

Consequences of Injustice: Pre-Trial Detention and Health

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Keywords: pre-trial detention, HIV, tuberculosis, drug dependence

ABSTRACT

Excessive use of pre-trial detention (PTD) has resulted in overcrowded, unhygienic, chaotic, and violent environments for detainees in many countries. Severe health problems for detainees result from inadequate health services, the impact of inhuman and degrading treatment, and failure of the state to ensure humane living conditions, and protection from violence. This article summarizes a literature review on health problems in pre-trial detention in low- and middle-income countries.

Although literature explicitly on health in PTD is somewhat sparse, this review suggests that health challenges are often more severe in PTD than in prison for a number of reasons, including that (1) governments invest less in health services in PTD, especially for chronic conditions, because of the assumed transience of the population; (2) cruel and inhuman treatment is most likely to occur in the first days of detention; (3) overcrowding is often more severe in PTD than in prisons; and (4) there are unlikely to be special services and protection for women and children or systems to minimize sexual and physical violence.

Conditions such as HIV, drug dependence and tuberculosis, to which detainees are especially vulnerable, require prompt and sustained care. In many countries, there are few or inadequate efforts to ensure that pre-trial detainees enjoy basic services to address these conditions, with disastrous effects for the course of these epidemics in custodial settings and in the community. The lamentable state of health services and outcomes in PTD should be one more reason to argue for minimizing its use. The engagement of health professionals in advocacy toward this end is urgently needed.

INTRODUCTION

The overuse of pre-trial detention (PTD) in its various forms, detailed in this issue of the *International Journal of Prisoner Health* by Schönteich and Tomasini-Joshi (*IJPH*, 2010), has profound consequences for the health of detainees and the communities to which most of them will return. The purpose of this article is to summarize the findings of a literature review on health in PTD, including the health status of those detained, the health services available to them and the ways in which these may differ between pre-trial detainees and prisoners. The article's focus is on developing and transitional countries. Implications for research and engagement of health professionals are considered.

and medical literature (using key words such as “prison” “remand,” “juvenile detention” and “pre-trial”), 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. Earlier extensive reviews by Jürgens (2007), Dolan et al (2007), and the World Health Organization (WHO, 2008) were useful resources.

Part of the challenge of finding information on PTD and health is that much of the literature on prison health does not clearly distinguish prison from PTD. In some cases, this lack of distinction reflects the reality that pre-trial detainees and prisoners are housed together and not well distinguished with respect to services, needs, and rights. There is some scholarly

METHODS

A broad review of scholarly and grey literature on PTD and health was conducted. Scholarly literature was located by using a combination of search indexes, including PubMed for health

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literature on PTD 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 non-governmental organizations (NGOs) and international organizations, and other grey literature, which are included in this review.

Human Rights Standards for Health in PTD

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). 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 Convention Against Torture (1984).

The ICCPR specifies that persons accused but not tried should be separated from convicted prisoners, and juveniles on remand always separated from adults (art. 10(2)). 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). They also emphasize that “untried prisoners,” though separated from convicted prisoners, have the right to all services accorded to all prisoners (art. 91). The health provisions of the Standard Minimum Rules are wide-ranging and include that psychiatric services should be available in all institutions; that ill detainees should be transferred to specialized care when needed; that women get complete pre- and post-natal care and that children be allowed to be born in hospitals; and that a medical officer examine every detainee as soon as possible after admission (articles 22-24). The Convention on the Rights of the Child (CRC) (1989) emphasizes two key principles about detention of children: (1) that it should “be used only as a measure of last resort and for the shortest appropriate period of time” (art. 37b), and (2) that children in detention must be separated from adults (art. 37c).

FINDINGS

Both convicted prisoners and pre-trial detainees face extreme health challenges in most countries. Available studies indicate that pre-trial detainees, however, face greater health risks in several respects, which are noted as follows:

Overcrowding

Pre-trial detention facilities are often more overcrowded than prisons (European Committee 2006:21; Schönreich 2008:18). This may be because intake at remand facilities depends on

events that are not subject to long-term planning, such as police crackdowns. Overcrowding has dire health consequences, including facilitating the spread of disease, making privacy impossible, overburdening services and increasing tension and therefore violence among detainees and between detainees and staff (European Committee 2006:21).

Overcrowding helps make detention facilities breeding grounds for, among other diseases, tuberculosis (TB), including its drug-resistant forms (Reyes, 2007). Management of TB is difficult in any overcrowded setting but may be especially so in PTD because the turnover of detainees – including movements within remand institutions and to prisons – may impede systematic prevention, diagnosis, and treatment. Numbers of detainees often overwhelm inadequate medical staff for TB screening of new entrants (WHO-Europe, 2007). Overcrowding in detention in Azerbaijan, for example, was both a cause of TB and also the main obstacle to being able to segregate active TB cases from others (Rodley, 2000a).

Overcrowding and TB have been studied in the PTD centers known as SIZO (*sledstvenny isolator*, or investigative isolator units) in Russia and other post-Soviet countries. A study that followed TB in two SIZOs in Saint Petersburg for three years found that of 876 cases detected among detainees during this time, half were contracted in the SIZO (Lobecheva et al, 2005). 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 disproportionate detention of people who inject drugs in post-Soviet countries has brought together HIV and TB in the SIZO in lethal combination (Bobrik, 2005).

Overcrowding contributes to health problems beyond TB and highly contagious illnesses. Severe overcrowding among both prisoners and pre-trial detainees in South Africa was judged by experts to add to HIV risk 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 detained for inability to post bail. In Paraguay, overcrowding was reported to lead to violence among detainees (Nowak, 2007c). In Ecuador, overcrowding in PTD was used as a reason to keep people for longer periods in police lock-up, where they are subject to inhuman conditions (Working Group, 2006).

Access to Water, Sanitation, Food, Basic Living Conditions

Monitors of PTD have portrayed scenes of misery and inhumanity that challenge the imagination. In Zimbabwe, for example, detainees without access to basic sanitation were reported to be dying from cholera and other infectious diseases at a rate that would be considered a humanitarian emergency in

any circumstances, at times sleeping next to corpses that could not be removed fast enough (Alexander, 2009). Many detainees had “sat in remand prison without access to the courts for months, in some cases years” (Alexander, 2009). Poor sanitation and ventilation, inadequate food, and inadequate protection from the cold in post-Soviet SIZOs have been judged to be worse than in prisons in the same countries (Bobrik, 2005). Human rights monitors who visited SIZOs in Belarus and Moldova concluded that poor sanitation, poor food and lack of heat were maintained at inhuman levels expressly to force detainees to incriminate themselves to be sent to prison colonies where they thought conditions were better (Working Group, 2004; Nowak, 2009). In several eastern and central European countries, new arrivals to PTD are “quarantined” ostensibly until they can undergo a medical examination, which can mean being isolated for days without access to basic sanitation (Rodley, 1994; Nowak, 2009a; Rodley, 2000a).

Lack of basic services along with overcrowding has been documented 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 pre-trial detainees than convicted prisoners (Working Group, 2005). 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 (Working Group, 2008b). In Kenya, pre-trial detainees were given half the food ration of convicted persons because they did not work (Rodley, 2000). An outbreak of beriberi or severe thiamine deficiency (a condition rarely seen outside of refugee situations) was documented among detainees in Côte d’Ivoire in 2002-2003, resulting from inadequate food and exacerbated by cholera (Ahoua et al, 2007).

Torture and Physical Abuse

The Council of Europe’s Committee for the Prevention of Torture (CPT) (2006:9) emphasizes that “the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest,” an observation borne out in monitoring by many human rights entities. Pre-trial detention facilities may be less subject to regular independent inspections and less open to NGOs and to family members than are prisons in some countries. A comprehensive look at torture and physical abuse is beyond the scope of this article. Suffice it to say here that the short- and long-term impact of torture on physical and mental health cannot be overstated.

Amnesty International (2006, 2009) and other human rights groups (Human Rights Watch, 2008c) continue to raise concerns about torture in prolonged detention in the SIZOs of Russia, Ukraine, and other post-Soviet countries. Denial or manipulation of health care or use of health problems as a

means of control or coercion is a form of torture seen in police custody and pre-trial 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). The cruel practice of using the pain of withdrawal symptoms to coerce confessions has been recognized as a form of torture by the UN Special Rapporteur on Torture, who has called for it to end (Nowak, 2009b). In Ukraine, police even offered illicit drugs in exchange for confessions (Belayeva, 2008).

Inadequacy of Diagnosis and Prevention Services – Focus on HIV and TB

As inadequate as health services may be for convicted prisoners, they are frequently even more lacking in PTD where they are unlikely to be a priority for governments and, as is also the case for prison health services, may not be under the jurisdiction of the health ministry (Coninx et al, 2000; WHO-Europe, 2007). Qualified medical personnel may not be present to conduct intake screenings essential to the management of TB and sexually transmitted infections (STIs), among other conditions (Reyes, 2007). Ministries responsible for PTD do not always report TB and STIs cases, for example, to health authorities, making it difficult to know the importance of PTD-based disease transmission to national and regional epidemics.

Services for HIV prevention (and treatment [see below]) are lacking in many prisons and PTD facilities. In most countries, HIV is much more prevalent among persons in state detention than in the population at large mostly because people who inject drugs are over-represented among detainees, there is unprotected sex, and comprehensive prevention and treatment services are absent (Dolan et al, 2007). Few jurisdictions report HIV prevalence of pre-trial detainees separate from that of prisoners. Nonetheless, pre-trial detention plays a crucial role in what [first name] 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, sterile injection equipment and other prevention measures are absent or inadequate (Wolfe, 2004 [quoting Beyrer]).

Jürgens (2007: 21-25) reviews studies that quantified drug injection in prison, most of which did not specify whether pre-trial detainees were included, as well as studies from several western European countries, Russia, Thailand, and Australia demonstrating that many people who inject drugs on the outside continue injecting in prisons and that some 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. Studies of 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 hepatitis C virus (HCV) infection, similar results were found in Iran (Mohtasham Amiri et al, 2007; Alizadeh, 2005), Brazil (Oliveira, 2006) and Ghana (Adjei, 2007). A 2009 study in Iran, one of very few focused on police detention, suggested that sterile syringe programs would have their greatest health impact in police lock-ups as new detainees there are inclined to switch from opium smoking to heroin injection (Jahani et al, 2009).

The 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 and tattooing equipment and sharing of razors – namely, provision of sterile needles and syringes, razor blades, and sterile tattooing equipment (UNODC, 2006: paragraph 60; WHO, UNODC, UNAIDS, 2007). Countries should also ensure prisoners' access to drug dependency treatment 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 (UNODC, 2006: paragraph 77). Unfortunately, the implementation of these measures in low- and middle-income countries – in prison and in remand – remains rare even though experience indicates that they would be effective for pre-trial detainees.

Methadone therapy is a central element of HIV prevention in countries where opiates are injected. As of 2010, nearly 40 countries or sub-national jurisdictions offered methadone therapy in prison (Jürgens et al, 2010). Larney and Dolan (2009) estimated that in 2008 some 37 countries had methadone programs in the community but not in prison. Methadone maintenance therapy has been shown to be feasible without security problems in a wide range of detention settings (Jürgens, 2007). But access to scientifically sound treatment for drug dependency such as methadone is beyond the reach of detainees in most countries. Discontinuation of methadone because of detention among persons on treatment is a serious public health concern; it may lead to unsafe injection and high risk of overdose. A study in Scotland showed that methadone patients who are required to withdraw from methadone because of incarceration often returned to injection of opiates while in custody (Shewan et al, 1994). Denial of methadone therapy for a prisoner in the United Kingdom 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*).

Access to sterile injection equipment remains very limited for people in state custody. As of 2007, 12 countries had syringe exchange programs or planned pilot programs in prison (Jürgens, 2007), most of them in Western Europe, but also in Kyrgyzstan, Iran, Moldova, and Belarus. Moldova recently announced its intention to begin syringe exchange in pre-trial facilities after years of experience with it in prisons (Jürgens, personal communication).

The epidemic of denial that plagues rational policy-making around injection-linked HIV transmission in prison is also a problem with respect to sexual transmission (Jürgens, 2007) even though it is well documented that both consensual and coerced sexual activity take place in prison (Jürgens, 2007). Again, studies generally do not indicate whether pre-trial detainees were included. Of relevance to both remand and prison, Jürgens notes that the frequency of unsafe sex is influenced by factors such as 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 (Jürgens, 2007).

In southern Africa, prisoners face very high risk of sexual transmission of HIV because of high underlying rates of HIV prevalence. South Africa, reportedly the only country in the region that provides condoms in prison with any regularity, distributed over 1.2 million condoms in the correctional system in 2007-2008 (Muntingh and Tapscott, 2009). Lubricants were not provided, and prisoners complained that the condoms provided were not durable enough for anal sex without lubricants (Goyer and Gow, 2002). It is unclear whether condom distribution differs between PTD and prison. In some high-prevalence countries, notably Zambia, Malawi, and Namibia, legal prohibitions against homosexuality impede the provision of condoms in that policy-makers see condoms as encouraging same-sex intercourse, an illegal activity (Simoooya et al, 2000; Herget, 2006; Zachariah et al, 2002).

An evaluation of a condom program in a Thai (longer-term) remand facility and prison noted that even if condoms are available, detainees may fear reactions of guards in asking 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). United Nations agencies recommend that condoms be available such that detainees can gain access to them confidentially and without discrimination (UNODC et al, 2006).

Access to Longer-Duration Treatment and Care – Focus on TB and HIV

Governments may be reluctant to start treatment during PTD for infectious diseases that require a sustained period of therapy, such as TB (Reyes, 2007), HIV or HCV, or longer-term treat-

ment such as methadone maintenance. Beginning effective longer-term care in PTD would mean allowing for continuity of care and support between PTD and prison or between PTD and the community. It may also be challenging for PTD authorities to ensure that people already being treated for an infectious disease, drug dependence, or mental illness are able to continue their treatment in PTD and beyond.

With respect to TB, for example, failure to ensure a full course of treatment may contribute to the emergence of multi-drug-resistant TB (Reyes, 2007). Efforts to ensure uninterrupted treatment in Russian SIZOs were undermined by frequent movement of detainees to other SIZO or jails (Slavuckij, 2002). Persons diagnosed with TB on admission to the SIZO were later kept from being transferred in the first two months of detention to facilitate uninterrupted treatment (Slavuckij, 2002), 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 treatment of TB in a Russian prison was judged to have been possible because of the relative stability of the prison population compared to a high-turnover SIZO population (Farmer and Yang, 2004).

Treatment for HIV is still not part of standard care for detainees in some low- and middle-income countries. Muntingh & Tapscott (2009) note that South Africa's 2007 "framework" for comprehensive HIV services, including antiretroviral therapy (ART), explicitly excludes unconvicted prisoners (estimated to comprise about one third of people in custody). A chilling account by a former prisoner in Russia who died in 2009 alleged that the ART he was able to begin through a Global Fund-supported treatment program was denied him during his incarceration in a SIZO and a TB prison (Protelarsky, 2009). In Thailand, in contrast, the inclusion of HIV treatment in the national health insurance scheme and the involvement of the Ministry of Health in prison health services made ART possible for detainees and prisoners (Wilson et al, 2007).

Violence and Sexual Abuse

Because many remand facilities do not respect human rights norms on the separation of pre-trial detainees from convicted prisoners or even, in some cases, of women from men and children from adults, physical violence and sexual assault may be more likely than in prisons (Tomasini-Joshi, 2008). In addition, prisons are more likely than PTD facilities 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).

Human rights monitors have documented many instances of sexual violence tolerated or even abetted by detention

authorities. In both Moldova and Russia, monitors concluded that prison officials placed sexual predators strategically within the SIZO to help "keep order" in the facilities (Rodley, 1994; Nowak, 2009). In Ecuador, it was noted that the excessive duration of pre-trial detention allowed for the formation of violent gangs that posed grave threats to most detainees (Working Group, 2006).

In many countries, sex workers – men, women, and transgender persons – are frequently detained without trial and without proper charges brought against them and may be kept in police lock-ups for long periods (van Boven, 2003; Crago, 2008; Human Rights Watch, 2002). Sex workers are particularly vulnerable to sexual violence, beating, and extortion while in police custody (van Boven, 2003; Crago, 2008; Human Rights Watch, 2002).

Vulnerability of Children in Detention

In most countries, children who are detained because they are in conflict with the law are in pre-trial situations, and the great majority of them are accused of petty, non-violent offenses (Pinheiro, 2006). Many of the most shocking accounts of physical and sexual abuse of children derive from the failure of governments to detain children separately from adults, both where there is officially no juvenile justice system separate from the adult system (e.g., Belarus, Ukraine, Nigeria, Angola, Burundi, and Nepal; see Working Group, 2004, 2008a, 2008b, 2009; Nowak, 2007b; Human Rights Watch, 2007, 2008b) and elsewhere (South Africa and Papua New Guinea; see Working Group, 2005; Human Rights Watch, 2005b). 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). Street children whose families are not readily apparent in their lives may be especially vulnerable to physical abuse, as reported in Kenya (Rodley, 1999; see also Pinheiro, 2006).

Children who are locked up with mothers who are in extended detention may be subjected to physical abuse and deprived of education, cognitive stimulation, play, and appropriate medical care (Chirwa, 2004). A UN report noted cases, as in Cambodia, in which infants and young children were beaten by adult detainees when they cried (Pinheiro, 2006).

Health of Women in PTD

Women in state custody are disadvantaged with respect to health services because there are fewer of them than men, and investments are not made to ensure services designed for them (UNODC, 2008). This is probably even more so the case in PTD than in long-term prisons although in many countries the number of women held in some form of pre-trial detention is as great as or greater than the number held as convicted prisoners (UNODC, 2008; WHO-Europe, 2009). 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). Specialized services to address these concerns are rare.

For women, pre-trial detention can be a period of extremely high risk of sexual abuse and violence (UNODC, 2008). As noted above, this risk is higher when women detainees are housed with convicted offenders and men, and when they are guarded by men. The UN Special Rapporteur on Violence Against Women underscored this concern, for example, following a visit to Haiti where women were detained in facilities with men and guarded by male officers (Coomaraswamy, 2000). In this case, 90% of the women were awaiting trial or in “preventive detention.” Most international and regional human rights norms state that women detainees should never be supervised by male staff and that male staff members should not have access to their living or bathroom areas (UNODC, 2009; WHO-Europe, 2009).

HIV prevalence of incarcerated women has been found to be significantly higher than that of men in many studies, including from India, Moldova, and Brazil (Jürgens, 2007). These studies do not distinguish pre-trial detainees from prisoners, but it is likely they include both. Little is known about the risk of HIV transmission among women in prison (Dolan et al, 2007; Jürgens, 2007). One study estimated that between one third and one half of women entering prison in Russia from 2000 to 2002 had STIs (UNODC, 2008). There is very little literature on other infectious illness among women detainees.

Reproductive health services for women in pre-trial detention in developing or transitional countries have also been little studied. Penal Reform International (2008) 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 even sometimes withholding them as a form of punishment. An estimated 87% of incarcerated women in Brazil and 80% in Russia are mothers (UNODC, 2008). It is difficult to find information on access to gynecological care in remand facilities in developing or transitional countries. Meeting the special nutritional and other needs of pregnancy should be well established services for any corrections facility housing women.

Ineligibility of Pre-Trial Detainees for Educational and other Programs

Pre-trial detainees often do not have access to exercise, sports, 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. Health-related peer education programs – which may be

among the most effective health education programs in prisons (Dolan et al, 2004; Devilly et al, 2005) – appear to be mostly unavailable in pre-trial detention. Knowledge of HIV risks, for example, is compromised as a result. Many reports suggest that peer educators are a key to the success of HIV education programs in prisons and that peer educators can be trained relatively quickly and supported at low cost (Goyer & Gow, 2002). Peer-based health education programs are feasible in pre-trial detention but have apparently been little tried.

Abuses Faced by Lesbian, Gay, Bisexual, and Transgender Detainees

There is little peer-reviewed literature on the health problem of lesbian, gay, bisexual, and transgender (LGBT) detainees from developing and transitional countries, but many monitoring reports suggest that they are subject to violence and abuse in PTD as well as prison. 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). Taboos around homosexuality and poor understanding of life in prison have impeded rational policy discussion and effective measures to address rape of gay (or other) men in prison (Gear, 2007; Muntingh & Tapscott, 2009). Reports from NGOs such as the International Gay and Lesbian Human Rights Commission (IGLHRC) and the International Lesbian and Gay Association (ILGA) about violence against LGBT persons in state custody are numerous but do not always distinguish prison from pre-trial settings (IGLHRC 2008, 2007, 2006, 2000, 2002; Human Rights Watch, 2004; Amnesty International, 2001). Some 72 countries and sub-national units of three others allow people to be imprisoned for the “crime” of homosexuality, of which at least 11 mandate imprisonment of over ten years (ILGA, 2009); in these countries, there is an obvious concern that LGBT persons will always be present in custodial facilities, and the protection of their rights will not be a high priority.

Transgender persons, particularly those who may not have initiated or completed sex-transforming surgery, face the ordeal of being classified for 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 most countries the absence of such a policy puts transgender people at high risk of abuse in detention.

Population Least Likely to be in Medical Care

Pre-trial detainees, particularly those not recently in the criminal justice system, are less likely than prisoners to have

had regular access to medical care or preventive health measures. It is wrong to speak of PTD as an opportunity for introducing this population to medical care if that assertion has any ring of endorsement for the use of PTD. But to the degree that PTD is applied, PTD facilities should introduce detained populations to health care. As noted above, the opportunity to initiate care for the range of physical and mental disorders that present themselves at admission to remand and to create effective links to care in the community is valuable and too often missed.

CONCLUSION AND RECOMMENDATIONS

Along with human rights and justice grounds, a public health crisis among detainees adds to the case for reducing the use of PTD as a crime-fighting tool. Failure to protect men, women, and children from cruel, inhuman, and degrading conditions, torture, violence and sexual abuse, overcrowding, and the absence of health services to address physical and mental disorders exact an untold cost among persons wholly dependent on the state. Pre-trial facilities, including police lock-ups, are too often out of the sight of independent monitors and apparently not a priority for measures that might make conditions in them more humane.

Early detection and treatment of physical and mental health disorders is possible in PTD with links to care in the community or in prison when detainees are discharged or transferred. But with respect to HIV, drug dependency, TB, HCV, and many forms of mental illness, which require continued care and support, there is little evidence that there is systematic initiation or sustaining of basic care with disastrous consequences in the form of infectious disease epidemics and neglected problems of addiction. 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 and sometimes even when they are available to prisoners. Problems of women and children in detention do not appear to be a priority to prison authorities and governments.

It is not possible to know the full cost in death and disease of the problems described here, but the cost is sufficient to warrant a global effort to address health in PTD settings. It cannot be too much repeated that most of the problems described here would be greatly diminished by reduction in the use of PTD and greater use of alternatives to detention. Indeed, without reduced use of PTD and attendant problems of overcrowding and poor living conditions, it is difficult to imagine how these problems will be addressed. To the degree that PTD continues to be used, however, a number of measures could improve health services and enhance the possibility for realizing the health rights of persons in detention. Research and monitoring that would inform better services should also be used to inform

advocacy for reduced use of PTD. The following actions are recommended:

- **Improved PTD health services to improve early detection, care, and linkage to continued care.** Research and monitoring accounts suggest that pre-trial health services and staffing are inadequate compared to those of prisons or the community at large. Because the remand environment may be relatively chaotic and subject to rapid turnover of detainees, there is a tendency to give up on initiating services that might nonetheless be possible to sustain even in such an environment. Again, links to community- and prison-based care are crucial. Some important elements of health services have shown themselves to be feasible and effective in a wide range of circumstances in correctional facilities. It should be possible to include pre-trial detention in a continuum of care with regard to methadone therapy, for example, as well as directly observed therapy strategies (DOTS) for TB and ART 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.
- **Research and access to research results.** Scholarly research on key elements of health in PTD in developing and transitional countries is lacking. Access to these settings for researchers may be restricted in many countries. The fact that health services, such as they are, 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. The literature reviewed here indicates research needs in at least the following areas:
 - > *To generate information for advocacy for reduction of PTD:*
 - Better data on the extent of PTD, particularly among women, children, people who live with drug dependence, people with mental illness, LGBT persons, sex workers, and others vulnerable to abuse and health problems;
 - Research on the relationship between the extent of use of PTD and health outcomes;
 - The health impact of overcrowding in PTD, including whether critical levels of crowding trigger accelerated transmission of infectious diseases;
 - The physical and mental health impact of failure to segregate pre-trial detainees from prisoners, children from adults, women from men; and
 - The physical and mental impact of extended PTD on adults and children.

- > *To improve practices:*
 - Best practices for ensuring continuity of care for physical and mental health conditions between PTD on the one hand and prison or the community on the other;
 - Feasibility of and best practices in TB detection, treatment and support and in offering voluntary HIV testing and providing treatment and support to HIV-positive detainees, in PTD and beyond;
 - Feasibility of and best practices in sterile syringe programs, methadone and buprenorphine therapy, and other drug dependency treatment in remand; and
 - Best practices in detection, care and support of mental illness among persons in remand.
- > *Where there are efforts to reform pre-trial justice and reduce the use of PTD:*
 - Ensure that health officials are involved in the planning and implementation of reforms; and
 - Study the health impact of reforms.

In addition to contributing to research, health professionals can participate in monitoring with independent monitors who have access to PTD facilities.

- **Transparency, complaint mechanisms and access to counsel.** It is of concern that so much of what is known about unhealthy and inhumane conditions faced by pre-trial detainees is found in reports of occasional visits by human rights monitors. There is an urgent need to open PTD to wider scrutiny and to establish mechanisms of regular monitoring and public reporting. Access to legal counsel and to the courts for pre-trial detainees would be one avenue for addressing abusive and negligent health practices.
- **Mechanisms for prison staff to be independent and to speak out against abuse.** Pre-trial detention-based health professionals need to be able to make independent evidence-based decisions about health care practices 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). Medical professional societies should advocate with correctional health authorities to ensure that physicians working in prisons can make independent recommendations about services and are not overruled for medically unsound reasons.

Professional associations should have training programs and guidelines for prison-based professionals on ethical challenges, including avoidance of participation in any cruel, inhuman or degrading treatment or torture, as in Norway (Fleck, 2004). Professional societies should advocate for adequate salaries and good working conditions for health care providers in pre-trial settings.

- **Ministries of Health.** Some of the more promising PTD health initiatives described in the research literature, including the DOTS program in Thai prisons, were apparently possible because of the extensive involvement of health-sector officials. 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, at least, for monitoring the quality of care for detainees.
- **Awareness-Raising among Key Stakeholders.** In addition to the need for more research, there is an urgent need for what is already known about health in PTD to be more widely known among potential decision-makers and the public. Ministries of Health may be shielded from day-to-day knowledge of PTD conditions and must be made aware of them to enable them to contribute to positive change. Beyond the health sector, judges, prosecutors, police, juvenile justice officials, and others in law enforcement, and human rights commissions should be made aware of the health consequences of heavy use of PTD.

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