lack of space, poor sanitation facilities, along with inadequate bedding, food and water, are daily threats to the well-being of these children. Whilst in prison children receive no education. In breach of international law, children and adult prisoners are in contact for much of the day, making child prisoners in Burundi vulnerable to physical and sexual abuse.

Vietnam is a country that routinely and arbitrarily detains street children. Children are held in state 'rehabilitation' centres for periods of time ranging from two weeks to six months. Serious abuses of street children held at the Dong Dau and Ba Vi 'social protection centres' on the outskirts of Hanoi

have been documented. Children were confined to their cells for twenty-three hours a day in filthy, overcrowded conditions with only a bucket available for use as a toilet. Lights were kept on both day and night. There was no access to medical or psychological treatment and frequent beatings and verbal abuse by prison staff were also reported (HRW 2006b).

Children and the death penalty

Despite clear prohibitions in international law against the use of the death penalty for juvenile offenders, child executions still exist in some parts of the world. Amnesty International (2006) has documented a total of fifty-three child executions in eight countries since January 1990. Offending countries include Iran, Nigeria, Saudi Arabia, the Democratic Republic of Congo, Yemen, China, Pakistan and the US. Iran and the US accounted for more executions than all other countries combined. Twenty-one executions took place in Iran and nineteen in the US. In 2005, the US Supreme Court finally found the execution of child offenders to be unconstitutional.

Response of the international community

While prisoner health remains by and large a neglected public health domain, a number of important initiatives have been undertaken by various organisations to address some of these critical issues. These include efforts to improve data collection and monitoring; advocacy for more effective and just penal systems; and the development of guidelines and instruments to improve prison health programmes. However, many of these initiatives are in urgent need of funding, as well as greater attention and support from the health community at the levels of both policymaking and implementation. A brief overview of some of these initiatives and the organisations leading them is available from the GHW website at: www.ghwatch.org.

Recommendations

Governments

GHW reiterates the call to governments worldwide to incorporate prison health into public health policy; for prison health to fall under the jurisdiction of ministries of health; and for the right to health to be recognised in prisons. Firm political commitment is needed to combat the spread of infectious disease, particularly TB, HIV and hepatitis C. Mental health-care provision and substance dependency management are two other areas that require urgent attention and that could help to break the revolving-door syndrome of reoffending and reincarceration. Urgent steps must be taken

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to improve basic sanitation, living conditions and treatment of prisoners. Robust mechanisms for monitoring prison conditions are required that allow rapid action to be taken when incidences of abuse and injustice are uncovered.

WHO and the United Nations

Efforts made by the World Health Organization (WHO) and the UN in advancing health in prisons in Europe (particularly eastern Europe) are encouraging. However, this needs to be extended, particularly to countries in Africa and Asia. Initiatives such as the WHO Prison Health Database need to be promoted and supported to ensure progress and sustainability. Other initiatives such as the UN Special Rapporteur to African Prisons require increased funding and support to enable them to widen their scope of activities and influence.

National medical associations

National medical associations need to lobby governments to make prison health a public health priority and encourage continual professional development and conduct among prison doctors. They need to support doctors within their own countries to speak out against incidences of abuse, neglect and torture. Disciplinary action should also be taken whenever members are found to violate ethical codes of conduct.

Non-governmental organisations

Much of the research into prison conditions and health has thus far been conducted by non-governmental organisations (NGOs). Whilst their contribution has been vital, greater government, UN funding and private philanthropy are needed to ensure that a systematic, comprehensive and coordinated review of prison conditions takes place at least every five years. Whilst the Health in Prison Project has made good progress in Eastern Europe and Asia in particular, little information is available on prison conditions in China, South America and Southeast Asia.

In summary, prison health is a major public health issue in need of urgent and immediate attention. Overcrowding, unsanitary living conditions, the dangers of transmittable and highly infectious diseases, poor mental health services, torture, abuse and the scandal of child imprisonment continue to plague prison services worldwide. We need to remember that prisoners are sent to prison as punishment, not for punishment. Dying from TB, dysentery, malnutrition or from a beating by prison officials should never form part of a prisoner's sentence.

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