

HEALTH CARE IN DETENTION

A PRACTICAL GUIDE



ICRC



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This guide is dedicated to all those ICRC expatriate and national staff members who died working to save the lives of others.

TABLE OF CONTENTS

1. INTRODUCTION.....	5
1.1. Introducing the guide	5
1.2. Background concepts.....	6
1.3. The role of the health professional in prison assessments	8
1.4. Organizing prison assessments	9
1.5. Discussions with detainees	10
1.6. Standards for detention and imprisonment	11
2. ACCOMODATION, WATER, SANITATION AND HYGIENE	15
2.1. Accommodation and overcrowding.....	15
2.2. Water: Source, storage, distribution and access	19
2.3. Personal hygiene	22
2.4. Toilets	24
2.5. Wastewater and sewage system.....	26
2.6. Waste management and hygiene of premises.....	27
2.7. Vectors and pests	29
3. FOOD AND NUTRITION.....	31
3.1. The food chain	32
3.2. Food supply	33
3.3. Food storage	35
3.4. Food preparation	37
3.5. Access to food	41
3.6. Nutrition	43
3.7. Malnutrition	46
3.8. Assessing nutritional status in prison populations.....	49
4. HEALTH-CARE SERVICES.....	51
4.1. Background principles	51
4.2. Health staff	52
4.3. Medical facilities and equipment.....	55
4.4. Access to health care INSIDE the prison	57
4.5. Access to health care OUTSIDE the prison.....	63
4.6. Individual patient records.....	66
4.7. Clinical registers.....	67
4.8. Medicines and health budget	69
4.9. Health care for women in prison	71
4.10.Promoting health in prisons.....	73
5. HEALTH STATUS OF DETAINEES	76
5.1. Assessing health status and collecting measurable indicators.....	76
5.2. Mortality.....	77
5.3. Morbidity.....	79
5.4. Torture and other forms of ill-treatment	82
5.5. Individual medical cases.....	85
6. ADDITIONAL RESOURCES.....	87
Annex: Standards for Health-Related Issues in Prisons.....	91
Index.....	93

Key

- Bullet-pointed lists of sample questions for each topic are included in boxes like this one. These lists are not exhaustive: they do not cover *all* questions and *all* places of detention. Every prison assessment should be adapted to the specific situation and the realities of the prison visited.

Abbreviations

CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CMR	Crude mortality rate
MCH	Mother and child health
SMR	Standard Minimum Rules for the Treatment of Prisoners
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
WMA	World Medical Association
NGO	Non-governmental organization
HIV	Human immunodeficiency virus
EPI	Expanded Programme on Immunization
PoD	Place of detention

1. INTRODUCTION

1.1. Introducing the guide

Who the guide is for

This guide is intended for individuals or organizations dealing with the issue of health in prisons. Health personnel (doctors and nurses) who visit or work in prisons will find it especially pertinent.

It is hoped that the contents of the guide will be applicable in a broad range of contexts. Also, although the guide refers mainly to prisons, the approach it sets out, to assessing health and health determinants, may be used in other places of detention, such as police stations or immigration detention centres.¹

Aim

The guide aims to be of assistance in **assessing** and **documenting** those aspects of life in prison that can affect the health of detainees. Collating this information can yield an objective perspective on any problems or shortcomings within a prison. The information can then be used to help the detaining authorities ensure the best possible standards of health among detainees, as required by law.

The guide provides a logical and uniform approach to assessing health and health determinants within a place of detention, which should make possible the following:

- definition of baseline conditions – health and living conditions – of the population
- assessment of the way the situation might evolve over time
- identification of key problems that may need specific measures in response or more detailed assessment.

Furthermore, by following a uniform approach to assessing and reporting, the guide will allow comparisons to be made *between* prisons.

Using the guide

Chapters in the guide address particular aspects of life in prison that can affect the health of detainees. The chapters are divided into sections on particular subjects. These sections generally contain some background information on the issue in question, references to pertinent standards, and sample questions for prison visits.

The guide will not address every aspect of health in prisons. The final chapter includes a list of resources that provide further information.

¹ For the sake of simplicity, in this guide the term 'prison' is used to refer to any facility where people are detained.

The term 'detainee' is used in preference to 'prisoner' for two reasons: first, to emphasize the range of people to which the contents of the guide may apply, for not all of them have been convicted and not all are held in prisons; and, second, because, in many contexts, the term 'prisoner' tends to be loaded with unfavourable associations.

1.2. Background concepts

The 'health pyramid'

A '**health pyramid**' is useful for assessing health in prisons (see figure 1.1). Following this model, a healthy environment is 'based' on: adequate **food and nutrition**; adequate **hygiene and sanitation**; and appropriate **accommodation**. To build on this base, measures for the **protection and promotion of health** must be undertaken. In the health-pyramid model a **curative approach**, at the peak of the pyramid, is part of the system for sustaining overall health. However, curative medical care can be effective only where it is added to the essential components of nutrition, water, sanitation and habitat, and to measures for promoting health and preventing diseases.

Supporting the health pyramid at every level are 'psychosocial factors', discussed below.

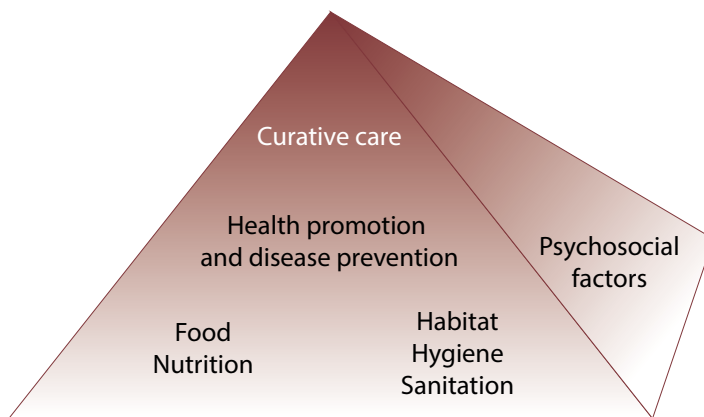


Figure 1.1 A 'health pyramid' for prisons

Psychosocial factors

Most aspects of life in detention have some impact on health. The health pyramid describes the basic and essential influences on health in prisons (food and nutrition; hygiene and sanitation; accommodation; health protection and promotion; and, finally, curative health care). However, when assessing health in prisons it is important to look beyond these basic elements. Other factors – less obvious, or even invisible – can also powerfully influence health. They are sometimes loosely called '**psychosocial factors**', and include: the psychological effects of arrest and imprisonment; separation from support structures; internal prisoner hierarchies; violence including sexual violence; drug use; prison routines; respect or not of judicial guarantees; promiscuity.

Psychological effects of arrest and imprisonment

During their arrest or interrogation, most people will experience high levels of stress. They may also be subjected to ill-treatment or torture, which could have lasting consequences for their physical, mental and social health. While in detention, they will inevitably suffer anxieties about the future, such as whether they will be released after interrogation, sent to trial, or if convicted, what life in prison will entail and what the effects on their families will be. For many people, these stresses and uncertainties go well beyond their normal range of experience. Additionally, while in prison, many people feel hopeless and suffer from low spirits and depression.

Separation from support structures

People who are suddenly removed from their day-to-day world and placed in detention find themselves without their usual coping mechanisms and support structures (such as families, friends, and in many cases, their work environment). This increases their vulnerability to psychological harm.

Internal hierarchies

Internal prisoner hierarchies and unofficial prison 'rules' exist, to a greater or lesser degree, in prison communities throughout the world. Within a prison, various criminal, political, or ethnic groups may establish rules that detainees must obey. These groups may compete with each other for influence, power or material gain; this may involve extortion, coercion, bullying, or physical or sexual violence. Various forms of discrimination might also be practised, and that could include restricted access to health-care facilities. These activities may be knowingly tolerated by the prison authorities and in some cases, may even involve the authorities directly.

Drug use

In many contexts, a sub-culture of drug use exists within prisons and often it is intertwined with the internal prisoner hierarchies mentioned above. Intravenous drug use greatly increases health risks in prison settings. Two factors contribute to this increased risk: first, the prevalence of blood-borne diseases tends to be higher among people in prison than among the general population; second, the scarcity of clean needles, and the fact that drug paraphernalia must be concealed from authorities, leads to more sharing of needles and other equipment. Some prisons have established needle exchange programmes to tackle these issues.

Sexual behaviour

Sexual behaviour in prisons may be consensual or non-consensual and may include sexual violence. There is often risk of exposure to sexually transmitted infections, including HIV, because of the greater than usual prevalence of the disease in prisons and the scarcity of condoms. In response, some prisons have introduced condom distribution programmes.

Prison environment and routines

Many aspects of the detention environment and routines that are governed by official prison regulations may also have an impact on health. The extent to which prisoners are in contact with their families, either through mail (and Red Cross messages) or through family visits; access to work, or being forced to work; access to fresh air, physical activity or sports; the extent to which prisoners are able to enjoy recreational activities such as reading and games; being able to practice their religion; access to education (especially for children, but also further education for adults); and of course, access to health care: all these factors may have a direct or indirect impact on health, but they can also be subject to interference from prisoner hierarchies or from guards and the prison administration.

It will be clear from the above that most aspects of life in detention may be encompassed by the term 'psychosocial factors'. Many of these factors may be difficult to understand, deal with or change. However, it is important to be aware of them and of the ways in which they can affect the health of the prison population.

Availability, accessibility and quality

It is important while assessing prison health to distinguish between *availability* and *accessibility*. AVAILABILITY describes the existence of infrastructure and services within the prison: health-care facilities, drugs, water and sanitation facilities, kitchens, food, etc. ACCESSIBILITY describes the extent to which detainees have equal access to these facilities and services without barrier or interference.

Facilities and services within prisons should operate on the principle of non-discrimination and must be equally accessible to all; they must also acknowledge that certain vulnerable or marginalized groups may have greater needs (for instance, women, children, the elderly, the disabled, those with HIV/AIDS, and ethnic minorities). Accessibility can be further divided into **physical accessibility** (for instance, does the location of the facilities interfere with physical access?); **economic accessibility** (are there any financial barriers that hinder access to the facilities, services, food, and so on?); and **access to information** (for instance, can detainees ask for and receive information on health, sanitation and nutrition, and can they themselves provide information or feedback?).

The **accessibility** and the **quality** of services and infrastructure are two of the main determinants of health in prisons.

Understanding the prison staff

It is tempting sometimes to regard detaining authorities as ‘the bad guys’, particularly where the treatment of detainees seems especially poor. In most cases, however, the authorities are unlikely to fit this description. And adopting an adversarial position with regard to the prison staff is unlikely to benefit anyone, especially the detainees. During the prison assessment, it is important to try and move beyond a simplistic conception of the detaining authorities.

If possible, look into the facilities available to the prison staff for accommodation, hygiene and recreation. Also look into the quality of their food and health care. Sometimes the facilities and services available to prison staff are not much better than those for detainees. Obviously, this cannot justify poor conditions for detainees. However, it should be recognized that poor conditions for the prison staff will affect their morale and well-being, and that will ultimately affect their work and their attitude towards the detainees.

Study how motivated the prison staff are, and the challenges they have to face. Find out about their payment and reward structure. Ask whether they applied for their jobs and if so, why. And ask whether they enjoy their job and why they enjoy it (or why they do not enjoy it). These conversations may provide useful information and may also help to establish more collaborative relationships.

1.3. The role of the health professional in prison assessments

Health professionals (doctors or nurses) generally take a public-health approach to the assessment of health in prisons: they address the health of the prison population as a whole, not that of individual inmates.² The health

2 H. Reyes, “The role of the physician in ICRC visits to prisoners,” ICRC, Geneva, 1994. See: <http://www.icrc.org/eng/resources/documents/misc/57jmk5.htm>

professional must assess the organization of the prison and conditions within it, as well as *their* effects on the general health of the prison population. Health professionals must also identify anything in the conditions or regime that has an adverse impact on detainee health. Finally, practical recommendations and suggestions for solutions must be drawn up for submission to the detaining authorities. This guide aims to be of assistance in carrying out prison assessments. To that end, it draws attention to those aspects of a prison's conditions and regime that are most likely to affect health, and provides sample questions that should be of help in analysing them. Note that the lists of questions contained in each section are *only examples* and will need to be adapted to each place of detention. Also, this guide is **not** meant to be a checklist; it provides an approach to prison assessment, one that is general and analytical. **Where the prison assessment reveals shortcomings in the conditions or regime, the health professional must aim to analyse the causes and evaluate their impact on the health of detainees.**

A thorough assessment of health in a prison entails assessing the prison health system in depth, through observation, discussions with the prison health staff, and private talks with sick and/or healthy detainees. This will take time. The health professional may also have to assess such matters as accommodation, food, hygiene, water and general sanitation, as well as various psychosocial factors associated with detention. Whenever possible, a prison assessment should include a visit to the local health facility to ascertain the level of health care available to the community, and to find out if there are any issues in connection with detainees referred to that facility.

It is important to be clear about what the health professional must **not** do during an assessment of prison health. In general, he or she should **not** take over the work of the prison staff or run a parallel health system by performing individual health checks and treating detainees. Prison authorities or members of the prison assessment team should generally not be encouraged to draw up lists of detainees who 'want to see the doctor'.

However, the health professional should meet selected detainees individually, to discuss issues relating to the health system. The health professional may use *general* or *specific* criteria for choosing these detainees. *General criteria* may include: most recently arrested detainees, female detainees, or detainees above or below a certain age. *Specific criteria* may include: detainees who have passed through specific places of interrogation, who exhibit features of a particular disease, or who show clear signs of mental illness.

In contexts where ill-treatment is an issue, the health professional may want to assess detainees who have been subjected to it, in order to medically document it.

1.4. Organizing prison assessments

Assessments of prison health by health professionals will often take place during team visits to prisons. At the ICRC, these teams usually consist of detention delegates, legal advisers, water and sanitation engineers, nutritionists, etc. During these visits, other team members may assess specific aspects of a prison and have discussions with detainees. Good teamwork and coordination are essential to ensure that no issues are overlooked during an assessment, and that no duplication of work takes place. All team members should be aware of **who** will gather **what** information within the prison. The division of tasks will depend upon the size of the team and the issues and circumstances associated

with the prison. For example, an acute health crisis in a prison might consume the bulk of the visiting health professional's attention and require that much of his or her usual workload be delegated.

Non-medical team members may assess accommodation, food, hygiene, water and general sanitation as well as many of the psychosocial factors associated with detention. A health professional can then use the findings to judge the impact on health within the prison, or to determine whether further investigation is needed. Thus, non-medical members of the prison assessment team may find the contents of this guide useful. The guide is not, however, meant to take the place of a health professional in the prison assessment team. A medical background is required for understanding many health issues. Non-medical team members assessing health-related issues in prisons must discuss their findings with a health professional.

After a prison visit, team members, including the health professional, should collaborate in reporting their findings and making recommendations. These recommendations may be for internal use (for example, strategies for monitoring developments in the prison) or for submission to the prison authorities (for example, recommending changes to the prison environment or regime). Recommendations for action should aim to be as comprehensive as possible, taking into account all challenges and all stakeholders. This guide concerns itself only with the process of prison health *assessment*; it does not contain advice on the measures to be taken.

1.5. Discussions with detainees

Discussions with detainees are an important source of information about health, health determinants, and health care in prisons. Below are some suggestions for making these discussions as fruitful as possible.

Arranging the interviews

Before arriving at the prison, decide which groups of detainees you would like to meet. Try to meet detainees from vulnerable groups, such as women, children, the elderly, the disabled, and foreigners. People in prison may also be vulnerable for reasons of ethnic, religious or political affiliation. Vulnerable groups are at particular risk of health problems.

Do not let the prison authorities choose which detainees will talk to you.

Use a quiet space for discussions, out of earshot of other detainees and the prison authorities.

Avoid, as far as possible, any imbalance in the situation: for example, try to use chairs of the same height, and ensure that detainees are not shackled during discussions.

Working with interpreters

Let interpreters know in advance the subjects you plan to discuss with detainees, especially if they are sensitive matters. Interpreters will then have time to prepare suitable expressions or words to use and will not be taken by surprise.

Speak slowly and clearly in short sentences. Working with interpreters can be very challenging; make sure you continue to speak slowly and clearly even if you are feeling frustrated.

Introductions

Introduce yourself to detainees with your name and your job title; tell them what you are there for. Explain that even though you will be discussing health-related issues you cannot treat them or provide clinical advice. This is important: you must not give detainees the impression that you will personally intervene in their behalf. It will also ensure that you are not requested to provide medicines or referrals.

Assure them of the confidentiality of your conversations with them. Explain that if they do not want you to disclose any details of the conversations to anyone, you will not do so; also, that should they give you permission to talk to others about these conversations, the sources of any information you pass on will remain anonymous.

Explain to the detainees that they are not obliged to talk to you.

During the discussion

Be polite and respectful at all times.

The different groups within a prison may provide very different stories and perspectives. This may reflect actual differences in experience, or different beliefs about the way things should be. As there is no single 'truth', do not be surprised if you hear conflicting accounts.

Closing

At the end of the discussion, ask the detainee if he or she has any questions or anything further to say. This will signal the end of the discussion. It may also elicit useful information – by now the detainee will have a good idea of the sort of information you are seeking and may provide information on matters that you did not bring up.

1.6. Standards for detention and imprisonment

'Standards' include laws, recommendations, and principles of good practice. They exist for most aspects of detention. Where these standards are not met, they can be used to guide action.

There are three main types of standard that can be referred to during prison assessments:

- **national** standards, which may be found in domestic laws relating to detention, or in publications by national health bodies (public health associations, for example)
- **regional** standards set by regional bodies, such as the Council of Europe and the African Commission on Human and Peoples' Rights
- **universal** standards on prison conditions set by the UN.

These three kinds of standard will be described in greater detail below.

The ICRC has also established some reference values in the area of water, sanitation and habitat, drawn from its long experience of work in prisons.³ Standards do not always consist of clearly defined indicators or figures. Reference values for basic health indicators (such as crude mortality rates and numbers

³ P.G. Nembrini, *Water, Sanitation, Hygiene and Habitat in Prisons*, 2nd ed., ICRC, Geneva, 2013. Available at: <http://www.icrc.org/eng/resources/documents/publication/p0823.htm>

of medical consultations) are generally not available for prison populations. However, in some instances, reference values developed for displaced persons (including refugees) are used as an approximation or 'best estimate' for prison populations.⁴

In relation to the accessibility of health care, the standard often invoked is that of *equivalence* with the community: in other words, people in prison should have access – to health care – that is *at least equivalent* to that afforded to people in the community.

National standards

Many countries have domestic laws related to detention. A law on prisons will often have a name like 'Prison Act' or 'Jail Act'. These laws do not define prison conditions, but they usually stipulate the drawing up of 'prison rules' or 'prison regulations' containing detailed provisions on the management of prisons, including matters touching on health. Prison regulations often set out responsibilities for prison doctors or nurses that go beyond the provision of curative health care and include oversight of matters related to hygiene and nutrition, for example. However, some provisions of these national 'prison rules' might be outdated and/or contrary to internationally accepted practice.

Professional health associations such as national medical associations may have issued other national standards⁵ or participated in intersectoral meetings on health care in detention and adopted their findings. These do not have the force of law, but might be useful points of reference.

Regional standards

Some regional human rights bodies have developed standards on conditions of detention that also address health aspects: for example, the European Prison Rules adopted by the Council of Europe.⁶ One of the basic principles underlying the European Prison Rules is maintaining the health of people in custody. The Council of Europe also established the CPT, which has developed binding standards for police custody and imprisonment, including provisions on health.⁷ In addition, the Council of Europe has elaborated recommendations on the ethics and the organization of health care in prisons.⁸

The African Commission on Human and Peoples' Rights adopted the Robben Island Guidelines in 2002.⁹ The principal aim of these guidelines is the prevention of torture, but they include provisions on conditions of detention. The Committee for the Prevention of Torture in Africa¹⁰ is mandated to

4 P. Perrin, *H.E.L.P.: Public Health Course in the Management of Humanitarian Aid*, ICRC, Geneva, 2001; The Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, 3rd ed., The Sphere Project, Geneva, 2011. Available at: <http://www.sphereproject.org/>

5 See, for example: American Public Health Association Task Force on Correctional Health Care Standards, *Standards for Health Services in Correctional Institutions*, 3rd ed., APHA, Washington D.C., 2003.

6 The European Prison Rules were adopted by the Council of Europe in 1973, revised in 1987, and rewritten in 2006. See: Council of Europe. Recommendation Rec (2006) 2 of the Committee of Ministers to member States on the European Prison Rules. Adopted on 11 January 2006.

7 The CPT was established on the basis of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, adopted by the member States of the Council of Europe in 1987. See: CPT, *The CPT Standards: "Substantive" Sections of the CPT's General Reports*, CPT/Inf/E (2002) 1 - Rev. 2011 (<http://www.cpt.coe.int/en/docsstandards.htm>).

8 Council of Europe, Committee of Ministers, Concerning the Ethical and Organisational Aspects of Health Care in Prison, Recommendation No. R (98) 7. Adopted 8 April 1998.

9 The African Commission on Human and Peoples' Rights, Resolution on Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa, 32nd session, 17-23 October 2002, Banjul, The Gambia.

10 United Nations Economic and Social Council, Kampala Declaration on Prison Conditions in Africa, Resolution 1997/36, 36th plenary meeting, 21 July 1997.

disseminate the Robben Island Guidelines and promote their implementation. The Kampala Declaration on Prison Conditions in Africa, adopted by the UN in 1997, addresses prison conditions in Africa, overcrowding in particular. Recommendations made by the Special Rapporteur on Prisons and Conditions of Detention in Africa, appointed by the African Commission on Human and Peoples' Rights, are a useful point of reference.

In Latin America, the findings of the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights are pertinent.

Universal standards

The main source of guidance for the treatment of detainees and the management of penal institutions is the SMR.¹¹ The SMR were approved by the UN Economic and Social Council in 1957. However, the SMR do not constitute a binding treaty; they are a set of recommendations or guidelines.¹² These 'rules' should be adapted to every country because social, economic, legal, climatic and geographical conditions vary from one State to the next. It should also be noted that internationally accepted practice and norms in certain areas have evolved since the SMR were drawn up; as a result, sections of the SMR are outdated and are being revised,¹³ especially those related to medical services and medical ethics.

In 1988, the UN adopted the Body of Principles for the Protection of All Persons under any Form of Detention or Imprisonment.¹⁴ Principles 24 to 26 make clear the necessity of the following: a proper medical examination for every newly arrived detainee, unhindered access to medical care, and proper medical record-keeping.

Other relevant standards are: the 1990 UN Rules for the Protection of Juveniles Deprived of their Liberty and the 2010 UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules).

The International Covenant on Economic, Social and Cultural Rights is a binding treaty that came into force in 1976. Article 12 of the treaty assures "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." An elaboration of that statement asserts that parties to the treaty will refrain from "denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services."

With regard to universal *health ethics* in detention, reference may be made to statements and declarations made and principles defined by bodies such as

11 United Nations. Standard Minimum Rules for the Treatment of Prisoners; adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders in 1955, and approved by the Economic and Social Council through its resolutions of 31 July 1957 and 13 May 1977.

12 This type of document is regarded as 'soft law', as it is not a treaty signed by States but a set of universally agreed standards and principles that are considered to be a minimum to which States should adhere.

13 For an explanation of the SMR see: Penal Reform International, *Making Standards Work: An International Handbook on Good Prison Practice*, 2nd ed., 2001. This handbook provides an overview of the UN rules on prison conditions and treatment of detainees, and explains the practical value and meaning of the rules for prison policy and practice. It has found widespread acceptance and has been translated into many languages. **Careful study of this useful analysis of the SMR is highly recommended.** (It can be downloaded from Penal Reform International's website: www.penalreform.org)

14 UN General Assembly, Body of Principles for the Protection of All Persons under any Form of Detention or Imprisonment, (A/Res. 43/173), 9 December 1988. Available at: <http://www.un.org/documents/ga/res/43/a43r173.htm>

the UN,¹⁵ the International Council of Nurses,¹⁶ and the WMA.¹⁷ Of particular note is the Declaration of Tokyo, adopted by the WMA in 1975, which provides guidelines for doctors regarding “torture or other forms of cruel, inhuman or degrading procedures,” including force-feeding.

Standards for detention during armed conflicts (international humanitarian law) and the role of the ICRC

The Third Geneva Convention deals with the internment of prisoners of war during international armed conflicts; internment of civilians is dealt with by the Fourth Geneva Convention. Both Conventions contain specific articles addressing the provision of health care, as well as accommodation, food, water, exercise, etc. Consult the pertinent Convention and give it close attention.¹⁸ The rules applicable to non-international armed conflicts are found in Article 3 common to the four Geneva Conventions and in Protocol II of 8 June 1977 additional to the Geneva Conventions (Additional Protocol II),¹⁹ as well as in customary international humanitarian law.²⁰

The ICRC has a mandate to work for the protection of both prisoners of war and civilians during international armed conflict. And, under common Article 3, the ICRC may offer its services to parties in a non-international armed conflict. The ICRC also has – under the Statutes of the International Red Cross and Red Crescent Movement – a right of humanitarian initiative in circumstances that do not amount to armed conflict.²¹

15 Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by UN General Assembly Resolution 37/194 of 18 December 1982.

16 For example, see: International Council of Nurses, *The Nurse's Role in the Care of Prisoners and Detainees*, 1998.

17 For example, see: World Medical Association, *International Code of Medical Ethics*, adopted in 1949 and amended in 1968, 1983 and 2006 (See: <http://www.wma.net/en/30publications/10policies/c8/>). On ethics for prison physicians, see also: International Council of Prison Medical Services, *The Oath of Athens*, 1979.

18 Third Geneva Convention relative to the Treatment of Prisoners of War, 12 August 1949; Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, 12 August 1949.

19 See particularly Articles 4 (Fundamental Guarantees) and 5 (Persons whose liberty has been restricted) of Additional Protocol II.

20 J-M Henckaerts, “Study on customary international humanitarian law: A contribution to the understanding and respect for the rule of law in armed conflict,” *International Review of the Red Cross*, Vol. 87, No. 857, March 2005, pp. 175-212. Available at: <http://www.icrc.org/eng/resources/documents/publication/p0860.htm>

21 Statutes of the International Red Cross and Red Crescent Movement, Article 5(3).

2. ACCOMODATION, WATER, SANITATION AND HYGIENE

2.1. Accommodation and overcrowding

Prison authorities should ensure that detainees have: adequate shelter and protection from the elements; access to hygiene and sanitary facilities; sufficient space for sleeping, exercise and recreation; and protection from violence. They should also ensure prevention of the spread of infectious disease. These are essential elements of prison accommodation and must not be affected in any way by the requirements of security and deprivation of freedom that are inherent in a place of detention.

Capacity

Detention facilities and prisons have an **official capacity**: the number of people the facility can accommodate whilst fulfilling their basic needs for space, light, ventilation, hygiene, sanitary installations, water, sufficient kitchen capacity, and health-care services, as well as the requirements of safety and security. The official capacity is established when the building is constructed: there are a fixed number of cells, each for a specified number of detainees. **Occupancy** refers to the actual number of people being held in the prison. **Occupancy rate** is the indicator usually cited.

$$\text{Occupancy rate (\%)} = \frac{\text{Occupancy}}{\text{Capacity}} \times 100$$

When the occupancy rate is 100%, the prison contains the number of detainees that it was designed for. Where it rises beyond 100% (especially when it exceeds 150%), essential needs may not be adequately met (see the section on 'overcrowding', below).

Space

'Space' refers to both the **size of the facility** and the **accommodation space** available to each individual. The assessment must also take into account the amount of time the detainees are locked up in their cells. Rule 10 of the SMR states:

"All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation."

The vagueness of this formulation reflects the impossibility of defining the space necessary per person, given the wide variation in detention facilities

worldwide. There is considerable global variation in regulations covering space in prisons. In Europe, a general standard exists of 6 m² per person for prison cells, but 3.0 to 3.5 m² is considered acceptable for dormitory-style accommodation. The Russian Federation have set 2.5 m² as the minimum space per adult male offender in their prisons. At an interministerial meeting on prisons in Guinea-Conakry in 2002, the minimum was set at 2 m².

The ICRC recommends – *purely as a guideline and not as an absolute rule* – a minimum of 20-30 m² per person within the prison compound. In sleeping quarters, the minimum recommended space is 3.4 m² of surface area per person for cells with multiple occupants and 5.4 m² for single-occupancy cells.²²

Light

Rule 11 of the SMR sets out the standards for light and ventilation thus:

“In all places where prisoners are required to live and work,

- a) The windows shall be large enough to enable the prisoners to read or work by natural light, and shall be so constructed that they can allow the entrance of fresh air whether or not there is artificial ventilation;
- b) Artificial light shall be provided sufficient for the prisoners to read or work without injury to eyesight.”

Temperature and ventilation

The temperature in the prison and the requirements relating to it depend on the climate of the country: there should be adequate heating in cold climates and means of cooling in hot climates. Ventilation of cells is important for ensuring circulation of fresh air and preventing the spread of airborne infections such as tuberculosis and influenza.

The ICRC recommends that the size of the cell opening be at least 1/10 of the cell's surface area, to allow renewal of air and proper lighting.

Bedding

The bedding provided in prisons must be adapted to the climate, but would generally be expected to include some form of mattress or bedroll, sheets and/or blankets. The requirements of personal hygiene also extend to bedding. Mattresses must be kept clean, aired and exposed to sunlight regularly. Clean sheets, or facilities and materials for detainees to be able to wash their sheets, must also be ensured.

Access to open air

For their physical and mental well-being, detainees should be permitted regular access to the open air. They should also have access to sports facilities or adequate space to exercise. The generally accepted minimum, as stated in the SMR, is that access to the open air should be granted to all categories of detainee for a minimum of **one hour each day**, and protection from the elements ensured during these periods – through covered areas and through

22 P.G. Nembrini, *Water, Sanitation, Hygiene and Habitat in Prisons*, 2nd ed., ICRC, Geneva, 2013. Available at: <http://www.icrc.org/eng/resources/documents/publication/p0823.htm>
Water, Sanitation, Hygiene and Habitat in Prisons: Supplementary Guidance, ICRC, Geneva, 2013. Available at: <http://www.icrc.org/eng/resources/documents/publication/p4083.htm>

suitable clothing (for example, heavy coats should be made available in winter). Ideally, detainees should spend as much time as possible outside their cells.

Minimum recommendations for accommodation space

Overall available space in compound	20–30 m ² /person	(ICRC)
Minimum floor space in single-occupancy cell	5.4 m ² /person	(ICRC)
Minimum floor space in multiple-occupancy cell	3.4 m ² /person	(ICRC)

Memorize the layout of the facility and draw a plan after the visit.

Overcrowding

Overcrowding in prisons causes health problems because of the overuse of resources and the competition for them. It is not simply a matter of physical space. Overcrowding affects the mental and physical health of detainees through the pressure it puts on every aspect of their lives: food and water, sanitary facilities, work, medical services, rest and recreation, and even in the form of increased competition for family visits.

This competition for resources may contribute to poor nutrition or malnutrition. It may threaten the maintenance of good hygiene for the prison population and lead to the spread of disease (vector-borne, faecal-oral transmission, etc.). And it may cause tensions amongst both detainees and prison staff, which contribute to bullying, coercion, and physical and sexual violence. Overcrowding may also lead to an increase in drug use, raising the risk of blood-borne disease. All of these factors, to a greater or lesser degree, may also have an impact on the mental health of detainees.

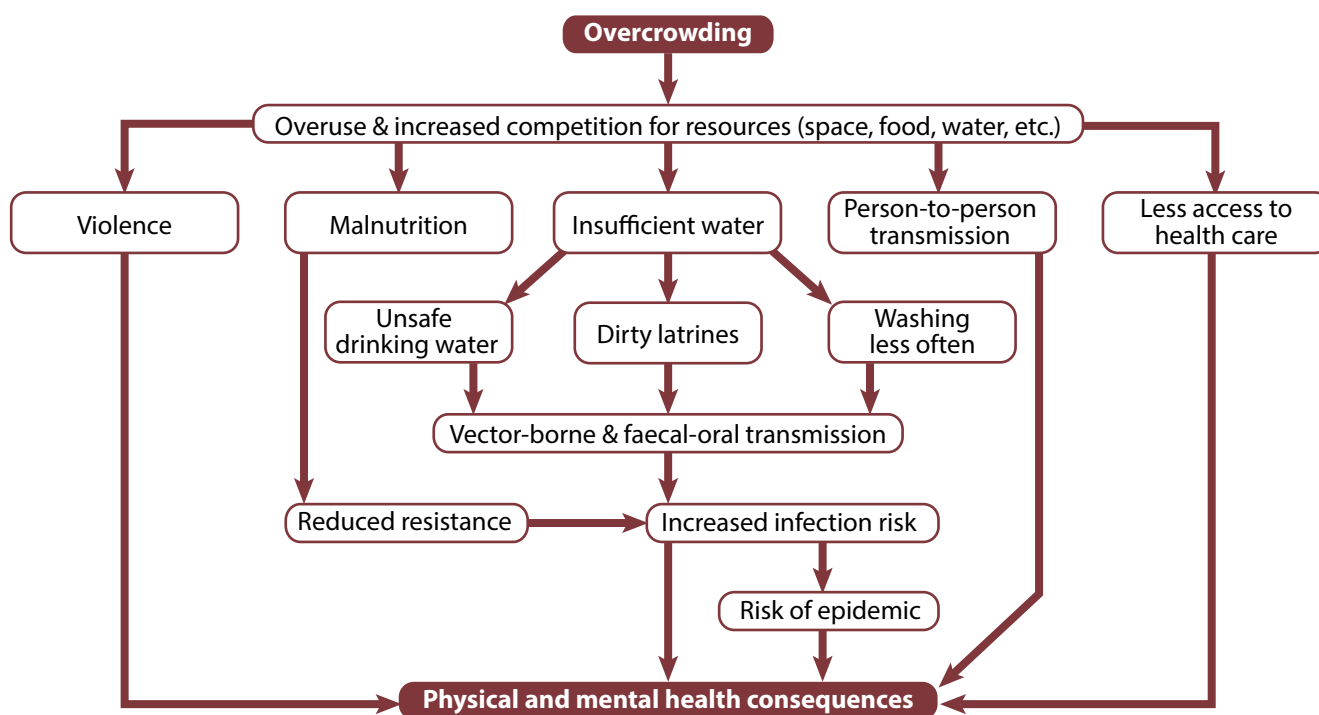


Figure 2.1 Overcrowding in prisons and its health effects

SAMPLE QUESTIONS ON ACCOMMODATION

Space

- What is the official capacity of the prison?
- What is the *actual* prison population (occupancy)?
- Calculate the space available per person: the total surface area in m²/total number of detainees. This may vary from cell to cell and will often need to be calculated for different areas of the prison.
- Note that space per person is of particular concern when detainees spend most of their time inside their cells, but may be less so when there is unrestricted access to the outdoors during the day. Enquire about lock-up and opening times throughout the day.

Buildings

- What is the general state of the buildings? Does the roof leak? Are there signs of mould or damp (visible fungal growth, mouldy odours, excess condensation on windows)? Is there evidence of rodent or insect infestation (droppings or frass, holes or tunnels in walls or materials, live insects or carcasses)?
- What protection is there from the elements (wind, rain, heat, cold)? What measures are taken to control the temperature of the prison cells or quarters? Are there windows or other openings? Do the windows have glass and/or shutters that can be opened? Do they permit entry of daylight and adequate ventilation? Is there artificial lighting in the cells? How is this controlled and when are the lights switched on and off?

Living arrangements and routines

- Are detainees allowed out in the open air? Under what circumstances? And what constraints apply? How long and how often are detainees allowed out? Are outdoor areas protected from the weather (covered or shaded)?
- Is the bedding suitable for the climate? What provisions are made for cleaning and airing bedding? Is it ever replaced? Is there a budget for this?
- What can be said about the detainees' accommodation and facilities in comparison with that of the prison staff, particularly that of the guards?

Overcrowding

- What measures have the authorities taken to improve the situation? Have detainees been transferred to other detention facilities? Have new buildings been constructed? Do detainees take turns to sleep? Is there a schedule for this?
- How do detainees cope with overcrowding? Describe the effects of overcrowding on the general living conditions and on detainees' health (use the flowchart above).

2.2. Water: Source, storage, distribution and access

When considering water in prisons it is useful to think of **WATER IN** – the water that arrives at the facility – and **WATER OUT** – the wastewater (from cooking, washing and cleaning) and sewage that is produced and that *should* leave the facility. Wastewater is considered in Section 2.5. below.

The assessment of 'water IN' should follow the various stages of the water's progress, as this will help to identify the source of any problems that might develop (see Figure 2.2 below). Assessment of water IN should include the following:

- **Water source** – water may come from the town system, boreholes, a river, or may be delivered in tanks
- **Supply** – how the water reaches the prison
Any treatment used to make the water potable (drinkable)
- **Primary water storage** – the main reserve in the prison, to cope with any interruption of the water supply; this should amount to at least 15-20 litres per person
- **Distribution** of the water within the prison – by pipe, by bucket, etc.
- **Secondary storage points** – smaller water reserves in each area or block
- **Water points** and taps – their number and location
- **Access to water** – the degree of **access** that the detainees have to the water is crucial; water may not be distributed equally between sectors or between different population groups in the prison, as various factors may be at work, such as the category of detainees, their location in the facility, corruption and the amount of time that inmates are locked in cells without water.
- Ultimately, the **quantity** and the **quality** of the water available must be considered.

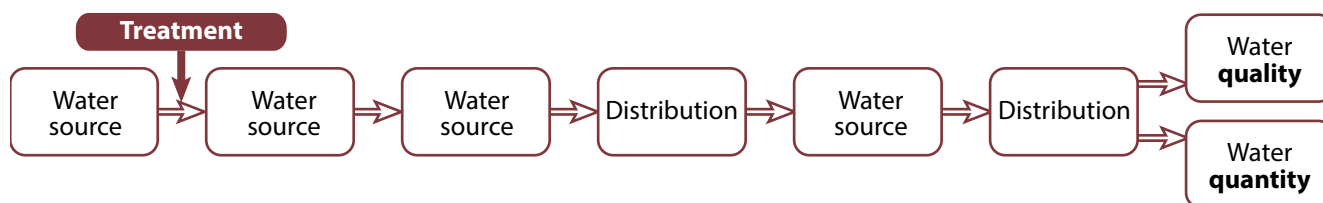


Figure 2.2 Water IN (example): The passage of water through a detention facility

Water quantity and quality

With regard to water, matters related to **quantity** should be tackled before concerns about **quality**. Data on water-related diseases show that it is better to have the *right quantity of medium-quality* water than small quantities of high-quality water. Also, there are simple ways to make water safe for drinking purposes (boiling for 20 minutes, chlorination, filtration, etc.).

Water **quantity** is defined as the number of litres available per person per day. The quantity of water used by individuals varies globally, depending on availability, climate, cultural preferences and practices. The ICRC considers

10-15 litres per person per day to be the minimum amount of water sufficient for all purposes. This includes water for drinking, cooking, and personal hygiene (for washing clothes, using the sewage system, cleaning the facilities). Because cells are often locked from sunset to sunrise, at least 2 litres of water per person should be available overnight, but this, too, depends on the climate and on the availability of water. Women in prison require special consideration because pregnancy, menstruation, and the nursing of babies all increase the need for water. Hospital wards and clinics also add to water requirements in prisons.

The prevalence of poor standards of cleanliness within a prison, and poor personal hygiene and diseases related to this (mostly skin diseases), may indicate that the prison needs more water.

Water **quality** is defined by the level of microbiological and chemical contaminants, but in practice such things as colour, taste and smell have also to be taken into account, since the water will be drunk and used in cooking. Note that the mere presence of microbiological agents or chemicals does not render the water unsafe: it is only when specific thresholds are reached that problems may arise. Acceptable levels of microbiological agents and chemicals are usually defined by each country (by water boards or departments of public health, for instance); where this is not the case, WHO standards may be referred to.

Water from boreholes is usually safe for drinking. Nevertheless, all water sources and secondary storage containers (buckets, drums, jerrycans) can, in principle, be sources of contamination.

One simple sign of poor water quality may be the prevalence of water-borne diseases among detainees.

When assessing water quantity and quality in prisons, it is important to also study and understand constraints that the surrounding civilian population may be facing, in connection with access to water.

Water supply standards*

Minimum supply per person for all needs	10-15 litres /person/day	(ICRC)
Number of water points	1-2 taps/100 persons (absolute minimum)	(ICRC)
Water flow rate from taps	10 litres/minute (absolute minimum: 3-5 litres/minute)	(ICRC)

Water stock standards

Reserve capacity for the whole facility	15-20 litres/person
Minimum stock for the night in cells	2 litres/person/night

* Note that these standards are only recommendations and that actual water requirements will depend upon factors such as climate, washing habits, and the existence of flushing toilets.

SAMPLE QUESTIONS ON WATER

Water source

- What is the main water source for the prison (town network, borehole, spring, river)? Where is it located? Is the supply dependable? Is it protected (coverings for wells, for example)?
- Are there additional water sources, such as rainwater collection systems?
- How is water supplied to the prison (pipes, pumps, tankers, buckets)? What is the quantity and frequency of delivery? Is the supply continuous (24 hours) or interrupted?
- How is the water treated to make it potable (filtration, chlorine, boiling)? Who is responsible for the water treatment? Where do the treatment materials/chemicals come from, and is there a reliable supply?
- What is the water source for the surrounding community and what constraints, if any, do people outside face regarding access to water? Are they comparable to the constraints in the prison?

Primary water storage

- What type of primary water storage system is used within the prison compound (concrete reservoir, plastic water tanks)? Where is it located? What is its capacity (in litres) and condition? Is there an elevated water tank? What is its storage capacity? Is it functioning properly? How does it fill up (at night, via pumping system)?
- How many litres per person does the storage capacity yield?

Distribution

- How is the water distributed from primary storage to where is it needed (by pipes, bucket, hose)?
- What sorts of water point are in use (stand-pumps, taps, basins, buckets)? What state are they in, and where are they located (in the compound or inside cells)?
- If there is a problem in connection with the quantity of water available, the rate of water flow can be estimated by filling a container of known volume (e.g. 5 litres) from one water point and noting the time needed to fill it (only applicable in small prisons).

Secondary water storage

- Is water being stored adjacent to or inside the cells/blocks, toilets, bathing areas and laundry areas? What types of secondary storage container are in use? How many of them are there, and what is their capacity? The use of a large number of containers to store water might be a sign of irregular or insufficient supply.
- Is there sufficient secondary water storage within the cells during the time that the detainees are locked up, especially at night? How much water is being stored for this purpose?

Access (quantity/quality)

- Is there equal access to water for all categories of detainee?
- Are there constraints on access to water (e.g. payment required)?
- What is the quantity of water available per detainee per day? How much water is available for drinking?
- How reliable is the supply? What is the rate of flow? Are there problems with storage or distribution?
- How is the water? Is it safe for drinking? Have there been epidemic diseases that might be related to contaminated water?
- How is the water checked for quality, and how often is that done?

2.3. Personal hygiene

Poor personal hygiene leads to greater incidence of skin disease and the transmission of faecal-oral infections. It may also have an impact on the mental well-being of the population. Infested mattresses and clothes may give rise to a never-ending spread of skin diseases and some vector-borne diseases as well.

Water is essential for the maintenance of personal hygiene, but it must be accompanied by sufficient amounts of soap and regular access to facilities for bathing. In the interest of personal hygiene, but also of public health within the prison, inmates must be informed of the rules of basic hygiene (see box below) and encouraged to respect them. Instruction can be given to prison nurses or health assistants who can then conduct hygiene-promotion sessions for the detainees.

Each detainee should be given body soap (100-150 grams per month) and laundry soap regularly. Note that some soap is suitable only for laundry, because of the quantity of alkali that it contains, and the type of soap supplied should be checked. Frequency of showers or baths will depend on the climate and on the workload of the detainees. Pregnant and menstruating women, as well as women imprisoned with their children, will need to bathe more frequently. Cultural and religious norms must also be taken into account, since these may require people to bathe more often. While the SMR recommend at least one shower per week in temperate climates, more frequent showering is necessary in tropical climates. Those engaged in moderate to heavy physical exercise must be permitted to shower daily.

The level of personal hygiene also depends on the frequency with which clothes can be laundered. This again depends on the climate and on the amount of physical exercise undertaken. Detainees will probably not be provided with regular changes of clothing, in which case they should have access to laundry facilities and laundry soap, to wash their clothes. Bedding also has to be washed regularly; it must also, wherever possible, be aired regularly.

Unrestricted access to free-of-charge sanitary items for women (sanitary towels, etc.) and children (diapers) must be ensured.

Basic hygiene for detainees and prison staff

- Keep body and clothes clean. Cut hair (except if not culturally acceptable) and nails regularly.
- Air and wash bedding regularly.
- Wash hands with soap after using toilet and before eating; and also after handling garbage or working on the sewage system, and after contact with potential germs.
- Keep toilets clean.
- Place all rubbish in refuse containers and ensure regular collection.
- Do not spit on the floor.
- Do not keep perishable food in the cell.

Minimum recommendations for personal hygiene

	1 shower facility per 25 persons	(ICRC)
Shower access	Minimum 1 shower/week	(SMR)
	1 shower/day when required by heavy physical exercise or climatic conditions	(ICRC)
Body soap	100-150 grams/per person/month	(ICRC)

SAMPLE QUESTIONS ON ACCESS TO WATER AND PERSONAL HYGIENE

Bathroom/Washing areas and laundry areas (for 'toilets', see Section 2.4. below)

- Where are the bathrooms, washing areas and laundry areas situated, and what state are they in?
- Are there separate facilities for men and women? If not, how is privacy assured?
- What is the ratio of showers and water points to inmates? Where are the taps and showers situated? Are they functioning and in good repair?
- Where are the laundry areas situated? Are they functioning and in good repair?

Hygiene

- What degree of access do detainees have to showers, water points and laundry areas? How often may they use them, and for what length of time?
- Do detainees have sufficient soap? Where do they get it (official distribution, family, purchase)? How much, and how often? What is the quality of the soap?
- Is there any problem with the water supply to the bathrooms? Is the supply regular and adequate?
- Can detainees wash their clothes and bedding? How often? Is laundry soap provided? Is bedding aired?
- Are hygiene-promotion sessions provided for detainees? Who runs them, and how often? Do all detainees have access to them?
- Are hygiene-promotion sessions provided for kitchen staff?
- Are there any generalized health problems associated with personal hygiene, such as scabies, fungal skin infections, or outbreaks of gastrointestinal infections? Fix a period of time and find out how many detainees are affected, or what proportion of the detainee population.

2.4. Toilets

Toilets will be overused if there are not enough of them. This will lower the level of basic hygiene and permit the spread of contagious diseases.

Detainees should have access to some form of toilet facility at all times. For instance, toilet blocks can be situated in the prison's compound if detainees have free access to that part of the prison. If they are locked up in cells or blocks (for example, at night), and if they are not allowed outside, there should be a toilet within the cell or block. If the toilets are kept locked then the mode of access should be looked into: for instance, is the key held by a guard or by a detainee? Evidence of open defecation, anywhere on the prison site, suggests a problem related to access to toilets or that the toilets are not working.

Given the resource constraints of many contexts, a toilet within the cell may not be feasible; in such cases, a bucket that can be closed with a lid is acceptable. Toilets within a cell should be separated from the living area, for reasons of both privacy and hygiene. If a bucket is used it should be emptied daily, in a suitable spot at a distance from water and food sources.

Access to water and soap must be provided, for the washing of hands after use of the toilets. Sanitary conditions in the vicinity of prison toilets is vital to the health of the detainees.

Toilet standards

	1 for 20 persons – Optimum	(SPHERE) *
Toilets	1 for 25 persons – Recommended	(ICRC)
	1 for 50 persons – Acceptable minimum	(ICRC)

* The Sphere Project (www.sphereproject.org) defines minimum standards in humanitarian response. In prison contexts however, pre-existing limitations of space and structure may prevent the construction of additional toilets (unlike in refugee camps and other situations of humanitarian crisis where there is usually sufficient space to construct the required number of toilets). ICRC experience has shown that 1 toilet for 50 persons may be acceptable in resource-constrained contexts, but only if the toilets are well maintained and clean. This should not preclude the construction of more toilets where that is indicated and feasible.

SAMPLE QUESTIONS ON HYGIENE AND TOILETS

- How many toilets are there in each prison area (compound, block, cell, and so on)? Of what kind are they? Where are they situated, and what state are they in?
- What is the ratio of toilets to detainees (the number of toilets per detainee)?
- How well are the toilets functioning, and how clean are they? Who is responsible for cleaning them, and what materials are provided for this?
- Are there any obvious problems, such as blocked toilets?
- Are there signs of difficulties related to access (e.g. locked toilet blocks, open defecation)?
- Are toilets accessible at all times?
- What access to toilets is there at night? How many toilets or buckets, if any, are there in blocks/cells? Of what kind are they? Where are they situated, and what state are they in? How clean are they? If a bucket is used, is a lid provided? How often and where is the bucket emptied? Is there any risk of contamination of water or food at the disposal site?
- Is access to toilets particularly difficult for certain individuals or categories/groups of detainees? Is access limited by discrimination? Is payment of a fee or bribe necessary?
- Are there separate facilities for men and women? Are both sexes assured of privacy?

2.5. Wastewater and sewage system

Improper disposal of human excrement leads to faecal contamination of the environment, which may be caused by leakage or overflow from the sewage system, or by open defecation (detainees may defecate in open spaces if toilets are blocked or broken, or if access to them is limited). Stools can contain pathogens (viruses, parasites, bacteria), which may infect others directly (faecal-oral transmission) or through direct contamination of the water and/or food supply, or through flies or other vectors that spread them.

Water engineers may refer to water as 'white', 'grey' or 'black'.

'Whitewater' is clean water suitable for drinking.

'Greywater' or 'wastewater' is dirty water from washing (of hands or bodies); it may also include water from kitchens or laundry.

'Blackwater' or 'sewage' is any water that contains human faeces or urine.

Where there is no municipal sewage system, separate outflows should be provided for grey and black water. Greywater or wastewater may then be recycled (for use in irrigation, for instance), but only if it is not contaminated by sewage. The outflow of greywater may be via a closed system of pipes or tanks or via uncovered drainage channels. Blackwater outflow may go directly into pit latrines, or into septic tanks, or out through a piped sewer system. Ideally, the blackwater/sewage system should be covered or closed. Black water/sewage may be deposited in septic tanks, but in order to work properly these must not be contaminated by detergents that might be present in grey water. The detainees responsible for cleaning the wastewater and sewage disposal systems must be issued with protective clothing (rubber gloves, boots and apron) and additional soap, and must also be given time to shower.

SAMPLE QUESTIONS ON WASTEWATER AND SEWAGE

Wastewater and surface water drainage

- What is the drainage system for wastewater from the showers/baths, the laundry and the kitchen? And what is it for surface water (rainfall)? Are these systems open or closed?
- Is the system functioning properly? Is it regularly cleaned and maintained? Is there any stagnant water in or near the prison?
- Identify the location and cause of drainage outflow problems, if any.

Sewage outflow system

- Does the sewage system use pit latrines, septic tanks, or closed sewage pipes?
- What state is the system in? Mention specific problems, if any (blockages, breaks, leaks), and their location.
- Are the septic tanks soak pits that do not need to be emptied, or are they sealed tanks that require emptying? If they are sealed tanks, how often are they emptied? (Once every year or two may be sufficient if the tanks are not overused.)
- Who is responsible for sewage and for emptying septic tanks (e.g. municipality, detaining authority)?
- How does the functioning of the wastewater and sewage system affect the community?

2.6. Waste management and hygiene of premises

Areas where detainees live should be cleaned daily with water, and once a week with disinfectant. This also applies to the kitchen and to the toilet blocks.

Solid waste, which may be **organic** (food) or **non-organic**, should be stored before collection, and after removal from the prison, buried or burnt. Stored organic waste should be placed in rat-proof pits (these need be nothing more than raised, smooth-edged concrete cylinders) and covered, to discourage flies and other insects. If possible, the prison should use the solid-waste-collection services of the community, where such services exist. Organic waste – food remnants, for instance – can also be fed to animals such as pigs. The frequency of waste removal will depend not only on the climate (hot climates necessitate daily collection), but also, where such a service exists, on the schedule of the community's services. Bear in mind that because prisons concentrate large numbers of people in a confined space, the risks to public health are greater when the waste-collection system is not functioning well or when it is non-existent.

Medical waste (needles, used swabs, etc.) is a significant source of infection, which may be contracted through needlestick injuries or exposure to pathogens. All waste of this kind must be collected separately (e.g. in 'sharps boxes' for used needles) and then burnt and buried.

Minimum recommendations for solid waste

Solid waste	100-litre covered container per 50 people
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SAMPLE QUESTIONS ON GENERAL HYGIENE

General state of hygiene of the compound

- Is old food or rubbish lying around in the compound?
- Who is responsible for cleaning the compound?
- How often does cleaning occur and what materials are provided for this?

General state of hygiene of living quarters

- Is there old food or rubbish in cells or blocks?
- Who is responsible for cleaning the living quarters?
- How often does cleaning occur and what materials are provided for this?

Solid waste (organic or non-organic) disposal

- How is waste collected inside the prison?
- How many waste containers are there? What is their capacity? Where are they placed? Are they covered? Are they rat-proof?
- Is the waste disposed of inside or outside the prison? If waste is disposed of inside the prison, is it dumped in open pits, buried, or burnt? Is organic waste fed to animals? If waste is disposed of outside the prison, is it removed by the municipality, by contractors, or taken outside by detainees? How often does collection or disposal occur? How is this waste disposed of?
- What are the difficulties, if any, with collection and disposal of waste?

Medical waste

- How is this collected and stored (e.g. 'puncture-proof sharps safety boxes')?
- How is it disposed of (e.g. burning, burying)?

2.7. Vectors and pests

Insects, parasites and rodents thrive in prisons. Some of these are hosts to pathogens and may act as disease vectors. They may transmit disease by bites, via excreta, or simply by mechanical carriage (e.g. flies carrying faecal material with pathogenic agents from one spot to another).

The following factors may encourage the proliferation in prisons of flies, mosquitoes, lice, cockroaches and other insects, as well as rodents: poor personal hygiene amongst detainees, overcrowding, poor standards of cleanliness within the prison, and the existence of refuges and breeding grounds (holes or cracks in walls, stagnant water, and piles of rubbish).

Insects and rodents can be disease vectors, transmitting diseases among humans. Control of insects and rodents is an important measure to prevent the spread of disease in a prison. Methods include: ensuring good hygiene amongst detainees and on the premises, regular removal of refuges and breeding grounds, screens on windows and doors, mosquito coils, fumigation, and spraying (keep in mind that fumigation and spraying both require the involvement of a knowledgeable technician).

Stray dogs, cats and other animals such as pigs may also act as reservoirs for disease, or contribute to unhygienic conditions.

Main vectors and vector-borne diseases

Vector	Examples of illness (<i>not holistic</i>)
Mosquitoes	Malaria, filariasis, dengue, yellow fever, Japanese encephalitis, chikungunya
Lice	Epidemic typhus, relapsing fever
Fleas	Plague, murine typhus
Ticks	Encephalitis, rickettsiosis, borreliosis
Mites	Scabies, scrub typhus
Flies	Salmonellosis, trachoma, etc.
Bedbugs	Cause bites/irritation, but do not transmit any diseases
Cockroaches	Hepatitis A, typhoid fever, amoebiasis, etc.
Rodents	Leptospirosis, Lassa Fever

SAMPLE QUESTIONS ON VECTORS

- Is it obvious that there are rodents, insects, or other pests on the premises?
- Is there evidence of rodent or insect infestation (droppings or frass, holes or tunnels in walls or materials, live insects or carcasses)?
- Do inmates have vector-borne diseases such as malaria, relapsing fever, or gastrointestinal problems? Are there cases of such diseases in the community?
- Does the prison have a prevention/disinfestation programme? Is this integrated with any national control programmes (e.g. malaria or dengue control)? What methods are used (e.g. fumigation, spraying, mosquito nets)? What chemicals are used, and how were they acquired (e.g. open market, health department, or government agricultural department)? Who carries out the disinfestation? Have they been trained? Do they have protective equipment?
- What measures are taken to control rodents? Are the food stores and the solid waste (garbage) disposal sites rodent-proof? Have poison traps been set?

3. FOOD AND NUTRITION

Food is an important and complex issue in prisons. Significant financial resources are required in order to ensure its regular supply; good practices of hygiene are needed for its storage and preparation; it has to be provided in the form of a well-balanced diet; and its distribution has to be equitable. Its importance and the sensitivities that surround the subject in prisons are such that food may be at the root of tensions and even of riots in these settings.

'Food' refers to edible items, and the term 'nutrition' to the metabolic impact on individuals of what they eat.

This chapter discusses issues related to food, using the concept of **THE FOOD CHAIN**, which refers to the supply, storage and preparation of edible items, as well as the access to or distribution of such items. **NUTRITION** is then dealt with by outlining the basic caloric and nutrient requirements of the human body, the underlying and immediate causes of malnutrition, and sample questions for assessing the nutritional status of detainee populations.

It is always good practice to conduct a rapid assessment of the food system within a prison and record the findings, even where no significant problems are immediately apparent. This assessment will establish the baseline functioning of the prison food system and will be useful in the event of any future problems, or to enable comparison between prisons. A more comprehensive assessment is required only in prisons where the initial rapid assessment reveals a food or nutritional problem. The nutritional assessment should be carried out by a multidisciplinary team that includes a health professional with expertise in nutrition.

This chapter makes references to two documents:

1. *Guidelines for ICRC Activities on Behalf of Persons Deprived of their Freedom in the Event of Nutritional Problems* (2010), which provides a framework for nutrition-related activities in places of detention. When the ICRC is deciding whether to act in place of the authorities, it is guided mainly by this document.
2. *Food and Nutrition Guidelines in Places of Detention: A Practical Guide for Detention Teams* (2013), which aims to provide practical and standard references for assessing and responding to nutrition issues in detention. The guidelines are intended for the entire detention team (protection staff, nurses, doctors, nutritionists, economic security staff, etc.) and is in the form of four separate booklets:
 - Booklet 1: Basic concepts of nutrition in detention
 - Booklet 2: Assessment of the food and nutrition situation in detention
 - Booklet 3: Food and nutrition programmes in detention
 - Booklet 4: Monitoring and evaluation of food and nutrition programmes.

3.1. The food chain

The **FOOD CHAIN** refers to food supply, including budgeting, storage, preparation, and access (distribution). All of these factors are likely to be subject to constraints within prisons; there tends to be less food along the prison food chain. Assessments of the food chain must focus on its weak links. Critical points in the chain include: the budget for food supply; the procurement system; the supply or storage phase (especially with regard to nutritionally valuable items such as oils and pulses); food storage conditions; and cooking procedures. Assessment of the food chain will require interviewing authorities, cooks and detainees, as well as inspecting food stores and kitchens and examining methods of food preparation and distribution.

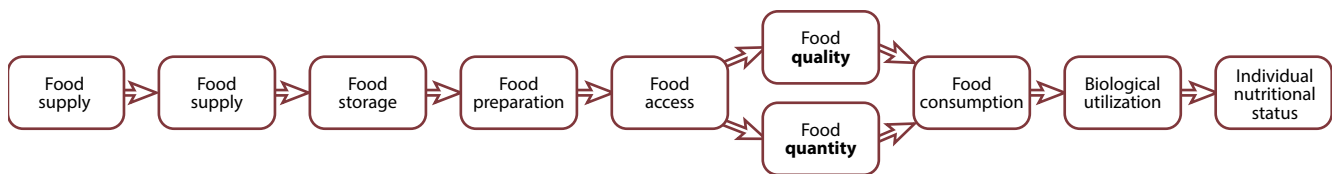


Figure 3.1 The food chain. A more representative diagram might show boxes of decreasing size, reflecting the tendency for food to attenuate along the chain.

Assessment of **nutrition** includes those elements that follow or occur 'downstream' of food supply, storage, preparation and access. A nutrition assessment looks at the actual nutritional content of food consumed by detainees, and is based on the quality and quantity of that food. It also involves consideration of the potential biological utilization of ingested food (for example, the presence of intestinal parasites may reduce the availability of nutrients). Finally, the general nutritional status of the detainees can also be assessed. Evidence of malnutrition in a prison is a sign of a food or nutrition problem. Other factors can exacerbate the situation: the health status of detainees (TB, HIV, mental health, etc.), the relationship between detainees, how food is shared, etc.

When evaluating the food situation in prisons, all testimonies must be carefully weighed. Remember that both the authorities and detainees may have their own reasons for influencing visitors' views on the food in their prisons, and ways of doing so. For instance, detaining authorities may prepare food – different from that usually given to detainees – specifically for the benefit of visitors. And detainees may complain about food simply to release pent-up tension. It is also useful to compare the food situation in the prison with that in the **community outside** (for example, local dietary habits and patterns during 'normal' and 'exceptional' circumstances).

3.2. Food supply

All essential food groups should be represented in sufficient quantities in the food supplied to prisons, so that detainees can benefit from a balanced and varied diet. A proper supply of food for prisons requires:

- **Planning and budgeting by the prison authorities**
National or local prison regulations may stipulate a set daily food ration for each detainee.
- **Logistics management**
Food may be supplied to the prison daily (if pre-cooked), weekly (if bought on the open market), monthly or even quarterly (when provided by central authorities). Arrangements for this supply must be properly managed to ensure reliability. Food may also be supplied from prison gardens; this, too, requires proper planning and management.

Insufficient supplies of food from the authorities may be the result of poor planning, inadequate finances, fluctuations in food prices, or corruption. Both the officially stipulated food rations and the food actually received by detainees should be assessed and compared with nutritional requirements.

Official prison food supplies are often supplemented by food from families, NGOs, or shops or stalls within the prison, as well as from detainees who obtain extra food while working outside in the community. Nonetheless, prison authorities should be expected to provide a full daily food ration that, in quality and quantity, meets the nutritional needs of detainees. Additional supplies should not be included in calculations of a prison's food supply; they should be assessed separately. Additional food sources (and their often unequal distribution) will be considered further in Section 3.5. below, on access to food.

SAMPLE QUESTIONS ON FOOD SUPPLY

Budget

- How is the budget calculated at the PoD level and at HQ level?
- Are there contingency plans for dealing with a sudden increase in one PoD or within the entire system?
- Are the staff included in the same budget, or is there a separate one for them?
- Is there a budget for energy, equipment and maintenance of infrastructure related to nutrition? (See Booklet 1: Basic concepts of nutrition in detention.)
- Are there mechanisms for supervision? For calculating budgets and making allocations, and for procurement/production processes at HQ and PoD levels?
- What arrangements are in place for paying for supplies?
- Are these arrangements honoured by both parties? If not, what are the consequences and how are these remedied?

Requests for and receipt of food

- Does the prison only receive food? Does it also purchase food?
- How does the person in charge request food from the prison authorities? How frequently are these requests made?
- What is the frequency and reliability of the delivery of food (seasonal variations, market prices)? Are there any problems in ordering and receiving regular supplies?
- How is the quantity of the food to be ordered calculated? How much food is ordered for fixed periods? Are the amounts of food fixed or can they be changed as needed? What changes do prison authorities make when the number of detainees is particularly large?
- How does the person in charge check the quantity and quality of food on receipt?
- How is the quality of the supplies evaluated? How is food determined to be of poor quality rejected and replaced?

Official supply from the prison authority

- What is the total budget for food (note that some commodities are also received in kind) for the whole prison or per prisoner? What is the period covered by it?
- Is the budget/in-kind provision sufficient for the real needs? Does it take current market prices into account?
- What is the source of the official food supply (government stores, local market, prison fields or kitchen gardens)?
- Is the prison receiving food from the prison farm (quantities, frequency, seasonal variations)?
- What are the ingredients of the prison diet?
- Is there an official daily/weekly menu?
- Who are the consumers of the prison diet? Do prison staff eat the same food as detainees?

Availability of food

- What is the overall availability of food (raw materials) for the prison from official and other sources?
- Is any food being diverted before or upon reaching the facility? By whom, where, and how much?
- Is availability affected by external factors such as climate, market prices, social conditions and conflict, or by the geographical situation of the prison?
- Is the food provider reliable? If not, why?
- What is the availability of food for detainees? Are there differences based on categories and groups of detainees, or on their location in the facility? What proportion of detainees receive family visits? And what proportion get food from their families?
- What proportion of detainees are working? And what kind of work are they doing?

3.3. Food storage

Food must be stored properly in order to keep it free of contaminants, prevent spoilage by pests, and to preserve its nutritional content (infested cereals and pulses have fewer proteins, for example). Food stores should be clean, dry, well protected from the elements, and free of rodents and insects. Food storage facilities should be inspected and food losses due to improper storage noted.

Minimum recommendations for solid waste

Food store	50 m ² /1000 persons	(ICRC)
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SAMPLE QUESTIONS ON FOOD STORAGE

Food storage rooms

- Where is food stored? Is it well-constructed and in what condition is it (e.g. leaking roofs)? Is it well maintained and kept clean? How is it protected from the weather, and from insects and rodents?
- Is the storage room adequate in terms of the food to be stored, food rotation and the number of beneficiaries?
- Is the storing room adapted in terms of temperature (less than 30°C, with a thermometer to make sure that this is always the case), access (closed windows and doors), and ventilation?
- Are windows equipped with screens?
- Do you see rodents/insects in the room? Or their faeces?
- How are insects/rodents controlled and how often is this done?
- Is food put on wooden planks? Are stocks piled away from the walls?
- What is the overall quality of the food delivered (clean, properly closed sacks/boxes, insect-free or already infested, damp and torn packaging)?

Stock control

- Who is in charge of stock control (recording the amounts used and remaining, and re-ordering or purchasing)?
- What is the usual stock of food (types and quantities)? What is the period covered? What is the expiry date on the main food items? What is your general impression of the condition of food stocks?
- How much food is lost each year because of rodents/insects/humidity? (Storekeepers often know how to estimate this.)
- What procedures are in place to prevent pilfering of stock by detainees, staff or other persons?
- Are other products stored in the same room? If so, could they be harmful if accidentally mixed with food (medical drugs, pesticides, insecticides)? Can they give the food an odour that would affect its consumption (fuel, soap, chlorine)?
- Based on the number of detainees currently in the prison, how long will stocks last?
- What are the minimum stock levels that the prison authority aims to maintain?
- Is the stock rotation principle of 'first expired first out' respected?
- Are stocks provided to the food preparation area in time?
- Are expiry dates respected? What is done with food whose expiry date has passed, or that is infested or mouldy?
- Are food scales working and/or in use? Are they used to weigh stock when it arrives at the prison and when it is issued by the stores? Or are bags counted and weights calculated according to bag size?
- Record the date of delivery and the amounts of the various food items received over the course of the last 30 days, as noted in the register book (optional).
- Make a tally or inventory of the food in stock and record the information in a 'bin card' with batch numbers and expiry dates.

3.4. Food preparation

The kitchen is usually a critical point in the food chain: food can be stolen or diverted here. Poor cooking processes can also result in the loss of nutrients. Improperly handled food in the kitchen can become contaminated and cause disease among detainees. Prison kitchens are also workplaces with their concomitant occupational health hazards. Kitchen inspections must always be part of a prison health assessment.

The kitchen will probably be visited during the tour of the premises. It should also be visited at other times, with a view to observing the preparation of food and the provision of meals, as well as discussing pertinent matters with cooks and the catering staff.

Nutrition and food preparation

Processing and cooking procedures can drastically alter the nutrient content of food. For example, water-soluble vitamins can be lost in water during washing or boiling, and the vitamin content of fruits diminishes when they are dried.

Occupational health and food preparation

Prison kitchens are workplaces and subject to occupational hazards, including burns and cuts, as well as ailments caused by prolonged exposure to high temperatures, humidity and smoke. Kitchens should be covered and well ventilated; they should also have a chimney and a regular supply of sufficient quantities of water.

Hygiene and food preparation

Kitchens are potential sources of food-borne diseases, and these can lead to epidemics. Food may be contaminated by pathogens (disease-causing agents) while it is being prepared. Pathogens may come from contaminated water, insects (especially flies), animals (rats and cats are found in many prison kitchens), or from infected humans (cooks may carry bacteria). The handling and preparation of food must be regulated by rigorous hygiene practices. Prison health staff should ensure that people working in the kitchen are educated in food hygiene issues and adhere to basic rules of kitchen hygiene (see 'Kitchen hygiene rules', below).

Other sensible precautions include encouraging food handlers to notify their supervisor before commencing work if they have experienced diarrhoea or vomiting in the last 48 hours or if they have skin infections, boils or burns, or ear, nose or throat infections. Routine health screenings for all food handlers may also be considered (screening for carriage of salmonella, tapeworm, etc.).

There is no evidence that TB, hepatitis B or C, or HIV/AIDS and other sexually transmitted diseases can be passed on via food or beverages. People with HIV/AIDS should not be prevented from working with food. The main food-borne diseases are: food poisoning, typhoid fever, salmonellosis, cholera, hepatitis A, leptospirosis and intestinal parasitosis.

When large numbers of detainees complain of gastrointestinal problems the prison health staff should have some idea of the possible causes and be able to suggest potential solutions. If prison staff are unable to define or resolve the issue, cooperation should be sought from the local public health office, health

centre or hospital. This should not only lead to resolution of the problem, but also foster links between the prison and the community's public health system.

Kitchen hygiene rules²³

Keep clean

- Wash hands before preparing food, after visiting the toilet; do this frequently while handling food.
- Ensure: clean clothes, good personal hygiene, short fingernails, covered hair. Do not wear wristwatches, rings or bracelets while preparing food; cover all cuts, burns and sores with waterproof dressings.
- There should be no eating or smoking in areas where food is being prepared.
- Anyone showing signs or symptoms of an infection transmissible by food should not be allowed to work in the kitchens.
- Wash and sanitize surfaces and equipment used for preparing food.
- Protect kitchen areas and food from insects and pests, and animals of all kinds.

Separate raw and cooked foods

- Keep raw meat, poultry and seafood separate from cooked foods. Store raw food in separate containers. Use separate equipment and utensils (knives, cutting boards, etc.) for raw and cooked foods.

Cook food properly

- Cook food thoroughly, especially meat, poultry, eggs and seafood. Juices of meat and poultry should be clear, not pink.
- Boil soups and stews to 70°C.
- Take care while reheating cooked food; heat it thoroughly.

Keep food at safe temperatures

- Do not leave cooked food at room temperature for more than two hours. Consume food soon after cooking, especially in hot climates.
- Refrigerate all cooked and perishable food (preferably below 5°C).
- Keep cooked food hot (more than 60°C) before serving.

Use safe water and safe ingredients

- Use safe water or treat water to make it safe.
- Use fresh fruits and vegetables and wash them before use (especially if they are to be eaten raw).
- Choose foods processed for safety, such as pasteurized milk.

²³ Adapted from WHO, *Five Keys to Safer Food Manual*, WHO, Geneva, 2006.
Available at: http://www.who.int/foodsafety/publications/consumer/manual_keys.pdf

Minimum recommendations for food preparation

Cooking capacity needs	1.2 - 1.4 litre pot/person	(ICRC)
Water stock in the kitchen	3 m ³ /1000 persons	(ICRC)

Besides the recommended water stock and cooking pot capacity, sufficient fuel for stoves is required, so that meals may be cooked properly.

Remember that meals for detainees, while being safe and nutritionally balanced, should also look edible and be tasty. Efforts should be made to provide variety in the meals.

SAMPLE QUESTIONS ON FOOD PREPARATION

Kitchen

- Is there a written contract between the detention authority and the contractor? What are the conditions stipulated in the contract in terms of types of food, frequency of delivery, adjustment of amounts delivered, etc.?
- What policies/guidelines/roles and responsibilities are applicable to the management of food services in the PoD in terms of hygiene, quality control, transportation (e.g. Ministry of Health regulations)?
- Is the cooking area adequate in terms of space, illumination, ventilation, ambient temperatures and proximity/conditions of toilets and hand-washing facilities?
- Who is responsible for the management of food services?
- Are the utensils – pots and pans, dishes, and cutlery – of adequate quality? What is their state of repair? Are there sufficient quantities of them in relation to the number of detainees?
- Is there a maintenance programme for the catering facilities?
- What is the level of hygiene? Do people wash their hands? Is soap available? Are there towels? If so, how clean are they? Are wristwatches and jewellery removed from hands and arms whilst cooking? Is hair covered? Do cooks have aprons? If so, who cleans them?

Food handling/cooking

- Who is responsible for the overall management of the kitchen? What roles do detainees have, and what roles do staff have? Is there a vocational training component? If so, how does it work?
- How many cooks are there? Are they internal or external staff? Do detainees also serve as cooks? If so, to what category do they belong?
- Is the number of cooks/kitchen staff proportional to needs? Are there too many of them? (An excess of cooks/kitchen staff often leads to less accountability, to food becoming prone to diversion/contamination. In general, the fewer, the better.)
- Is there any systematic health screening for cooks (e.g. for salmonella, worms)?
- Are cooks trained? Are they aware of basic rules of hygiene? Is anyone supervising their hygiene practices?
- Are staple foods ground by machine or by hand? Is the grinding sufficient?
- If access to grinding mills and other processing facilities (within or outside the PoD) is limited, does this have an impact on the amount of food provided and the number of daily meals? Explore possibilities for motor-driven forms of food processing (including grinding), as it reduces the time (and the amount of water and fuel) required for cooking.
- Food handling procedures: Are raw or cooked ingredients kept separately, at proper temperatures, and protected from insects? Are there possible sources of contamination? And of cross-contamination?
- Preparation and cooking processes: Are the methods used (prolonged soaking, excessive boiling) such as to reduce the micronutrient contents (vitamins and minerals)?
- Are vegetables (after they have been washed) added only at the end of the food preparation, to avoid overcooking (and thus loss of micronutrients)?
- Organic waste handling: Is the collection of waste and the frequency of its disposal adequate?
- After it has been prepared, where is the food kept before distribution? How long is it left in the open air or in the sun? Is it left uncovered?
- Are there reports of occupational hazards such as injuries from burns and cuts as well as prolonged exposure to high temperatures, humidity and smoke?

Stoves and fuel

- Stoves: How many of them are there, and of what type? Is their capacity sufficient for the needs? Are the stoves fuel-efficient?
- What type of fuel is used? Are the quantities available, per day or per meal, sufficient for proper cooking? Does the prison authority economize on cooking time because of shortage of fuel?
- How are the fuel supplies and what is the budget for fuel? Are there any difficulties associated with the supply of fuel? How frequently do they occur?
- Are pots covered to reduce cooking time?

3.5. Access to food

'Access to food' refers to access to: a) the official rations prepared and distributed by the prison authorities, and b) additional sources of food, such as family visits or guards or prison shops.

The official distribution of prison meals should be equitable, but some detainees' access to food may be limited or influenced by the category or group to which they belong. For example, foreigners may be the last to receive the meals, and so may have less, and juveniles may get smaller portions because adults take more. The organization of food distribution (e.g. by cells or at a central point) should be assessed with these considerations in mind; the use of measures to ensure equal portions (e.g. food scoops) should be assessed as well. Prisoner hierarchies may influence access to food even after an equitable official food distribution, because lower 'classes' of detainee may have to 'donate' or 'pay' food to higher 'classes'.

Access to food from supplementary sources is likely to be uneven. Detainees without families, money, or employment (entitlement to work and earn a small income is often a privilege in prisons) will probably have less access to food.

SAMPLE QUESTIONS ON ACCESS TO FOOD

Access to food and amounts available to detainees

- How is food distributed? By and to whom?
- Do all detainees receive the same ration of cooked food? If not, what are the differences, and the reasons for them?
- Who gets what food *and why*?
- Identify those vulnerable detainees who are likely to have less regular access to food, who cannot improve their access to food without resorting to conduct that does them harm (theft, prostitution, etc.).
- What are the characteristics of detainees with the power to purchase food? And of vulnerable detainees who don't have such power?
- Are certain detainees specifically entitled to benefit from food privileges? Who and why? (Detainees with chronic diseases such as TB and HIV are sometimes given extra meals because of their treatment.)
- Are malnourished detainees provided a different nutritional regime?

Access to other food sources

- What proportion of detainees receive food through family visits? What kind of food, typically? And what, typically, is the frequency with which this happens?
- How much food do NGOs and others donate? And how frequently? (Note: A helpful rule in this connection is to disregard external food donations if they take place less than twice a month.) Find out whether these donations/meals replace or supplement the prison diet.
- Visit the prison shop, examine what is on offer, ask about seasonal issues, and find out how many detainees buy food there.
- What proportion of detainees obtain food through work? Do the amounts or types of food vary according to the type of labour (e.g. physical work)?
- What proportion of detainees have a 'stable' cash income? What proportion of detainees have a stable supply of food (besides that provided by their families)?
- Can detainees prepare their own food (fuel, electricity, space)?
- What proportion of detainees share their food entitlement, voluntarily or involuntarily? Are family rations partially consumed by guards or more powerful detainees? Is the prison meal partially taken by the 'head of cell' and his friends?

Quality and quantity of food consumed

- How are the quantity and quality of food monitored? How often? By whom?
- Is there a system for detainees to complain if they do not receive the prescribed diet?
- Are there groups or categories of detainees that are disadvantaged in relation to food distribution – high-security detainees, security detainees, people on death row, juveniles, recidivists, etc.? Is this discrimination imposed by the authorities? Or is it carried out by some detainees but tolerated or encouraged by the authorities?
- What is the general state of access to food in the PoD? Are certain cells or areas provided less food? Why?

3.6. Nutrition

The human body needs a diet of adequate **quantity** (sufficient amount of kilocalories, or kcal) and **quality** (balance among the various food groups) in order to maintain health.

Prison authorities are responsible for providing all detainees with an adequate diet. Because all the nutritional requirements cannot be met by only one meal, a **minimum of two meals** should be served each day.

The energy content of detainees ration should be 2,400Kcal at least. Energy content should, however, be adapted according to detainees' profiles and their physical activities (see Table 3.2). Nutritional requirements vary according to: age, gender, physical activity, health status, and environmental temperature. However, the figures in the tables below provide useful approximations.

The nutritional balance of the prison diet and its energy content should be calculated during a prison assessment. These calculations should be checked against the recommendations for food groups outlined in Table 3.1 and for energy requirements in Table 3.2.

Food groups	Recommended dietary amount, per person per day*	Example foods
Carbohydrates Staple	400 g	Grains and cereal products (including wheat, rice, bread, oats, barley, pasta, and noodles) Also, tubers and roots (cassava/manioc, yams, potatoes) Note that the nutritional value of tubers and roots is lower than that of cereals. If tubers or roots replace cereals, quantities should be doubled.
Proteins Meat, fish, dairy, beans, nuts	130 g	Beans, peas and lentils Meat, poultry, fish Dairy products (milk, yoghurt, curds and cheeses, dried milk powder), eggs, and nuts
Energy Fat	65 g	Butter, ghee, margarine Palm or vegetable oil (fortified with vitamin A)
Micronutrients Vegetables and fruits	200 g	Vegetables and fruits (especially green leafy and red/orange varieties)
Flavour /Socio-cultural complement	6 g salt	Iodized salt, sugar, tomato paste, tea, herbs and spices
	30 g sugar	

* Weights are for uncooked food and based on a diet providing approximately 2.400 kcal ($\geq 10\%$ energy from protein and $\geq 25\%$ from fat).

Table 3.1 Food groups: Recommended quantities (per person per day) and example foods to ensure a balanced diet. These are only recommendations; the food groups available will vary between contexts.

		Activity level		
		Light (very little or no activity)	Moderate (walking, occasional exercise)	Heavy (farming, construction work)
Energy requirements	Male	2,400	2,900	3,400
(Kcal/person/day)	Female	1,950	2,100	2,350

Table 3.2 Individual energy requirements for detainees, by gender

People may be insufficiently nourished even when a diet adequate in quantity and quality is available. This may be owing to illness altering the body's biological utilization of food. Certain diseases increase nutritional needs (especially AIDS, dysentery, TB, cancer, severe infections). At the same time, they may inhibit or decrease food consumption (for example, by causing nausea, loss of appetite, mouth ulcers, or problems in the digestive tract). Disease may also reduce food absorption (through 'malabsorption syndrome') and impair food utilization (among people suffering from diarrhoea, for instance, large numbers of bacteria in the small intestine can decrease the quantity of vitamins in food).

SAMPLE QUESTIONS ON DIET

- Find out if the official daily/weekly menu is indeed provided to and consumed by the majority of the detainees.
- Do meals look appealing? Are they tasty/liked by the detainees? Do people seem to like their food? Do they eat fast?
- What do you observe with regard to the variety of foods eaten by the individual? Assess the composition of the meal(s) in terms of percentage of staple food, beans, vegetables, etc.
- Ask to see people who are sick and assess their meals.
- Find out whether detainees are still hungry after their meals and why.
- Are most meals finished? Are there leftovers? (Ask to see the leftovers and what is done with them.)
- Assess the quantity of food consumed: weigh individual meals provided to detainees. As a guide, take no less than 10% of a representative sample of the total population (the larger the variability expected between the portions served, the larger the sample should be) and measure the weights of cooked food provided. Select the meals randomly and make sure that your sample meals are collected throughout the distribution period, e.g. not just at the beginning or at the end.
- Weigh various bowls/plates of food and divide by the number of people for whom they are intended. Cross-check the food consumption information obtained on the day of the visit to the PoD (what has been observed and measured) with interviews with detainees and prison staff on what they actually eat.
- Conduct the weighing in different areas in the PoD, in high-security areas, in 'wealthier' parts of the prison, in areas used for 'punishment', etc. and compare weights and food in the different areas.
- Weigh also family food rations or self-prepared food if this is an important source for the detainee population.
- Do specific groups (pregnant or lactating women, the elderly, children, etc.) consume additional/specific foods? If so what?
- Do detainees with specific dietary preferences (e.g. religious) consume particular foods?
- Are there any general health problems that may affect consumption of food (mouth ulcers, fevers, lack of teeth, etc.) or that may affect the biological utilization of food (e.g. intestinal parasites, outbreaks of diarrhoeal diseases)?
- Find out specifically what food TB and HIV-affected people consume, and whether they are on medical treatment and whether food is offered when they take their medicine.
- Find out what detainees with food entitlements consume: e.g. are they included in a feeding programme and receive additional food for being malnourished?
- Find out if the food consumed by different groups of detainees is adjusted according to their levels of physical activity or to climate conditions: Are detainees doing manual labour or other work in the prison system given more or different food? Is more food distributed in cold weather?

3.7. Malnutrition

Malnutrition occurs in an individual when the *quantity* (energy in kcal) and/or *quality* (balance of food groups, presence of vitamins and minerals) of his or her daily food intake is insufficient over a period of time. This is often, but not always, due to lack of food. Malnutrition can be associated with other diseases as either a cause or a consequence. Malnutrition can cause disease because it impairs the functioning of an individual's immune system. Malnutrition can be a *consequence* of disease (and not only owing to lack of food), because many diseases increase the body's need for nutrients while impairing its ability to utilize those nutrients.

Broadly, adult malnutrition can be divided into two types:

- **Acute malnutrition** – caused by an overall deficiency of nutrients
- **Micronutrient deficiencies** – caused by lack of specific micronutrients.

The appearance and assessment of these two types of malnutrition are discussed separately below. However, the separation is artificial: in reality, an undernourished individual will often suffer from *both* acute malnutrition *and* one or more micronutrient deficiencies.

Acute malnutrition

Acute malnutrition is caused by a deficiency of those basic food groups (carbohydrates, protein, fats) that are necessary for growth and general body metabolism. When these food groups are not consumed in sufficient quantities (and where the diet does not meet the energy requirements in Table 3.2), the body breaks down its own stores of proteins and fats. In adults, this very often results in *wasting* – loss of muscle mass and body fat. People with wasting look very thin and have little strength or energy. More rarely, *oedema* – accumulation of fluid, initially in the lower limbs – can be a second clinical aspect of acute malnutrition. People may look swollen and puffy; fluid accumulation may mask the loss of muscle and fat. In adults, differential diagnosis of oedema should be done for tropical oedema, hard oedema or oedema associated with kidney failure.

Acute malnutrition is associated with a very high mortality rate.

Body Mass Index (BMI) is used to give an indication of an individual's nutritional status; it can also be used to identify acute malnutrition (either severe or moderate stage). An individual's BMI is calculated from his or her weight and height, by dividing the weight in kilograms by the square of the height in metres.

$$\text{BMI (kg/m}^2\text{)} = \frac{\text{Weight (kg)}}{(\text{Height (m)})^2}$$

BMI can be matched with the various categories of nutritional status (see Table 3.3).

Nutritional status	Normal nutritional status	Mild malnutrition	Moderate malnutrition	Severe malnutrition
BMI (kg/m ²)	18.5–25	17.0–18.4	16.0–16.9	Less than 16

Table 3.3 WHO categories of nutritional status according to BMI

BMI cut-offs for malnutrition are the same for all adults, irrespective of their age, sex, or height. However, *BMI should **not** be used to assess the nutritional status of children and adolescents, pregnant women, or people with oedema.* For assessing nutritional status in children and adolescents, use weight-for-height charts. For pregnant women, measure the mid-upper arm circumference (MUAC). There are no universally recognized MUAC cut-off levels for adults, but an MUAC of 23 cm has been suggested as the lower cut-off for an adult of normal nutritional status; below this level the individual may be malnourished. For people with oedema, that alone may indicate malnutrition; an MUAC may provide further evidence. Examining for oedema involves applying pressure for three seconds with the thumb to the front of the patient's lower leg or the back of his or her foot. After three seconds the pressure is released; if a dent remains in the skin, pitting oedema is present. Pitting oedema due to malnutrition always affects *both* feet.

Micronutrient deficiencies

Micronutrients are required for *specific* metabolic functions. They take various forms: for instance, the many vitamins and minerals found in fruit, vegetables, and protein foods. Micronutrients are stored in the body, often in particular tissues. When a micronutrient is absent from the diet the body's store is gradually depleted until, eventually, none of the micronutrient remains and the specific metabolic function that depended upon the nutrient can no longer occur. At this stage, *specific* physical signs and symptoms emerge, indicating the micronutrient deficiency. Such deficiencies have no direct effect on overall body mass or growth (except deficiency in iodine in children), but may nonetheless still result in death.

Signs and symptoms of some of the most important micronutrient deficiencies are described below. Clinical assessment of signs and symptoms remains important for diagnosing micronutrient deficiencies, because biochemical testing using blood or urine samples is often very expensive or simply impossible to arrange.

- **Iron deficiency** (anaemia)
Tiredness, breathlessness on exertion; pallor of palms, inside eyelids or mouth; high pulse rate.
- **Vitamin A deficiency** (xerophthalmia)
Initially causes night blindness (poor vision in dim light). Later: dryness of eyes with keratin accumulation on the conjunctiva (Bitot's spots). Eventually: dry, dull, or milky corneal appearance (corneal xerosis), with corneal softening and ulceration (keratomalacia).
- **Iodine deficiency**
May cause goitre; also, cretinism (impaired physical and mental development) in children.
- **Vitamin B1 (thiamine) deficiency** (beriberi)
Early symptoms are: fatigue, irritability, poor concentration, loss of appetite. Later: pain and altered sensation in limbs (often starting with reduced sensation in feet), tenderness in calf muscles on pressure and muscle cramps, muscle wasting and weakness (causing difficulty in walking or in getting up from squatting position), reduced tendon reflexes. Eventually: lower-limb oedema, pulmonary oedema, breathlessness and palpitations. In 'dry beriberi', features are predominantly neurological; in 'wet beriberi', heart failure is predominant: the two forms often overlap.

- **Vitamin B3 (niacin) deficiency** (pellagra)

Early: weakness, anxiety, loss of appetite.

Later: epithelial changes – dermatitis, vaginitis, stomatitis, bright-red glossitis. A 'classic' manifestation is a scaly pigmented rash on areas of the skin exposed to the sun (especially backs of hands, neck and face). Diarrhoea and fluctuation of mood may also happen in later stages.

- **Vitamin C deficiency** (scurvy)

Scurvy develops gradually with fatigue, bone/joint pain in lower limbs, swollen and bleeding gums, possible loss of teeth, slow-healing wounds, haemorrhages around hair follicles, brittle hair, swollen and hard lower limbs and spontaneous bruises.

3.8. Assessing nutritional status in prison populations

Nutrition is an important issue in prisons. Assessing the nutritional status of detainees and the nature, extent and severity of malnutrition among the prison population may be an important part of the overall prison health assessment.

When considering the nutritional status of people inside prisons, remember that malnutrition normally affects a *group* or *groups* (signs of malnutrition in a single individual are more likely to suggest an underlying disease, which should be investigated). Also, malnutrition tends to affect *vulnerable groups* first (in prisons this may include the elderly, ethnic minorities, and detainees who receive few or no family visits).

Warning signs of a nutritional problem within a prison may include:

- unusually high death rates
- unusually high rates of sickness
- malnourished detainees (observed during the prison visit).

Health staff may have data showing death rates and sickness among detainees. They may also keep records of the nutritional status of individual detainees (for example, weights documented in clinic records). However, these records may not be a reliable indicator of the nutritional status of the general prison population, because the data will refer only to those detainees who have accessed medical care, and they may not be representative of the general population. Also, nutritional data may not always be recorded and analysed accurately or systematically when health staff attempt to do this alongside their other clinical tasks.

Nutritional surveys of the prison population

The rule is to carry out yearly nutrition surveys in prisons that could have a nutrition problem, and quarterly nutrition surveys in prisons with ongoing malnutrition problems.

A survey of this kind is, most frequently, a targeted assessment of the nutritional status of the entire prison population, and, when there are too many detainees for that to be possible, of a sample of that population.

Conducting a nutritional survey successfully requires time, effort and good organization. It will probably entail the clinical assessment of many detainees over several days. If a population sample (rather than the entire population) is being used for the survey, it must be ensured that this sampling really represents the whole prison population – including members of those vulnerable groups that may be most at risk of nutritional problems. Nutritional surveys can provide information about the prevalence and severity of malnutrition in prison. They may be conducted routinely, or in response to specific concerns about nutrition within the prison. (See Chapter 8 of Booklet 2: Assessment of the food and nutrition situation in detention.)

A comprehensive nutritional survey could include the following for each individual (see Chapter 8, Table 10 of Booklet 2: Assessment of the food and nutrition situation in detention):

Compulsory:

- measurement of BMI (or MUAC if indicated)
- clinical examination for signs of oedema

Possible:

- specific micronutrient deficiencies, or disease
- questions about symptoms of malnutrition and disease, and about access to food.

The results of a nutritional survey should be interpreted carefully. The interpretation should include analysis of the prevalence and degree of malnutrition. For instance: Does malnutrition within the prison affect many detainees or only a few? Is it severe or moderate? Equally important is analysis of which groups within the prison are most affected. A nutritional survey will not reveal the underlying causes of a nutritional problem. Ultimately, identifying the causes is essential and will require consideration of the entire food chain (as outlined earlier in this chapter) and of any disease factors.

4. HEALTH-CARE SERVICES

4.1. Background principles

Imprisonment should not increase the risk to the health of detainees. In the context of health-care services this means that the **principle of equivalence** should apply. That is, the health care available in prison should be at least equivalent to that available in the surrounding community. For this reason, it is important that all detention visits include a visit to the local health facilities as well. Visiting the local health facility will give you a grasp of the levels of service available to the community. It will also allow you to study the provisions that have been made for detainees who may be referred to this facility for further care. It is important to see how detainees are treated at the facility and to discuss any specific concerns with local doctors.

It might be argued that even the principle of equivalence is inadequate in relation to prison health-care services. Prisons contain people who are often vulnerable to ill health because of their background, their environment, and their behaviour inside prison. Detainees are often socially, educationally and economically disadvantaged before entering detention – all of which increases their risk of ill health and reduces the likelihood of their having made use of health services before entering prison. Detainees are also more likely whilst in prison to be exposed to behaviour (physical and sexual violence, substance use, and other risky conduct) that increases their risk of contracting infectious diseases such as hepatitis and HIV, and that also increases the incidence of psychological disorders among them. As a result, the demands on the health services of prisons are greater than those on community health services; even so, prisons usually receive far less help, in terms of resources and funding. Consequently, health services for detainees are often of lower quality than those available to the community outside. One significant element of health care in the community for which there is rarely, if ever, an equivalent in prisons, is choice: detainees cannot choose their health-care provider. If detainees do not like or trust their health-care provider, or if they think the standard of care is inadequate, they can only very rarely choose another provider.

4.2. Health staff

Role and responsibilities of health staff

The level of health care provided in a prison will depend upon the number of health staff, their qualifications and training, and their motivation. These factors should be assessed during the prison visit.

In some contexts the role of health-care staff in prisons may be defined in the country's '**prison regulations**'. These regulations may specify that prison health staff are responsible not only for running the health-care services, but also for other tasks such as oversight of hygiene, sanitation and nutrition. This is consistent with the ideal that health staff have duties that go beyond curative care: they must also be responsible for protecting and promoting health.

Prison health-care structure and hierarchies

In many contexts, the authority in charge of the management and security of the prison (usually the Ministry of Justice or the Ministry of the Interior) also has authority over the prison health staff and responsibility for prison health. Health staff may have no official connection with the Ministry of Health and may be entirely accountable to the Ministry of Justice. They may even have a police or military rank. This arrangement means that health staff in prisons often take no part in ongoing training and have no professional contact with their colleagues in the national health system, which can adversely influence the care that they are able to provide. The professional independence of health staff may also be compromised in these circumstances by 'dual loyalties' (see below), and this may have a further adverse impact on their performance.

In order to better understand the forces acting upon prison health staff, it may be useful to map the structure of health-staff hierarchies. This map should show who the health staff report to – within the prison and at the local health authority or ministry. It should also show the points of contact between health staff and community health services, district authorities, and relevant ministries. Completing this mapping will help to ensure that any actions intended to bring about change are directed at the appropriate individuals or authorities, or at the proper level.

Relations between health staff and detainees

Relations between health staff and detainees vary considerably in prison settings. Some health staff may carry out their work with empathy and compassion, treating detainees as they would any other patient; they may know each detainee by name and be willing to see anyone who wishes to have a consultation. Others may treat detainees impersonally, referring to them by their prison number, for example; and they may view detainees with suspicion, regarding their complaints as no more than malingering. Some health staff may seek to do as few consultations as possible, especially in contexts where salaries are low or where staff have been obliged to work in the penitentiary system.

During the prison visit, try to gauge the attitude of health staff towards detainees.

Dual loyalties and health-care ethics in prisons

'**Dual loyalties**' commonly exist for health staff working in prison settings. The problem of dual loyalty for health professionals has been defined as

“simultaneous obligations (...) to a patient and to a third party.”²⁴ The obligations may be expressed or implied, real or perceived. The third party may be an employer, an insurer, a relative of the patient, the State, or the authorities in charge of a prison. Dual loyalties are not the same as a conflict of interest: in a conflict of interest the health professional’s self-interests vie with those of another individual or group; when dual loyalties are at stake, the health professional’s self-interests are not necessarily involved, he or she has nothing personal to gain from the outcome, and the conflict is between two incompatible accountabilities. In practice, however, even when dual loyalties are clearly in play, as in a conflict between the patient’s health interests and the security interests of prison authorities, the health professional will also experience a conflict of his or her own interests, since he or she will likely be dependent upon the prison authorities for employment and income, meaning that it is in his or her interests to align with, or be more loyal to, the authorities. Thus, in situations where the health professional’s clinical independence is threatened by conflicting loyalties to prison authorities and patients, the risk that patients will suffer is considerable.

Nonetheless, it is important to recognize that **health professionals working in prisons are bound by the same ethical obligations as their colleagues working in the community.**

In prisons, health staff may be confronted with various ethical issues. The nature of these ethical issues and the frequency with which they arise, as well as the health staff’s response to them, needs careful and sensitive evaluation. The visiting health professional should obtain information from various sources: direct observation, discussions with detainees, and discussions with health staff and authorities.

Examples of medical ethical issues in prison settings

- Requests to disclose clinical records to non-medical staff
- Shackling of detainees during medical procedures or hospitalization
- Withholding of medical care
- Treatment without consent
- Hunger strikes
- False certification of medical reports
- Medical certification of fitness for interrogation, punishment, or solitary confinement
- Medical participation in torture, ill-treatment, or executions

Discussions with prison health staff should take place in an atmosphere of trust so that ethical issues can be fully explored. The conversation may become unproductive if the health staff have knowingly subverted their ethics to the security needs of the prison, and are made to feel defensive about this. Where prison health staff are uncertain of their ethical duties, teaching seminars can be undertaken.²⁵ Staff may also need support to comply with their ethical codes. Where serious breaches of ethics come to light they must be discussed and clarified with the health staff concerned, and documented in detail; advice can

24 Physicians for Human Rights and University of Cape Town Health Sciences Faculty, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms*, Boston, MA, 2002. Available at: <http://physiciansforhumanrights.org/library/reports/dual-loyalty-and-human-rights-2003.html>

25 The website of the World Medical Association (www.wma.net) is a very useful resource. The WMA’s *Medical Ethics Manual* may be downloaded from it; the website also contains links to online courses in medical ethics and prison medicine. There are also links to the texts of: the International Code of Medical Ethics and the Declaration of Geneva; the Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment; and the Declaration of Malta on Hunger Strikers.

then be sought as to whether or not the ethical breach should be reported to the prison authorities, the Ministry of Health, or the national medical association.

SAMPLE QUESTIONS ON HEALTH STAFF

Staff training

- Record impressions of individual doctors and other health staff with regard to their competence, professionalism and motivation. Impressions may be gained from observation of working practices, staff meetings, patient consultations, and patient registers, as well as from discussions with detainees and the health staff.
- What qualifications do the prison health staff have? Do they have regular contact with the national health system? Do they have any ongoing training or education? Do they have any training specific to prison health?

Staff motivation and attendance

- What are the official working hours of the medical staff? And what are the *actual* hours worked by them?
- Are the working hours of medical staff such that detainees are ensured access to health care?
- What are the standards used to gauge access to health? Is a nurse available all the time? Does a doctor attend daily? Are these standards included in the prison regulations or other guidelines?
- Are there any notable gaps in attendance by any of the staff? Do medical staff choose to work in the prison? Or are they required to be there, regardless of their wishes?
- Are the health personnel given responsibilities/duties other than curative health services? Are they required to inspect the state of hygiene in the living quarters, the sanitary facilities and the kitchen? To monitor food and nutrition? Are these defined in prison regulations or other written orders?

Structure of the prison health service

- Who employs the prison health staff (Ministry of Health, Justice, Home Affairs, Interior, or Defence)? Is there a prison medical service under these ministries and does it have formal links with the Ministry of Health? Are prison health services integrated with the national health system?
- Do detainees work for the health service? What are their roles and responsibilities?
- Map the structure of the health personnel within the prison, including: doctors, nurses, health assistants, laboratory staff, dentists and detainees. Briefly list the names, qualifications, level of training and approximate date of appointment of the health personnel.
- Are there any vacant posts in the prison health team? How long have these vacancies existed?
- Map the links between the prison health service and the relevant district or central authorities (local health authority, Ministry of Health, Ministry of Justice, etc.).

Relations between staff and detainees

- How are relations between prison health staff and detainees? Try to form an impression based on observation of the daily clinical routine, treatment of inpatients, and discussions with staff and detainees.

4.3. Medical facilities and equipment

Clinic

All prisons and places of detention should have a clinic or health facility on site (it may be called the 'health post' or the 'outpatient department').²⁶ The clinic area should include: a consultation room, an area for treatment, and a waiting area for patients. The consultation room should allow for discussions in confidence and for privacy during the examination of patients. It must be equipped with an examination couch and basic medical equipment (thermometer, stethoscope, sphygmomanometer, etc.); absence of these items suggests that medical examinations cannot be performed properly.

The situation of the clinic should be noted. It may be situated beyond the main security perimeter if it is the local community clinic or if health staff are unable to enter the prison premises (for security or other reasons). If the clinic is beyond the perimeter, detainees' access to it may be impaired (especially if guards obstruct passage or demand bribes); it may also mean that health staff do not regularly enter the prison to check the hygiene condition of cells, kitchens, toilets and other shared premises or to assess the food and directly observe the health of detainees.

Sick ward/ Hospital

Large prisons might have a hospital or sick ward, which allows detainees to receive continuous monitoring and treatment, to be isolated from the general prison population, and to recover from their illness in a quiet environment with easy access to sanitary facilities.

Whether or not a prison has a hospital or sick ward may depend on: the criteria for hospital construction set out in the country's Prison Act or prison regulations, the facilities available to the community, and the structure of the national health service. Prison hospitals have the advantage of being 'within the system', meaning that transferring a detainee to hospital involves less red tape, and no issues with transport or custodial staff. However, there is this disadvantage attached to prison hospitals: they may become liabilities at some stage: in a system that is hard pressed for funding, there may not be enough money available for maintenance and supplies, and for keeping a permanent staff on hand at all times.

Acceptable standards for a prison hospital or sick ward may vary, depending on: the standards of the medical facilities available to the community outside; the seriousness of illnesses treated inside the prison; and possibilities for referring seriously ill detainees to hospitals outside. As a minimum, though, inpatient wards should have: good levels of hygiene; suitable sanitary facilities; good ventilation and a heating or cooling system (adapted to the local climate). The ward must also be staffed by a team with appropriate levels of training and supplied with all necessary medical equipment and consumables.

All larger prisons should be equipped with an **isolation room or ward to separate detainees with contagious diseases**, in order to prevent the spread of disease among the entire prison population. As a minimum, there should be a spare room that can be rapidly converted into an isolation ward if the need arises.

²⁶ There may be no clinic at a police station, but there should be a first-aid kit and someone with basic first-aid training. The police should have quick access to a local clinic or to a doctor or nurse who can be summoned at short notice.

On-site laboratory facilities, if there are any, should be evaluated for such things as: state of repair, supply of parts and reagents, and knowledge of staff regarding the use of lab items.

SAMPLE QUESTIONS ON MEDICAL FACILITIES AND EQUIPMENT

Prison clinic

- Is there a clinic in the prison, or do detainees use the local community clinic? Where is the clinic situated: inside or outside the main prison compound?
- Provide a general description of the clinic: its size, lighting, ventilation, water supply, hygiene, furniture, examination couch, etc.
- What medical equipment is available? Thermometer, stethoscope?
- Does the clinic area ensure confidentiality for patients? Is the consultation area separate from the waiting area?
- Are medicines stored in the clinic? Are they stocked in a secure and orderly fashion? (Types of medicine will be discussed in Section 5.7. below.)
- Does the clinic have space for treatment? Is there equipment and space for someone to receive IV medicines or fluids if required?
- Remember to visit the local health centre or hospital used for referrals, and write a brief description of the facility.

Sick ward/Hospital

- Where is the sick ward situated? What is the state of its water supply? Lighting? Ventilation? And its furnishings, bedding, and so on?
- Is there an isolation room or ward?
- Is there a laboratory? Is diagnostic equipment (X-ray, ultrasound) available? How often is this used? Are staff trained and experienced in its use?
- If there is a prison hospital, how many wards does it have and of what kind (general medicine, surgery, psychiatric, infectious disease, women)? What is the surgical capacity? How are blood-bank services arranged?
- What is the condition of the wards? How are they staffed? How are services organized (kitchen, laundry, sterilization, etc.)?

Laboratory facilities

- What laboratory equipment is available and what condition is it in?
- Are staff adequately trained in the use of such equipment?
- How is quality ensured and controlled?
- What tests can be performed, and how frequently?
- Where do laboratory supplies/reagents come from? Are there any shortages?
- Are health and safety procedures in place and respected?
- If tests are performed outside the prison, does the detainee have to go in person to the community facility, or is just the sample sent?
- Who interprets the results from the laboratory? Is there a system for checking results? Is there one to ensure that clinical staff are made aware of abnormal results from the laboratory?

4.4. Access to health care **INSIDE** the prison

The level of the health infrastructure does not necessarily reflect the kind of health care that detainees actually receive: in other words, there is no guarantee that the existence of a comparatively well-developed health infrastructure will result in high-quality health care for detainees. Assessing **ACCESS TO HEALTH CARE** is important: that is, assessing the degree of access that inmates have to health staff, consultations and treatment. Access must be considered at two levels: access to health care **within the prison** (covered in this section) and access to health care **outside the prison** (see Section 4.5. below). Access to care outside prison will be necessary when medical needs go beyond the capabilities of the prison health staff and facilities.

The role of prison health staff in ensuring access to health care

Health care available to people in prison should at least be equivalent to that available to people in the community outside. In large prisons, or in contexts where the community outside has relatively easy access to health care, one or more doctors may work full-time in the prison. In small prisons, or where the surrounding community has only limited access to health care, a doctor working part-time may visit the prison intermittently. Nurses or health assistants may be more available and they may be able to take on many health-care tasks in prisons: for example, performing the initial detainee health screening and treating sick detainees for common or minor ailments. However, these first-line health personnel must be able to refer patients to a doctor if further care is required, and they must be capable of recognizing cases that require referral. The working hours of these first-line health staff (and their availability) will reflect the health-care situation in the community. Irrespective of contextual variations, the degree of access to health care is acceptable only if: detainees with acute symptoms are able to have them reviewed by a member of the health team on the same day (sooner if possible or necessary); and if detainees with chronic or complex illnesses are able to receive medical follow-up regularly.

Within the prison, all detainees should have equal access to health services. Health care is often a scarce resource; any rationing of health care should be done according to clinical need, as determined by a member of the medical staff. Non-medical staff should not screen detainees or limit their access to health care. This is for several reasons: first, non-medical staff lack the expertise to determine the health-care needs of individual detainees; second, they may make choices or impose restrictions based on non-health-related reasons (political affiliation, bribery, etc.); and third, because the principle of medical confidentiality dictates that a detainee should not have to divulge the state of his or her health to non-medical staff. Ideally, detainees should be able to report their names and health complaints directly to a member of the health staff, either at the clinic itself, or during rounds of the prison made by the health team. In reality, however, non-medical prison staff often draw up the list of detainees who wish to see the doctor or nurse: particular attention must be paid to ensuring that there is no discrimination in this process.

Non-medical determinants of access to health care

Difficulty in getting **access** to health care is a common problem inside prisons. It may affect the entire prison population, or only certain groups or individuals. Where the *entire prison population* is affected, a number of factors

may be responsible: geographic or demographic factors that limit the supply or availability of staff or medical consumables; insufficient budget for salaries of medical staff, medical supplies or medicines; or negligence or lack of will on the part of the prison authorities.

Specific groups or individuals may find their access to health care limited by hierarchies or 'gangs' within the prison. One group of detainees may not want another to get medical care. Vulnerable groups might include: women, minors, the elderly, minority groups, those with mental-health problems, and detainees in particular categories or locations (e.g. those on 'death row' or in solitary confinement). These groups may suffer discrimination because they are thought to be inferior and less deserving or, in the case of political or security detainees, because they are regarded as 'enemies' or 'traitors'.

Corruption involving the prison authorities (and even other detainees) can also impair access to health care. Some form of corruption or bribery exists in almost every prison in the world. This is a complex and delicate issue and often difficult to assess, let alone respond to. But a response strategy must be formulated, in case corruption hampers access to basic services for all or even some detainees.

Information on access to health care can be obtained from the health staff, the administration, the detainees themselves, and from direct observation. Medical registers may also be a useful source of information in this regard, as they may contain a record of the days on which the clinics are open, and on the number of consultations and the reasons for them.

Consultation rates

The number of medical consultations carried out in a prison may disclose information on such matters as: detainees' access to medical services; availability of health staff and their willingness to see patients; and the overall health status of the prison population. However, these *findings must be interpreted cautiously*.

Reference or 'baseline' values for the number of health consultations expected to take place in prisons do not exist. References to displaced populations (including refugees) provide some guidance, but these too must be interpreted cautiously. It is expected that in a population of 1,000 displaced people, 10 consultations will be performed daily (representing about 1% of the population).²⁷ Higher figures may indicate poor health in the population. When the number of daily consultations exceeds 3% of the population, the patterns of morbidity must be studied carefully. It is important to find out whether the higher numbers of consultations are related to minor ailments such as headache or back pain, or to serious illnesses. While studying the consultations consider also whether the patients seen by medical staff represent new cases of sickness, or whether these are detainees with chronic diseases attending the clinic several times a week.

Remember the other important tools for assessing detainee health and access to health care: discussions with the health staff and with the detainees themselves, and direct observation of sick detainees. The presence of obviously sick detainees who have not attended the clinic, or of detainees with chronic diseases or injuries who have not had any medical follow-up, suggests a potentially significant problem affecting access to health care in the prison.

27 P. Perrin, H.E.L.P.: *Public Health Course in the Management of Humanitarian Aid*, ICRC, Geneva, 2001.

Medical assessment of new arrivals

Prisons should have a system for the medical assessment of all newly arrived detainees. An individual's medical history should be documented, and an examination conducted, as soon as possible after arrival, preferably within 24 hours. Ideally, a doctor should perform the initial medical examination, but where this is not possible, a qualified nurse can fill in. An initial medical examination is not always feasible in police stations, but a medical consultation should be available on request of the detainee, or if the authorities have reason to think one is needed. All medical information obtained during the initial medical examination is confidential and should be stored accordingly.

It is important that newly arrived detainees undergo a medical assessment. There are a number of reasons for this:

1. Detainees may have immediate medical needs that require treatment. This may include treatment for an acute condition (a wound, broken limb, or acute infection, for example), or for a chronic condition (a diabetic may need to continue his or her insulin regime, a person with a mental-health problem may need to continue taking his or her antipsychotics, etc.).
2. Detainees may have contagious diseases when entering a prison, and may have to be isolated until their disease has been treated, or until it is no longer contagious. It may be appropriate to isolate newcomers temporarily, until an initial medical assessment has confirmed that they pose no risk to the general population. The isolation ward should be of the same standard and as comfortable as the rest of the prison so that detainees who have to be isolated for a contagious disease do not feel that they are being punished. Isolation should end immediately after the contagious stage of a disease has passed (e.g. detainees in the continuation phase of anti-TB treatment should not be kept in isolation once their sputum test has come up negative).
3. Detainees may bear physical or psychological evidence of ill-treatment that needs to be documented. For example, if detainees arriving from interrogation centres or police stations have been abused, the fact must be recorded and any scars described. Such documentation can be beneficial both to the detainee and to the prison authorities. Medical documentation of evidence of ill-treatment may help the detainee in the event of future legal action against those responsible; and recording evidence of injury or psychological distress at the time of their arrival at the prison may help to prove that these occurred *prior* to the detainees' arrival and were not caused by the current detaining authority.

Medical involvement with persons in solitary confinement

An international agreement prohibiting **solitary confinement** in places of detention has not yet taken shape. However, prolonged or indefinite periods of solitary confinement are, increasingly, considered unacceptable. Solitary confinement of certain categories of detainee (particularly those considered 'vulnerable') may also not have much support. The SMR of 1955 are currently being revised with these matters in mind.²⁸ The UN Basic Principles for the Treatment of Prisoners (1990) encourage efforts to abolish or restrict the use of solitary confinement.²⁹ The revised European Prison Rules (2006) recommend

28 SMR, Rule 31, currently states: "Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences."

29 Paragraph 7 of United Nations General Assembly, Basic Principles for the Treatment of Prisoners (A/Res. 45/111), 14 December 1990. Available at: <http://www.un.org/documents/ga/res/45/a45r111.htm>

that solitary confinement be used only in exceptional cases and for short, pre-specified time periods.³⁰ The Istanbul Statement on the Use and Effects of Solitary Confinement (2008) states that “solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort”; it also sets out the circumstances in which solitary confinement should be “absolutely prohibited.”³¹ Nonetheless, while the use of solitary confinement is banned in some countries, in others a judge may authorize its use; and in certain other countries, prison superintendents can decide whether to put detainees in solitary confinement.

This can be a delicate issue for doctors who work in detention. It is unethical for a doctor to be involved in ‘medical certification of punishment’, and since solitary confinement may be used as punishment, a doctor certifying someone as fit for it would be behaving unethically.³² However, it is a doctor’s duty, and therefore acceptable, to tend to the health of someone in solitary confinement.³³

30 Paragraph 60.5 of Council of Europe, European Prison Rules (Recommendation Rec(2006)2), 11 January 2006. Available at: <https://wcd.coe.int/ViewDoc.jsp?id=955747>

31 The Istanbul Statement on the Use and Effects of Solitary Confinement. *Torture*. 2008; 18: 63-6. Available at: http://solitaryconfinement.org/uploads/Istanbul_expert_statement_on_sc.pdf

32 Note that this is contrary to the now-outdated statement contained in Rule 32 (1) of the SMR: “Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.”

33 For further information and discussion, see: S. Shalev, *A Sourcebook on Solitary Confinement*, Mannheim Centre for Criminology, London School of Economics, London, 2008. Available at: www.solitaryconfinement.org

SAMPLE QUESTIONS ON ACCESS TO HEALTH CARE INSIDE THE PRISON

Procedures for getting access to health care

- According to the *authorities* (health and administration), what procedure do detainees follow in order to gain access to the health staff or clinic for consultations? For example, are lists drawn up by the guards, the detainees, or the health staff? Do various groups of detainees have access only on specific days?
- According to the *detainees*, what procedure do they follow to gain access to the health staff or clinic for consultations?
- If most consultations are conducted by a nurse or health assistant, to what extent are they supervised by a physician? Is there a special procedure for detainees to be referred to the prison physician?
- How are complex and/or chronic cases followed up? Does follow-up depend on the initiative of the patient or that of the medical staff?
- Is there a problem for the entire prison population in connection with access to health care? Why? What consequences does this have for the health of detainees?
- Are there any differences in access for particular groups or categories of detainees? Or for detainees in certain locations within the facility? Why? What are the consequences for their health?

Consultations

- Check the consultation register for the average number of detainees seen in one day or week by the prison nurse, health assistant or physician. Look also at seasonal variations in numbers.
- Does the consultation register record the date, name of the detainee, complaint, diagnosis and treatment?
- Is there a logical link between the diagnoses and the treatment provided?
- Does this register list the medicines dispensed, or is that recorded elsewhere?
- Do detainees receive full courses of antibiotics, or only incomplete treatment?
- Is the number of consultations restricted by category or status of detainee?
- Or is the clinic open to all sick detainees who request a consultation on a given day? Are detainees able to ask for a consultation after the clinic's patient list has been drawn up?
- What are the working hours of the clinic? Do different cells or groups of detainees have access to the clinic on different days or at different times?

Entry screening

- Is there a procedure for assessing the health of new detainees? Is the medical assessment carried out by the doctor, nurse or health assistant?
- Do the prison authorities inform the health staff of the arrival of new detainees, or do the detainees have to present themselves at the clinic?
- Where are the notes from the assessment recorded (e.g. in a personal medical file, a register)? What details are recorded (age, relevant past medical history, injuries, chronic conditions, regular medications, general examination, blood pressure measurement, etc.)? Is the record kept confidential – available to health staff only?
- Are any screening tests conducted routinely – STI, HIV, hepatitis? Is the informed consent of detainees required? Are some tests compulsory? What if a detainee refuses? If a test result is positive, are treatment and counselling available (especially for HIV)?
- Are detainees kept in temporary isolation until after the initial medical assessment?
- What measures are taken for new arrivals suffering from a contagious disease (TB, scabies, etc.)?

Solitary confinement

- When and why is solitary confinement used, and who must order its use?
- Are the prison health staff involved in screening or certifying detainees for solitary confinement?
- Do health staff monitor detainees in solitary confinement?
- What access do detainees in solitary confinement have to health care?
- What are the general conditions of solitary confinement (access to water, food, light, etc.)?
- How much access to the outdoors, and how much time with other detainees, are people in solitary confinement permitted?

Night duty / Emergencies

- Who is on duty after hours and at night? Is a member of the health staff present at all hours, or is one on call?
- What are the emergency arrangements at night? Is any authorization needed to obtain urgent treatment, especially if a sick detainee has to be transferred to a community hospital? How much longer does it take to reach health staff at night?
- Are night emergencies recorded in a register and/or in individual files?
- Ask about the handling of the most recent night emergency. The information will show what procedures are actually in use.

Visiting specialists and specific health care

- Do doctors from hospitals outside visit the prison regularly? What is their specialty and to what hospital are they attached? Record the specific expertise of visiting specialists, when they visited the prison and the number of consultations performed.
- What must a detainee do to secure a referral, within the prison, to the visiting specialist?
- How are such cases followed up (if the detainees need to be seen again, if they need referral for tests, etc.)? Is there any discrimination or payment of money involved?
- Is there a dental service? A permanent or visiting dentist? What kinds of dental treatment are available?
- For prisons holding women and children: Are antenatal/postnatal and gynaecological care available? Who provides it? Are deliveries carried out within the prison or at a facility outside? Are children regularly immunized?
- Is psychiatric care available? If not, what is done for psychiatric cases?

Links with national health programmes and health NGOs

- Do representatives from government health programmes or health NGOs visit the prison? Is the national TB programme involved? Are the HIV/AIDS and malaria eradication campaigns? Do they run specific health programmes or activities within the prison (vaccination campaigns, TB programmes, children in detention, etc.)?

4.5. Access to health care OUTSIDE the prison

Prisons mostly provide only basic health care; a link to medical institutions outside is therefore essential. Detainees may need to make use of health services outside the prison for a variety of reasons: urgent hospitalization, medical investigations, specialist consultations, and medical and surgical procedures. As with referrals from the community, detainees may be in hospital as *outpatients* (the hospital visit covers a single day, as for an appointment at a clinic – sometimes called ‘ambulatory’ care) or as *inpatients* (the patient is ‘admitted’ overnight).

The number of referrals made to a hospital outside will depend on: the level of medical care available *within* the prison, the availability of health services *outside* the prison, the general health status of the prison population, and the ability and willingness of the administration to transfer cases. Detainees’ access to health services outside the prison may also be impaired by other factors, such as: security regulations, transport, hospital restrictions and financial constraints.

Transport and security logistics may be a problem. There may be no vehicle to transport detainees from the prison to the hospital; or, if a vehicle is available, the space in it may be limited. There may also not be enough security guards to escort patients, or these guards may not be available on a regular basis. In some contexts, it is not the prison but the police or army who must provide security for detainees outside the prison, and this can create problems related to communication and coordination. The necessity of appearing in court may also complicate hospital visits for detainees, as it might be difficult to find a suitable day.

The hospital may set limits on when detainees may attend clinics, the number of detainees that may attend, and the length of time that detainees may spend in hospital as inpatients. These limits may be explained by concerns for security, or by perceptions that the presence of detainees disrupts hospital routine.

Financial constraints can also limit access to medical care outside. Detainees may be excluded from health insurance coverage, and the detaining authorities may have only a limited and insufficient medical budget. Corruption may be involved at all levels. Since conditions in hospital are usually more favourable than in detention (fewer security restrictions, better food, better access to families in some instances), influential detainees may pay to stay there far longer than they need to, or sometimes even when they are not sick. Some detainees may also feign illness in order to be hospitalized.

Visiting the referral hospital will lead to a better understanding of the difficulties faced by the prison, the hospital and the detainees; and that will help to formulate effective responses where they are needed to ensure access for detainees to health care outside the prison. The condition of any detainees receiving inpatient care should be assessed, as should the treatment they are being given; the attitudes of the hospital staff towards the detainees should also be noted.

There is one final aspect of access to health services outside prison that should be assessed: the mechanism for ensuring communication between hospital and prison. Prison health staff should communicate their requests and concerns to hospital staff (in a referral letter), and in return, hospital staff should communicate investigation results, diagnoses, management plans and any further follow-up required to the prison health staff (in a clinic or discharge letter). These

communications should be kept confidential, and there should be a system in place to ensure that they are acted upon or followed up where necessary.

SAMPLE QUESTIONS ON ACCESS TO HEALTH CARE OUTSIDE THE PRISON

Transport and security escort

- Who provides the security escort for transport to external health facilities? The district police, prison guards, or army?
- Who provides the vehicle? The police, prison, or army?
- If the prison does not provide the guards and the vehicle, does it have to pay for them?
- What are the main difficulties faced in transport and security for transfers?
- Is a limit on detainee transfers imposed by the security escort? Or by the hospital?
- How are transport and security arranged in emergencies, including at night?
- How are detainees handled during transfer? Are they handcuffed or shackled?

Procedure for referral to outpatient clinics

- What medical facility are detainees referred to? Provide a brief description of staff and facilities.
- Who is authorized to make referrals, and what does the process entail?
- What problems do the detainees, or the prison health staff, face in connection with referrals to external facilities? Is there any discrimination or payment of money involved?
- What is the attitude of the hospital or clinic staff towards the detainees?
- How many referrals are issued in a week or month? Is there a quota or limit?
- What happens to emergency cases?
- Are there particular days for each area of specialization in the clinic? Are detainees sent on the correct dates?
- Are detainees shackled or handcuffed during consultations in the hospital?

Procedure for medical investigations

- If there are no laboratory or other facilities for medical investigation within the prison, how are routine tests – such as X-rays and blood, urine and stool tests – conducted?
- Do detainees have to go to the hospital outside for simple laboratory tests, or can a sample be taken in the prison and sent to the laboratory outside?
- Is the hospital system or the security escort under strain from the number of detainees sent for investigations? Are there any quotas? Any costs involved? For whom?
- How are results communicated and how are they followed up?

Procedure for inpatient hospitalization

- Are detainees ever admitted to hospitals outside? Which hospitals? Who decides? Who is authorized to make referrals, and what does the process entail? What delays are involved?
- Is there a special (locked or secure) ward for detainees within the hospital?
- Are inpatient detainees shackled or handcuffed in the hospital?
- What authority (prison, police, army) is responsible for guarding detainees in hospital?
- What difficulties do the hospitals have with inpatient detainees? How are relations between the hospital staff and the detainees?
- What difficulties do inpatient detainees face (e.g. costs, access to food or family)?
- Are there any clear-cut cases of corruption in connection with hospitalization (threats to hospital staff, detainees paying to stay longer than they need to or feigning illness to gain admission, etc.)?

4.6. Individual patient records

Individual patient records – also known as ‘case notes’, ‘patient charts’, ‘medical records’, or ‘clinical files’ – should be a standard component of most health-care systems. They contain information relating to one person’s health: for instance, that person’s medical history and documentation of various medical encounters, test results, diagnoses, treatments, progress notes, and care plans. Individual patient records allow the health status of individuals to be managed and followed properly over time. In prisons, however, individual medical files often do not exist; where they do, they may be messy and disorganized.

When assessing individual detainees’ medical records it is important to confirm two points. First, that detainees’ health issues are accurately and honestly recorded: you may need to confirm this by taking a random sample of detainees’ records and going through them. It is not unknown for prison authorities to force health staff to update or falsify records in preparation for a prison visit. Second, it must be confirmed that the information in medical files is kept confidential and handled only by health staff, without interference from the administrative detention staff. This also applies to individuals and organizations visiting prisons: only health professionals should have access to detainees’ medical files.

SAMPLE QUESTIONS ON INDIVIDUAL PATIENT RECORDS

- Does each detainee have an individual medical file? Are they kept and organized by the prison health team? Or do detainees keep their own records and test results in the cells?
- Is the confidentiality of medical files respected and ensured? Who has access to medical information? Why – if that is the case – do non-health personnel have access to medical records?
- Are detainees’ files sent with them upon transfer or release?
- Do detainees arrive with their old medical records or a medical summary from other PoDs?
- What records exist for detainees who have been referred to health facilities outside?

For outpatient records

- Where are hospital examinations, recommendations and tests recorded? Are hospital outpatient cards kept by the prison health staff or is the information recorded directly in the detainee’s individual prison medical file? Are medical files sent with the detainee to the hospital? How does the prison health staff follow up, with regard to the hospital’s recommendations and the making of further appointments?

For inpatient records

- Is a discharge summary kept in the prison? What about other records of inpatient treatment? How does the record-keeping system affect the course of follow-up (e.g. can records be easily retrieved for later appointments)?

4.7. Clinical registers

Clinical registers are generally used to record activities in health-care settings. These registers are generally **not** intended to serve as the primary repositories or sources of clinical information on individuals. Keep in mind that medical registers will likely contain patient-identifiable medical information. This information is confidential and must be treated as such – meaning that the registers must be stored appropriately and must be accessible only to medical staff.

If a prison has no clinical registers, a basic system should be introduced. This could be based on the system used in the community, if it exists. The registers should be a record of consultations, deaths, significant infectious diseases, pharmacy stock and budgetary developments. Some examples of clinical registers that might be expected to be in use in prisons are described below.

Register of initial medical examinations

Prisons seldom have a register of the initial medical assessments of newly arrived detainees. Results are recorded in the detainees' individual medical files, in the main register, or in the detainees' individual administrative files.

Consultation register

Consultation registers should indicate the name of each detainee seen in the clinic, the date of the consultation, the nature of the health complaint, the diagnosis, and the treatment prescribed. Accurate recording of information in health registers is important because data extracted from the registers may shed light on: the attendance of health staff; the number of daily clinical consultations; patterns of morbidity (illness) and mortality (deaths) among detainees; referrals to hospital; patterns of prescribing and dispensing drugs; and sometimes, the occurrence of ill-treatment. These indicators can be used to monitor the performance of prison health services and the overall health status of the prison population.

If patients' symptoms, and the treatment for them, are properly recorded, the consultation registers can also indicate the quality of care – by showing the link between diagnosis and treatment.

Pharmacy stock and dispensing register

The pharmacy stock register records the number and types of medicines received and stocked. It can serve to justify budgets and to prevent (or detect) corruption associated with medicines and other medical supplies.

A separate dispensing register should record medicines that are used in the clinic. Drugs listed in the pharmacy stock register minus those listed in the dispensing register, and minus stock wastage due to expiration or damage (which should also be recorded), would be expected to equal the quantity of drugs currently in stock. Where the quantity of stock drugs is less than expected, the matter should be investigated: theft or corruption may be the explanation.

Other registers

Other medical registers may exist: to record night emergencies, transfers in and out of hospital, deaths in custody, etc. Enquiries should be made and the contents of these registers reviewed.

Health statistics

Health data (number of consultations a month, number of contagious diseases, number of deaths, etc.) may be recorded regularly and reported to external authorities (prison medical services, district medical officer, department for health statistics, etc.). Some prison regulations or jail manuals may specify the types of register that a prison is obliged to keep. The national health authorities may also require the recording of certain kinds of data (e.g. mandatory reporting of contagious diseases such as TB and leprosy).

SAMPLE QUESTIONS ON MEDICAL REGISTERS

- Note what details of the **initial medical assessment** were recorded, and what action was taken in response to significant findings.
- Note what is entered in the **consultation register**.
- Note what is entered in the **pharmacy stock and dispensing registers**. Is the use of stock accounted for in the dispensing register, or is there lost stock that is unaccounted for?
- Note what other registers exist and what they record.
- Note any reporting of health data to medical authorities. Does the prison visiting team have access to this data, either in the prison or at central level?

4.8. Medicines and health budget

Pharmacy stock

The stock of medicines available in the prison clinic should be sufficient for treating all diseases commonly occurring among the detainee population. Medicines should be unexpired and of proven efficacy and good quality. They should be in accordance with the 'national list of essential medicines' that exists in most developing countries. The types and the quantities of medicine that a prison's stock should contain varies from one country to another, and may depend on: local patterns of morbidity (e.g. endemic disease); the general health status of the prison population (e.g. a malnourished population will have high morbidity rates); and the level of training of prison health staff (especially in prisons where only a health assistant is available, oral medicines should suffice for treating the most common illnesses; injectable drugs should be available only to staff trained in their use).

Difficulties related to budgets, supply, corruption, security or inappropriate use might lead to shortfalls in medicines within the prison. Prison authorities should be encouraged to address these issues. Bear in mind that few other goods are as valuable as medicines within a prison: they may become a 'parallel currency', exchanged for goods or services.

During prison visits, health professionals should attempt to assess whether medicines are prescribed and used properly.

SAMPLE QUESTIONS

Pharmacy stock and dispensing

- Is there a standardized list of medicines that all prisons are permitted to stock? Is such a list available? What drugs are used: generic or brand?
- Does the actual stock of medicines in the pharmacy match what is recorded in the pharmacy stock register?
- Do the medicines cover all common illnesses? Are there any significant gaps?
- Are there any expired medicines in the stock?
- Does the stock contain medicines unsuited to the level of training of the health staff (e.g. injectables, antipsychotics, or second line anti-TB drugs)?
- Is it possible – by examining the pharmacy stock and the consultation or treatment registers – to draw any conclusions about the prescribing habits of staff? Do they seem to be acting as they should?

Make a *brief* list of the *types* of medicine stocked in the prison. A more detailed list may be obtained from the pharmacy stock register and can be included as an annex if necessary.

Supply of medicines

- Where are medicines usually obtained? Are they ordered from a central medical store attached to the Ministry of Health or Justice? What is the frequency of orders? Who has to authorize the order? Are the medicines ordered actually received? Is the supply sufficient? Are there any delays?
- Are there other sources of medicines for detainees (private donors, NGOs, families, local markets or pharmacies, etc.)? Try and estimate the proportion of medicines supplied by each source to the prison.
- Do detainees request prison guards to purchase medicines from the market or from a private pharmacy? How is that done?
- How may detainees request medicines from their families? And how do they gain access to these medicines? Is there a record book showing receipt of the drugs? Is it difficult for detainees to receive such drugs from their families?
- Is there any control over medicines brought into the prison via external sources? Could these drugs pose specific problems to the prison population (e.g. psychotropic drugs, anti-TB drugs that can lead to TB drug resistance if misused)?

Health budget

Information on budgets for medicines and for health activities in prisons is often difficult to obtain. Detaining authorities may be reluctant to release figures, and often the budget is mixed up with other 'spending lines' (for food, sanitary materials, salaries, etc.). Nonetheless, it may be necessary to obtain access to information on health budgets, particularly if there are serious health problems among the detainees that may be related to budgetary restrictions, and also if such budgetary problems are related to corruption within the detention system. Prison health staff are often an important source of information regarding deficiencies in health spending and corrupt use of the health budget.

The health budget must be explored with officials at the particular prison and with the detention service or ministry responsible. Action on prison health budgets would usually involve the entire detention system; so, information from all the prisons in question must be compiled to create a composite picture and to identify common problems and points for action.

SAMPLE QUESTIONS ON HEALTH BUDGET

- Where does the prison medical budget come from? The prisons department? The Ministry of Health/Justice/Defence?
- How is the budget allocated? Does it depend upon the number of detainees? What is the budget for this prison?
- Is there a shortfall in the budget or any overspending? What are the underlying reasons?
- Does the facility have access to other sources of funding? Does it make use of these sources?
- If there is a need for additional or emergency funds (e.g. during outbreaks of epidemic disease or to pay bills for surgery), where do these come from?

4.9. Health care for women in prison

Women in prison have specific health issues and specific health-care needs. However, prisons and prison regimes are usually designed by men and for men: the women among prison authorities are usually not in a position to make decisions; and women make up less than 10% of the prison population in most countries. Consequently, arrangements for health care, security, family contact, work and training opportunities within prisons are all likely to prioritize the needs of men, and neglect the needs of women. Women detainees are often left vulnerable and comparatively unattended. The UN Rules for the Treatment of Women Prisoners (the Bangkok Rules),³⁴ adopted in 2010, include provisions to ensure that the specific health-care needs of women in prison are met.

Specific health issues for women in prison

- High likelihood of exposure to violence and sexual abuse *before* imprisonment
- Vulnerability to violence and sexual abuse *within* prisons
- High incidence of physical and mental trauma
- High incidence of sexually transmitted diseases
- Generally, greater mental-health needs, including drug and alcohol dependency
- Gender-specific health-care needs, including the need for gynaecological and obstetric services

SAMPLE QUESTIONS ON HYGIENE AND HEALTH-CARE NEEDS OF WOMEN IN PRISONS

- Do women have easy access to hygiene materials, including sanitary pads (without having to ask the authorities)?
- Do women have additional access to water for washing?
- Are female doctors and other female health-care personnel available? If not, are female chaperones used during physical examinations?
- During the initial health screening, are female detainees asked about: STIs and STI risk factors; mental health; reproductive health; and sexual abuse and violence?
- Are women's health services within the prison equivalent to those in the community (including, for example, access to screening for breast cancer and cervical cancer)?
- Do women in prisons have access to gender-specific health-care services, including access to a gynaecologist and an obstetrician?

Pregnancy in prisons

Ideally, pregnant women should not be imprisoned unless there are truly compelling reasons for doing so. If there are pregnant women in a prison, it must be ensured that they have access to additional water for washing and a diet that meets their nutritional needs (including protein, fresh fruit and vegetables); and access also to all necessary health checks and antenatal

³⁴ United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules). Adopted by the UN General Assembly on 21 December 2010, A/RES/65/229. Available at: <http://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf>

and postnatal care. Women detainees should also have access to facilities for terminating pregnancy if these are available in the community outside.

Childbirth should not take place in prisons because the environment is generally less safe and less hygienic than in hospital. During delivery, women should not be shackled or otherwise restrained. Breastfeeding women should be assured privacy and a suitable diet. Official birth certificates should be prepared for newborn infants. The place of birth should indicate the hospital where the mother delivered. If the delivery took place in prison, that should not be mentioned in the birth certificate.

4.10. Promoting health in prisons

Health promotion refers to activities that enable people to have greater control over their health and its determinants. Health promotion should be carried out in prisons, and should include health education and measures for preventing disease. Its aim is twofold: to ensure that people in prison do not acquire diseases or health-defeating habits; and to ensure also that they adopt health-promoting attitudes and practices that enable them to remain healthy whilst in prison, and after leaving.

The World Health Organization has stated that providing detainees with health information and education, as well as the means of preventing disease, is vital for protecting and promoting health in prisons.³⁵ However, detainees also need to be given the sense that they are in control over their health, so that they can make decisions and act on them. Clearly, this requires the prison authorities to demonstrate a commitment to health and well-being by implementing supportive policies and practices. Prison health staff also have a key role in assessing the health needs of the prison population and individual detainees, and in ensuring that health promotion programmes meet the needs of detainees.

Examples of health promotion in prisons include: education in aspects of health and hygiene, such as prevention of HIV and sexually-transmitted diseases; training in food hygiene and nutrition; and drug and alcohol counselling, including harm-reduction education. Smoking cessation and exercise-promotion activities can also be undertaken in prisons.

Challenges to promoting and protecting health in prisons

Promotion and protection of health may be neglected in prisons. A prison health assessment can put this subject on the agenda of prison authorities. Nonetheless, there are many challenges to effective promotion and protection of health in prisons. Detainees may be in poor health, have bad health-related habits, and know very little about health when they arrive at a prison. Detainees may also find it difficult to involve themselves in health education and promotion. They may find it hard to change their habits whilst in prison – for various reasons, including loss of independence and lowered self-esteem. Meanwhile, conditions in prison, such as overcrowding, widespread smoking and drug use, inherently compromise health. Prison staff and authorities might not acknowledge the need for action, and there may be a lack of commitment to protecting and promoting health.

Benefits of promoting and protecting health in prisons

Initiatives to protect and promote health in prisons should generally be planned to be of immediate and long-term benefit to detainees. However, there are other benefits that can be emphasized while promoting initiatives among interested parties. Prison staff may benefit indirectly from health promotion efforts aimed at detainees, since healthier detainees will result in a healthier workplace for staff. Health promotion efforts in prisons should also aim to promote the health of staff directly, for their own well-being and because a

³⁵ In 2003, delegates to the joint World Health Organization/Russian Federation International Meeting on Prison Health and Public Health called for “a whole range of urgent measures to be carried out, aimed at preventing the spread of diseases among detainees, carrying out vigorous information and education work among them and providing them with the means of preventing diseases.” (See: World Health Organization, Declaration on Prison Health as Part of Public Health, Moscow, 24 October 2003.) This call was repeated in Spain in 2009. (See: World Health Organization, The Madrid Recommendation: Health Protection in Prisons as an Essential Part of Public Health, Madrid, 30 October 2009.)

healthy and motivated workforce will be more able to promote the health of detainees. Health promotion in prisons can also benefit the wider community by eliminating or drastically curbing the role of prisons as breeding grounds for infectious diseases that are then released into the world outside. Improved health in prisons also means that detainees will require less health care after their release. By these means, protection and promotion of health in prisons can reduce the health-care burden on society.

SAMPLE QUESTIONS ON HEALTH PROMOTION

- What health promotion activities are undertaken in the prison?
- Do prison authorities understand the need for health promotion?
- Do the prison authorities regularly assess the health needs of their population to ensure that health protection and promotion programmes meet the needs of detainees?
- Are health assessments of new detainees used as opportunities for providing them with information on health or on health promotion activities in prison?

SAMPLE QUESTIONS ON HEALTH EDUCATION AND INFORMATION

- Is there a programme that provides instruction for detainees on health? If not, is one planned?
- Does the programme include basic information about physical and mental health? Healthy diets and lifestyle? Prevention of communicable diseases? Prevention of drug overdoses?
- Are measures taken to protect detainees' mental health and preserve their well-being (e.g. encouraging social interaction, meaningful activities, building and maintaining strong family relationships)?
- Is there a peer education programme?
- Are other sources of information on health available?
- Is information available on specific illnesses, especially on the transmission, prevention, and treatment of HIV/hepatitis and TB?
- Do the detaining authorities undertake any activities related to protecting and promoting health? Do they allow other departments (e.g. public health) or organizations (NGOs, for example) to do so?

SAMPLE QUESTIONS ON SUPPORT FOR CHANGING HARMFUL HABITS

- Is there access to training in psychological skills and to support in this regard (e.g. cognitive behaviour, anger-management, self-esteem)?
- Is there support in detainees' immediate surroundings for changing their habits in connection with health (e.g. restrictions on smoking, access to exercise facilities, healthy foods in canteen)?
- Is information on health easily accessible to detainees, and in confidence if necessary?

SAMPLE QUESTIONS ON HARM REDUCTION

- Is there access to sterile injecting equipment and safe tattooing equipment? Are condoms freely available? (These services might be available through the prison's health service or through NGOs/external services working in prisons.)
- Are confidential voluntary testing, counselling, and treatment available for HIV and for hepatitis B and C?
- Is substitution therapy available for detainees suffering from opioid dependence?
- Is naloxone in pre-filled syringes available for use in overdose emergencies?
- Is post-exposure prophylaxis available for women, men, boys and girls who have been exposed to a risk?

SAMPLE QUESTIONS ON ACCESS TO SPECIALIZED SERVICES

- Are specialized services available for HIV? Hepatitis? Sexually transmitted diseases?
- If there are women in the prison, do they have access to reproductive care, including antenatal and postnatal care?
- What services are available for mental health? Do detainees have access to counselling?
- Is there professional contact with community services, so that access to services in the community can be facilitated if required?
- Do detainees have access to health initiatives in the community, such as vaccination campaigns and screening programmes?

SAMPLE QUESTIONS ON PRE-RELEASE PREPARATIONS

- Is there planning and preparation in connection with the health needs of detainees after they leave prison? What form does this take?
- What measures are taken for those detainees at risk of drug overdose in the immediate post-release period?
- What arrangements are made for those detainees who will require continuation of medical treatment after leaving prison? In this regard, are arrangements being made to treat the following: mental-health needs; substance-use problems; communicable diseases (particularly HIV/AIDS, hepatitis, sexually transmitted diseases and TB); non-communicable diseases (diabetes, respiratory diseases, cancer and other chronic diseases)?
- What happens to a detainee's medical file? Are detainees given copies of their files?

5. HEALTH STATUS OF DETAINEES

5.1. Assessing health status and collecting measurable indicators

To assess the overall health status of detainees, information must be collected from a broad range of sources and through various means: discussions with the health staff and detainees; review of detainees' medical records; direct observation of clinics and health-care procedures; and analysis of certain measurable health indicators for this population.

The following end-point indicators should be collected systematically during prison visits:

- Mortality – i.e. deaths within a population. The mortality rate can be calculated. Causes of death can be recorded. The number and proportion of deaths by cause can be noted and the most common causes identified.
- Morbidity - i.e. ill health or disease within a population. The prevalence of illnesses among detainees can be observed. The most common causes of morbidity can be recorded.

Other useful health indicators are: ratio of health staff to detainees; number of daily health consultations; number of referrals to hospitals or clinics outside; any deaths that occurred among detainees referred elsewhere; number of visits to the prison under specific health-care programmes (e.g. HIV, TB); and number of visits to external specialists. Also, disease-specific treatment indicators include: number of detainees enrolled in treatment programmes; number of detainees receiving the full course of appropriate treatment for selected indicator diseases; and stock of drugs available for treatment of selected indicator diseases.

Health professionals visiting prisons should ensure that a data gathering system exists to collect these indicators.

The systematic collection of basic health indicators should be an integral part of any prison visit. It establishes baseline data and allows for the subsequent recognition of changes and trends in the overall health status of the prison population and in the health-care delivery system. Trends may be observed at the level of individual prisons, or in a country's detention system as a whole. Findings from systematic monitoring may also serve as a basis for the planning of visits and assistance programmes. In prisons where medical assistance programmes (e.g. HIV prevention, provision of medicines, feeding programmes) have been introduced, the systematic collection of relevant indicators should be incorporated in the programme from the beginning. This will allow the effectiveness of the programme – its contribution to achieving pre-determined results – to be evaluated, and may enable changes to be made if objectives are not being met.

5.2. Mortality

The number of deaths occurring in a prison population over a given period of time is an important indicator of the health of a prison population.

The crude mortality rate (CMR) is defined as the number of deaths in a population at risk during a specified time period. It can be readily calculated.

Calculating the Crude Mortality Rate³⁶

$$\text{Crude mortality rate} = \frac{\text{Number of deaths in a period of time}}{\text{Population at risk of death} \times \text{Duration of time period}} \times \text{Population unit}$$

Mortality rates are often expressed in units of 'deaths per 1,000 individuals per year'. In this case, the time period is one year and the population unit is 1,000. The 'population at risk of death' is usually an estimate of the mid-year population size. The calculation is then as follows:

$$\text{CMR (Deaths/1,000/Year)} = \frac{\text{Number of deaths in one year}}{\text{Population at risk of death} \times \text{One year}} \times 1000$$

For example, during one year, 18 people die in a population that has an estimated mid-year size of 241 persons. The crude mortality rate is calculated as follows:

$$\text{CMR (Deaths/1,000/Year)} = \frac{18}{241 \times 1} \times 1000 = 74.7 \text{ Deaths/1,000/Year}$$

Deaths per 1,000 individuals per year is a useful measure for relatively stable populations. However, in acute emergency situations involving large numbers of deaths and rapidly changing mortality rates, it makes sense to use a shorter time interval and a larger unit of population in the calculations. In these situations the mortality rate is often calculated as 'deaths per 10,000 individuals per day'.

For example, over 120 days, 440 deaths occur in a population with an estimated mid-year size of 18,000. The crude mortality rate is calculated as follows:

$$\text{CMR (Deaths/10,000/Year)} = \frac{440}{18000 \times 120} \times 10000 = 2.04 \text{ Deaths/10,000/Day}$$

Mortality rates can also be calculated for each month and this may be useful if analysing monthly reports. Monthly rates are usually reported as 'deaths per 1,000 individuals per month'.

For example, over two months, nine people die in a population with an estimated mid-time-point size of 1,300. The average monthly CMR is calculated as follows:

$$\text{CMR (Deaths/1,000/Month)} = \frac{9}{1300 \times 2} \times 1000 = 3.46 \text{ Deaths/1,000/Month}$$

For reference, 1 death per 10,000 per day = 3 deaths per 1,000 per month = 36 deaths per 1,000 per year. It is important to note that the units in these calculations differ, but the maths remains essentially the same. Conversion from one format to another is an exercise in arithmetic.

When calculating mortality rates it is usually preferable to use formats and units that are consistent with those already in use, so as to allow easier comparisons of data.

36 For further discussion of mortality rates, see: F. Checchi, L. Roberts, *Interpreting and Using Mortality Data in Humanitarian Emergencies: A Primer for Non-Epidemiologists*, Humanitarian Practice Network Paper No. 52, Overseas Development Institute, London, 2005. Available at: <http://www.odihpn.org/documents/networkpaper052.pdf>

The mortality rate should be calculated during every prison visit. This will provide useful baseline data. Global mortality data for prison populations do not exist and national prison mortality rates may be unavailable or unreliable; making accurate baseline calculations is therefore often very important. An increase in mortality above the baseline rate may reveal deterioration in overall prison population health or the outbreak of disease. Comparison with baseline mortality rates will enable you to judge the severity of the problem. Mortality rates may show seasonal trends; it may be useful to calculate baseline mortality rates for each month or season.

While studying mortality in prison populations it is important to analyse not only the rate, but also the **causes of mortality**. Causes of death may suggest unsatisfactory detention conditions or shortcomings of the medical services, particularly where detainees have died of curable diseases. It may be useful to count the number of deaths and then calculate proportions by cause.

Causes of death may reflect local population patterns to some extent, and it may be useful to obtain community health and mortality data from local health officials. However, community mortality rates and causes may not be a reliable source of reference for prisons because of the generally higher prevalence of HIV, TB and other diseases among detainees.

An immediate and thorough analysis is indicated when: mortality increases above the prison baseline mortality rate; mortality is due to curable diseases; or mortality exceeds the regional reference value. Determinants of the high mortality must be identified and measures negotiated with the authorities. Close monitoring and follow-up visits should be planned.

SAMPLE QUESTIONS ON MORTALITY

- What is the system for recording deaths in detention? Is it reliable?
- Calculate the mortality rate.
- Document the causes of death. Record the number and proportion of deaths by cause. Note any deaths due to curable diseases.
- What are the regulations for investigation and for post-mortem procedures? (Usually these are specified by the prison regulations and the country's code of criminal procedure.)
- Examine the death register, death certificates, and post-mortem reports of all deaths that occurred in the prison.
- What records are kept for detainees who died in the referral hospital? If most detainees died on the day they were admitted to the hospital, it may be a sign that referrals are made too late.
- Are deaths due to diseases that are notifiable? That is, must the local or central health authority be notified of deaths from certain causes? For which diseases? What are the recent statistics?
- Do families receive a death certificate? Such certificates are important in many contexts, as they are needed to settle issues of inheritance.

5.3. Morbidity

As in any other population, people in prisons may experience a broad range of illnesses. However, infectious diseases and mental-health problems are especially common in prisons.

In many contexts, people in prisons come from social backgrounds in which certain **infectious diseases**, such as HIV, hepatitis, and TB, are more common. The general conditions of detention may encourage the spread of infectious diseases through poor hygiene, poor water supply or sanitation, and poor food hygiene. Overcrowding, and the resulting strain on resources, may further promote the spread of disease. Drug use, sex and violence (including sexual violence) among detainees may also add to health risks.

People with **mental-health problems** may be at greater risk of imprisonment. They may be imprisoned because their mental-health problems contributed to their committing a criminal act. Or they may be imprisoned simply because they have a mental-health problem, particularly in contexts where 'unusual' behaviour is not tolerated or where no proper mental-health-care services are available. In societies where conditions are bad for people with mental-health problems, the situation in prison will be even worse. Imprisonment can also cause or contribute to the development of mental-health problems. Conditions of detention that can have an impact on mental health include: reduced contact with the world outside, including friends, family and social support networks; reduced opportunities for exercise and leisure activities; disruption of personal ties to work, education, or religion; internal hierarchies and violence; and the loss of freedom and independence. The consequences of imprisonment for mental health can manifest themselves in unexplained or psychosomatic symptoms, low spirits or anger, and an increase in psychiatric disorders and in the incidence of self-harm and suicide.

Although this is not restricted to detention, resorting to hunger strikes – for personal reasons or in protest against a regime – is more common in prisons. Clearly, this too will have an impact on health.

Diseases commonly associated with detention conditions

Skin diseases – e.g. fungal skin infection, scabies, lice. May be due to lack of water, poor hygiene, overcrowding.

Eye illnesses – e.g. trachoma, conjunctivitis. Associated with lack of water and poor hygiene.

Respiratory tract illnesses – e.g. TB, upper respiratory tract infections. Associated with overcrowding, damp conditions, and poor nutrition.

Gastrointestinal diseases – e.g. diarrhoea, typhoid fever, cholera, intestinal parasitosis. Faecal-oral transmission through polluted water, improper human waste disposal or presence of vectors.

Hepatitis A - faecal-oral transmission.

HIV, hepatitis B and C – associated with intravenous drug use, consensual sex, and sexual violence.

Sexually transmitted infections – through sexual violence and consensual sex.

Vector-borne diseases

Mental illnesses – associated with overcrowding, detention regime, ill-treatment, pre-existing condition.

Unexplained symptoms - psychosomatic complaints may be an expression of suffering.

Measuring morbidity

Epidemiologists may use two different measures of morbidity: incidence and prevalence. **Incidence** tells us how many new cases of a disease emerged during a particular period of time. It tells us about the *rate* at which a disease is spreading or being diagnosed. **Prevalence** tells us how many people actually *have* the disease at a particular moment. Prevalence does not differentiate between old and new cases; it tells us about *how common* the disease is at a single point in time.

Calculations for rates of incidence and of prevalence, as percentages, are given below:

Incidence rate (%) = Number of new cases of a disease during a specified period of time / Size of the population at risk of the disease x 100

Prevalence rate (%) = Number of people with disease at a particular time / Size of the population at risk of disease x 100

These two measures provide very different information, but both may be useful. Prevalence may be more useful than incidence as an indicator of the impact of the condition within the community, and of the health services that will have to be provided. **Incidence** may be useful for assessing the risk of contracting the disease. A chronic disease like HIV/AIDS may have a low rate of incidence, but a relatively high rate of prevalence. A short-duration condition such as the common cold may have a high rate of incidence, but a relatively low rate of prevalence.

Outbreaks of disease in prison

An outbreak or epidemic is said to be taking place when there are more cases of a particular disease than expected in a given area, or among a specific group of people, over a particular period of time. The cases are presumed to be related to each other or to have a common cause.³⁷

During a prison visit, if it is apparent that many detainees are suffering from a particular disease, the number of cases should be quantified. This can be done by studying the clinic consultation book and by discussing the matter with the prison health staff. If necessary, the exact prevalence rate of the disease can be determined by screening the prison population, or a representative sample of detainees, for the disease.³⁸

Remember, an outbreak is **not** defined by the number of cases meeting a specific numerical threshold; it is defined by an *unusually high* number of cases. This obviously depends upon what is thought to be an acceptable or usual number of cases. Having reliable baseline morbidity data is therefore essential.

Confirmation of an outbreak should prompt immediate assessment and the taking of countermeasures.

37 This definition is from the United States Centers for Disease Control and Prevention (CDC). The terms 'outbreak' and 'epidemic' have very similar definitions and are sometimes used interchangeably. However, 'outbreak' is more commonly used to refer to situations in smaller areas or groups, such as villages or towns, or in specific institutions such as prisons; 'epidemic' tends to be reserved for situations involving large numbers of people and a wide geographical area.

38 The CDC also has a short guide, *Steps of an Outbreak Investigation*, which is available at: <http://www.cdc.gov/excite/classroom/outbreak/steps.htm>

SAMPLE QUESTIONS ON MORBIDITY

- Are there diseases or health problems among the prison population that may be spread by the conditions of detention? How prevalent are tuberculosis, HIV/AIDS, sexually transmitted infections, and hepatitis B and C? What specific factors promote them?
- If contagious diseases or health problems exist, are there any programmes addressing them specifically (through health promotion, preventive measures, treatment)? For example, is there a DOTS (directly observed treatment, short-course) programme for TB? Is it incorporated in the national TB programme? Are there measures for addressing HIV/AIDS, STIs, or substance abuse?
- Are there consequences for health and/or illnesses owing to specific problems within the prison related to hygiene, water or sanitation?
- Are there any consequences for health owing to problems in the food chain?
- Have any outbreaks of disease occurred? How did the prison health team deal with them?
- Are there seasonal variations in the prevalence of disease?
- What mental-health problems exist among the detainees?
- What factors in the prison might increase the risk of mental-health problems?
- Is there awareness of mental-health issues among the authorities? Do the prison authorities or external organizations undertake programmes to prevent or deal with mental-health problems?
- How are detainees with severe mental disorders dealt with? What kinds of treatments are available? Are detainees with severe mental disorders held elsewhere (in a secure psychiatric unit)?
- Did the detainees with severe mental disorders develop symptoms before or *during* their detention?
- Are detainees with mental-health problems discriminated against, in connection with accommodation, food, water or access to health services?

Occupational health and safety

Work in prisons is still governed by international standards and national regulations. Medical aspects that might involve the prison health staff include: a mandatory health check of detainees' physical and mental fitness for work; an assessment of workplace safety, work schedules and workload. However, it would be inappropriate for health staff to take part in these checks and assessments if the work undertaken by detainees was involuntary or a form of punishment.

SAMPLE QUESTIONS ON OCCUPATIONAL HEALTH AND SAFETY

- Is there a medical check-up to gauge fitness for work? Does the check-up fit the actual nature and conditions of work?
- What are the age limits for working in the prison?
- How might workplace safety, working schedules and arduousness of work affect or endanger the health of the workers?

5.4. Torture and other forms of ill-treatment

Where torture or ill-treatment of other kinds is known to be a problem within a prison, a doctor should always be on the prison visiting team. There are no exceptions to this rule. Allegations of torture can be collected by non-medical visitors, but the detainees in question must then be seen by the doctor.

It is the duty of doctors trained in this work to supplement the general documentation of cases of ill-treatment done by non-medical persons with clinical documentation of the medical consequences of ill-treatment and, where relevant, with forensic documentation of the alleged acts. Medical personnel are the only people authorized to conduct this type of assessment and to request access to patients' files. The support of a doctor is therefore required in all situations where severe-ill treatment is frequent or systematic.

As someone with special access to medical personnel in the place of detention, and to the authorities in charge of medical matters, the visiting doctor is also responsible for analysing the roles and responsibilities of medical personnel and the part they may have played in the ill-treatment, and for working, where necessary, to promote the independence of health workers and respect for medical ethics.

The role of the doctor when detainees allege torture or other forms of ill-treatment is to assess health-care needs and, as appropriate, to address them in coordination with the authorities. The visiting doctor should ensure that people needing treatment are adequately cared for, and should support and encourage prison health staff to record the allegations and the physical and mental consequences of the alleged ill-treatment in the detainees' medical files. Where the prison health staff are unwilling or unable to do so, the visiting doctor should record the alleged ill-treatment, taking great care to explain to the detainee the use to which the recorded allegation may be put, and to obtain his/her informed consent to it.

Issues of ill-treatment should be given special attention, always bearing in mind the 'do no harm' principle. The visiting doctor may provide a degree of solace to victims of ill-treatment by listening sympathetically as they describe their experiences, and by informing them, not only of the possible repercussions of the ill-treatment they have suffered, but also of means of remedying them. Detainees may place their trust in the independence of the visiting doctor, and may appreciate the medical opinion and comfort provided by a professional from outside the prison.

The visiting doctor and the prison health staff must respect medical ethics while conducting assessments, providing care and documenting findings.

During conversations with victims of torture or other forms of ill-treatment, it should be kept in mind that most detainees in such circumstances will find it difficult to communicate or to give expression to their suffering; particular care should therefore be taken in approaching them. Remember also that people from different cultures deal differently with this issue. Some feel the need to 'open up' to others and to 'work through' reactions; others may wish to internalize their thoughts and feelings and not share them, out of guilt or shame. The doctor should gain the trust of the detainee and create an atmosphere conducive to the sharing of difficult or painful information; there must be no witnesses to the interview. The role of the visiting team with regard to ill-treatment should be explained to the detainees concerned, as should the limits within which the team has to work.

The steps in the medical documentation of torture or ill-treatment of detainees are fully explained in a number of publications.³⁹ Medical documentation should include information on: what was done, by whom, when and where; medical attention received; healing of any injuries suffered; clinical findings at the time of examination by the visiting physician and whether they match the allegation of ill-treatment.

It may be prudent when dealing with the authorities involved, and when writing reports that they might read, to refer to legal definitions of torture and other forms of ill-treatment. Be clear about the allegations to be sent on to the authorities, and, if explicit consent is not obtained, ensure that the source of allegations or evidence is not identifiable.

There are essentially three stages in the medical documentation of torture or other forms of ill-treatment:

1. A description of each form of ill-treatment. This should include: when it occurred; what the victim was wearing; whether he or she was sitting, standing, lying, or strapped to a table; and also whether she was blindfolded, tied up, handcuffed, etc.

Remember, ill-treatment includes psychological abuse (verbal threats, insults, oaths, shouting) as well as physical abuse, and that should be documented if it occurred.

Ill-treatment may also include the conditions under which the person was detained, if these have physical and psychological consequences and if they were imposed with the intention of breaking the person down. For example, it may be relevant to document conditions of detention, including hygiene, the state of the toilets, the size of the cell, and any withholding of food or medical care that would count as aggravating factors.

Any allegations of participation by health personnel must also be documented. This participation may be: direct (taking an active part), indirect (advising on methods or refinement of techniques), and by omission (falsifying medical examinations or reports).

Note that ill-treatment is most common in the immediate arrest-and-detention phase; it can also occur in prisons, but that is more likely to be related to disciplinary rules and punishments (official and unofficial).

2. A description of consequences, physical and mental, immediately after the events in question. This should include an account of open wounds, bruises, and loss of limb function, as well as any adverse consequences for the detainee's mental or emotional state during or soon after the ill-treatment. Detainees should also be asked about medical treatment and recovery (sequela) after the abuse. This is a key part of the documentation because corroboration of ill-treatment can be obtained even in the absence of any

39 UN Office of the High Commissioner for Human Rights, *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 2004. HR/P/PT/8/Rev.1. Available at: <http://physiciansforhumanrights.org/issues/torture/international-torture.html>

International Rehabilitation Council for Torture Victims, *Preventing Torture through Investigation and Documentation* [website]. Available at: <http://www.irct.org/Default.aspx?ID=1396>

M. Staiff, "Visits to detained torture victims by the ICRC (I): Management, documentation, and follow-up," *Torture*, Vol. 10, No. 1, 2000, pp. 4-7. Available at: <http://www.icrc.org/eng/resources/documents/misc/57jqum.htm>

M. Staiff, "Visits to detained torture victims by the ICRC (II): The psychological impact of visits and interviews with detained torture victims," *Torture*, Vol. 10, No. 2, 2000, pp. 41-44. Available at: <http://www.icrc.org/eng/resources/documents/misc/57jqun.htm>

H. Reyes, "Doctors in prison: Documenting torture in detention," *Torture*, Vol. 18, No. 3, 2008, pp. 176-182. Available at: http://www.irct.org/Files/Filer/TortureJournal/18_03_2008/176-182_Doctors_in_prison.pdf

lasting consequences. In other words, even though the person may not show physical evidence of ill-treatment by the time of documentation, his or her description of events can provide significant clues and support for his or her allegations.

3. The last part of the process involves: determining whether there are any chronic physical or psychological consequences of torture or ill-treatment; enquiring about any recent treatment received; and conducting a physical and mental examination.

Ill-treatment before arrival at the prison

- Was there any ill-treatment in official places of detention (police stations, for example) or in unofficial/secret places?
- Are people subjected to systematic ill-treatment in that context?
- What was the nature of the ill-treatment? What forms did it take?
- What were the general conditions of detention?

Ill-treatment within the prison

- What forms of punishment are authorized by the prison regulations? Solitary confinement? Extended solitary confinement? Other forms of restrictive regimes? Shackling? Who decides the method of punishment? What safeguards are in place to prevent abuses?
- Is unofficial punishment handed out by prison guards or by other detainees acting as guards?
- Is there any ill-treatment related to violence or hierarchies among detainees?
- What is the nature of the ill-treatment? What forms does it take?

Always use the standard three-stage process for medical documentation of torture/ill-treatment.

5.5. Individual medical cases

The visiting prison doctor should conduct medical interviews and examinations among a sample of detainees. The purpose is to gain information on the general state of health of the population and on the quality of the medical care provided by the detaining authorities. The sample of detainees should include healthy people from different areas of the prison, as well as sick people identified by other detainees and the authorities, or by direct observation.

It is important to make clear to detainees and prison staff that visiting health professionals conducting prison assessments will not provide medical care to the prison population. If the visiting health professional encounters seriously ill detainees who have not received proper medical attention, he or she should alert the authorities to this fact, either at the end of the visit or immediately if the need is urgent. Such cases should be used as *examples* to illustrate the shortcomings of the health-care system, so that improvements can be made for the prison population as a whole. The objective is not to produce a list of all detainees who need some form of medical attention: detaining authorities are more likely to follow up lists containing only serious medical cases, rather than lists of people with minor ailments.

Requests for release on medical grounds

Requests for the release of seriously ill detainees may sometimes be considered. These requests must not be made routinely and should be reserved for serious cases; otherwise such interventions will begin to lack credibility. Release in these circumstances may be described as 'compassionate', 'humanitarian', or simply 'medical'. Not every country has a legal basis and procedures for releasing people from prison on medical grounds. Release on medical grounds may be requested for a number of reasons, such as: the detainee is suffering from a serious, chronic and debilitating disease or handicap for which suitable care and attention cannot be provided in prison (e.g. permanent paralysis, severe mental-health problems, or dementia), and/or that continued detention would lead to the deterioration of such a condition, which might be preventable in other circumstances; the detainee is in the latter stages of a terminal illness and release would permit him or her to die with dignity at home or in some other appropriate setting. Other factors that may be considered include the detainee's age and vulnerability, the risk of recidivism, the danger to the public posed by him or her, and the overall conditions of detention.

From detainees spoken to in private

- Assemble a picture of the health of the prison population. Identify ill-treatment or torture. Identify any problems in the prison's health-care system.
- Are there cases that illustrate particular failings in the health system? Are there cases of seriously ill detainees that warrant discussion with the authorities, with a view to securing urgently needed access to health care, or release on humanitarian or medical grounds?
- Cases brought to the attention of prison authorities must be followed up during subsequent visits.

Remember that medical confidentiality has to be respected at all times by visiting health professionals. Access to the diagnoses and medical histories

of sick inmates must be secure and restricted; individual patients must remain anonymous when data related to them are presented in internal reports. Sick detainees may be recommended to the authorities for medical follow-up, or for release on medical or humanitarian grounds, **only after they have given their consent.**

6. ADDITIONAL RESOURCES

The following is a list of some further resources relevant to health in prisons. The list of is far from exhaustive.



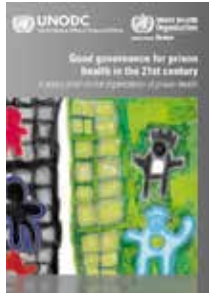
Health in Prisons: A WHO Guide to the Essentials in Prison Health. Edited by Stefan Enggist, Lars Møller, Gauden Galea and Caroline Udesen. WHO Europe, Copenhagen, 2014.

Available at:

<http://www.euro.who.int/en/publications/abstracts/prisons-and-health>

189 pages. English, Russian and Arabic.

A comprehensive guide to health and health-care issues in detention. Includes chapters on: primary health care, communicable diseases, non-communicable diseases, dental health, ethical challenges in detention health care, and drug use. Although its focus is on health care and the provision of quality services, the WHO guide encourages a whole-prison approach, promoting the health and well-being of people in detention. See also WHO Europe's Health In Prisons Project.



**Good governance for prison health in the 21st century
A policy brief on the organization of prison health**

ICRC documents



"Protection of detainees: ICRC action behind bars." Alain Aeschlimann. *International Review of the Red Cross*, Vol. 87, No. 857, March 2005, pp. 83-122.

Available at:

http://www.icrc.org/eng/assets/files/other/irrc_857_aeschlimann.pdf

40 pages. English and French.

Describes the principles and purpose of the ICRC's work in detention; the characteristics and constraints of the ICRC's approach; and the legal and historical background explaining why the ICRC works in the way that it does.



The role of the physician in ICRC visits to prisoners. Hernán Reyes. ICRC, Geneva, 1994.

Available at: <http://www.icrc.org/eng/resources/documents/misc/57jmk5.htm>

A brief (3,000 words) overview of the ICRC detention doctor's role.

Policy on torture and cruel, inhuman or degrading treatment inflicted on persons deprived of their liberty, adopted by the Assembly Council of the ICRC on 9 June 2011. *International Review of the Red Cross*, Vol. 93, No. 882, 2011, pp. 547-562.

Available at:

<http://www.icrc.org/eng/assets/files/review/2011/irrc-882-policy-torture.pdf>

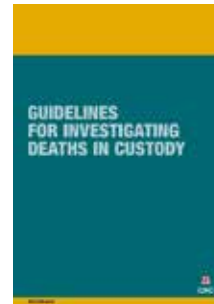
A reaffirmation of the ICRC's commitment to tackling torture and an explanation of its policy and practices.



Guidelines for Investigating Death in Custody, October 2013.

Available at:

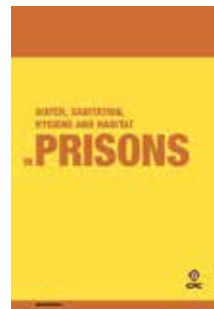
<https://www.icrc.org/eng/assets/files/publications/icrc-002-4126.pdf>



Water, Sanitation, Hygiene and Habitat in Prisons, 2nd ed. Pier Giorgio Nembrini. ICRC, Geneva, 2013. (ICRC Publication Reference: 0823) Available at: <http://www.icrc.org/eng/resources/documents/publication/p0823.htm>

125 pages. Available in English pdf online. Languages available: Arabic, Chinese, English, French.

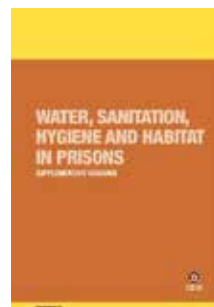
This illustrated and easy-to-read text provides technical guidance for practical measures to improve material conditions in prisons. There is some overlap with the content of Chapter 2 of our own *Practical Guide to Health in Detention*, but *Water, Sanitation, Hygiene and Habitat* is more detailed and provides a useful source of in-depth information on these subjects.



Water, Sanitation, Hygiene and Habitat in Prisons: Supplementary Guidance. ICRC, Geneva, 2013. Available at: <http://www.icrc.org/eng/resources/documents/publication/p4083.htm>

80 pages. Available online in English and French.

Additional practical guidance, developed to supplement the handbook titled *Water, Sanitation, Hygiene and Habitat in Prisons*. Intended to be more comprehensive and applicable to the wide variety of prisons found throughout the world. Includes chapters on women, girls and dependent children and juveniles.



FOOD AND NUTRITION IN DETENTION; FOUR BOOKLETS

United Nations documents

The UN has produced many documents of pertinence to the ICRC's work in prisons. Many of these can be accessed via the *Refworld* website (www.refworld.org) of UNHCR (the UN refugee agency).

Standard Minimum Rules for the Treatment of Prisoners (SMR), adopted 30 August 1955 (available at: <http://www.refworld.org/docid/3ae6b36e8.html>). Though out of date in some important respects, the SMR contain many generally accepted standards in relation to the treatment of detainees and the management of prisons. (For an explanation of the SMR and their implications for policy and practice, see also: *Making Standards Work: An International Handbook on Good Prison Practice*, which can be downloaded from the Penal Reform International website: www.penalreform.org)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the UN General Assembly on 10 December 1984, A/RES/39/46 (available at: <http://www.refworld.org/docid/3b00f2224.html>).

Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol"). Office of the UN High Commissioner for Human Rights, 2004, HR/P/PT/8/Rev.1. (Available at: <http://www.refworld.org/docid/4638aca62.html>). The *Istanbul Protocol* provides a comprehensive set of guidelines for assessing cases of torture and ill-treatment, and for reporting such findings to the judiciary and other investigative bodies.



Handbook for Prison Managers and Policymakers on Women and Imprisonment. UN Office on Drugs and Crime. September 2008.

Available at:

<http://www.refworld.org/docid/4a096b0a2.html>

117 pages.

Relevant chapters on the special needs of female detainees and on the management of women's prisons.



Handbook on Prisoners with Special Needs. UN Office on Drugs and Crime. March 2009.

Available at:

<http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=4a0969d42>

179 pages.

Describes the needs of certain vulnerable groups of people in prisons, cites relevant international standards and makes recommendations. Includes chapters on: prisoners with mental-health needs; prisoners with physical disabilities; ethnic and racial minorities; foreign nationals; lesbian, gay, bisexual and transgender prisoners; older prisoners; prisoners with terminal illnesses; and prisoners under sentence of death.

Other useful sources

World Medical Association. www.wma.net

The second (2009) edition of the **Medical Ethics Manual** can be downloaded free of charge from the website of the World Medical Association. The *Manual*, which was intended as a teaching guide for medical students, provides a valuable introduction to medical ethics.

The WMA website enables access to various other useful documents, including: the WMA Declaration of Malta on Hunger Strikers (1991/1992/2006); the WMA Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases (2000/2011); and the WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2003/2007).

There is also a link to a free Web-based course (“Doctors Working in Prison: Human Rights and Ethical Dilemmas”) for health-care personnel working in prisons, developed by the Norwegian Medical Association and the WMA.



Medecins Sans Frontieres (MSF)

MSF makes several key sources of reference available online, free of charge, at: <http://www.refbooks.msf.org/>

The following titles can be accessed: *Tuberculosis; Measles; Obstetrics in Remote Settings; Refugee Health; Rapid Health Assessment of Refugee or Displaced Populations; Public Health Engineering; Essential Drugs; Clinical Guidelines.*

Women's Health in Prison: Correcting Gender Inequity in Prison Health. UN Office on Drugs and Crime. 2009.

Available at:

http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

56 pages. English, French, German, Russian.

Women's needs in prison are often overlooked; this document provides evidence of that and calls for change. It highlights the high levels of mental illness, drug and alcohol dependence, and sexual and physical abuse and violence among women in prisons, as well as the gender-specific health-care needs and family responsibilities of women.



A Sourcebook on Solitary Confinement. Sharon Shalev. Mannheim Centre for Criminology, London School of Economics, London, 2008.

Available at: www.solitaryconfinement.org/sourcebook

89 pages. English, French, Russian, Chinese, Spanish.

Provides evidence of the health effects of solitary confinement and the harm done by it; describes the role of health professionals; and sets out ethical guidelines and human rights case law.





CPT Standards. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

The CPT was established in 1987 by the Council of Europe to prevent ill-treatment of people deprived of their liberty in Europe. The **CPT Standards** bring together sections of the CPT's annual *General Reports*, with the aim of providing clear guidance for the treatment of detainees. The Standards include chapters on women, juveniles, psychiatric care and health-care services in prisons. (Available at: <http://www.cpt.coe.int/en/docsstandards.htm>)

Medical Investigation and Documentation of Torture: A Handbook for Health Professionals. Michael Peel, Noam Lubell and Jonathan Beynon. Human Rights Centre, University of Essex, 2005. Available online, free of charge.

Covers the same subject matter as the *Istanbul Protocol*, but more accessible and user-friendly.

ANNEX: STANDARDS FOR HEALTH-RELATED ISSUES IN PRISONS

NOTE: These standards should be regarded only as INDICATIONS and not as absolutes.

Accommodation standards

Overall available space in compound	20–30 m ² /person	(ICRC)
Minimum floor space in cell	3.4–5.4 m ² /person	(ICRC)

Water supply standards

Minimum supply per person for all needs	10–15 litres/person/day	(ICRC)
Number of water points	1–2 taps/100 persons (absolute minimum)	(ICRC)
Water flow rate from taps	10 litres/minute (absolute minimum: 3–5 litres/minute)	(ICRC)

Water stock standards

Reserve capacity for the whole facility	15–20 litres/person	
Minimum stock for the night in cells	2 litres/person/night	

Personal hygiene standards

Shower access	1 shower facility per 25 persons	(ICRC)
	Minimum 1 shower/week	(SMR)
	1 shower/day where indicated by heavy physical exercise or climatic conditions	
Body soap	100–150 grams/per person/month	(ICRC)

Sanitation standards

Latrines	1 for 20 persons – Optimum	(ISPHERE)
	1 for 50 persons – minimum acceptable	(ICRC)

Solid waste standards

Solid waste	100 litre-covered container per 50 people	
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Food storage standards

Food store	Minimum 50 m ² /1000 persons	(ICRC)
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Food preparation standards

Cooking capacity needs	1.2–1.4 litres pot/person	(ICRC)
Water stock in the kitchen	1 litre/person/day	(ICRC)

BMI categories

Satisfactory nutrition status	> 18.5
Moderate malnutrition	16.1–18.4
Severe malnutrition	< 16.0

Expected health-service use

Number of consultations/day	1–3% of the population/day
Hospitalization	1/10,000 persons/day

Baseline Crude Mortality Rate (CMR) reference by Region (Deaths/10,000/Day)⁴⁰

Regions	2004 CMR (Baseline)	CMR (Health crisis)
Sub-Saharan Africa	0.44	0.9
Middle East, North Africa	0.16	0.3
Central/Eastern Europe, CIS, Baltic States	0.30	0.6
East Asia/Pacific	0.19	0.4
South Asia	0.25	0.5
Latin America, Caribbean	0.16	0.3
Least developed countries	0.38	0.8
Industrialized countries	0.25	0.5

For instance, in the Middle East or North Africa, any prison mortality rate above 0.3/10,000/day (corresponding to 3 deaths a month in a prison with 1000 detainees) indicates a serious health crisis.

40 The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, The Sphere Project, Geneva, 2004, p. 261.

INDEX

Access	
Health care INSIDE the prison	57
Health care OUTSIDE the prison	63
Health services	8
Accommodation	15
Accommodation standards	17
Sample questions	18
Bedding (accommodation)	16
Behaviour change	73
Blackwater	26
Body Mass Index	46
Capacity (accommodation)	15
Cases notes. <i>See</i> Patient records	
Clinical registers	67
Committee for the Prevention of Torture (CPT)	12
Compassionate grounds for release	85
Confidentiality	
Clinical registers	67
Inappropriateness of health screening	
by non-medical staff	57
Medical records	66
Referral and discharge letters	64
Consultation rates	58
Corruption	58
Detainees	
Discussions / interviews	10
Disease. <i>See</i> Morbidity	
Drug use in prisons	7
Dual loyalties	52
Entry screening. <i>See</i> Medical assessment of new arrivals	
Equivalence	
Principle of	51
Equivalence, principle of	12
Ethics	52
WMA Medical Ethics Manual	89
European Prison Rules	12
Food	
Access	41
Access, sample questions	42
Chain	32
Distribution	41
Nutrition. <i>See</i> Nutrition	
Preparation	37
Preparation, sample questions	39
Preparation, standards	39
Storage	35
Storage, sample questions	36
Storage, standards	35
Supply	33
Supply, sample questions	33
Greywater	26
Health care	
Access INSIDE prison	57
Access INSIDE prison, sample questions	61
Access OUTSIDE prison	63
Access OUTSIDE prison, sample questions	64
Budget	70
Isolation	55
Medical Facilities and Equipment, sample question	56
Women	71
Health education	73
Health indicators	76
Health professional	
role in prison assessment	8
Health promotion	73
Health staff	52
Sample questions	54
Health status of detainees	76
Health care	
Clinic	55
Medical facilities and equipment	55
Principles	51
Hierarchies	
internal, among detainees	7
Humanitarian grounds for release	85
Hygiene	
Kitchen hygiene rules	38
Of premises	27
Personal	22
Personal, sample questions	23
Personal, standards	23
Ill-treatment. <i>See</i> Torture and ill-Treatment	
Ill-Treatment. <i>See</i> Torture and Ill-Treatment	
Incident rate calculation	80
Individual medical cases	85
Initial health check. <i>See</i> Medical assessment of new arrivals	
Isolation (for health reasons)	55
Kitchen	37
Kitchen hygiene rules	38
Light (accommodation)	16
Malnutrition	46
Protein-Energy	46
Medical assessment of new arrivals	59
Medical grounds for release	85
medical records. <i>See</i> patient records	
Medical records. <i>See</i> Patient records	
Mental health	79
Micronutrient deficiencies	47
Morbidity	79

Measuring morbidity.....	80	Space (accommodation).....	15
Sample questions	81	Standard Minimum Rules for	
Mortality	77	the Treatment of Prisoners.....	13, 88
Calculating the Crude Mortality Rate	77	light and ventilation	16
Sample questions	78	Solitary confinement.....	59
New arrivals health check. <i>See</i> Medical assessment of		Standards for detention.....	11
new arrivals		National	12
Nutrition	43	Regional	12
Assessing nutritional status	49	Universal	13
Diet, sample questions	45	Standards for fetention	
Food groups: Recommended quantities.....	43	Health-Related.....	91
Individual energy requirements.....	44	Temperature (accommodation)	16
Malnutrition	46	Toilets.....	24
Micronutrient deficiencies.....	47	Sample questions	25
Nutritional		Standards.....	24
Surveys	49	Torture and ill-Treatment	
Occupational health and safety	81	Convention against Torture	88
Outbreaks (of disease)	80	ICRC Policy document.....	87
Overcrowding.....	17	Istanbul Protocol	89
Pests	29	Medical documentation.....	83
Pharmacy.....	69	Vectors.....	29
Stock and dispensing register	67	Sample questions	30
Pregnancy in prisons.....	71	Ventilation (accommodation).....	16
Prevalence rate calculation.....	80	Waste management	27
Psychosocial factors	6	Wastewater.....	26
Pyramid, health.....	6	Sample questions	26
Referral to health services outside prison	63	Water.....	19
Requests on medical grounds	85	Sample questions	21
Robben Island Guidelines	12	Water stock standards.....	20
Role of health professional	8	Water supply standards.....	20
Sawage.....	26	Women	
Sample questions	26	Bathing	22
Sexual behaviour in prisons	7	Healthcare needs in prison.....	71
SMR. <i>See</i> Standard Minimum Rules for the Treatment of		Pregnancy.....	71
Prisoners		UN document on Women and Imprisonment	89
Soap	22	WHO document, Correcting Gender Inequity	
Solitary Confinement.....	59	in Prison Health	90
Sourcebook.....	90		

MISSION

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