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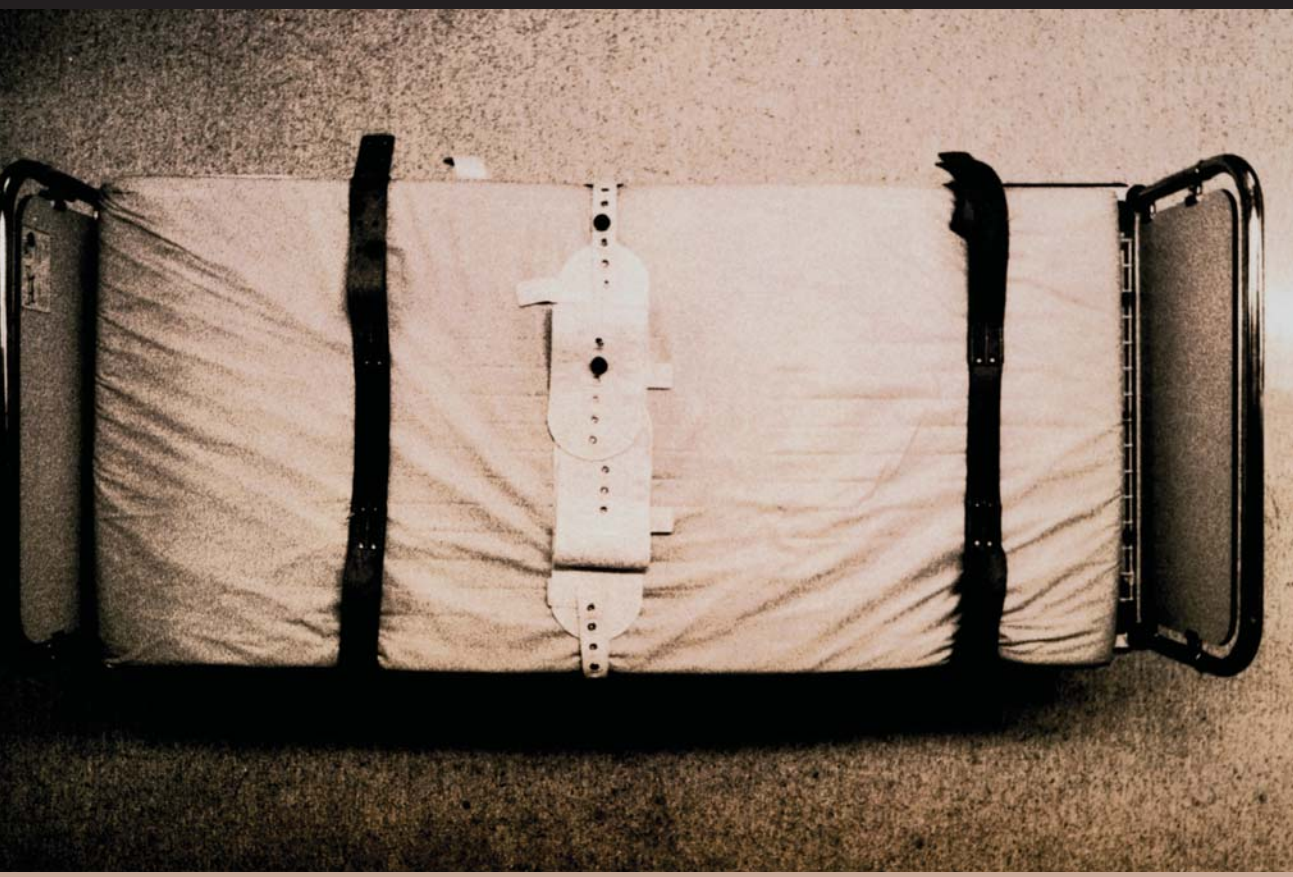

# Pretrial Detention and Health: Unintended Consequences, Deadly Results

A Global Campaign for Pretrial Justice Report

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*Literature Review and Recommendations for Health Professionals*

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# About the Global Campaign for Pretrial Justice

Excessive and arbitrary pretrial detention[1] is an overlooked form of human rights abuse that affects millions of people each year, causing and deepening poverty, stunting economic development, spreading disease, and undermining the rule of law. Pretrial detainees may lose their jobs and homes, contract and spread disease, be asked to pay bribes to secure release or better conditions of detention, and suffer physical and psychological damage that last long after their detention ends. In view of the magnitude of this worldwide problem, the Open Society Justice Initiative, together with other partners, is engaging in a *Global Campaign for Pretrial Justice*. Its principal purpose is to reduce unnecessary pretrial detention and demonstrate how this can be accomplished effectively at little or no risk to the community.

Current activities of the Global Campaign include collecting empirical evidence to document the scale and gravity of arbitrary and unnecessary pretrial detention; building communities of practice and expertise among NGOs, practitioners, researchers, and

1. "Pretrial detention" is defined as the period during which an individual is deprived of liberty (including detention in police lock-ups) through to conclusion of the criminal trial (including appeal). Other terms commonly used for pretrial detainees include "remand prisoners," "remandees," "awaiting trial detainees," "untried prisoners," and "unsentenced prisoners."

policy makers; and piloting innovative practices and methodologies aimed at finding effective, low cost solutions. In addition, the campaign strives to establish linkages with associated fields such as broader rule of law and access to justice initiatives and programs.

The goal of this paper is to focus on an important and underappreciated issue and assist health professionals and governments to better understand it and more effectively design policy responses to it. Although this paper makes reference to specific situations and countries, it is important to note that excessive pretrial detention is a global issue affecting developing and developed countries alike.

This paper is part of a series of papers examining the impact of excessive pretrial detention. In addition to the public health impact of pretrial detention, the papers in the series look at the intersection of pretrial detention and economic development, torture, and corruption.

More information about the *Global Campaign for Pretrial Justice* is available at http://www.soros.org/initiatives/justice/focus/pretrialjustice.

The other three papers in this series are available as follows:

- *The Socioeconomic Impact of Pretrial Detention*
  http://www.soros.org/initiatives/justice/articles_publications/publications/socioeconomic-impact-detention-20110201;
- *Pretrial Detention and Torture: Why Pretrial Detainees Face the Greatest Risk*
  http://www.soros.org/initiatives/justice/articles_publications/publications/pretrial-detention-and-torture-20110624;
- *Pretrial Detention and Corruption* (summary)
  http://www.soros.org/initiatives/justice/focus/criminal_justice/articles_publications/publications/pretrial-detention-corruption-20100409.

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The Open Society Justice Initiative bears sole responsibility for any errors or misrepresentations contained in this report.

# Contents

# I. Executive Summary and Recommendations

The excessive use of pretrial detention leads to overcrowded, unhygienic, chaotic, and violent environments where pretrial detainees—who have not been convicted—are at risk of contracting disease. Pretrial holding facilities, which include police lock-ups not designed for large numbers or extended stays, often force detainees to live in filthy, teeming conditions without access to fresh air, minimal sanitation facilities, health services, or adequate food. In the worst cases, detainees die from these conditions and associated disease, and surviving detainees sleep with the corpses. Some pretrial detention centers are so bad that innocent people plead guilty just to be transferred to prisons where the conditions might be better. For many pretrial detainees, being locked away in detention centers where tuberculosis, hepatitis C, and HIV are easily contracted can be a death sentence.

This paper reports on a review of published and grey literature on health conditions and health services in pretrial detention in developing and transitional countries. This paper takes as its point of departure that the negative health impacts of excessive pretrial detention are an important reason to pursue pretrial justice reform. Problems identified in the literature are linked both to inadequate health services and to the health impact of cruel, inhuman, and degrading treatment of detainees and failure of the state to ensure humane living conditions and protection from violence. Together these constitute pervasive and often heinous human rights abuses among people, not convicted of any crime, who are entirely in the control of the state.

Monitoring visits made by human rights experts and committees in many countries have revealed a complete lack of respect for the health rights and other human rights of detainees. In pretrial holding facilities, detainees often live in filthy spaces so small they can't lie down, without access to fresh air, sanitation facilities, or clean water and adequate food. Health services, even if they were adequate, could not undo the physical and psychological damage done by these conditions, which can be so bad that people beg to be convicted of crimes they did not commit, or actively seek to be diagnosed with tuberculosis, so that they might be transferred to long-term prisons or specialized TB facilities.

Any point of entry into the correctional system is an opportunity for early detection and treatment of physical and mental health disorders and a challenge to ensure that care is continued when detainees are admitted, discharged, or transferred. Conditions such as HIV, drug dependency, tuberculosis, hepatitis C, and many forms of mental health problems require continued care, and few reports indicate that the links to prison-based and community-based care are being made in many low- and middle-income countries at the point of admission, detention, transfer or discharge.

Comprehensive HIV prevention, voluntary testing, care, treatment, and support are often not provided in pretrial detention—even where these services exist in the community. Condom provision is exceptional and is impeded in some cases by discriminatory laws against sodomy or rules against having sex in prison. Failure to ensure appropriate detection and treatment of tuberculosis is contributing to deadly epidemics of drug-resistant TB. The norm from the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955) of having one psychiatric specialist available for every institution seems to be widely violated as mental illness is neglected among people in remand. Basic health needs of women—including reproductive health services and protection from violence—are often not met as remanded women are sometimes housed in men's facilities or other institutions without services designed for them.

Human rights experts warn that torture is most likely to occur in the first hours and days of detention. Monitors uncovered evidence of torture in police lock-ups and other pretrial detention facilities, and were denied access to other institutions where torture was suspected. The short- and long-term impact of torture and inhuman treatment on physical and mental health cannot be overstated. Heinous abuse of children in detention, including beating and sexual abuse, has been documented in many locations. Street children and others whose families are not immediately evident may be subject to particular abuse. Other kinds of cruel and inhuman punishment take the form of physical and sexual violence at detention facilities that fail to separate women from men, children from adults, and pretrial detainees from convicted prisoners. It is impossible, with the uneven monitoring and research available, to put figures on mortality and morbidity

associated with abusive conditions and failures of health services in pretrial detention, but the human cost is high. Health professionals, including academic experts, play a crucial role in addressing this crisis as researchers, technical experts, practitioners, and advocates. Health professionals with experience in prison and pretrial health can help build capacity of their counterparts in the prison health field, and can help open the eyes of a new generation of practitioners to the importance of the health rights of people in state custody. They can ensure that professional societies and governments do more to protect prison and remand health professionals who denounce abuses in their institutions, and who seek to ensure that evidence-based health services are not the constant casualty of overriding security interests or cruel neglect.

## Recommendations

The following recommendations are focused on the potential role of health professionals and organizations that support them in addressing the problems described in this paper. Health professionals from all parts of the world, including professional societies and international organizations such as the World Health Organization, have an important role to play in improving pretrial detention in developing and transitional countries.

**Participate in research and building research capacity:**

There is an urgent need for health researchers to undertake research activities on health and health services in pretrial detention, particularly in places where it is unlikely that they will be encouraged or invited to do so by correctional authorities. Where pretrial detention practices are changing—one hopes in the direction of reducing pretrial detention—the health impact of those changes should be a high priority for research and evaluation. Health researchers in countries with extensive experience in prison health, as well as international organizations such as WHO and UNODC, can help build capacity among their less experienced counterparts. Academic researchers should set examples of ethical research in closed settings, including informed consent and confidentiality, and meaningful and respectful participation of detained persons in the design and implementation of research. University-based health experts and professional societies can be an important force in advocating for the openness of remand facilities to research that will contribute to the realization of health rights of pretrial detainees. Institutional review boards that set standards for ethics of research should be made aware of pretrial detention issues, and medical professional societies and organizations such as WHO and UNODC should make training materials and other information available toward this end.

In too many countries, health researchers are discouraged from studying conditions of detention. Even in many wealthy countries, there is little funding for prison health research, and few researchers manage to overcome challenges of access to detention facilities and lack of interest in this research on the part of medical and health journals (F. Altice, Yale Univ., personal communication). Universities and professional societies should work to raise the profile of detention-related health concerns in teaching and research.

**Provide technical support to remand service providers and to the prison health profession:**

In addition to research, academic health experts can lend technical support to service providers in correctional institutions by sharing technical developments and good practices relevant to prison health services. Ideally, ministries of health would provide this kind of technical support, and they might be encouraged to do so through private initiatives by universities and health professionals. An editor of the *South African Medical Journal* urged his colleagues in the medical profession to consider designating a number of days of pro bono work each year to assisting prison care providers in whatever ways are appropriate (van Niekerk 2005). Establishing practicum experiences in prisons and remand facilities for nursing, dental, medical, and public health students could provide unique learning experiences and expose new professionals to the importance of prison health careers. In addition, academic experts can influence their universities and professional societies to include prison health concerns in curricula and continuing education programs. They can also advocate for the involvement of health ministries in prison health services, and help ensure that health professionals are aware of neglected issues such as protecting gay men, transgender persons, and sex workers from abuse in detention. In their materials on prison health, WHO and UNODC should make explicit problems specific to pretrial detention. Attention to pretrial detention in all UN prison health guidance, technical reports, monitoring, and consultancies would greatly help to draw attention to neglected pretrial detention health issues. WHO and UNODC should work with relevant authorities to ensure that regular government inspections and monitoring include attention to health issues in pretrial detention settings including police cells. Incorporating explicit pretrial detention sections on the WHO and UNODC web sites would also be a step forward.

**Support the independence and ethical actions of prison health professionals:**

Professional societies and university-based health professionals have an important role to play in advocating with correctional health authorities to ensure that doctors working in prisons can make independent recommendations about care and services. Prison health professionals should be assisted in advocating for adequate legal protec-

tions in cases where they act as whistle-blowers or object to prison policies on health grounds. Professional associations should have training programs and guidelines for prison-based professionals on ethical challenges, including not participating in any cruel, inhuman, or degrading treatment or torture. The Norwegian Medical Association, for example, has developed a course for prison doctors to help them detect signs of torture and act as independent advocates for the health of prisoners (Fleck 2004). The Indian Medical Association in 2007 pledged to improve protections for physicians who encounter torture in prison-based interrogations (Nathanson 2007). The Istanbul Protocol (Office of the UN High Commissioner, 1999) is an international guide for diagnosis, documentation, and reporting by physicians and others who examine victims or alleged victims of torture.

**Support adequate working conditions for prison health professionals:**

Professional societies and university-based experts should advocate for adequate salaries and good working conditions for prison and pretrial detention health care providers. In spite of the obvious challenges, they should help ensure that prison health jobs are not always the least attractive in the profession. In their interactions with policymakers, WHO and UNODC should advocate for good working conditions for health professionals working in custodial settings.

**Participate in monitoring:**

Of the many accounts of remand facility visits by human rights monitors reviewed in this report, those that were most revealing about health issues came when health professionals, including forensic physicians, were part of the monitoring team. Health professionals and professional associations could play an important role in monitoring visits and reinforcing the technical capacity of human rights experts who are not trained in health or medicine. Having become familiar with health conditions in pretrial detention, they can be important voices in the media, before parliamentary and other government hearings, as expert witnesses in legal proceedings, and in professional associations. This would also be an appropriate pro bono activity for professional associations to organize with corrections officials or monitors.

**Participate in public awareness raising:**

Health professionals as well as WHO and UNODC should help raise public awareness of health conditions of pretrial detention and the urgency of greater investment in services. They should use every opportunity to emphasize that health of persons in pretrial detention and prison is of concern to everyone and that all people have a right to the highest attainable standard of health services. Perhaps most importantly, they should

be important advocates for reduction of the use of pretrial detention and should build capacity of their professional societies to do the same.

**Engage in donor support and advocacy:**

The Global Fund to Fight AIDS, Tuberculosis and Malaria has become a major supporter of HIV prevention, treatment, and care, including for marginalized populations that were not readily included in national programs before the Global Fund was created. The Global Fund's "information note" on harm reduction encourages applicants for funding (mostly so-called country coordinating mechanisms that include government and civil society representatives) to take into account continuity of care for drug users who are arrested and detained (Global Fund 2010). Though it is committed to "country-driven" processes, the Global Fund should consider requiring countries applying for funds for prison health activities to provide information about the state of care in pretrial detention. It should ensure that there is adequate staff capacity to work with applicants and grantees to ensure that PTD concerns are included in proposals and funded programs. Staff of the Joint United Nations Programme on HIV/AIDS (UNAIDS), who also work with Global Fund applicants on proposals and monitoring of funded programs, should be briefed on PTD health and AIDS. Bilateral donors should also make PTD health interventions a priority in their work.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) identified the removal of "punitive laws and policies" regarding sex work, drug use, and homosexuality as a priority in its 2009-2011 action plan. As it works with member states, it should combine this effort with advocacy for reduction in the use of PTD.

# II. Introduction

An estimated one third of people in state custody at any given time are detained on a pretrial basis—that is, they are "detained without a sentence and awaiting legal proceedings" (Penal Reform International 2009). This is also known as being on remand. While minimizing its use is consistent with human rights norms, many governments use pretrial detention widely and cavalierly.

The purpose of this paper is to review existing knowledge of health in pretrial detention, including the health status of those detained and the health services available to them. The paper reviews published and grey literature on health in pretrial detention with a focus on developing and transitional countries, and suggests ways in which the health situation of pretrial detainees may differ from that of convicted prisoners. Implications for health research and other activities and engagement of health professionals and other stakeholders are considered. Informing and engaging a wide range of health professionals and advocates on the negative health impacts of pretrial detention may enable them to help pursue pretrial justice reform.

# III. Methods

There is some scholarly literature on pretrial detention and health, but much of what is known on the topic is covered in reports of independent human rights monitors, non-peer-reviewed reports of NGOs and international organizations, and other grey literature. Scholarly literature was located by using a combination of search indexes, including PubMed for health and medical literature (using key words such as "prison," "remand," "juvenile detention," and "pretrial"), Lexis-Nexis for legal literature (using "prison health," juvenile detention," and related terms), the Social Science Citation Index, and Google Scholar for a broad-based search of publications through September 2009. The search was greatly assisted by the extensive review by Ralf Jürgens (2007) for the World Health Organization of prison interventions related to HIV, and the review on HIV and drug use in prison by Kate Dolan and colleagues (2007). In the area of HIV and drug use, it was possible to focus on updating those earlier reviews. Similarly, WHO's literature review on tuberculosis in prisons (WHO 2008) was a helpful resource.

A number of human rights bodies and experts conduct visits to prisons and pretrial detention facilities. Reports of the Special Rapporteurs on Torture were reviewed, along with those of the African regional Special Rapporteur on Prison, the UN Working Group on Arbitrary Detention, and the European Committee for the Prevention of Torture. Reports of Human Rights Watch, Amnesty International, Prison Reform International, the Council of Europe's Committee for the Prevention of Torture, and other human rights organizations were reviewed. This report also benefited from a

consultation with 24 distinguished experts on prison health who attended a meeting in New York in November 2009.

It is a methodological challenge that much of the published and grey literature does not clearly distinguish prison from pretrial detention, a distinction of interest in this project, but perhaps less critical in places where pretrial detainees and prisoners are housed together and otherwise not well distinguished with respect to services, needs, and rights.

# IV. Extent and Types of Pretrial Detention

A comprehensive overview of pretrial detention in the world is beyond the scope of this paper. To give context to health problems in pretrial detention, however, some figures are useful. The most complete analysis of pretrial detention in the world is by Schönteich (2008). As many as 10 million people may be detained on a pretrial basis every year, of which a significant number also leave detention in the course of that year. On any given day, an estimated three million persons are in pretrial detention. Regionally, pretrial detention was most prevalent in the Americas (89.6 per 100,000 population, heavily influenced by the very high proportion in North America), followed by Europe (46.2), Asia (40.6) and Africa (37.7). As a percentage of the prison population, nearly half of persons in state custody in Asia were pretrial detainees, 35.2 percent in Africa, 25.2 percent in the Americas, and 20.5 percent in Europe. Further details about the extent and impact of pretrial detention of adults are found in the Spring 2008 edition of *Justice Initiatives* of the Open Society Justice Initiative, and will not be reprised in this paper.

In addition to the excellent accounts about adult detention in *Justice Initiatives*, an overview of pretrial detention of children under the age of 18 was compiled as part of the UN Secretary-General's global report on violence against children (Pinheiro 2006). Though data are unavailable in many countries, this report estimates conservatively that at least 1 million children are in state custody at any given moment globally because

they are accused of crimes (Ibid.). In Pakistan, some 83 percent of children in prisons in 2003 were awaiting trial or in the midst of trials; only about 17 percent of these were ever convicted of an offense (Ibid.). Pretrial detention of children has been found in several countries to be for periods of months or even years, sometimes lasting longer than the maximum sentence for the alleged crime—and the crimes in question are almost always non-violent (Ibid.: 191). Street children may be particularly vulnerable to arbitrary detention. In South Asia, for example, bail is rarely allowed for street children who are arrested (Ibid.).

Many countries, particularly in South Asia and sub-Saharan Africa, have provisions on the books for juvenile justice systems that are separate from the adult criminal law system, but resources have not been allocated to enable these special juvenile systems to function (Ibid.: 192). In addition, a significant percentage of children in criminal detention in many countries are arrested for "status offenses" that are crimes only when committed by children, such as running away from home, being "beyond parental control," and truancy (Ibid.: 194).

"Pretrial detention" in most countries includes forms of remand that are not strictly "pretrial." Persons involved in criminal proceedings may be detained in an investigation or interrogation stage when it is still being determined whether a case will be brought against them, while they are awaiting trial, while their trial is occurring, and when they have been convicted and await sentencing or final sentencing (Walmsley 2007). Police lock-up may precede transfer to a larger remand facility. Juveniles may be remanded for significant periods without the intention of trial as a way to keep them from having criminal convictions while rehabilitative measures are being determined (Pinheiro 2006). Many countries also detain asylum seekers and other immigrants pending resolution of their appeals for legal status. Psychiatric institutions and facilities for the treatment of drug dependency may also be remand settings, whether or not a trial is envisioned. This paper focuses largely on detention in the criminal justice system, but many of the problems highlighted also pertain to immigration and other forms of detention.

# V. Human Rights Standards for Health in Pretrial Detention and Related Monitoring Mechanisms

All persons have the right to the "highest attainable standard" of health goods and services (International Covenant on Economic, Social and Cultural Rights [ICESCR] 1966: art. 12), without regard to whether the person is in state custody and without discrimination. People in custody of the state have the right to "the health services available in the country without discrimination on the grounds of their legal situation" (Basic Principles 1990). The right to be free from torture and cruel, inhuman, or degrading treatment is specified both in the International Covenant on Civil and Political Rights (ICCPR, art. 7) and the UN Convention Against Torture (1984).

The ICCPR specifies that persons accused but not tried should be separated from convicted prisoners, and juveniles in pretrial detention must always be separated from adults (art. 10(2)). There are numerous human rights instruments and other important international agreements and guidelines on health services for persons in state custody, including standards for pretrial detainees in particular. The Standard Minimum Rules for the Treatment of Prisoners (1957) lay out norms for all detainees with respect to adequacy of space, lighting, heating, ventilation, sanitation facilities, clothing, bedding, food, and provisions for physical exercise (articles 9-21). Article 9(1) optimistically suggests that "each prisoner shall occupy by night a cell or room by himself" except for

"special reasons, such as temporary overcrowding." The health and medical provision of the Standard Minimum Rules are wide-ranging and include:

- Every institution should have "at least one qualified medical officer who should have some knowledge of psychiatry," and psychiatric services should be available "for the diagnosis and...the treatment of states of mental abnormality" (art. 22(1)).
- Capacity at all institutions to transfer ill prisoners to specialized hospitals when needed (art. 22(2)).
- Pre- and post-natal care in women's institutions, with provisions "wherever practicable" for children to be born in a hospital, and a "nursery staffed by qualified persons" in institutions where infants are allowed to be with their mothers (art. 23).
- A medical officer should examine every prisoner "as soon as possible after his admission and thereafter as necessary," should oversee segregation to prevent infection, should determine the fitness of prisoners for work, and should note "physical or mental defects that might hamper rehabilitation" (art. 24). Medical examinations at the time of admission can provide something of a check on mistreatment of detainees in police lock-ups or during arrest.
- The prison medical officer should see prisoners who are ill or complain of illness "daily" and should report to the prison director any cases where a prisoner's health is "injuriously affected by continued imprisonment or by any condition of imprisonment" (art. 25). The medical officer will also regularly inspect and advise the director on food, sanitation, lighting, heating, cleanliness, etc. (art. 26).

The Standard Minimum Rules are also explicit on the subject of "untried prisoners," emphasizing that they are to be kept separate from convicted prisoners (art. 85(1)), and noting they should be in single occupancy rooms (art. 86) and allowed to wear their own clothing or prison-supplied clothing different from that of convicted prisoners (art. 88). Untried prisoners should be offered the opportunity to work, but not required to work (art. 89). They have the right to all services, including medical care, accorded to all prisoners and should be allowed to be visited by their own doctor or dentist if there is "reasonable ground" for such a visit (art. 91).

The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988), another UN agreement, emphasizes that a medical examination should be offered to detainees as soon as possible after detention and that detainees have the right to request a second medical opinion (art. 24, 25).

Detention of juveniles is of particular concern in human rights law. The Convention on the Rights of the Child (CRC) (1989), the most widely ratified human rights

treaty, emphasizes two key principles: (1) that "the arrest, detention of imprisonment of a child…shall be used only as a measure of last resort and for the shortest appropriate period of time" (art. 37(b)) and (2) that "children in detention must be separated from adults" (art. 37(c)). In a "general comment," the UN committee overseeing compliance with the CRC asserted that pretrial detention for juveniles in particular must be "strictly limited" and used only as a last resort (Committee on the Rights of the Child 2007). Both the CRC (art. 40(3)) and the general comment (para 27) enjoin governments to find alternatives to "judicial proceedings" for children, without violating children's right to due process.

Several international declarations address the role of physicians and other health professionals in prison. A resolution approved by UN member states emphasizes that the participation of physicians and other health professionals in any form of torture or cruel, inhuman, or degrading treatment, or in certifying prisoners as fit for any torture or inhuman treatment, is a gross violation of medical ethics (Principles of Medical Ethics 1982). That resolution includes the strong human rights statement that public emergencies of any kind do not justify contravening this principle. Other international declarations by professional societies have underscored these ideas (World Medical Association 1975).

The Standard Minimum Rules, while an important human rights document, is not a treaty and does not have a UN committee established to oversee it. The UN Human Rights Committee, which oversees compliance with the International Covenant on Civil and Political Rights, and the UN Committee Against Torture, which oversees the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (1984), both review country reports and make statements on matters related to conditions of detention. The two committees also hear individual cases that are for the most part appeals from persons who assert that they have exhausted domestic judicial mechanisms and still seek justice (ICCPR Optional Protocol 1966, articles 1–2; Convention Against Torture, art. 22). In hearing these individual cases, the Human Rights Committee often relies on the Standard Minimum Rules and thus gives them additional authority, to the point where "some of their specific rules may reflect legal obligations" (Rodley and Pollard 2009, p. 383). The impact of the committee's work in this area is, however, limited because relatively few countries allow individual petitions.

The Subcommittee on Prevention of Torture (of the Committee against Torture) undertakes country visits to prisons and other sites of detention (Optional Protocol to the Convention against Torture 2002, articles 4, 11). State parties to the Optional Protocol to the Convention against Torture are also obliged to established independent "national prevention mechanisms" that should investigate conditions of detention domestically and make recommendations to improve protections against abuses, including legislative change (Ibid., articles 17–23).

Countries are also visited by UN special rapporteurs, individual experts appointed by the UN Human Rights Council, whose country visit reports become part of the record of the council's sessions. The mandate of the Special Rapporteur on Torture includes conditions of detention. The mandates of the Special Rapporteurs on the Right to Health and on Violence Against Women also allow for investigation of health conditions and protection against violence in prison and pretrial detention. The Commission on Human Rights, the predecessor of the Human Rights Council, set up a special Working Group on Arbitrary Detention in 1991, in response to increasing reports on abuses in state detention (UN High Commission on Human Rights 2009). The Working Group hears individual cases, conducts country visits, and issues reports and statements, frequently commenting on pretrial detention. A number of reports from these bodies and experts are referred to below.

There have been some regional norms and actions pertinent to health in pretrial detention. Noting the deplorable conditions in African prisons, the African Commission on Human and Peoples' Rights created the position of Special Rapporteur of Prisons and Conditions of Detention in 1996 (African Commission 1997). As of 2005, the Special Rapporteur had visited 13 countries of the African Union, three of them twice (Viljoen 2005). The Kampala Declaration on Prison Conditions in Africa (1996), endorsed by 40 African countries, urged all countries in the region to "ensure that prisoners are kept in remand detention for the shortest possible period" and to establish a regular review of remand periods. It also noted that in "many countries" in Africa, "the level of overcrowding in prisons is inhuman...there is a lack of hygiene, insufficient or poor food, [and] difficult access to medical care."

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) is an experienced regional oversight mechanism. It was established by the European Convention in 1987. The CPT is made up of independent experts from each Council of Europe state that is party to the convention, and has medical doctors among its members (European Committee 2009). Under the convention, the CPT has unlimited access to detention facilities; its mandate includes prisons, juvenile detention centers, psychiatric hospitals, police holding centers, and immigration detention centers. As of August 2009, it had made 272 country visits and issued over 200 reports (Ibid.). In the course of its extensive work, the CPT established standards for implementing human rights-based policies in prisons that go beyond most human rights norms in operational detail and monitoring benchmarks (European Committee 2006). The CPT standards are also increasingly reflected in the activities of other institutions of the Council of Europe. The 2006 European Prison Rules, which are the modern European equivalent of the United Nations Standard Minimum Rules for the Treatment of Prisoners, contain an entire chapter on health issues that were developed with the CPT standards in mind.

Significantly, the European Court of Human Rights has begun to rely on both the CPT standards and the European Prison Rules in interpreting the human rights of prisoners, lending additional legal weight to both instruments (van Zyl Smit and Snacken 2009). This is highly important because many detainees, from Eastern Europe in particular, approach the court for binding rulings on whether their inadequate medical treatment amounts to inhuman or degrading treatment or other infringements of their human rights guaranteed under the European Convention on Human Rights. The reported judgments also give graphic accounts of the poor medical care that many detainees have to endure.

The European Court of Human Rights has been very responsive to the needs of detainees in this regard. In the leading case of *Kalashnikov v. Russia* (2002) the court found that holding detainees in severely overcrowded conditions could itself amount to inhuman and degrading treatment. Where it was combined with evidence of unsanitary conditions and inadequate medical treatment, such a finding would be made even if there was no evidence that the authorities intended to treat the detainee in an inhuman or degrading manner. Similar findings have subsequently been made in other cases originating in Russia and other Eastern European countries (van Zyl Smit and Snacken 2009).

More recently, the European Court has gone further. It has held that, where a detainee dies in prison, inadequate medical treatment may make the state liable to a finding that it has infringed the detainee's right to life (*Tarariyeva v. Russia* 2006). This also extends to cases where insufficient attention was paid the mental condition of a detainee who subsequently committed suicide (*Keenan v. United Kingdom* 2001; *Trubnikov v. Russia* 2005). In one recent case, where a detainee was diagnosed as HIV positive and developed AIDS and further complications while awaiting trial, the court found not only that his medical treatment had been inadequate to an extent that was inhuman and degrading, but that his continued detention in his weakened condition was not justified (*Aleksanyan v. Russia* 2008). It held that he posed no serious escape risk and, given the inadequate treatment that he had suffered in detention, ordered that he be released from pretrial detention so that he could be treated in an outside hospital. Such direct intervention is exceptional, even in Europe, and human rights tribunals in other regions can rarely act with such authority.

In 2005, the Inter-American Commission on Human Rights established a Special Rapporteur on the Rights of Persons Deprived of Liberty. The Special Rapporteur's first task was to develop and shepherd through the General Assembly of the Organization of American States a resolution on the rights of persons in detention, which was finally adopted in March 2008 (Inter-American Commission on Human Rights 2009). The resolution asserts a wide range of health rights of detained persons, underscoring the right to see a medical professional upon being taken into detention, the right to

informed consent and confidentiality of medical procedures, and the right to reproductive health care, among others. The Special Rapporteur made his first country visits in 2008, to juvenile, women, and men's detention centers in Chile, and to a psychiatric hospital in Paraguay.

# VI. Why Pretrial Detention Poses Particular Health Risks

Convicted prisoners and pretrial detainees face severe health challenges in most parts of the world. This section attempts to highlight health risks that may be more severe or prevalent in pretrial detention than in prisons. As noted in the methods section above, it is often difficult to separate the two, because in many countries the two groups are held together, and because most prison health literature does not make a distinction between persons in remand and convicted prisoners.

**Overcrowding:**

It is not a universal rule that overcrowding is more likely in remand than in prison, but in many countries this is the case (European Committee 2006: 21; Schönteich 2008: 18; Stern 2002: 9 ff.). This may be because the intake at pretrial detention facilities depends on events that are not subject to long-term planning, such as changes in police practices. To the degree overcrowding is a feature of pretrial detention, it has dire health consequences:

> An overcrowded prison entails cramped and unhygienic accommodation; a constant lack of privacy (even when performing such basic tasks as using a sanitary facility); reduced out-of-cell activities, due to demand outstripping the staff and facilities available; overburdened health-care services; increased tension and hence

more violence between prisoners and between prisoners and staff. This list is far from exhaustive (European Committee 2006: 21).

**Inadequacy of health services, health staffing, and health-related activities:**

As inadequate as health services may be for convicted prisoners, they are frequently even more lacking in remand facilities. The right of newly-detained persons to be seen by a health professional upon admission to state custody is, according to accounts cited below, widely disrespected. Many low-income countries do not seem to involve their ministries of health in prison health service delivery (Coninx et al. 2000), and even where they are involved, pretrial detention is unlikely to be a priority for improving care. The absence of qualified medical personnel to conduct intake screenings may contribute to the difficulties of detection and management of tuberculosis and sexually transmitted diseases, among other conditions (Reyes 2007). Again, as inadequate as they may be in prisons, peer education programs—which may be among the most effective health programs in prisons (Dolan et al. 2004; Devilly et al. 2005)—are unlikely to be developed or sustained in the high-turnover environment of pretrial detention. The CPT asserts that in parts of Europe, remand facilities are more likely than prisons to use devices to shut out natural light and prevent fresh air from reaching detainees (European Committee 2006: 25), with obvious ramifications for health.

**Access to longer-duration treatment and care:**

States are obliged to do everything they can to ensure early detection and management of infectious diseases and continuity of care for pretrial detainees who were being treated for chronic or acute conditions before their detention. Even when health services are present in remand facilities, there is often a reluctance to start treatment for infectious diseases that requires a sustained period of therapy, such as for tuberculosis (Reyes 2007), HIV or hepatitis C, or methadone maintenance. Whether pretrial detainees are found guilty and sentenced to prison or judged innocent and returned to the community, failure to treat them at the remand stage is a major missed opportunity. With respect to infectious diseases, addictions, or other conditions, authorities may be less concerned about ensuring continuity of care and support for people in temporary custody (even if "temporary" custody turns out to be of long duration), including continuing treatment initiated before arrest and detention.

**Vulnerability to torture and physical abuse by remand authorities:**

The CPT (2006: 9) emphasizes that "the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest." Pretrial detention facilities may be less subject to regular independent inspections and less open

to NGOs and family members than prisons in some countries. In addition, access to the legal counsel guaranteed to pretrial detainees by international law and national law in many places is often lacking. Access to lawyers, as least in some circumstances, would provide a means of averting or at least documenting physical abuse and intimidation.

**Likelihood of violence and sexual abuse:**

Because many remand facilities do not respect human rights norms on the separation of pretrial detainees from convicted prisoners, and in some cases do not secure the separation of women from men, physical violence and sexual assault may be more likely than in prisons (Tomasini-Joshi 2008). In addition, prisons are more likely to have formal or informal screening systems that enable corrections authorities to house persons most vulnerable to sexual assault, including gay men and transgender persons, separately from those most likely to perpetuate sexual violence (Stop Prisoner Rape 2007).

**Vulnerability of children in detention:**

The vast majority of children detained because they are in conflict with the law are accused of petty, non-violent offenses, including vagrancy and homelessness (Pinheiro 2006: 193). A United Nations report on violence against children found that children awaiting trial in these circumstances are often housed with adults and convicted offenders in violation of international human rights norms, sometimes for extended periods in Nigeria, Burundi, Pakistan, and the Philippines, for example (Ibid.: 191). This failure to observe human rights standards for children puts them at risk of egregious human rights violations with adverse physical and psychological health effects.

**Population less likely to be in medical care:**

It is both a challenge and an opportunity that pretrial detainees, particularly those not recently in the criminal justice system, may come from circumstances in which they have not had regular access to medical care or preventive health measures. The opportunity to detect and initiate care for the range of physical and mental disorders with the admission of a treatment-naïve population to remand facilities is important.

**Circumstances of detained women:**

To the degree that pretrial detention facilities are less likely than prisons to maintain rigorous separation of women from men—and of remanded women from convicted women—and less likely to have systems in place to protect detainees from violence, remanded women may be at high risk of abuse with profound health effects. The circumstances of women's detention may also put them at risk of health problems. In some countries, women can be imprisoned for attempting or realizing an illegal abor-

tion (Boland and Katzive 2008). In the case of these "reproductive crimes," pretrial detention is likely to be a period of dramatically heightened psychological and health needs, which would challenge the best of pretrial health systems (UNODC 2008). Women placed in "protective detention" if they have been or may be victims of "honor crimes" are likely to be living in deep fear and need special support (Nowak 2007a).

**Authorities overseeing pretrial detention:**

Pretrial detention facilities may be even less likely than prisons to benefit from the involvement of ministries of health in the design, implementation, or evaluation of health services. The right of detainees to the highest attainable standard of health services and goods argues for the involvement of the state's best health authorities in their care, and they are likely to be in health ministries. In some countries, some or all forms of pretrial detention may be under the authority of an internal security ministry or body, even if the rest of the prison system is under the minister of justice. UN Special Rapporteurs and the Working Group on Arbitrary Detention (see below) have also repeatedly found sweeping and arbitrary practices that undermine detainees' health and access to health services, as well as denial of access to lawyers and NGOs on the same grounds. The involvement of health ministries is unlikely to solve all these problems, but health officials should ideally be an independent voice for the health rights of detainees under all circumstances.

**Ineligibility of pretrial detainees for educational and other programs:**

Pretrial detainees often do not have access to exercise, educational, vocational, and other programs that may be available to convicted prisoners (Tomasini-Joshi 2008). These are services that can greatly enhance physical and mental health, and their absence undermines the effectiveness of whatever health services may exist for pretrial detainees.

There may also be elements of pretrial detention that offset some of the above health risks. Populations of pretrial detainees should, in principle, have lower concentrations of hardened criminals than in prisons, perhaps facilitating a less violent environment more conducive to delivering health services. The relative youth of pretrial populations might also be an opportunity for delivering health information and services. In theory, pretrial detainees often have better access than prisoners to family members and lawyers (Ibid.), though, as noted above, pretrial detention facilities may not have developed systems for enabling regular programs and services of NGOs, including legal NGOs. In some places, persons in pretrial detention may be better positioned to receive food and other assistance from family members, though this benefit is sometimes arbitrarily denied to detainees (Goyer and Gow 2002).

# VII. Findings of a Review of the Literature: Health Problems and Underlying Conditions

## A. Inhumane living conditions linked to overcrowding and lack of food, sanitation, and protection from the elements

Reports of human rights monitors and peer-reviewed literature document conditions of extreme overcrowding and deprivation in pretrial detention facilities. These conditions contribute to serious health problems, including rapid spread of infectious illness such as tuberculosis, cholera, and other diarrheal diseases linked to inadequate sanitation, poor nutrition and related conditions, and psychological disorders.

The inhumane conditions in pretrial detention can be horrific. In Zimbabwe in 2009, for example, detainees were reported to be dying at a rate that would be considered a humanitarian emergency in any circumstances, and at times "the dead took over whole cells and competed for space with the living" (Alexander 2009). People lived and slept in overcrowded cells, nose to nose with corpses until the dead were removed. In early 2009, a cholera outbreak in Harare Central Prison killed up to 18 prisoners per day

(Ibid.). More than half the detainees in Zimbabwe prisons were estimated to be HIV-positive; starvation, cholera (spurred by lack of sanitation), and tuberculosis contributed to the exceptionally high mortality. Alexander reports that most of the people caught in this horror "have sat in remand prison without access to the courts for months, in some cases years" (Ibid.). Others have recounted similar conditions in remand facilities (Sokwanele 2009). A Zimbabwean magistrate, John Masimba, said: "The failure by prison authorities to bring remand prisoners to court remains our biggest challenge," noting that the economic crisis in the country made it impossible to maintain the vehicles used to transport detainees to trial (Help Zimbabwe 2009).

Zimbabwe is not an isolated case. A 2010 report on detention conditions in Zambia recounted similar atrocities: high mortality and morbidity as a result of gross overcrowding, slow removal of corpses, inadequate space to allow everyone to sleep lying down, and horribly inadequate sanitation, food, and clothing (Human Rights Watch et al. 2010). Some 35 percent of people living in these inhumane conditions were pretrial detainees; many waited long periods for even an initial appearance before a judicial official (Ibid.: 7). In Haiti before the 2010 earthquake, it was estimated that over 80 percent of persons in state custody were pretrial detainees who, along with convicted prisoners, faced inhuman and degrading conditions of overcrowding, sleeping in shifts, and lack of access to sanitation and basic medical care in spite of widespread disease (Institute for Justice and Democracy 2009).

Some of the worst pretrial conditions have been documented in countries of the former Soviet bloc. The pretrial institutions, usually known as SIZOs (*sledstvenny isolator* or investigative isolator units), have been routinely judged by human rights monitors to be vastly worse than conditions faced by convicted prisoners in the same countries. Nigel Rodley, the former UN Special Rapporteur on Torture, described pretrial facilities in the Russian Federation in 1994 as places where there was "insufficient room for everyone to lie down, sit down or ever stand at the same time" and where detainees all suffered festering sores and boils.

> When the door to...a general cell is opened, one is hit by a blast of hot, dark, stinking (sweat, urine, faeces) gas that passes for air. These cells may have one filthy sink and a tap, from which water does not always emerge, near a ground-level toilet around which the inmates may drape some cloth for a minimum of privacy and to conceal the squalor of the installation. There is virtually no daylight from covered or barred windows, through which only a small amount of fresh air can penetrate (Rodley 1994).

Recent accounts suggest that while conditions in some Russian facilities may have improved, extreme overcrowding, poor sanitation and lighting, and inadequate

food prevail (Bobrik 2005). Human rights monitors who visited several former Soviet states, including Belarus and Moldova, have suggested that inhuman pretrial detention conditions are maintained at extreme levels specifically to force people to incriminate themselves and be sent to prison colonies where conditions are better (Working Group 2004; Nowak 2009). People in Russian SIZOs begged the Special Rapporteur to intervene with the authorities to convict them (Rodley 1994). In addition to the difference in physical conditions, people in prison colonies may be eligible to benefit from amnesties, conditional release, and a number of rehabilitation programs in which pretrial detainees are not included (Working Group 2004).

It is a practice in several Eastern and Central European countries that new arrivals to pretrial detention are "quarantined" until they can undergo a medical examination. In Moldova, Azerbaijan, and Russia, human rights monitors said the quarantine sites were extremely unsanitary and that the quarantine period could last for days (Rodley 1994; Nowak 2009; Rodley 2000a).

Extreme overcrowding in remand was reported in all the monitoring accounts from Central and Eastern Europe reviewed here. In this region, overcrowding is a principal determinant of the extensive tuberculosis epidemic in pretrial detention and prisons (WHO-Europe, undated). In Azerbaijan, the authorities said that overcrowding was both a cause of tuberculosis and also the main obstacle to being able to segregate active TB cases from the rest of the population (Rodley 2000a). Overcrowding also contributed to violence and disorder.

Overcrowding has been identified as a human rights abuse and a health risk in detention facilities in other regions. In South Africa, the Working Group on Arbitrary Detention judged conditions of overcrowding and disease to be much worse for pretrial detainees than convicted prisoners (Working Group 2005). Pretrial detainees who were later convicted did not get credit for time served in remand (Ibid.). In 2002, South Africa's Inspecting Judge of Prisons concluded that severe overcrowding among both prisoners and pretrial detainees in the country contributed to the spread of HIV by contributing to a "culture of sexual abuse and promiscuity" (Bateman 2003). At the time, 53,000 of South Africa's 181,000 inmates were in remand, of which over 15,000 were there due to inability to post bail. A Prison Reform International report concluded that overcrowding was directly related to sexual coercion and violence in prisons and remand facilities in Malawi (Jolofani and DeGabriele 1999: 8). In one police lock-up in Equatorial Guinea, monitors found 40 people, including pregnant women, children, and men together, stuffed into a dark and filthy room with no beds and not enough room to lie down. Some people showed signs of having been in leg irons (Working Group 2008b). In Kenya, pretrial detainees were given half the food ration of convicted persons, ostensibly because they did not work (Rodley 1999). In Angola, pretrial detainees, housed with convicted persons, showed signs of starvation and mental illness, with

three times as many people as beds (Working Group 2008a). In Paraguay, overcrowding reportedly led to violence among detainees (Nowak 2007c). In Ecuador, overcrowding in pretrial detention centers was used as a reason to keep people for longer periods in police lock-up, where they were more likely to be subjected to abuse and inhumane conditions (Working Group 2006).

Lack of access to adequate food and water is frequently reported by independent monitors and corroborated by accounts in public health literature on outbreaks of severe nutritional deficiencies. For example, an outbreak of beriberi (severe thiamine deficiency), a condition rarely seen outside of refugee situations, was documented among detainees in Côte d'Ivoire in 2002-03, resulting from inadequate food and exacerbated by cholera in the detention center (Ahoua et al. 2007). An earlier study in Nigeria found that after a few months in detention, pretrial detainees suffered from malnutrition almost as severe as that of sentenced prisoners (Olubodun et al. 1996). In Zambia, human rights monitors found that pretrial detainees were allowed to eat only after convicted prisoners were fed, leaving them with virtually nothing to eat (Human Rights Watch et al. 2010: 35). Penal Reform International reported that remandees and prisoners in Malawi, including children, often had to provide sexual favors to obtain food either from guards or from other detainees (Jolofani and DeGabriele 1999).

Though prison health literature tends to focus on the most lethal epidemics in prisons and remand, non-lethal problems such as scabies, lice, and skin rashes linked to poor sanitation and exposure to rats, roaches, and other vermin, have a very harmful effect on the quality of life of detainees (Ibid.). Insect infestation may be exacerbated by inadequate facilities to launder clothing and blankets. There is little research on the public health or psychological consequence of such afflictions, but they are frequently noted by independent monitors (M. Bochenek, Amnesty International, personal communication).

## B. Torture and physical abuse

The short- and long-term impact of torture on physical and mental health cannot be overstated. In addition to the cruel, inhumane, and degrading conditions described above, human rights monitors have noted torture and physical abuse of detainees in a number of countries, including in police lock-ups before transfer to pretrial institutions. Human rights monitors in countries including Georgia, Azerbaijan, Equatorial Guinea, South Africa, Ecuador, Mauritania, and Uzbekistan confirm the CPT's observation that the first hours of detention, especially in police custody, are those in which torture, beating, and other physical abuse are most likely to occur (Nowak 2006, 2008; Rodley 2000a; Working Group 2005, 2006, 2008b; van Boven 2003). In some cases, as in

South Africa, the monitors noted that improvements were being undertaken but that the complaints and inspection mechanisms established to deal with these abuses were horribly overextended or disempowered (Working Group 2005).

Amnesty International (2006, 2009) and other human rights groups (Human Rights Watch 2008) continue to highlight the torture and other abuses of persons in prolonged pretrial detention in the SIZOs of Russia, Ukraine, and other former Soviet countries. Amnesty International (2009) cites numerous reports of forced confessions through torture in the pretrial detention system of Russia. Monitors in Ukraine and Belarus were unable to secure permission to visit SIZOs or secret detention facilities where use of torture was suspected (Working Group 2009; Working Group 2004).

Monitors lamented the broad powers held by police and military police in some countries and the hidden quality of their actions. In Brazil, for example, the rich can buy their way out of mistreatment by the military police, leaving the poor to suffer abuse (Rodley 2000b). In virtually all countries cited here, monitors noted that national laws placed strict limits on the amount of time people could be held in police custody, but that these limits were routinely violated. In many cases, it was noted that prosecutors collude in allowing, or not preventing, arbitrary extensions of periods of police custody during which detainees are not afforded the opportunity to appear before a judge or other independent authority (Rodley 1994; Nowak 2006; Working Group 2008a, 2008b; van Boven 2003). Monitors often found no clear records of the number of people in police custody and the duration of their custody.

Human rights monitors have documented many instances of sexual violence tolerated or even abetted by detention authorities. In both Moldova and Russia, independent monitors concluded that prison officials placed sexual predators strategically within the SIZOs to help "keep order" in the facilities (Rodley 1994; Nowak 2009). In Ecuador, it was noted that the excessive duration of pretrial detention allowed for the formation of violent gangs that posed grave threats to most detainees (Working Group 2006).

Denial of health care or the use of health problems as a means of control is another form of torture seen in police custody and pretrial detention. For example, human rights organizations have documented instances of interrogation in police custody of people in withdrawal or otherwise suffering from drug dependency in Kazakhstan and Ukraine (Human Rights Watch 2003b, 2006c). These cases exemplify the practice of using the pain of withdrawal symptoms to coerce confessions. This cruel treatment of people living with drug dependency has been recognized as a form of torture by the UN Special Rapporteur on Torture, who has called for it to end (Nowak 2009). The denial of methadone therapy in pretrial detention or prison may also constitute inhuman punishment. In *McGlinchey v. UK* (2003), the European Court of Human Rights found that failure to provide adequate withdrawal treatment to a detainee amounted to

inhuman or degrading treatment, though the case did not involve use of withdrawal symptoms to coerce a confession. In addition, Vietnam, China, Cambodia, Malaysia, and Laos detain drug users for extended periods in "re-education" centers that are little better than forced labor camps, usually closed to independent monitors and lacking basic medical care (Wolfe and Saucier 2010; World Health Organization Western Pacific Regional Office 2009).

## C. Conditions for juvenile detainees

The most comprehensive recent account of human rights abuse faced by children in detention is found in the *World Report on Violence Against Children* (Pinheiro 2006). Accounts of human rights organizations and independent monitors in many countries also highlight many of the abuses recounted in the global report.

Many of the most shocking accounts of physical and sexual abuse of children stem from the failure of governments to house children separately from adults. Lack of segregation of children has been reported in places where monitors say there is officially no juvenile justice system separate from the adult system (including Belarus, Ukraine, Nigeria, Equatorial Guinea, Angola, Burundi, and Nepal; see Working Group 2004, 2008b, 2009; Nowak 2007b; Human Rights Watch 2007; 2008b). Lack of segregation of children has also been reported where separate juvenile systems exist in theory, but in practice children were found housed with adults in police lock-ups, pretrial facilities, and even maximum security prisons (as in South Africa and Papua New Guinea; see Working Group 2005; Human Rights Watch 2005b). In Angola, the Working Group on Arbitrary Detention (2008a) reported that children whose birth certificates were lost or never issued because of the extended civil war were housed in detention with adults, and faced sexual abuse in custody. Violence against children perpetuated by adult detainees with whom they are housed has been reported in many countries, including at least three in the Council of Europe (Pinheiro 2006: 199).

Housed with adults or not, children in detention may face torture and abuse, according to human rights monitors in numerous countries. In at least 78 countries, it is legal to beat children in criminal detention, and beatings are inevitably not limited to places where they are legal (Pinheiro 2006: 196). Some 31 countries allow corporal punishment to be part of sentences handed down to children (Ibid.: 198). In Moldova, the Special Rapporteur on torture found that corporal punishment and forced labor in juvenile facilities was applied liberally "to prepare minors for life in adult prisons" (Nowak 2009). In places ranging from Yemen to Brazil to Laos, as well as the US and the UK, children reported numerous incidents of sexual abuse by guards, beatings, having meals withheld, punching and kicking by guards, administration of electric shocks,

use of painful restraints, and being forced to stay in uncomfortable positions for hours (Pinheiro 2006: 197). Torture used in interrogating children in criminal detention has been reported in Pakistan and Papua New Guinea (Ibid.). Juvenile offenders in Malawi, many of them pretrial detainees, were forced to trade sex for food and protection; long-term prisoners sometimes took juvenile detainees as "wives" (Jolofani and DeGabriele 1999).

Children who are locked up with mothers in extended detention may be subjected to physical abuse and deprived of education, cognitive stimulation, play, and appropriate medical care, as noted by the Africa regional Special Rapporteur in Ethiopia (Chirwa 2004). The UN global report noted cases in Cambodia where adult detainees beat infants and young children when they cried (Pinhiero 2006: 194). In Zambia, children of detainees were not counted when detention authorities planned for food and other supplies, and they had to share the minimal rations of their mothers (Human Rights Watch 2010).

## D. HIV/AIDS

Governments have greater ability to exercise humane and effective control over HIV/AIDS among detained persons than perhaps among any other population. Nonetheless, in most countries, even high-income countries, HIV is much more prevalent among persons in state detention than in the population at large (Dolan et al. 2007). This disparity is the result of the disproportionate presence of people who inject drugs, as well as the widespread practice of unprotected sex, and the absence of comprehensive prevention and treatment. In 20 low- and middle-income countries, prevalence of HIV among prisoners is over 10 percent (Ibid.). Few jurisdictions report HIV prevalence of pretrial detainees separate from that of sentenced prisoners. Nonetheless, pretrial detention plays a crucial role in what Beyrer calls the "mixing bowl effect" of putting HIV-positive and HIV-negative people together where sex and drug use are prevalent, and where condoms and sterile injection equipment are rarely to be found (Wolfe 2004).

Thanks to the work of some dedicated researchers, there is considerable published literature on the extent and consequences of HIV in prisons, the effectiveness of measures to prevent HIV transmission in prisons, and care of detainees and prisoners living with it (see esp. Jürgens 2007; Jürgens et al. 2009; Dolan et al. 2007). It is striking that little of this work distinguishes between pretrial detainees and convicted prisoners, mostly because national data do not make this distinction. The current review similarly found few studies that distinguish prison from remand with respect to HIV.

Whether HIV transmission is linked to injection equipment or sex, treatment for HIV is clearly a challenge in pretrial detention because of the brevity or uncertainty

of the duration of detention. In some places, treatment for HIV is unavailable in the community at large. Even where treatment is available in the community, HIV treatment and care for prisoners are provided by few low- and middle-income countries (Jürgens 2007); for pretrial detainees, governments may be even less motivated. Improving links between health services in pretrial detention facilities and both prison-based and community-based services is essential for many reasons, but not least for initiating and sustaining antiretroviral therapy (ART). Muntingh and Tapscott (2009: 312) note that the 2007 "framework" of the South African Department of Correctional Services for management of comprehensive HIV services explicitly excludes unconvicted prisoners (estimated to comprise about one-third of people in custody)—a serious omission in the world's most AIDS-affected country. A chilling account by a former prisoner in Russia who died in 2009 alleged that antiretroviral therapy he was able to begin through a Global Fund-supported treatment program was denied him during several years of incarceration, including in a SIZO and a TB prison (Protelarsky 2009).

Initiating treatment is impossible without HIV testing. UN agencies urge states to ensure that prisoners have access to voluntary, confidential HIV testing with counseling, and never be subjected to mandatory testing (UNODC 2006; UNODC and WHO 2009). In his extensive review of available literature, Jürgens (2007) noted that most countries that tried to institute mandatory HIV testing of prisoners have abandoned the practice. The Russian Federation is an exception as well as some countries in Asia. Jürgens cites correspondence indicating that in some places in Russia, detainees may be tested in the pretrial system and when entering a prison colony (Ibid.: 68). There is no evidence that mandatory HIV testing or the policy of segregating HIV-positive prisoners or detainees has any public health benefit (Ibid.). Persons newly remanded to pretrial custody have the right to be seen early in their detention by a medical professional; it would be possible to offer an HIV test at this time. Even in places where there is a policy to make voluntary testing available, as in South Africa, shortages of health staff often make it effectively beyond reach (Goyer and Gow 2002).

## D.1. HIV and hepatitis C linked to injection drug use

Pretrial detention, including time in police lock-ups, is an especially vulnerable time for persons living with drug dependency. As noted in section B above, police can manipulate drug users experiencing painful withdrawal into coerced confessions. People who inject drugs and have no access to sterile injecting equipment in remand will be likely, out of desperation, to inject with whatever sharp items are available, running a high risk of HIV, hepatitis C, and infections and abscesses.

The excellent review by Dolan and colleagues (2007) found data on HIV prevalence in prison in 75 low- and middle-income countries, noting HIV prevalence greater

than 10 percent in at least 20 countries. The authors sought to link rates of drug-related incarceration to prevalence of HIV in prison but ran into a paucity of available data on both the proportion of prisoners who injected drugs in prison and the prevalence of HIV among them (Ibid.: 36). The review does not distinguish prison from pretrial settings. Only nine countries reported the percentage of prisoners who injected drugs. The lack of data on this question is undoubtedly linked to zero-tolerance policies with respect to drug use in prison, and official denial on the subject.

Jürgens (2007: 21–25) reviews studies that quantified drug injection in prison, without information about whether pretrial detainees were included, demonstrating that prisoners initiate drug injection while in custody. It would be useful to know the degree to which adoption of this behavior occurs in remand settings. There have been several notable outbreaks of HIV among people who injected drugs in prison, notably in Lithuania in 2002 when 299 persons were infected in about three months, and in Russia, Indonesia, Iran, Scotland, and Australia (Ibid.: 43–44). Transmission of the hepatitis C virus (HCV) has also been demonstrated in prisons in several countries, linked to both drug injection and tattooing (Ibid.: 47–48).

In several studies, including Thailand and Greece, risk of HIV transmission linked to drug use was shown to be associated with having previously been in prison or being in prison as opposed to remand (cited by Jürgens, Ibid.). Other studies have highlighted the risk of prison with respect to HIV and HCV transmission. Studies among male prisoners in Iran, Thailand, and Brazil (Zamani et al. 2006; Suntharasamai 2009; Burratini 2000) and women prisoners in Brazil (Strazza et al. 2007) found that being HIV-positive was associated with longer time served in prison, higher number of previous arrests (which may be a proxy for longer duration of detention), and a higher number of previous prison terms served. With respect to HCV, similar results were found in Iran (Mohtasham Amiri et al. 2007; Alizadeh 2005), Brazil (Oliveira 2006), and Ghana (Adjei 2007), where HCV positivity was associated consistently with duration of incarceration. According to a 2009 study from Iran, one of the few specifically focused on persons in police detention (Jahani et al. 2009), opium smoking was common among new detainees but, as they mixed with injectors, many quickly switched to injection once in detention because smoking was hard to hide. The authors note that sterile syringe programs, which are available in some Iranian prisons along with HIV education and testing programs, are still controversial in pretrial settings but would have their greatest impact there (Ibid.).

In 2006, UNODC, UNAIDS, and WHO urged countries to make available in prisons all measures available in the community at large to prevent transmission of HIV through contaminated injection, tattooing equipment, and sharing of razors—namely, provision of sterile needles and syringes, razor blades, and sterile tattooing equipment (UNODC 2006: para 60). They also enjoined countries to ensure prisoners' access to

the same measures for treatment of drug dependency available to those outside prison, including "no-cost access to methadone maintenance and other substitution treatments for opioid-dependent prisoners" and other "pharmacologically supported" drug treatment (Ibid.: para 77).

Unfortunately, the implementation of these measures in low- and middle-income countries—in prison and in remand—remains rare even though their implementation in a wide range of settings indicates that they would be effective for pretrial detainees. As of 2007, 12 countries had syringe exchange programs or planned pilot programs in prison (Jürgens 2007: 84–85), most of them in Western Europe, but including the Kyrgyz Republic, Iran, Moldova, and Belarus. In Switzerland and Germany, prison wardens and other staff who opposed these programs at first have become ardent supporters, seeing that the reduction in exposure to contaminated syringes protects them, and prisoners, from harm (Lines et al. 2006). South Africa sought to avoid the HIV and HCV risk of sharing shaving equipment by providing prisoners with razors in a reliable and controlled way, but researchers (Muntingh and Tapscott 2009: 208) could not determine whether pretrial detainees could benefit from this service.

Opiate maintenance therapy with methadone or buprenorphine is a central element of HIV and hepatitis prevention in countries with significant levels of opiate injection. As of 2008, some 29 countries or sub-national jurisdictions offered methadone therapy in prison, while another 37 countries had methadone programs in the community but not in prison (Larney and Dolan 2009). Methadone maintenance therapy has been shown to be feasible without security problems in a wide range of detention settings (Jürgens 2007). Discontinuation of methadone because of detention is a serious public health concern; it may lead to unsafe injection and high risk of overdose. An estimated 80 patients in Ukraine had their methadone treatment interrupted as a result of police arrest and detention in a year-and-a-half period (Opiate Substitution Treatment Patients Network, 2009). Denial of methadone therapy for a prisoner in the UK who died from illness related to heroin dependency was judged in 2003 by the European Court of Human Rights to constitute "inhuman and degrading treatment" (*McGlinchey and Others v. United Kingdom)*. Beyond methadone, access to humane and scientifically sound treatment for drug dependency is not possible in most countries.

The HIV and HCV transmission risk of tattooing has been little studied, though tattooing is widely practiced in prison settings around the world. A rare study from Lesotho found that in a prison in which two thirds of prisoners had been tattooed while incarcerated, less than 20 percent said the needles used were sterilized (Akeke et al. 2007). Jürgens (2007) reviews numerous studies reporting the use of bleach as a decontaminant for shared injecting, tattooing, and shaving equipment in prison. While providing bleach and instructions for its use is an intervention that should be feasible in pretrial detention and prisoners have been shown to use it when available,

Jürgens asserts that conditions of incarceration work against the use of bleach, which is only partially effective for preventing disease transmission from shared equipment (Ibid.: 82–83).

It should be noted that where it has been measured, HCV prevalence is also much higher in prison than in the general community. Treatment is rarely available in low- and middle-income countries, even in the population at large (WHO 2009; Wilson et al. 2007). WHO recommends HCV "risk reduction counseling for persons with high-risk drug and sexual practices" (WHO 2009), which presumably includes pretrial detainees.

Educational programs are the most prevalent HIV prevention measure in prisons, including where drug use is a major determinant of HIV. They can be especially effective if detainees are involved in their implementation (Dolan et al. 2007). An evaluation of an HIV education program in a prison colony in Siberia underscored that officials should not expect a major HIV prevention impact from education programs alone when prisoners who inject drugs do not have access to clean syringes or humane and effective treatment for drug dependency (Dolan et al. 2004). Education programs are less likely to be present in pretrial detention than in prison, even though they should be feasible in a wide range of settings.

Overall, the opportunity to learn from successes in reducing HIV transmission and other drug-related harms in other settings and replicate them in pretrial detention is being lost.

## D.2. Sexual transmission of HIV and other infections

The denial that plagues rational policymaking around injection-linked HIV transmission in prison is also highly prevalent with respect to sexual transmission (Jürgens 2007: 27). In spite of this denial and the sensitivity of studying sexual practices in any setting, a number of studies from around the world have documented both consensual and coerced sexual activity in prison (reviewed in Ibid.: 31–36). Of the 18 studies reviewed from Africa, Asia, and Central and Eastern Europe, most present strong evidence of sexual activity in prison in circumstances other than conjugal visits. The studies do not indicate whether pretrial detainees were included. In both remand and prison, Jürgens notes among the factors that affect the nature and frequency of sexual activity are overcrowding, whether accommodation is in single cells or dormitories, whether children are housed with adults, the nature of staff supervision, and whether prison authorities are responsive to complaints of sexual violence (Ibid.: 37).

In all custodial settings, overcrowding is linked to high risk of sexual violence and coercion, obvious risk factors for HIV (UNODC et al. 2007). To the degree that overcrowding is worse in pretrial detention or worsened in the corrections system overall, reducing overcrowding and pretrial detention should be central to HIV preven-

tion efforts of corrections authorities. The independent monitors cited in this report observed that remand facilities are less likely to have single-cell accommodations than prisons, a cause of concern in managing protection against sexual violence. In addition, remand facilities are more likely to be lacking established systems for separating those most vulnerable to sexual assault from potential predators (Stop Prisoner Rape 2007). Human rights monitors have noted numerous violations of the right of children to be detained separately from adults, and the sexual violence that ensues.

In Eastern and Southern Africa, the regions most affected by HIV in the general population, prisoners face very high risk of sexual transmission because of this high HIV prevalence. South Africa, the only country in the region that provides condoms in prison, distributed over 1.2 million condoms in the correctional system in 2007-08 (Muntingh and Tapscott 2009). Lubricants were not provided, and prisoners have complained that the condoms were not durable enough for anal sex without lubricants (Goyer and Gow 2002: 309). In other high-prevalence countries, including Zambia, Malawi, and Namibia, legal prohibitions against homosexuality impede the provision of condoms; policymakers see condoms as encouraging same-sex intercourse, which is an illegal activity (Simooya et al. 2000; Herget 2006; Zachariah et al. 2002). In 2005, the Judicial Inspectorate of Prisons in South Africa issued a report recommending that the corrections authorities regard consensual sex between inmates as a permitted activity, noting that denial of consensual sex is inconsistent with principles of human dignity (Cruess 2005). The Corrections Department disagreed, asserting that prisoners do not have a right to sexual intercourse.

An evaluation of a condom program in a Thai remand facility and prison noted that even if condoms are available, detainees may fear asking guards for them, or fear giving the impression to their peers that they are HIV-positive or have a sexually transmitted illness (Wilson et al. 2008). UN agencies recommend that condoms be available to detainees confidentially and without discrimination (UNODC et al. 2006).

While HIV has captured much of the attention and literature regarding sexually transmitted infections (STIs) in prisons, pretrial detention can be an opportunity to address all STIs. A study in Malawi, where condoms in prison are forbidden, found 4.2 percent of 4,229 prisoners and detainees living in overcrowded and unsanitary conditions had STIs (other than HIV), 28 percent of which were estimated to have been acquired in prison (Zachariah 2002).

Education programs, including information about HIV testing and how HIV and other STIs are transmitted, are the most common means of addressing sexual transmission in prisons. Many reports suggest that peer educators are central to the success of HIV education programs (Goyer and Gow 2002). In South Africa, one evaluation found that HIV-negative peer educators were more effective because of lingering stigma and discomfort among prisoners and detainees with HIV-positive educators (Sifunda

et al. 2008). This particular program assumed that peer educators would be able to participate for two years (Ibid.), making it unlikely for ready use in remand. However, the delivery of education and information services in a wide range of prison settings suggests that these interventions should be possible in remand facilities as well, even if networks of peer educators are not well established.

## E. Tuberculosis

Overcrowding, poor ventilation, and poor sanitation help spread tuberculosis, which is as a major problem in prisons and pretrial detention centers worldwide in both its traditional and more lethal drug-resistant forms (Reyes 2007; Dara et al. 2009). Pretrial detention may incarcerate people long enough for them to contract TB, but not long enough to ensure the disease is detected and treated (WHO-Europe 2007). Though the text that follows focuses on medical interventions to manage TB in remand and prison, addressing TB must include reducing pretrial detention as the most effective means of limiting transmission. A study based on longitudinal TB data from 26 countries in Eastern Europe and Central Asia concluded that the most important determinant of differences in TB rates in these countries was the rate of growth of prison populations (Stuckler et al. 2008).

Management of tuberculosis is difficult in any overcrowded and closed setting, but may be particularly so in pretrial detention. The turnover of detainees, movements within remand institutions, and movements of detainees to other institutions within the criminal justice system are particular challenges to systematic prevention, diagnosis, and treatment. In addition, inadequate medical staff in pretrial facilities makes screening new entrants for TB especially challenging (WHO-Europe 2007). The emergence of multi-drug-resistant (MDR) TB in prisons has raised concerns in many parts of the world about the role of incarceration in the perpetuation of TB epidemics. WHO emphasizes that in all regions, TB and MDR-TB prevalence are higher in prison than in the general population, but in some regions—notably the former Soviet Union, East Asia, and sub-Saharan Africa—MDR-TB prevalence in prisons is at epidemic levels (WHO 2008).

Many studies of tuberculosis in prison do not distinguish remand from prison. The tuberculosis situation in Russian SIZO facilities has, however, been studied explicitly. A study that followed tuberculosis trends in two remand centers in Saint Petersburg for three years raised an alarm about pretrial detention as a locus of high transmission risk (Lobecheva et al. 2005). Of 876 cases detected among detainees during this time, half were estimated to have been contracted in the SIZO (Ibid.: 94). Another study of TB in SIZOs in Siberia concluded that the highest risk of transmission was in the

early days of SIZO confinement (Slavuckij 2002). The authors in both cases signaled the opportunity that Russian health authorities have to prevent, detect, and treat large numbers of tuberculosis cases at SIZOs. Others note that considerable progress has been made in reduction of TB-related mortality in Russian prison colonies since 2000, even as challenges in the SIZO system remain (Bobrik et al. 2005). A recent account from a former TB colony inmate alleges gross mismanagement of TB and HIV among TB colony prisoners (Proletarsky 2009).

Care must be taken that beginning treatment for TB in pretrial detention not lead to interrupted treatment in prison or community-based care. Interruption of TB therapy in prison and remand, perhaps the rule rather than the exception, may contribute to the emergence of multi-drug-resistant TB (Reyes 2007). In the Russian case, efforts to ensure uninterrupted treatment while in SIZO were undermined by frequent movement of detainees to other SIZOs or jails at various stages in the investigation of their alleged crimes (Slavuckij 2002). It was later mandated that persons identified as having TB on admission to the SIZO could not be transferred to any other institution in the first two months of detention to facilitate uninterrupted treatment (Ibid.), though two months is insufficient for treatment of drug-resistant TB (WHO-Europe 2007). The impact of this rule on the ability of detainees to follow their legal cases is unknown. A successful intervention by one NGO to improve directly observed, short course therapy (DOTS) and prevent drug-resistant TB in a Russian prison was possible because of the relative stability of the prison population, compared to a high-turnover SIZO population (Farmer 2004). Persons screened as positive for TB in Russia are also ineligible for early release or amnesty if they are not finished with their treatment (Drobniewski et al. 2005). The authors recommend that DOTS, the standard TB treatment, be instituted in all institutions where pretrial detainees might be sent. This is a problem for the IVS (*izolyator vremennogo soderzhaniya*, or temporary containment cell) or short-term police detention centers to which detainees may return for processing, because those institutions generally do not have medical staff (Ibid.).

The correctional system of the Russian Federation includes one prison colony specifically for persons with TB (Bobrik et al. 2005). WHO-Europe (2007: 16) suggests that one perverse effect of having special TB facilities is that some pretrial detainees and convicted prisoners seek to be infected with TB (or to obtain TB-positive sputum) just to be assigned to the special facility, because it is perceived that food and other living conditions are much better than in the SIZO or other prisons.

Pretrial detention facilities are crucial actors in the detection of TB, as the Russian example illustrates. Too few countries have invested in TB screening and detention for new entrants to correctional institutions (Reyes 2007). Malawi is one of very few African countries to screen for TB when people are admitted to prison, and to ensure transmission of screening results to national health authorities (Harries et al. 2004).

A research intervention in Rio de Janeiro undertook TB screening by chest X-ray of all men admitted to the prison or remand system during a seven month period (Sanchez et al. 2009). The authors concluded that the three percent prevalence of active TB they detected at admission was in part because many of the men examined had been held in police custody for up to several months with virtually no medical care and severe overcrowding (Ibid.: 1250). Prevalence of TB was also associated with past incarceration. The authors urged the Brazilian authorities to institute a permanent system of TB diagnosis of all detainees, noting that the ideal method for this would be a centralized admission unit, though mobile X-ray units might also be used (Ibid.: 1251).

A number of studies have tracked the administration of DOTS protocols in Thai prisons, where there is active involvement by the Ministry of Health. Although DOTS was instituted in prisons and not remand facilities, turnover of prisoners was a challenge in the work (Nateniyom et al. 2004; Pleumpenupat 2003). Links were made with community-based programs, but in some cases prisoners left false or incomplete contact information and were lost to follow-up. A high prevalence of HIV co-infection also made the work challenging. An effort to bring DOTS to prisons in Azerbaijan also cited premature release or unplanned transfer of prisoners as factors in the program's modest cure rate, a point pertinent to the remand environment (Coninx et al. 1999).

Data on co-infection with HIV and TB in prison is lacking in many countries, including the highly HIV-affected countries of East and Southern Africa (Habeenzu et al. 2007). The combination of MDR-TB and HIV in prison has been rapidly fatal in a number of countries, including among women prisoners (e.g., Bobrik et al. 2005). HIV is obviously a major risk factor for TB, but ART is still rare in prisons in many of the countries most affected by co-infection (Reyes 2007).

Experts have bemoaned the lack of specialized care and good screening for TB and MDR-TB due to the non-involvement of health ministries in prison health care in many countries (Coninx et al. 2000; WHO-Europe 2007). Interior ministries do not always report TB cases to health authorities, making it difficult to know the importance of prison-based TB transmission to national and regional epidemics. Trained health professionals are also needed to recognize TB symptoms and develop treatment services that will gain the trust of detainees and discourage the self-medication that contributes to development of drug resistance (Reyes 2007).

## F. Sexual violence

Pretrial detention has been shown to be a period of extremely high risk of sexual abuse and violence for women (UNODC 2008: 74). This risk is obviously even higher if

women detainees are housed with convicted offenders and men. The UN Special Rapporteur on Violence Against Women underscored this concern following a visit to Haiti where women were detained in facilities with men and guarded by male officers (Coomaraswamy 2000). In Haiti, 90 percent of female detainees were awaiting trial or in "preventive detention." Sexual violence, heinous in itself, also exacerbates mental disorders and increases the risk of HIV and other sexually transmitted diseases.

International and regional human rights guidelines mandating that incarcerated women should never be supervised by male staff are widely violated. Amnesty International and other human rights organizations continue to document cases of free access by male guards to women detainees, including in the United States (Amnesty International 2007). The Kyev Declaration on Women's Health in Prison notes that not only should men never supervise women prisoners or detainees, they should also not have any routine contact with them or access to their living or bathroom areas (WHO-Europe and UNODC 2009).

As noted later in this chapter, gay and bisexual men, transgender persons, and transgender sex workers are at especially high risk of sexual violence and physical abuse in detention and may be at high risk of arrest, depending on whether sex work, homosexuality, and transgenderism are criminalized in a given country.

## G. Health of women detainees

Around the globe, an estimated 500,000 women are incarcerated at any given moment; the largest numbers are in the U.S., Russia, and Thailand (Penal Reform International 2008). In most of the world, women in pretrial detention are more likely than men to face violations of international standards for unconvicted detainees because special facilities for remanded women are lacking (UNODC 2008: 73). Women in pretrial detention are likely to be held with convicted prisoners in high-security facilities, and, in the worst cases, to be held with men. Being held in more restrictive custody than necessary may limit women's access to legal counsel—a crucial right for pretrial detainees—as well as contact with family members (Ibid.: 74). The UN Special Rapporteur on Violence Against Women found this exact situation at the Santa Teresa remand center in Guatemala, where women awaiting trial were kept "under maximum security conditions" that restricted their access to visitors as well as education and exercise (Ertürk 2005: para 41). In many countries, the number of women held in some form of pretrial detention is as great as or greater than the number held as convicted prisoners (WHO-Europe and UNODC 2009).

It is often repeated in the literature that women are disadvantaged with respect to health services in prisons because they constitute a small minority of most prison popu-

lations, and investments are not made to ensure adequate and specialized services for them. This is true with respect to both pretrial detention and the wider prison system. Women are being incarcerated at a rapidly increasing rate in some countries, thanks partly to the criminalization of women's often minor roles in drug crimes (WHO-Europe and UNODC 2009; Penal Reform International 2008). Women entering the corrections system are more likely than men to be living in poverty; to be living with drug or alcohol dependency; to suffer from depression, post-traumatic stress disorder, and other mental illness; to have a history of physical and sexual abuse; and to be at risk of self-harm and suicide (van den Bergh et al. 2009). Under the best of circumstances, women's health needs are rarely met in prisons, and pretrial detention is often the worst of circumstances.

The high prevalence of mental illness and drug dependency among women entering pretrial detention or prison has been studied in countries of the North, but there is little information from developing and transitional countries. In the United Kingdom, for instance, almost half of all women in remand facilities have attempted suicide in their lifetime (compared to about 27 percent of men), and women are 14 times more likely than men to engage in cutting or other self-harm in prison (Møller et al. 2007). About 40 percent of incarcerated British women—twice the percentage among men—have been treated for a mental illness in the previous month, and 90 percent of incarcerated women have a mental disorder, a substance use problem, or both (Ibid.). Women living with mental illness are at especially high risk of sexual abuse and violence in prison (Lines 2006). For this and many other reasons, it is important to have similar data for countries of the South, but they are generally not available

HIV rates among incarcerated women are significantly higher than among incarcerated men in several countries including India, Moldova, and Brazil (Jürgens 2007: 17–18). The same is true in studies from Canada and the U.S. (Ibid.: 19; Maruschak and Beavers 2010). Studies from Southern countries do not distinguish pretrial detainees from prisoners, and likely include both. Little is known about the risk of HIV transmission among women in prison (Dolan et al. 2007; Jürgens 2007). One notable study found that women in pretrial detention in Moscow, 79 percent of whom were sex workers, had higher HIV prevalence than juvenile detainees and homeless women tested at the same time (Shakarishvili et al. 2005). Other sexually transmitted infections were also highly prevalent among these women. The authors argued for systematic screening for STDs among women in remand. Another study estimated that between one third and one half of women entering prison in Russia from 2000 to 2002 had sexually transmitted diseases (UNODC 2008: 11).

One study from Brazil took a rare look at a range of sexually transmitted diseases among incarcerated women, concluding that women in a state prison faced high risk of syphilis, gonorrhea, chlamydia, human papillomavirus (HPV), trichomoniasis, and

bacterial vaginosis, in addition to HIV (Miranda et al. 2000). Few studies have been done on women and tuberculosis in prison in Southern countries. In an observation pertinent to pretrial detention, an older study from Brazil concluded that the early weeks of incarceration were the riskiest for women with respect to tuberculosis transmission (Ferreira et al. 1996).

Studies from Northern countries underscore that women who use illicit drugs, whether incarcerated or not, need services, treatment, and support that is different from those designed for men (Peugh and Belenko 1999). There is relatively little literature, even in the North, on drug use among women in prison and interventions to address drug-related harm. Pregnant women who use opioid drugs should have priority in access to methadone programs, but even in Northern institutions often do not (WHO-Europe and UNODC 2009: 25). The Kyev Declaration urges attention to the "acute risk of drug-related death among women prisoners in the first weeks after their release" (Ibid: 4). It is unlikely that the further problems of unsafe tattooing, cutting, and self-injury with contaminated sharp objects are adequately addressed for women in detention.

There have also been few studies on reproductive health services for women in pretrial detention in Southern countries. Penal Reform International (2008: 7) asserts that prison authorities across the world fail to manage women's needs linked to menstruation, including failing to provide sanitary pads, or the local equivalent, and sometimes even withholding them as a form of punishment. An estimated 87 percent of incarcerated women in Brazil, and 80 percent in Russia, are mothers (UNODC 2008). It is difficult to find information on access to gynecological care in remand facilities in Southern countries or on access to condoms and dental dams. Meeting the special nutritional and other needs of pregnancy should be well established practice for any corrections facility that houses women, yet there is little information to suggest that this is the case.

The norm from the Standard Minimum Rules that incarcerated women should be able to give birth in a hospital rather than in prison is pertinent to pretrial detention. Transportation of pregnant women to hospitals has included such practices as shackling, including across the abdomen, and shackling during labor, which some women's groups have characterized as cruel, inhuman, and degrading treatment (Clark 2009). Supporting incarcerated women who breastfeed and need assistance for infant care should also be a priority. As noted above, children incarcerated with their mothers in pretrial detention facilities or prisons often face a lack of appropriate stimulation and education, if not outright abuse.

In a visit to India, Bangladesh, and Nepal, the UN Special Rapporteur on Violence Against Women raised a concern about detention of women identified as victims of trafficking (Coomaraswamy 2001). These "rescued" women, regarded as minors under

the law, were put in "protective custody" in which they could languish for years in circumstances little different from prison (Ibid.: para 27). She called on these countries to reform this practice.

## H. Conditions for gay, lesbian, bisexual, and transgender detainees

There is little peer-reviewed literature on the detention-related health problems of gay, lesbian, bisexual, and transgender detainees in developing and transitional countries, but many reports from human rights monitors and NGOs raise concerns about the vulnerability of gay and transgender persons to violence and other abuse. An estimated 72 countries allow persons to be imprisoned for the "crime" of homosexuality, of which at least 11 mandate imprisonment of over ten years, and five allow the imposition of the death penalty (ILGA 2009). Even short of imprisonment, as Amnesty International notes (2001: 10), criminalization of homosexuality is "a license to torture" and affords police greater latitude to abuse LGBT persons during arrest and in detention.

There is some peer-reviewed research on sexual assault of gay men in state custody in South Africa. Gay men or men perceived to be gay are "targeted for sexual assault the moment they enter a correctional facility" in South Africa (Booyens et al. 2004). According to these authors and others (Gear 2007; Muntingh and Tapscott 2009), homophobia, taboos around homosexuality, and a generally poor understanding of life in prison, have impeded rational policy discussion about the implementation of effective measures to address the rape of men in prison. It is only since December 2007 that South Africa has a law that recognizes that men can be victims of sexual offenses (Department of Justice and Constitutional Development 2008). It is not clear from any of the research whether sexual offenses against gay men are as prevalent in remand as among sentenced prisoners, though the extensive mixing of pretrial detainees with convicted prisoners makes it unlikely that remanded persons are significantly protected from sexual violence (Muntingh and Tapscott 2009).

There are numerous NGO and press reports of violence against LGBT persons in police custody or detention, though not all of these distinguish prison from pretrial settings. These include beatings and sexual assault of gay and transgender men by other detainees in Romania (IGLHRC 2008); invasive and degrading "medical examination" of men awaiting trial on charges of homosexuality in Cameroon (IGLHRC 2006a, 2006b) and Egypt (Human Rights Watch, 2004); physical abuse of transgender persons in police detention in Venezuela (IGLHRC 2002); beatings and threats of sexual violence against detained LGBT rights defenders in Uzbekistan (IGLHRC 2003);

involuntary HIV testing of detained gay men, including having blood drawn with contaminated syringes in Chile (IGLHRC 1996); sexual assault of gay men in police custody in Jamaica and the Bahamas (Amnesty International 2001); and forced sex by prison guards and encouragement of sexual violence against gay men in Indonesia (IGLHRC 2007). Amnesty International (2001) documented torture and heinous physical abuse against lesbians in police custody in Romania and in a police station in Russia. "As homosexuals, we were the first in line for sexual abuse," reported a gay man released from detention in Cameroon (PlusNews 2006).

Transgender persons, particularly those who may not have initiated or completed sex-transforming surgery, face the ordeal of being classified for prison or detention housing based on their genitalia rather than their gender identity. In a few jurisdictions where the law allows for change of sex on birth certificates for people who have had sex-transforming surgery, prison or remand housing classification may be by gender identity (Blight 2000), but in many countries transgender persons face high risk of abuse in detention (Sex Workers' Rights Advocacy Network 2009: 28). As one transgender woman in Namibia said: "You are locked up in a cell with 20 or 30 men. They take you into the shower and rape you....But we feel like women ourselves, so we don't see why they don't put us with the other women in the cells" (Arnott and Crago 2009: 40). As transgender sex workers reported in Namibia, transgender persons may be more likely to be arrested and detained in the first place because they are more visible than non-transgender men and women (Arnott and Crago 2009: 40).

## I. Conditions faced by sex workers

Sex workers are frequently detained without trial in many countries and may be detained in police lock-ups for long periods during which they are at high risk of sexual abuse and physical violence at the hands of the police (van Boven 2003; Arnott and Crago 2009; Human Rights Watch 2002). In China, sex workers can be detained by law for 14 days with no formal charge or opportunity to be brought before a magistrate (Choi and Holroyd 2007); in Southern African countries they can be lawfully detained for 48 hours, but may be held longer if they cannot pay fines for administrative offenses (Arnott and Crago 2009).

Rape of sex workers by police in detention and the extortion of sex by police in exchange for release have been documented in many countries (FIDA Kenya 2008; Arnott and Crago 2009; Human Rights Watch 2002, 2003b; Sex Workers' Rights Advocacy Network 2009). The Federation of Women Lawyers of Kenya studied the situation of sex workers in six Kenyan cities and concluded that sex workers are frequently arrested on trumped-up charges expressly to enable police to extort sex from

them (FIDA Kenya 2008). Sex workers held in pretrial detention were denied food and humane living conditions, made to undergo invasive physical examinations by the guards, and forced to clean toilets in the detention facility (Ibid.).

In China and Vietnam, sex workers can be assigned to "re-education centers" where they can be detained for years (Choi and Holroyd 2007; Turnbull 2006). In India, Thailand, Cambodia, Nepal, Nigeria, and a number of post-Soviet countries, people, usually women, who are "rescued" from trafficking are often detained in prison-like conditions pending their serving as witnesses in prosecutions of alleged traffickers (Gallagher and Pearson 2010). This form of detention, ostensibly for the victims' own protection, raises serious human rights questions about the deprivation of liberty of these women (Ibid.). In India, sex workers whose workplaces are raided may be put in this kind of "protective detention" for long periods even if they were never trafficked and did not seek rescue (Rao and Sluggett 2009).

## J. Mental illness

Mental illness is a challenge for any correctional institution, and particularly for pretrial detention facilities. As the entry point in many correctional systems, remand facilities are more likely than prisons to receive people living with mental illness who have not yet been properly diagnosed or treated, including those who would ideally be remanded to a psychiatric hospital or institution. Remand facilities are also less likely to have adequate specialized staff to handle this challenge. The scientific literature on the handling of mental illness in pretrial detention facilities in Southern and transitional countries is not abundant, though experts have long noted this challenge in Northern countries (e.g. Fryers et al. 1999). An international review of mental disorders of 23,000 prisoners from 12 countries noted that, "about 99 percent of available data from prison surveys are derived from Western populations, which underscores the need for greater forensic psychiatric research in non-Western populations" (Fazel and Danesh 2002).

WHO notes that about half of all people in state custody around the world have personality disorders, more than 10 percent suffer from serious mental disorders, about 89 percent have depressive symptoms, and several thousand commit suicide every year while imprisoned (Møller et al. 2007). For many of these persons, the factors most likely to contribute to improved mental health are those least likely to be present in pretrial detention: protection from violence, access to educational and physical activity, and access to specialized care and support (Ibid.). This lack of specialized care coupled with the presence of abusive practices is of particular concern. The Working Group on Arbitrary Detention (2009), for example, noted the holding of persons in Ukraine in remand facilities while they were undergoing psychiatric assessment. The Special Rap-

porteur on Torture noted the confinement of mentally ill persons in punishment cells in Indonesia (Nowak 2008).

Mental illness in children and young people in detention is also a neglected subject in research on remand in Southern and transitional countries. The observations of human rights monitors and bodies in several countries raise urgent concerns about both the mental health of children entering the justice system and the threats to their mental health because of inhuman and violent conditions (e.g., Nowak 2007b, 2009; Rodley 1999, Working Group 2004, 2005, 2008a). When children are mixed with adult prisoners and face torture and inhumane treatment, police brutality, overcrowding, lack of education and sports activities, lack of legal assistance, and inadequate contact with their families, it would be surprising if mental and emotional problems were not rife (Abramson 2000). The inactivity often associated with extended detention is especially detrimental to child development (M. Bochenek, Amnesty International, personal communication). Children who have mental illness are undoubtedly unjustly detained as accused criminals because of lack of appropriate facilities, as suggested in Nigeria (Penal Reform International et al. 2003). In Russia, the testimony of mental health experts has not been allowed in determining the course of detention and punishment of children (Shestakov and Shestakova 1997: 225). The observation in Moldova, for example, of over-administration of strong tranquilizers to very young children underscores that even "specialized" care does not guarantee good practice (Nowak 2009).

# VIII. Possible Avenues toward Improved Practices

Most of the problems described here would be greatly diminished by the reduction of pretrial detention and the use of better alternatives. Without reduced use of pretrial detention and the attendant problems of overcrowding, it is difficult to even imagine how these problems will be addressed. In addition to this solution, however, a number of measures could improve health services and enhance the possibility for realizing the health rights of persons in detention. Some of these measures might also generate information that would be helpful in advocating for reduced use of pretrial detention. Some avenues toward improved practices and enhanced information are the following:

**Investing in improved pretrial detention health services as a state obligation and an opportunity for early detection, care, and linkage to continued care:**

Research and monitoring accounts suggest that pretrial health services and staffing are inadequate compared to prisons and do not fulfill the state's obligation for early detection of health problems and initiation of care. The non-involvement of ministries of health in remand health services, noted by several experts (e.g., Coninx et al. 2000), undermines links to community-based care and may compromise the quality of health services in remand and the right to equivalency of services for detainees. (It was noted, however, by one human rights observer that putting prison health services under the Ministry of Health in Kenya did not seem to have improved them tangibly; see Rodley

1999.) Particularly regarding conditions such as HIV, hepatitis, tuberculosis, and some mental disorders that require extended treatment and for which early detection and treatment are crucial to good outcomes, pretrial detention is often a missed opportunity to avert illness and even death. Ensuring continuation of therapy initiated before a person's entry into detention is also extremely important.

Because pretrial detention may be chaotic, with a rapid turnover of detainees, there is a tendency to give up on initiating services that might be possible to sustain even in such an environment. Again, links between community-based and prison-based care are crucial. It should be possible to include pretrial detention in a continuum of care with regard to methadone therapy, for example, as well as DOTS for tuberculosis, and antiretroviral treatment for HIV. Health promotion and information involving peers should be possible, even with high turnover, if staff develop rapid orientation and training to build capacity for peer leadership and engagement.

Results of this review indicate that the provision of adequate basic services, including health care, water, sanitation, food, and protection from the cold, would have important benefits beyond the obvious public health outcomes. To the degree that detainees, including children and women, have to trade sex for access to food, blankets, and water, adequate provision of these basic services will be a disincentive to coercive sex. Violence linked to competition for access to basic amenities would also be reduced.

**Transparency, complaint mechanisms, and access to counsel:**

Much of what is known about the unhealthy and inhumane conditions faced by pretrial detainees is found in reports of occasional visits by regional and international human rights monitors. There is an urgent need to open pretrial detention conditions to wider scrutiny, and to establish regular monitoring and public reporting mechanisms. In many countries, access to legal counsel and to the courts by pretrial detainees would be one avenue for addressing abusive and negligent health practices. As the experience with the European Court of Human Rights in Eastern Europe has demonstrated, access to international courts and tribunals may also be important. Though it is not the central subject of this paper, it is clear from many of the accounts cited here that the rights of detainees to counsel and to appear promptly before a judge are widely violated. The intervention of public interest lawyers in South Africa in obtaining life-sustaining treatment for HIV-positive prisoners is only one example of legal actions with enormous health impact (Berger 2007). There should also be functioning and sustained mechanisms for detainees to report abuses and seek redress without endangering themselves. Such mechanisms should involve competent and independent health professionals.

**Mechanisms for prison staff to be independent and to speak out against abuse:**

Prison-based health professionals need to be able to make independent, evidence-based decisions to ensure that health needs and rights are met. Their role as advocates for prisoner health should be safeguarded. They should also be protected from being complicit in any practice that may constitute cruel, inhuman, or degrading treatment, or torture, but must be held accountable if they cross that line (International Dual Loyalty Working Group 2003).

**Involvement of health ministries:**

There is not a lot of evidence about the impact of non-involvement of health ministries in pretrial detention health services. Some of the more promising initiatives described in the research literature, including the DOTS program in Thai prisons, were apparently possible only with the extensive involvement of health-sector officials and technical staff. Relations between correctional health practitioners and ministries of health are often difficult. The goal of equivalence of care in prisons and remand facilities to that of care in the community, nonetheless, argues for ministries of health to be responsible for at least monitoring the quality of care for detainees. The complete separation of prison and remand health services from the principal health authorities of the state is a recipe for trouble.

**Awareness-raising among key stakeholders:**

In addition to the need for more information and research, there is an urgent need for what is already known about health in pretrial detention to be more widely disseminated, especially to those whose actions might affect change. Ministries of health may be shielded from day-to-day knowledge of conditions and services if they are not involved in remand facilities, but their involvement and awareness of conditions are important for positive change to happen. Beyond the health sector, judges, prosecutors, police, juvenile justice officials, and others in law enforcement must be made aware of the health consequences of heavy use of pretrial detention. Human rights commissions and NGOs not already involved with prison health should be engaged.

**Research and access to research results:**

It is clear that scholarly research on health in pretrial detention in developing and transitional countries is lacking. Access to these settings for researchers may be restricted in many countries. The fact that health services may be managed in remand facilities by ministries other than the ministry of health may be a barrier to researchers accustomed to interacting with health-sector officials. Though the literature reviewed here is spotty, it indicates research needs in the following areas:

To generate information for advocacy for reduction of pretrial detention:

- Better data on the extent of pretrial detention, particularly among women, children, people who live with drug dependency, people with mental illness, and others vulnerable to abuse and health problems.
- Research on the relationship between the extent of pretrial detention and a variety of health outcomes.
- The physical and mental health impact of overcrowding in pretrial detention, including whether it is possible to determine critical levels of crowding that trigger accelerated transmission of infectious diseases.
- The physical and mental health impact of failure to segregate pretrial detainees from prisoners, children from adults, and women from men.
- The physical and mental health impact of extended pretrial detention on men, women, and children.
- The difficulties faced by health professionals in situations of pretrial detention where services are inadequate and abuse is prevalent.

To improve practices in pretrial detention:

- Best practices for ensuring continuity of care for a wide range of physical and mental health conditions between pretrial detention on the one hand and prison or the community on the other.
- Feasibility of and best practices in tuberculosis detection, treatment, and support in pretrial detention and beyond.
- Feasibility of and best practices in sterile syringe programs, methadone, and buprenorphine therapy and other drug dependency treatment in remand.
- Best practices in detection, care, and support of mental illness among persons in remand.
- Best practices in protecting women, gay and bisexual men, transgender persons, and sex workers from abuse in detention.

Where there are efforts to reform pretrial justice and reduce the use of pretrial detention:

- Ensure that health officials and practitioners are involved in the planning and implementation of reforms.
- Study the health impact of reforms.

# IX. Conclusion

The public health crisis among detainees adds to the case for reducing the use of pretrial detention. Failure to protect pretrial detainees from cruel, inhuman, and degrading conditions; torture; violence; sexual abuse; overcrowding; and neglect of physical and mental disorders exacts an untold cost among persons wholly dependent on the state. Pretrial facilities, including police lock-ups, are too far from the sight of independent monitors and apparently not a priority for the state resources that might make conditions in them more humane. The vulnerability of detainees to torture in the first hours and days of detention should make independent monitoring of pretrial detention a high priority for national and international bodies.

Pretrial detention entails state obligations for early detection and treatment of physical and mental health disorders and continued care when detainees are discharged or transferred. With respect to a wide range of conditions, it appears that those obligations are unfulfilled. With respect to HIV, drug dependency, tuberculosis, hepatitis C, and many forms of mental illness, which require continued care and support, there is little evidence that the links to prison-based and community-based care are being made in many low- and middle-income countries. Programs that are known to work in a wide range of settings, such as methadone therapy, are neglected for detainees even when they are available to the population at large. Problems of women in detention are not a priority. The high prevalence of mental illness, which should be assumed among pretrial detainees, has not inspired consistent, sound, and humane care. In addition to undermining detainees' right to health, this failure of state obligations undermines the

right of people to seek counsel and participate in their own defense when their cases come to trial.

It is not possible to know the full cost in death, disease, and injustice of the problems described here, but the cost is sufficient to warrant a global effort to reduce pretrial detention and address health in pretrial detention. Health professionals, including university-based experts, should be mobilized to provide leadership in this area—through their research and teaching, practice, technical assistance, membership in professional societies, and solidarity with prison health professions. They are a crucial voice in advocacy for reduction in the use of pretrial detention as well as the realization of the health rights of the detained.

# Appendix: Regional Profiles of Pretrial Detention and Health

The following profiles attempt to capture some features of the regions considered in this paper. Many papers that cover regional prison health trends and situations do not deal explicitly with pretrial institutions.

## Eastern Europe and Central Asia

Many of the corrections systems in Eastern Europe and Central Asia still embody the structures and practices of the former Soviet Union. These include police detention in various forms, notably the KPZ (*kamera predvaritelnogo zakliucheniya*, or preliminary holding room), often the first stop after arrest; IVS (*izolyator vremennogo soderzhaniya*, or temporary containment cell), which refers to short-term police lockups; and SIZOs (*sledstvenny isolator*, or investigative isolator units) or pretrial detention centers (Amnesty International 2006). SIZO facilities are under the jurisdiction of the Ministry of Justice, but the KPZ and IVS are under the Ministry of Internal Affairs (Ibid.). The KPZ are not meant to hold people overnight, though in practice they do, and the IVS are meant for short stays and generally have no provisions for health care. These police-run structures generally do not figure in the health literature, but for people who already have health problems when arrested, time in the IVS with no care or, worse, abusive treatment can have important long-term health consequences.

The inhuman conditions of overcrowding, lack of sanitation and ventilation, and harsh punishment in the SIZOs described in this paper are striking in their similarity to descriptions from monitoring visits in the early post-Soviet years (Human Rights Watch 1991). In the Russian system, there are "open" prisons for first-time, relatively minor offenses, in which prisoners have some degree of freedom of movement on the prison grounds (Bobrik 2005), but the SIZOs are "closed" facilities with tighter security and a harsh, punitive environment (Amnesty International 2006). Amnesty International (Ibid.) notes that some SIZOs have been made accessible to independent monitors and NGOs, but the organization continues to be concerned about torture, forced confessions, and inhuman conditions in these facilities. That many countries from the former Soviet bloc fall under the purview of the Council of Europe human rights judicial and monitoring structures is some cause for hope.

Tuberculosis is a major health problem in SIZOs. There has been some effort to diagnose TB in some of these facilities, but initiation and maintenance of TB treatment in SIZOs has proven difficult (Bobrik 2005; Slavuckij 2002). The disproportionate detention of people who inject drugs in the former Soviet countries has brought together HIV and TB in lethal combination in the SIZOs (Bobrik 2005). The well documented "silo" phenomenon of health specialization in the former Soviet Union, with separate medical institutions and specialists for HIV, drug addiction, tuberculosis, and so on—and even separate structures for TB diagnosis and TB treatment—may be another barrier to coherent and continued care for these health problems (Atun et al. 2005; Proletarsky 2009).

## Sub-Saharan Africa

In numerous African countries pretrial detention is extremely widespread, as are justice systems that fail to bring detainees to trial, resulting in extended detentions in extremely overcrowded and unsanitary conditions for unconvicted persons. Recent reports from Human Rights Watch (2008c, 2009) cite Côte d'Ivoire, Guinea, Liberia, Sierra Leone, Sudan, and Nigeria, among others, as having caused inhuman conditions by the excessive use of pretrial detention. Human rights monitors cited in this paper have bemoaned the frequent housing of pretrial detainees with convicted prisoners and the lack of humane conditions in police lock-ups in numerous countries. As noted elsewhere in this paper, political, economic, and human rights deterioration in Zimbabwe has led to extremely high mortality and cruel and inhuman conditions in detention facilities (Alexander 2009). High mortality and inadequate removal of corpses amid an inhuman lack of access to sanitation and health care has also been documented in Cameroon (Chirwa 2002).

HIV/AIDS has complicated the provision of health services for detainees in Africa and exacerbated the impact of epidemic levels of tuberculosis and drug-resistant TB in detention facilities. Since an estimated 70 percent of persons living with HIV and in need of antiretroviral therapy (ART) in the region are still unable to get it (UNAIDS 2008), it is unsurprising that HIV-positive detainees in many countries in the region are not offered treatment. South Africa is exceptional in that there is some ART for prisoners—following litigation on their behalf—but apparently not for pretrial detainees (Muntingh and Tapscott 2009). South Africa is also the only country that has a national policy allowing condom distribution to people in state detention. The alarming spread of HIV in prisons and the high turnover of prisoners and detainees across the continent have led epidemiologists to point to prisons as an important and often overlooked engine of the African AIDS epidemic (Senok and Botta 2006). While drug injection has not yet been widely documented in Southern African detention facilities (Muntingh and Tapscott 2009), growing drug injection elsewhere on the continent (Csete et al. 2009) and harsh criminalization of illicit drug use may mean the continent is not yet spared the challenge of drug-related health problems in state detention.

It is encouraging that bodies of the African Union have recognized prison conditions as an urgent health and humanitarian concern, and that the regional body supports a special rapporteur on conditions of detention (Viljoen 2005). Nonetheless, at the national level, the situation of persons in detention does not appear to be a matter of political urgency or budgetary priority except in the rare case where litigation has made it so. In addition to pretrial justice reform, there seems to be an urgent need in many countries in the region for detention facilities to be integrated into national health plans and to come under the oversight of health authorities.

## Asia

It is difficult to generalize about such a vast and varied continent, and there is undoubtedly a body of research literature on health in detention that does not appear in the English, Spanish, and French indexes reviewed for this paper. WHO's bibliography of peer-reviewed research on tuberculosis in South and Southeast Asia from 1999 to 2004, for example, includes many citations from India and Bangladesh, but the only citations related to tuberculosis in prison or detention facilities are from middle-income countries such as Thailand (WHO SEARO 2005). Very few studies reviewed in this paper made clear distinctions between pretrial and other detainees (and, in the case of Thailand, so-called "remand" centers are meant to detain people for long periods).

Tuberculosis, HIV, and hepatitis C are highly prevalent in detention facilities in many Asian countries, not least because of the disproportionate detention of people

who use drugs (WHO SEARO 2007). WHO judges the prevalence of TB to be as high as 100 times greater in prisons in the region than in the general population (Ibid.). The lack of condoms and sterile needles facilitates the spread of HIV among detainees, and poor sanitation and inadequate medical care contribute as well (Ibid.). The Thai experience in provision of DOTS treatment for persons with TB has been well studied and demonstrates the usefulness of active involvement of the health ministry in prison care. Thailand's continued repression of people who use illicit drugs, however, reflects a disregard for best practices in provision of health services to this population both in and out of detention.

Thailand is an example of a country in which the inclusion of HIV treatment in the national health insurance scheme and the involvement of the Ministry of Health in prison health services has made ART possible among people facing varying lengths of detention (Wilson et al. 2007). In this case, a so-called remand prison where stays ranged from two to seven years managed with the help of Médecins Sans Frontières to link treatment for detainees to community-based care or prison-based care.

Searches did not yield studies of health conditions in pretrial detention in India. Authors of a 2001 survey of health problems of convicted male prisoners in Pune, India said that there had never been such a survey in India before, partly because people in the medical establishment don't want to work in prisons (Gupta et al. 2001). A 2009 qualitative study of HIV in three men's prisons in Maharashtra State lamented a poor quality of care for HIV-positive prisoners and a lack of preventive programs in the face of widespread risky behavior (Guin 2009). The author noted, "the activities in prisons that spread HIV—notably sex and drug use—are usually criminal in the prison environment and met with disciplinary measures, not health measures" (Ibid.: 180). Studies on pretrial health conditions in China outside Taiwan and Hong Kong were also difficult to find.

## Latin America and the Caribbean

According to the International Centre for Prison Studies, 80 percent of countries in the Americas exceed a remand population rate of 40 per 100,000 in the general population, a higher percentage than in other regions (Walmsley 2008). In recent years, human rights NGOs have criticized several countries in the Americas for excessive use of pretrial detention, notably the United States, Haiti, Argentina, and Mexico (e.g. Human Rights Watch 2009). Haiti, Bolivia, and Paraguay are judged to have the highest prevalence in the region of pretrial detainees among persons in state custody. In Haiti, detention of unconvicted persons for extended periods in police stations as well

as prisons has led to extreme overcrowding, lack of access to adequate food and sanitation, and untreated tuberculosis, malaria, and scabies (Ibid.: 188). Human Rights Watch estimates that over 40 percent of people in state custody in Mexico have not been convicted of a crime, and many have awaited trials for years (Ibid.: 191). Remanded persons have reportedly been placed in solitary confinement for long periods and been subject to extortion by guards.

As noted elsewhere, the Organization of American States has recognized prison conditions, including health conditions, as a priority concern, and a 2007 Inter-American Commission on Human Rights resolution reiterates the health rights of persons in any form of state detention (Inter-American Commission 2009). Particular challenges of pretrial detention are not enumerated in this document except as they appear in international human rights instruments. The Pan-American Health Organization (PAHO), the WHO regional body for the Americas, has identified HIV, tuberculosis, and reproductive health as areas in need of urgent improvement in prisons in the region, but pretrial detention is not mentioned in its priorities.

There may be a much more extensive literature on detainee health in the region than what is reflected in this paper because some Spanish and Portuguese-language journals may not have been captured in the indexes searched. Tuberculosis in state prisons in Brazil has been the subject of considerable research attention (e.g. Sanchez et al. 2009). Brazil is the only country in the region that reported data on drug use and HIV in prison in a major international review (Dolan et al. 2007). HIV prevalence among prisoners in many countries in the region is among the highest outside Africa, notably in Jamaica, Trinidad and Tobago, Argentina, Brazil, El Salvador, Honduras, Nicaragua, Mexico, and Panama, but pretrial detention is not distinguished in existing data (Ibid.).

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The excessive use of pretrial detention leads to overcrowded, unhygienic, chaotic, and violent environments where pretrial detainees—who have not been convicted—are at risk of contracting disease. Pretrial holding facilities, not designed for large numbers or extended stays, are breeding grounds for disease, where detainees are denied access to fresh air, sanitation facilities, health services, or adequate food. Some pretrial detention centers are so bad that innocent people plead guilty just to be transferred to prisons where the conditions might be better. For many pretrial detainees, being locked away in detention centers where tuberculosis, hepatitis C, and HIV are easily contracted can be a death sentence.

*Pretrial Detention and Public Health* surveys extant literature to examine how overcrowding and appalling conditions in pretrial detention threaten the health of detainees. The report documents international standards for health care in pretrial detention, considers why pretrial detention poses such severe health risks, and provides recommendations for improved practice.

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