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From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons

RICK LINES

Irish Penal Reform Trust, Dublin, Ireland

Abstract
It is generally accepted that people in prison have a right to a standard of health care equivalent to that available outside of prisons. This "principle of equivalence" is one that enjoys broad consensus among international health and human rights instruments and organisations. However, given the extreme health problems evident in prisons worldwide, the legal obligations of the State to safeguard the lives and well-being of people it holds in custody and the implications of poor prison health on overall public health, this article suggests that – even if achieved – standards of prison health care only equivalent to that in the community would in some cases fall short of human rights obligations and public health needs. The article argues it is time to move beyond the concept of equivalent standards of health care, and instead promote standards that achieve equivalent objectives. In some circumstances, meeting this new standard will require that the scope and accessibility of prison health services are higher than that outside of prisons.

Keywords: *Equivalence, prison health services, human rights, public health*

It is generally accepted that people in prison have a right to a standard of health care equivalent to that available outside of prisons. This "principle of equivalence" enjoys broad consensus among international health and human rights instruments and organisations (e.g., Basic Principles for the Treatment of Prisoners, 1990; World Health Organization, 1993; UNODC/WHO/UNAIDS, 2006; Council Of Europe Committee Of Ministers, 2006), and is reflected in the prison policy and legislation in many States (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 1992). As such, it is an important tool in advocating for the health rights of people in detention.

Despite the international consensus supporting the principle of equivalence, the fact remains that most countries fall far short of achieving this standard. However, this gap between principle and practice should not deter prison health advocates from seriously

Correspondence: Rick Lines, MA, LLM, Executive Director, Irish Penal Reform Trust, 53 Parnell Square West, Dublin 1, Ireland. Tel: +353-(0)1-874-1400. E-mail: rlines@iprt.ie

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asking whether equivalent standards of care, even if achieved, would be sufficient to meet the unique and often extreme health problems found in prisons. Is the principle of equivalence, as it is currently articulated, sufficient in either public health or legal terms?

A discussion about methadone maintenance at a meeting of drugs and HIV workers in Dublin earlier this year provided an interesting illustration of the limitations of the principle of equivalence in meeting the health needs of people in prison. In Ireland, people on methadone in the community are able to continue treatment if arrested and imprisoned. However, prisoners are not able to initiate a new methadone maintenance regime while incarcerated. At the Dublin meeting, some argued in favour of allowing prisoners to initiate methadone as a harm reduction measure. Others suggested that current prison policy was appropriate. As there was a waiting list in the community to access methadone, it was reasoned that allowing prisoners to initiate treatment in prisons would enable them to unfairly "jump the queue" and receive preferential access.

Missing from both sides of this debate was an assessment of whether an equivalent policy of methadone access between prisons and the community – even if implemented – would meet the health needs of Irish prisoners. While bringing Irish prison policy into equivalence with community policy would indeed enable prisoners to place their names on the central methadone waiting list, and initiate treatment when their turn came, it would do little to reduce the risk of HIV and hepatitis C transmission via syringe sharing in prisons in the meantime. Unlike people who inject drugs outside of prisons, who may reduce their risk of infection by accessing syringe exchange programmes, the lack of needle/syringe programmes in Irish prisons means that prisoners who inject drugs would continue to inject while awaiting methadone treatment, sharing and reusing injecting equipment to do so.

If the public health objective of methadone maintenance is to be achieved – that of reducing injecting and the attendant risk of HIV and hepatitis C transmission – Irish prisoners should in fact be entitled to a standard of access greater than that available in the community. Indeed, without such enhanced access, the efficacy of methadone in this regard would be largely undermined. Therefore, the ability of prisoners to "jump the queue" would be a preferable and sensible policy, as opposed to a merely equivalent policy that would ensure the continuation of high risk injecting.

This is but one example where an equivalent standard of care falls short of meeting the unique health needs and circumstances of people in prison, therefore undermining broader public health objectives. It illustrates that the principle of equivalence, even if achieved, is a standard insufficient to meet the requirements of responsible public health practice in many circumstances. Rather than equivalence, States therefore have a responsibility to provide a higher standard of health in prisons than is generally available to people outside of prisons when necessary to ensure that the health of detainees is protected. Anything less not only violates the rights of persons in prison, but fails to address the numerous public health crises that are concentrated and exacerbated by the fact of incarceration.

The global scope of prison health problems

Over nine million people are incarcerated in penal institutions worldwide (Walmsley, 2005). As this figure represents only the prison population at any moment in time, it significantly underestimates the total number of persons who pass through prisons each year, often for short periods of detention. Indeed, annual admissions to prisons in countries across the world are estimated to be at least double, and in some cases ten times, the actual number of people incarcerated on any single day (Human Rights Watch, 1993).

It is the experience in countries around the world that health problems are more common, severe and complex in prisons than they are in the general population outside of prisons. For example, the rate of tuberculosis (TB) infection among incarcerated populations is as much as one hundred times higher than that found outside of prisons (International Committee of the Red Cross, 2006), and in many countries is one of the leading causes of mortality among prisoners (International Committee of the Red Cross, no date). According to Dr. Jaap Veen, "There is a clear relation between TB and poverty." Given that "Prisoners generally come from the most deprived strata of society," he concludes that it is "no wonder that TB in prisons in generally more prevalent than in civil society in general" (Veen, 2006).

Within prisons, the risk of the spread of TB is heightened by poor and overcrowded prison conditions (Maher et al., 1998), illustrating the relationship between environmental conditions in prisons and the health status of detainees. Inadequate medical infrastructure, or inconsistent access to medications, heightens the risk of developing multi-drug resistant strains of TB within prison populations (Bone et al., 2000). As a result, multi-drug resistant TB is common in the prison systems of both high income and low income countries (Bone et al., 2000). These multi-drug resistant strains of the disease, which often are not treatable with available TB therapies, pose an increased risk of illness, or even death, to prisoners and prison staff, as well as the population outside of prisons.

TB is only one example of health problems that are magnified within the prison environment. According to the World Health Organization (WHO), prisons are places where "two of the greatest public health problems facing all societies overlap: the epidemic of HIV/AIDS and the pandemic harmful use of psychotropic substances such as alcohol and illegal drugs." (World Health Organization, 2005) In many countries, this intersection fuels high rates of blood-borne infections, such as HIV and hepatitis C, among prisoners who share syringes to inject drugs. As a result, rates of HIV and hepatitis C infection are significantly higher among prison populations than in the community outside of prisons (Jürgens, 2006).

As with TB, HIV infection can spread with alarming speed in prisons, particularly among prisoners who inject drugs. For example, in 2002 an HIV outbreak among injecting drug using prisoners was identified at the Alythus Prison in Lithuania, during which time 263 prisoners tested positive for HIV within the space of a few months. Before this outbreak, testing had identified only eighteen HIV infections in Lithuania's entire prison system, and only three hundred persons were known to be living with HIV in the country as a whole (Jürgens, 2002). This example illustrates the implications of inadequate prison health systems on overall public health, and national levels of disease and ill-health.

High rates of HIV and other infectious diseases in prisons can lead to alarmingly high rates of mortality among prisoners. In South African prisons, where high rates of both HIV and TB infection are evident, officials recorded a 584% increase in "natural deaths" of prisoners between 1995 and 2000. When the Department of Correctional Services examined post-mortem reports on these deaths in 1999, it concluded that ninety percent were HIV-related. Based upon these figures and the continuing growth of the South African prison population, the study predicted that, by 2010, 45,000 people would die in the country's prisons (Goyer, 2003).

In addition to infectious diseases, mental health in prison is a growing international concern. The UN Special Rapporteur on the Highest Attainable Standard of Health has expressed concern that people with mental health problems are often "misdirected towards prison rather than appropriate mental health care or support services" (Commission on

Human Rights, 2005), creating a disproportionately high rate of mental illness within penal institutions. In Europe, the WHO estimates that as many as 40% of prisoners suffer from some form of mental illness (World Health Organization Europe, no date), and, as a result, are up to seven times more likely to commit suicide than are people outside of prisons. The Special Rapporteur has noted that although poor prison conditions "tend to exacerbate mental disabilities ... there is often little access to even rudimentary mental health care and support services." (Commission on Human Rights, 2005) Prisoners with mental illness are also particularly vulnerable to violence. For example, the Special Rapporteur on Violence Against Women has noted that, "mentally ill women are at high risk of sexual abuse in custodial settings. Consequently, it is imperative that prisons have adequate facilities to meet the needs and ensure the protection of such women." (Commission on Human Rights, 1999)

Despite the demonstrable need for States to provide medical and mental health care to meet these extreme conditions, few prison regimes boast health services that meet international human rights standards. As reported by Human Rights Watch,

> Complaints about medical care, or lack thereof were ... among the most frequent we heard in prisons throughout the world ... A complaint we heard almost everywhere was that prisoners were denied medical care because of indifference [and] neglect ... Health care for most of the world's poor is inadequate; for prisoners, often the poorest of the poor, it is usually miserable." (Human Rights Watch, 1993)

Human Rights Watch has also documented consistent problems with environmental health in prisons, including overcrowding, poor sanitary conditions, inadequate lighting and ventilation, extremes of temperature, insect and rodent infestation and insufficient/non-existent personal hygiene supplies. According to the report, any one of these factors can negatively affect a prisoner's health, and "Inadequate diet and unhygienic living conditions ... contribute to an extremely high rate of disease and death." (Human Rights Watch, 1993)

While the Human Rights Watch report dates from 1993, little has changed in the intervening years. A 2001 review of international prison conditions noted, "Living conditions in prisons have certainly not improved uniformly in the past decade and in many countries overcrowding has made these conditions even worse. The recognition of the rights of prisoners across jurisdictions has been uneven and progress uncertain." (van Zyl Smit & Dunkel, 2001)

The evidence clearly illustrates the degree to which the health needs of prisoners are far from being met around the world. Indeed, in all regions of the globe, the people committed to prison are those whose social and economic marginalisation places them at increased risk of physical and mental health problems. They are incarcerated in overcrowded, unsanitary, stressful and violent conditions, alongside others who share the same increased health vulnerabilities. As a result, the prison environment is one marked by disease transmission, environmentally exacerbated health decline and death, and heightened risk of mental illness. In the words of the WHO, "Ill-health thrives in settings of poverty, conflict, discrimination and disinterest. Prison is an environment that concentrates precisely these issues." (Bone et al., 2000)

The failure of Governments to address these health concerns has implications beyond detainees and prison authorities. Indeed, health experts and international organisations have consistently emphasised the fact that prison health cannot be isolated from broader public health concerns (e.g., World Health Organization Europe, 2003; *Dublin*

Declaration, 2004; UNODC/WHO/UNAIDS, 2006). Therefore, the provision of health services sufficient to meet these needs is not only a matter of pressing concern for persons in detention, it is also integrally linked to State obligations to fulfill the right to health within the population as a whole.

Given the extreme nature of prison health problems – problems exponentially more severe in many cases than those found in the population outside of prisons – providing a standard of health care in prisons equivalent to that outside prisons would not be sufficient to meet the need in many cases. Given the scope and urgency of the issues involved, Governments have a legal and ethical obligation to provide a standard of health care greater than that available in the community. Equivalence is only a minimum acceptable standard, rather than an ideal one.

The principle of equivalence in an historical context

The argument that the State has a higher obligation to provide health care to people in detention is not a new one. Indeed, the basis for this position can be found in the very earliest prison health legislation.

In 1774, the Parliament of the Great Britain passed the *Act for Preserving the Health of Prisoners in Gaol, and preventing the Gaol Distemper* (see Appendix A). The *Act* was the first Parliamentary legislation in Great Britain to specifically address health in prisons. As such, it was likely one of the earliest pieces of such legislation in Europe, if not the world.

Writing in 1777, three years after the *Act* became law, the English prison reformer, John Howard, described the content in this way.

> The late *act for preserving the health of prisoners* requires that an *experienced Surgeon or Apothecary* be appointed to every gaol: a man of repute in his profession. His business is, in the first place, to order the immediate removal of the sick, to the infirmary; and see that they have proper bedding and attendance. Their irons should be taken off; and they should have, not only medicines, but also diet suitable to their condition. He must diligently and daily visit them himself; not leaving them to journeymen and apprentices. He should constantly inculcate the necessity of cleanliness and fresh air; and the danger of crowding prisoners together: and he should *recommend*, what he cannot enforce. I need not add, that according to the act, he must report to the justices at each quarter-sessions, the state of health of the prisoners under his care. (Howard, 1777) [emphasis in original]

The principles enshrined in this 230-year-old law are notable for their relevance to a contemporary examination of prison health standards, and the legal context of the principle of equivalence. More than two centuries later, these principles continue to form the framework of State obligations in international law to safeguard the health of prisoners. They also describe a legal duty upon the State to provide a standard of health services in prisons superior than for people outside of prisons in 18th century England.

At the most fundamental level, in ordering the appointment of a "Surgeon or Apothecary . . . to attend each Gaol or Prison respectively", the *Act* enshrined the legal obligation of the State to provide universal access to medical care for all prisoners. In specifying that this surgeon or apothecary be "experienced", it mandated that prison medical staff meet recognised qualifications and standards.

The *Act* required that every prison have an acceptable medical infrastructure. It ordered that "Two Rooms in each Gaol or Prison, One for the Men, and the other for the Women, to be set apart for the Sick Prisoners, directing them to be removed into such Rooms as

soon as they shall be seized with any Disorder, and kept separate from those who shall be in Health." These medical units were required to be maintained in a hygienic manner, and were "to be regularly washed and kept clean, and constantly supplied with fresh Air, by Means of Hand Ventilators, or otherwise".

The *Act* identified the State's responsibility "for restoring or preserving the Health of Prisoners", therefore suggesting an obligation to provide both primary medical care for sick prisoners (restoring), as well as preventative health measures (preserving). The *Act's* attention to issues hygiene, cleanliness and ventilation, as well as the requirement to separate ill prisoners from the rest of the prison population, underlines the responsibility to take measures to prevent the spread of infectious diseases.

The legal obligation of the State to provide these medical services in prisons was highlighted by the fact that health care was to be paid for out of taxation. It was reinforced most vividly by the stipulation that if "any Gaoler or Keeper of any Prison shall, at any Time, neglect or disobey" the legislation, they were liable for prosecution, fine and possible imprisonment.

In each of these cases, the legal standards of care articulated in the *Act* were higher than those existing outside of prisons in that era and people in prison were entitled to be provided health services by the State that they were not entitled to outside of prisons. This entitlement is recognition that the very nature of the relationship between the State and the detainee, defined as it is by the authorities' complete control over the day-to-day lives of incarcerated individuals, necessarily places upon the Government a higher level of responsibility to protect the lives and well-being of prisoners.

The principle of equivalence in a contemporary legal context

While the 1774 *Act for Preserving the Health of Prisoners* established this legal concept early on, the notion that the State owes a higher duty of care to those it imprisons than it does to those outside of prisons also features in modern human rights law. It is on this basis that it can be reasonably argued that the principle of equivalence is at best a minimum acceptable standard, and that State obligations to protect people in their custody require it to provide a higher level of care to persons deprived of liberty when demanded by circumstance or conditions.

One contemporary example is found in the work of the African Commission on Human and People's Rights, the body responsible for monitoring State compliance with the provisions of the *African Charter on Human and Peoples' Rights*. The Commission takes the approach that the State's obligation to fulfill the right to health contained in Article 16 of the *African Charter* "is heightened in cases where an individual is in its custody" because the person's "integrity and well-being is completely dependent upon the actions of the authorities." (*International PEN and Others v Nigeria*, 1998) This articulates a higher standard of care owed by the State to prisoners than to non-prisoners. According to the Commission, "The State's responsibility in the event of detention *is even more evident* to the extent that detention centres are its exclusive preserve, hence the physical integrity and welfare of detainees is the responsibility of the competent public authorities." (*Malawi African Association and others v Mauritania*, 2000) [emphasis added]

The United States Supreme Court has also found that the Government has an obligation to provide people in prison with access to health services, a duty it does not owe to people outside of prisons. The late Justice Thurgood Marshall, writing the majority opinion in the 1976 case of *Estelle v Gamble*, affirmed

> the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," ... In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. (*Estelle v Gamble*, 1976)

The US Supreme Court's approach confirms that the very nature of the custodial relationship between State and prisoner places obligations on the Government to provide access to health care above and beyond that owed to people outside of prisons. While this is not to suggest that health care standards in US prisons are sufficient, the Court's decision does endorse the principle that the Government is legally obligated to provide a higher level of health services to people in prison. In this sense, this decision builds upon the case law of the North Carolina Supreme Court, which stated in 1926 that "it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself" (*Spicer v Williamson*, 1926).

The South African High Court has also taken the position that there is an increased duty upon the State to provide medical care to people in prison, and as a result the Government may be obligated to provide prisoners with a standard of care beyond that provided to the general public. In the 1997 case of *Van Biljon and Others v The Minister of Correctional Services*, the Court found there to be a higher obligation on the Government to provide medical care for particularly vulnerable prisoners, such as those living with HIV/AIDS, than to comparable patients outside of prisons (*Van Biljon and Others v The Minister of Correctional Services*, 1997; Gutto, 1998; Canadian HIV/AIDS Legal Network/UNAIDS, 2006). On this basis, the Court ordered the State to provide HIV anti-retroviral treatment to the imprisoned plaintiffs at a time when such treatment was rarely available in the general population (Ngwena and Cook, 2005; *Van Biljon and Others v The Minister of Correctional Services*, 1997; Canadian HIV/AIDS Legal Network/UNAIDS, 2006).

This position also finds support from the UN Human Rights Committee in the 2002 case of *Lantsova v The Russian Federation*. The prisoner's mother, who took the case on behalf of her deceased son, alleged that he was in good health when he entered the prison, but soon fell ill due to poor conditions. It was claimed that the prisoner "received medical care only during the last few minutes of his life" and "that the prison authorities had refused such care during the preceding days and that this situation caused his death." (*Lantsova v Russian Federation*, 2002).

The Human Rights Committee found that the failure of the authorities to provide a "properly functioning medical service" to diagnose and treat the prisoner's medical condition violated his right to life (*Lantsova v Russian Federation*, 2002). *Lantsova* therefore suggests that providing a "properly functioning medical service" in prisons is a legal requirement of States under Article 6(1) of the *International Covenant on Civil and Political Rights*, an obligation that does not exist for non-incarcerated persons under the same treaty. This view is echoed by the European Court of Human Rights, which found in the 2002 case of *Edwards and another v United Kingdom* that the failure of the State to provide medical care and mental health screening systems in prison, which in this case resulted in the death of the applicant, violated the right to life in the *European Convention on Human Rights* (*Edwards and another v UK*, 2002).

Indeed, the *European Convention* provides another basis in law to argue that a higher standard of health care is owed to people in prison. For example, while the *Convention* does

not contain a general right to health for European citizens, it does articulate a right to health of persons in prison under *Convention* Article 3, the prohibition of torture and inhuman or degrading treatment. The case law of the European Court of Human Rights is clear that the failure to provide necessary medical attention to prisoners – which unnecessarily exacerbates the person's suffering – can constitute a violation of Article 3. According to the Court, "the authorities are under an obligation to protect the health of persons deprived of liberty and the lack of appropriate medical care may amount to treatment contrary to art 3" (*Rohde v Denmark*, 2005; see also *Kudla v Poland*, 2000; *Melnik v Ukraine*, 2006).

Furthermore, the prohibition of inhuman or degrading treatment imposes upon States a "positive obligation" to take proactive measures to prevent the occurrence of inhuman or degrading treatment (e.g., *Keenan v UK*, 2001; *Hurtado v Switzerland*, 1994; *Pantea v Romania*, 2005). If inadequate medical services in prisons can constitute a violation of Article 3, it can be argued that the State's positive obligations to take action to prevent the occurrence of inhuman or degrading treatment requires it to implement effective and proactive medical services. As a result, it can be argued that providing a proper standard of medical care in prisons is a legal requirement under European law, and one not found to extend to persons in the general community for whom the *Convention* does not provide a generalised right to health. Once again, this higher standard of health care is owed by virtue of the custodial relationship between the keepers and the kept.

Related to this issue is the fact that the health decline of persons in prison – physical, mental and/or the contracting of diseases – has been cited by the European Court (e.g., *Kalashnikov v Russia*, 2003; *Nevmerzhitsky v Ukraine*, 2005; *I.I. v Bulgaria*, 2005; *Alver v Estonia*, 2005), the UN Human Rights Committee (e.g., *Williams v Jamaica*, 1997; *Cabal and Pasini v Australia*, 2003; *Matthews v Trinidad and Tobago*, 1998) and the Inter-American Court of Human Rights (*Caesar v Trinidad and Tobago*, 2005) as contributing to overall prison conditions that are cruel, inhuman or degrading and therefore illegal. This would therefore suggest that taking preventative health measures in prisons, such as those to prevent infectious diseases or mental health deterioration, is also a legal duty of the State.

Principle of equivalence in a public health context

Incarcerating an individual, by definition, places increased obligations on State authorities to protect his or her well-being, an increased obligation that necessarily brings with it increased responsibilities to provide health care services, even when those services exceed the scope or quality of those provided outside prisons. A failure to provide such services, which can result in the health deterioration or even death of a detainee, can violate State obligations in law.

However, the obligation to provide a higher standard of care to persons in detention is also a public health imperative. In an era where prisons are major sites fuelling the international pandemics of HIV, hepatitis C and (multi-drug resistant) tuberculosis, where prisons are becoming warehouses for persons with mental illness and people who use drugs, the mere achievement of equivalence is not only insufficient in human rights terms, it is an insufficient public health response.

A significant proportion of prisoners in most countries are members of groups that suffer social, economic or ethnic/racial discrimination in the broader society. Many of the same factors that make these populations more likely to find themselves in conflict with the law, and therefore incarcerated, also mean that they suffer disproportionately from a poor health status (Bone et al., 2000; UNODC/WHO/UNAIDS, 2006). According to the WHO,

> In all countries of the world, it is people from the poorest and most marginalized sections of the population who make up the bulk of those serving prison sentences, and many of them therefore have diseases such as tuberculosis, sexually transmitted infections, HIV/AIDS and mental disorders ... Penitentiary populations [therefore] contain an over-representation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions (World Health Organization Europe, 2003).

As a result, the health needs of people in prison are necessarily more intensive and complex than those outside of prison, demanding a more intensive and complex health care response. Clearly, the public health risks associated with failing to provide increased services to meet these increased needs have disproportionate implications for overall community health.

Conclusion

Whether examined from the perspective of public health or human rights, achieving equivalence standards of health care in prisons is not sufficient to fulfill State obligations to protect the health of people it holds in detention. It is therefore time to move beyond the concept of equivalent standards of health care, and instead promote standards that achieve equivalent objectives. This necessitates an analysis of those circumstances in which health services equivalent to those outside the prison environment still fall short of what is necessary to achieve the same health outcomes. While prison heath standards must never fall below those available outside of prisons, equivalence is a minimum standard, rather than one that satisfies the legal or health obligations of States. As was illustrated by the methadone discussion in Dublin, the unique challenges and barriers inherent to places of detention can mean that achieving equivalent health objectives will sometimes require enhanced services and standards in prisons.

In a context where even equivalent health standards in prisons are far from achieved, where prisoners are demonised and stigmatised by political leaders, and where poor prison conditions are at best met with indifference from the public, a call for a higher standard of health may seem a pointless and unrealistic exercise. However, the rights of people in prison, and the demands of prison health and human rights advocates, must not be curtailed by Governments' failure to meet their obligations. Nor should the rights and entitlements of vulnerable or marginalised populations be dictated by public prejudice, apathy or hostility.

In prisons, where health problems are more extreme, complex and widespread than in the general population – a situation driven by State criminal justice and prison policy decision-making – a response merely equivalent to that outside of prison is by definition not enough. In the words of the UN Human Rights Committee, "the State ... by arresting and detaining individuals takes the responsibility to care for their life." (*Lantsova v Russian Federation*, 2002) Because "the State party remains responsible for the life and well-being of its detainees" (*Fabrikant v Canada*, 2001) it is "incumbent on States to ensure the right of life of detainees" is protected (*Lantsova v Russian Federation*, 2002).

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Appendix A: An Act for preserving the Health of Prisoners in Gaol, and preventing the Gaol Distemper

14 Geo.3 c.59
Seventh Session of the Thirteenth Parliament of Great Britain (13 January 1774)

Whereas the malignant fever, that is commonly called *The Gaol Distemper*, is found to be owing to a want of Cleanliness and fresh Air in the fever Gaols in *England* and *Wales*, and the fatal Consequences of that Disorder, of which there has been, of late, too much Experience, might be prevented, if Justices of the Peace were duly authorised to provide such Accommodations in Gaols as may be necessary to answer this salutary Purpose: May it therefore please Your Majesty that it may be enacted; and be it enacted by the King's most Excellent Majesty, by and with the Advice and Consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the Authority of the same, That the several Justices of the Peace, in that Part of Great Britain called *England* and *Wales*, within their several Jurisdictions, in their Quarter Sessions Assembled, are hereby authorised and required to order the Walls and Ceilings of the several Cells and Wards, both of the Debtors and the Felons, and also of any other Rooms used by the Prisoners in their respective Gaols and Prisons, where Felons are usually confined, to be scraped and white washed, Once in the Year at least; to be regularly washed and kept clean, and constantly supplied with fresh Air, by Means of Hand Ventilators, or otherwise; to order Two Rooms in each Gaol or Prison, One for the Men, and the other for the Women, to be set apart for the Sick Prisoners, directing them to be removed into such Rooms as soon as they shall be seized with any Disorder, and kept separate from those who shall be in Health; to order a Warm and Cold Bath, or commodious Bathing Tubs, to be provided in each Gaol or Prison, and to direct Prisoners to be washed in such Warm or Cold Baths or Bathing Tubs, according to the Condition in which they shall be at the Time, before they are suffered to go out of such Gaols and Prisons upon any Occasion whatever; to order this Act to be painted in large and legible Characters upon a Board, and hung up in some conspicuous Part of each of the said Gaols and Prisons; and to appoint an experienced Surgeon or Apothecary, at a stated salary, to attend each Gaol or Prison respectively, who

shall, and be hereby directed to report to the said Justices by whom he is appointed, at each Quarter Sessions, a State of the Health of the Prisoners under his Care or Superintendance.

And be it further enacted by the Authority aforesaid, That the said Justices of the Peace, in their said Quarter Sessions assembled, are hereby authorised to direct the several Courts of Justice within their respective Jurisdictions to be properly ventilated; to order Cloaths to be provided for the Prisoners when the see Occasion; to prevent to Prisoners from being kept under Ground, whenever they can do it conveniently; and to make such other Orders, from Time to Time, for restoring or preserving the Health of Prisoners, as they shall think necessary.

And be it further enacted by the Authority aforesaid, That the Expences attending the Execution of the Orders of the said Justices, made in pursuance of this Act, so far as the same shall respect County Gaols and Prisons, and Courts of Justice belonging to the Counties, shall be borne and defrayed, at all Times, out of the respective County Rates; and so far as the same shall respect the Gaols and Prisons, and Courts of Justice, or particular Cities, Towns Corporate, Cinque Ports, Liberties, Frannchises, or Places, that do not contribute to the Rates of the Counties in which they are respectively situated, such Expences shall be defrayed out of the Publick Stock of Rates of such Cities, Towns Corporate, Cinque Ports, Liberties, Franchises, or Places, having such exclusive Jurisdictions, to which such Gaols, or Prisons or Courts of Justice, shall respectively belong: And if any Gaoler or Keeper of any Prison shall, at any Time, neglect or disobey the Orders of such Justices made in pursuance of this Act, he may be proceeded against in a summary Way, by Complaint made to the Judges of Assize, or to the Justices, in their Quarter Sessions; and if found guilty of such Neglect or Disobedience, he shall pay such fine as the Judges of Assize, or Justices, shall impose, and shall be committed in case of Nonpayment.