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Opening the Door to Zero New HIV Infections in Closed Settings

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Abstract

Prisons and other closed settings are high-risk environments for HIV and tuberculosis (TB) transmission. Prisoners often experience overcrowded living conditions and violence—including sexual assault—increasing their vulnerability to HIV and TB. However, high infection rates in prisons affect both prisoners and prison employees. Both groups, in interacting with their families and their communities, represent a potential risk of HIV transmission outside the prison setting. National HIV and TB strategies should therefore include measures to prevent transmission and increase access to HIV-related services in prisons. Courts have progressively recognized the human rights of prisoners, including the right to health and access to HIV-related services. A number of national and regional court decisions have affirmed that prison authorities have a duty of care to prisoners and an obligation to ensure that prisoners have access to HIV prevention measures and treatment. Policies and programs on HIV, AIDS, and TB for prison workplaces that are aligned with the ILO's international labor standards can benefit both prisoners and prison employees. In particular, the ILO's HIV and AIDS Recommendation, 2010 (No. 200) affirms the principle of universal access to HIV services and provides guidance for the HIV/TB response in prison settings.

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Introduction

An estimated 30 million people are incarcerated each year.1 In most instances, these persons will ultimately be released back into society, returning to their families and communities. During their incarceration, however, prisoners are at increased risk of HIV and tuberculosis (TB) infections. Conditions in prisons and other closed settings are conducive to high rates of HIV transmission as well as high rates of TB co-infection. The term "prisons and other closed settings" refers to all places of detention within a country, and the terms "prisoners" or "detainees" to all those detained in those places, including adults and juveniles, during the investigation of a crime, while awaiting trial, after conviction, before and after sentencing.

The increased risks that incarceration poses for prisoners' health reach beyond the prison walls. Prison conditions and risk behaviors prevalent in prison settings have the potential to affect a broad range of people, both inside and outside the prison environment. It has been noted that "the high prevalence of HIV infection among prisoners and pre-trial detainees, combined with overcrowding and sub-standard living conditions […], make prisons and other detention centers a high-risk environment for the transmission of HIV. Ultimately, this contributes to HIV epidemics in the communities to which prisoners return upon their release."[2]

Prisoners in many countries may be exposed to HIV infection by being subjected to violence, including sexual violence, perpetrated by other prisoners or even by prison guards.[3] Bearing in mind that most prisoners will return to their communities after serving their sentence, and that many prisoners enjoy conjugal visit privileges while in prison, responses to HIV and TB in prisons should be an integral component of national HIV and TB strategies. Noting that those employed in prisons, including guards, medical officers, administrators, and other workers, can also be exposed to HIV and TB through exposure to violence from prisoners or due to other workplace hazards, national HIV and TB strategies should also include HIV and TB workplace policies and programs to protect the health and well-being of everyone employed in prison workplaces, from security staff to medical and cleaning staff.

First, this article will examine the prevalence of HIV and TB in prison environments. In this context, it will look at relevant international legal instruments affirming the human rights of prisoners, particularly their right to health, and provide examples of national and regional jurisprudence addressing the right of prisoners to health and access to HIV-related services. The article will also look at the duty of prison authorities to ensure that the prisoners have access to HIV-related prevention services. Second, the article will explore the contribution that HIV, AIDS, and TB workplace policies and programs for prison workplaces can make to advance the health and human rights of prisoners, as well as the communities beyond the prison setting. These policies and programs can facilitate prison workers' role in ensuring respect for prisoners' right to health, including HIV services, as well as enhancing staff's well-being.

Prisons are high-risk environments for HIV and TB transmission

Prisons and other closed settings are often hotbeds for both HIV and TB transmission. HIV prevalence among certain prison populations is up to 50 times higher than in the general population.[4] However, access to HIV prevention and health care, including HIV treatment, is often minimal or non-existent. High rates of HIV infection among prisoners, combined with high rates of drug dependence and the common practice of sharing used needles, contribute to the spread of HIV.[5] Other factors contributing to high rates of HIV and TB in prisons include overcrowding, corruption, denial, stigma, lack of protection for vulnerable prisoners, lack of training for prison staff, and poor or non-existent medical and social services.[6]

Violence, including sexual assault, is a particular high-risk factor. For example, rape in prison carries the highest risk of HIV transmission among prisoners.[7] Despite the risks posed by coerced or non-consensual sex and sexual violence, many prisons fail to ensure that prisoners have access

either to condoms or treatment. Both are necessary elements of effective HIV prevention. Condoms are barriers that prevent sexual transmission of HIV, while antiretroviral treatment, by reducing an individual's viral load, also helps to reduce the risk of sexual transmission of the virus.[8]

A number of outbreaks of HIV infection have been reported in prison settings over the past few decades.[9] For example, in a Lithuanian prison, over the course of a few months in 2002, 263 prisoners tested positive for HIV. At that time, only 300 people in the entire country were known to be living with HIV, of whom 18 were incarcerated. Transmission among the prisoners was due to their sharing of contaminated drug injection equipment.[10] Another example is found in South Africa where, in 2000, the country recorded 1,087 "natural deaths" in its prisons. This represented a 584% increase compared to the number of "natural deaths" reported in 1995. Officials reported that 90% of those deaths were HIV-related.[11]

Increases in the numbers of new HIV infections are, however, not the only consequence of the failure of prison administrations to effectively address HIV prevention, treatment, and occupational safety and health measures in prison settings. TB is another frequent communicable disease threat. Globally, the rates of TB infection among prisoners have been estimated as being up to 50 times higher than in the general population.[12] These high rates are attributable to poor conditions of detention, including overcrowding, poor ventilation, poor nutrition, and the lack of TB prevention measures in most prisons.

People living with HIV have compromised immune systems that are less able to resist infections, particularly opportunistic infections such as TB; therefore, they are more susceptible to contracting TB than the general population, and there is a higher probability of HIV-TB co-infection among people living with HIV in general. For this reason, the practice of segregating prisoners living with HIV in separate wards facilitates the spread of TB among this group. In a US prison in South Carolina, the practice of segregating prisoners infected with HIV contributed to an outbreak of TB among HIV-positive prisoners in 1999 and 2000.[13] Outbreaks of TB have also been documented in Zambian prisons.[14]

In the United States, a 2007 study revealed that AIDS rates were 2.4 times higher among incarcerated men than in the general population.[15] According to the United States Bureau of Justice Statistics, AIDS was listed as the second most frequent cause of death in US prisons between 2001 and 2004.[16] Similarly, in Brazil and Argentina, studies from prisons reveal a particularly high HIV prevalence, reaching 20% in Brazil and 10% in Argentina.[17]

The HIV prevalence for some sub-Saharan African countries is also high: as of 2007, an estimated 41% of incarcerated people in South Africa were HIV-positive.[18] The high prevalence of HIV infection among prisoners and pre-trial detainees, combined with overcrowding, sub-standard living conditions, and stigma and discrimination make prisons and closed settings high-risk environments for the transmission of HIV and TB.

International legal instruments affirm the right to health for all persons. The bodies responsible for monitoring the implementation of these instruments have interpreted their provisions to cover prisoners in relation to the universal right to health as well as the right to access HIV-related services.

International legal instruments

The fundamental human right to the highest attainable standard of health is affirmed in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights (UDHR) recognizes that "everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services."[19] According to the United Nations Human Rights Committee, while the International Covenant on Civil and Political Rights (ICCPR) does not explicitly mention the right to health in detention, the treaty still raises the issue under the right to life or the right to humane treatment.[20]

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) further provides that the right to health is universal. Accordingly, there should be no discrimination in relation to the right to health. In this regard, the body responsible for monitoring the implementation of the ICESCR, the United Nations Committee on Economic, Social and Cultural Rights, has noted that "States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees... to preventive, curative and palliative health services [and]… abstaining from enforcing discriminatory practices as a State policy."[21] Moreover, the Committee has explicitly recognized that equitable access to medicines constitutes a fundamental component of the right to health.[22]

The UN has focused on the protection of human rights in prisons and other closed settings in a number of international instruments. Reflecting this concern, the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders adopted the Standard Minimum Rules for the Treatment of Prisoners (SMR) in 1955.[23]

Rule 6 of the SMR provides that the Rules should be applied impartially and that "there shall be no discrimination on grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[24] Thirty years later, in 1985, the Seventh UN Congress on the Prevention of Crime and the Treatment of Offenders adopted Resolution No. 10 on the status of prisoners and Resolution No. 17 on the human rights of prisoners. In Resolution No. 17, the Congress recalled the international instruments relevant to the human rights of prisoners. It called on the UN General Assembly to finalize work on the Draft Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment. [25]

Subsequently, on December 14, 1990, the General Assembly clarified the basic principles underlying the SMR by adopting the Basic Principles for the Treatment of Prisoners.[26] Paragraph 9 of the Basic Principles provides that "prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[27]

In December 2010, the General Assembly adopted Resolution No. 65/230, requesting the Commission on Crime Prevention and Criminal Justice (CCPCJ) to establish an inter-governmental group of experts to exchange information on best practices and to revise the SMR so that "they reflect recent advances in correctional science and best practices."[28]

In December 2013, the Committee Against Torture, the UN body responsible for monitoring application of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, submitted its observations on the revision of the SMR to the General Assembly.[29] The Committee reiterated the importance of the principle of non-discrimination, emphasizing that it is fundamental to the application of the Convention. In particular, the Committee recommended that Rule 6 of the SMR be amended to clarify that States are under an obligation to ensure freedom from discrimination, proposing that it clarify that "States must ensure application of the Rules to all persons, regardless of race, color, ethnicity, age, religious belief or affiliation, political or other opinion, national or social origin, gender, sexual orientation, gender identity, mental or other disability, health status, economic or indigenous status."[30] The Committee also urged that the SMR be revised to indicate that health care in prisons should be available and accessible to all prisoners, without discrimination or cost.[31] In particular, the Committee noted that "the State should also adopt all necessary measures to protect detainees from contracting tuberculosis, hepatitis C and HIV/AIDS," citing its conclusions in a matter involving lack of adequate medical services in an Ethiopian prison.[32]

On December 17, 2015, at its 70th Session, the UN General Assembly adopted a revised version of the SMR, referred to as the Nelson Mandela Rules (Resolution A/RES/70/175).[33] Rule 2 of the Nelson Mandela Rules is similar to the 1955 text of Rule 6(1) of the SMR; it provides that "there shall be

no discrimination on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or any other status." Rule 2 also provides additional protections, stating that in applying the principle of non-discrimination, prison authorities shall take into account the individual needs of prisoners, particularly the most vulnerable.

Rule 24 of the Nelson Mandela Rules affirms that provision of health care for prisoners is a state responsibility, providing that prisoners should enjoy the same standards of health care as those available in the community. In particular, Rule 24 provides that health care should be organized "in a way that ensures continuity of treatment and care, *including for HIV, tuberculosis and other infectious diseases* (…)." [emphasis added]

Rule 26 provides for the confidentiality of prisoners' medical files. In addition, subsection (c) of Rule 32 provides for the confidentiality of medical information. These safeguards would shield prisoners living with HIV from disclosure of their HIV status, providing them with increased protection from stigma and discrimination. Rule 32 also establishes that the ethical and professional standards applicable to the doctor-patient relationship outside the prison setting are equally applicable to the relationship between a prisoner and his or her doctor or other health care provider.

Regional human rights instruments also recognize and affirm the right to health. For example, Article 16 (1) of the African Charter on Human and Peoples' Rights provides that "every individual shall have the right to enjoy the best attainable state of physical and mental health." Article 16 (2) calls on governments to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick." Other regional instruments that affirm the right to health include the European Social Charter (Article 11), adopted in 1961, and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Article 10), entered into force in 1999.

The Committee on Economic, Social and Cultural Rights has observed that timely and appropriate health care is an inclusive right, which also extends to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information.[34] In addition, health services, facilities and goods must be made accessible to all without discrimination on any grounds.[35]

Another international instrument relevant to prisons is the ILO Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200). Recommendation No. 200 is the first international labor standard to provide for the protection of health and human rights in and through the workplace in the context of HIV and AIDS. It applies to all workplaces, including prisons. The Recommendation establishes key principles for the prevention and treatment of HIV and calls on governments and organizations of employers and workers as well as people living with HIV and other sectors, especially the health sector, to take specific measures to prevent HIV-related stigma and discrimination; prevent new infections; provide for equal access to treatment, care, and support; and ensure a safe and healthy workplace for all workers.[36] While Recommendation No. 200 is not directly applicable to prisoners, its key principles are in harmony with international legal principles affirming prisoners' right to health, including the right to access HIV-related prevention, treatment, care, and support services.

Respecting human rights and dignity in prisons

HIV- and TB-related stigma and discrimination compound the problem of high HIV and TB prevalence in prisons. Many prisons or detention centers across the world still apply segregation policies for prisoners living with HIV or TB. Such policies may deny prisoners access to rehabilitation, treatment, and other services.[37] Human Rights Watch and the American Civil Liberties Union (ACLU) reported an example of such a policy in 2010:

> All prisoners are tested for HIV at their arrival to a prison in Alabama and South Carolina. Those who test, or who are already known to be HIV positive, are housed in separate prison accommodation. In Alabama and South Carolina, most prisoners who test positive are required to wear an armband or badge to signify their HIV positive status.[38]

In 2013, an Alabama Federal District Court decision struck down the segregation policy applied by the Alabama Department of Corrections, holding that it discriminated against prisoners on the basis of a disability (their HIV status) in violation of the Americans with Disabilities Act.[39] The Court ordered the Department of Corrections to institute a non-discriminatory policy of integration of prisoners.

Fortunately, countries are increasingly recognizing the human rights abuses that discriminatory segregation policies represent, in addition to the negative impact on HIV prevention and treatment efforts. Consequently, fewer prisons are applying segregation policies. However, in prisons where these policies are still applied, prisoners living with HIV or TB continue to be subjected to stigma, discrimination, and denial of health services.

Protecting the rights of key vulnerable and at-risk groups

Certain populations, such as lesbian, gay, bisexual, and transgender persons (LGBT) and those perceived to be LGBT, are at increased risk of HIV infection and are often subjected to heightened stigma and discrimination, both inside and outside prison settings. Transgender prisoners are particularly at risk, as prison staff are usually not aware of or trained on how to address the specific needs of this population. In addition, legislation in many countries either criminalizes LGBT populations or fails to provide adequate protection of their fundamental human rights.

Transgender prisoners commonly experience violence and abuse from other prisoners, as well as from prison staff. The health risks faced by transgender prisoners due to stigma and discrimination are illustrated in the following judgment from the US Supreme Court, in the matter of *Farmer v. Brennan*:

> Dee Farmer, a transgender woman, was incarcerated among the male population in a US penitentiary in Indiana. Soon after her arrival, she was subjected to multiple rapes and violence by another inmate and subsequently was infected with HIV. She claimed that the prison officials should have known that she represented a vulnerable population to sexual violence and should have taken measures to prevent such violence from occurring. The Supreme Court ruled in favor of Farmer and claimed that it was the responsibility of the prison administration to prevent inmates from harming each other. The Court held that inhumane prisons violate the Eighth Amendment of the Constitution "even if no prison official has an improper, subjective state of mind."[40]

In its decision, the Court cited its prior judgment in *Hudson v. Palmer* affirming the principle that "prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must take reasonable measures to guarantee the safety of the inmates".[41]

Prisoners' right of access to medical treatment

Courts have held that countries have an obligation to protect prisoners' right to health. In its 2007 decision in *Yakovenko v. Ukraine*, the European Court of Human Rights (ECHR) held that this obligation includes provision of antiretroviral treatment (ART) to prisoners living with HIV. In that case, the applicant was convicted of a criminal offense and incarcerated. While in prison, he tested positive for HIV. He claimed that neither he nor his family was informed of his diagnosis, nor was he given treatment. The applicant was housed intermittently in the main prison and in a temporary detention center where detainees suffering from TB were lodged, as they were not permitted to be housed in the main prison. There was no medical officer on the staff of the detention center.

The applicant contracted TB during his stay at the detention center. Hospitalization was recommended by doctors who had examined the applicant, but the prison authorities ignored the

recommendation. The applicant also claimed that detention conditions were poor; he complained of overcrowding, a shortage of beds (with more detainees than beds), lack of daylight, poor ventilation, inadequate nutrition, and infestations of rodents and insects. The applicant claimed that lack of medical treatment and poor conditions of detention constituted a violation of his right to be free from torture and inhumane treatment or degrading treatment under Article 3 of the ECHR, which provides that "no one shall be subjected to torture or to inhuman or degrading punishment." The applicant died while the case was still pending before the Court, and his mother continued the proceedings on his behalf. In its decision, the Court held that state authorities are obligated to protect the health of persons deprived of liberty. It held that there had been a violation of Article 3 of the Convention in light of "the authorities' failure to provide timely and appropriate medical assistance to the applicant in respect of his HIV and tuberculosis infections."[42]

In *Estelle v. Gamble,* the United States Supreme Court held that the deliberate failure of prison authorities to address the medical needs of a detainee constituted cruel and unusual punishment in violation of the Eighth Amendment to the US Constitution. The Court held that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' prohibited by the Eighth Amendment."[43]

In *Odafe v. Attorney General of the Federal Republic of Nigeria,* the Federal High Court of Nigeria held that the refusal to provide HIV-positive pre-trial prisoners with access to treatment violated their right to enjoy the highest attainable standard of physical and mental health, as guaranteed under the African Charter. In that case, a number of prisoners awaiting trial were diagnosed with HIV while in detention. They were segregated from the general prison population and denied medical treatment. Although the Nigerian Constitution does not provide for the right to health care, the Court nevertheless held that, under the African Charter, which Nigeria had ratified, the state was obligated to provide the prisoners with adequate medical treatment. The Court noted the economic cost of the treatment, but held that the state had the obligation to provide ART regardless of the offense with which the prisoners had been charged.[44]

In *B v. Minister of Correctional Services,* the High Court of South Africa examined whether the state had an obligation to provide ART to prisoners living with HIV.[45] At the time of the decision, prisoners in South Africa were not treated for HIV, but only for opportunistic infections. This was also the case for members of the general population who were making use of public health facilities. Prisoners therefore did not have access to ART. The Court ruled that the state has an obligation to provide ART to all prisoners who are prescribed such treatment by their physicians. In reaching its decision, the Court specifically held that the state owes a higher duty of care to HIV-positive prisoners than to non-prisoners who are HIV-positive. The Court reasoned that prisoners have little access to other resources to assist them in acquiring medical treatment. In addition, prisoners are more likely to be exposed to opportunistic infections in overcrowded prison settings. The Court therefore concluded that the standard of adequate medical care in prisons cannot be determined by the lowest standard of care that may be available outside the prison.

In *EN v. Government of South Africa,* the High Court was asked to issue an order requiring the removal of all restrictions to accessing treatment at Westville Correctional Centre and instructing that ART be provided immediately to all medically eligible prisoners.[46] The prisoners argued that the restrictions violated their general right of access to health care services and their right as detained persons to adequate medical treatment. The state countered that it was providing adequate medical care, pointing to existing treatment plans. The Court held in favor of the prisoners, finding that the state's existing plan was insufficient since it would take approximately one year for all 50 prisoners who needed ART to access it. Given the importance of starting the HIV-positive prisoners on treatment as rapidly as possible, the Court issued an order giving the state a shorter period of time to develop and file a reasonable plan indicating how it would ensure provision of the necessary

treatment. The Court affirmed that the "authorities were legally and constitutionally bound to provide adequate medical treatment to prisoners who need it," citing Section 35 (2) (e) of the Constitution, and that the applicants were thus entitled to ART. As the applicants did not have access to HIV-related health care under the National Department of Health's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, the Court ruled that the respondents had not fulfilled their legal obligations.

Some countries have enacted policies that allow HIV-positive prisoners to receive ART, but exclude those that are not citizens of the country where the prison is located. In Botswana, the roll-out of Highly Active Antiretroviral Therapy (HAART) reached citizen prisoners, but excluded non-citizen prisoners.

In the case of *The Attorney General et al. v. Dickson Tapela et al.*, the Botswana Network on Ethics, Law and AIDS (BONELA), jointly with two HIV-positive non-citizen prisoners, brought a complaint before the High Court of Botswana challenging this policy on the grounds that refusal to include them in the HAART roll-out violated their rights under the Constitution of Botswana, including the right to life, the right not to be subjected to inhuman and degrading treatment, and the right to non-discrimination. The complainants also argued that the refusal contravened the national HIV and AIDS policy, as well as the state's duty to provide basic health care services to all prisoners. On August 22, 2014, the Court of Appeal of the Republic of Botswana held that the denial of HIV treatment to non-citizen prisoners living with HIV violated their rights as enshrined under the Constitution of Botswana.[47]

Disease prevention and preserving human dignity

The courts have also addressed the obligation of prison authorities to prevent transmission of HIV-related illnesses among prisoners. In *Dudley Lee v. Minister for Correctional Services*, the Constitutional Court of South Africa held that prison authorities have a duty of care to prevent prisoners from being infected with HIV-related illnesses such as TB. In that case, the applicant was incarcerated in a maximum security prison in Pollsmoor, South Africa. When he entered the prison, he was not infected with TB; he was diagnosed with TB three years into his prison term. The applicant lodged a complaint against the South African Minister for Correctional Services, alleging that he had become infected with TB due to congested prison conditions and the respondent's failure to provide him with adequate medical treatment or to prevent further transmission. The Constitutional Court held that the respondent had been negligent in failing to maintain an adequate system for management of TB in the prison. The Court found that prisoners "are amongst the most vulnerable in our society due to the failure of the state to meet its constitutional and statutory obligations." It held that, when the state imprisons an individual, "it must assume the obligation […] inherent in the right […] to conditions of detention that are consistent with human dignity." The majority in *Lee* observed that there is a legal duty on the responsible authorities to provide adequate health care services as part of the constitutional right of all prisoners to conditions of detention that are consistent with human dignity. This right includes "the provision, at state expense, of adequate accommodation, nutrition and medical treatment." In upholding the claim, the Court concluded that there was a probable chain of causation between the negligence of the responsible authorities and the appellant's subsequent TB infection.[48]

Nevertheless, not all courts have ruled in favor of prisoners' right to health. In particular, some have been reluctant to enforce the right to preventive health. For example, in a judgment from the United Kingdom, *R. v. Secretary of State for the Home Department, ex parte Glen Fielding*, a prison inmate challenged the prison's policy of denying prisoners access to condoms unless prescribed by a prison doctor.[49] The High Court held that the prison policy was lawful. Nevertheless, the Court rejected the argument that prisoners should have greater access to condoms, noting that the Prison Service was entitled to avoid a policy that appeared

to encourage homosexuality and that some level of control of condoms as a commodity, with uses other than those for which they are designed, should be the prerogative of the Prison Service.

Similarly, in *Prisoners A-XX Inclusive v. State of New South Wales*, 50 prisoners sued the Australian state of New South Wales for failing to supply or permit possession of condoms by male prisoners. The Court of First Instance held that the class of applicants could sue for a breach of the duty of care owed to them, but that the suit could only be brought on behalf of four aggrieved prisoners at a time, on the basis that proceedings involving 50 prisoners would be unmanageable and unwieldy. The Court also rejected the prisoners' claim to *habeas corpus*. The prisoners appealed the decision. The Court of Appeals upheld the lower court decision, holding that the writ of *habeas corpus* does not extend to situations involving deplorable detention conditions, and agreeing with the lower court's decision to limit proceedings to fewer plaintiffs at any one time.[50]

In some instances, legislatures, rather than judicial authorities, have taken steps to affirm prisoners' human rights, including their right to HIV-related health services, which includes access to preventive health supplies. For example, in 2011, the Republic of Congo adopted legislation establishing prisoners' right to confidentiality of their HIV status, freedom from discrimination, and their right to health services, including access to preventive health supplies. The legislation also provides that the ministry in charge of justice should make available to prisoners condoms and other materials for safer sexual relations, as well as adequate information on their use and their importance in preventing HIV infection and other sexually transmitted diseases.[51]

Workplace HIV, AIDS, and TB policies and programs in prisons

As workplaces, prisons can directly benefit prison workers, their families, and local communities through enacting and implementing workplace policies and programs. By raising awareness of the human rights implications of the HIV response, prison workplace policies and programs can indirectly enhance the protection of the human rights of prisoners, particularly their right to health.

In June 2010, at the annual International Labor Conference, the ILO's 185 member states adopted the only international labor standard focused on HIV and AIDS and the world of work: the Recommendation concerning HIV and AIDS and the World of Work, No. 200.

While Recommendation No. 200 does not apply directly to prisoners, prison workplace policies and programs on HIV, AIDS and TB can have an impact that reaches both prison employees and prisoners and extends beyond the prison workplace. Ghana and Kenya provide good practice examples. In 2011, at the request of its constituents, the ILO assisted the government of Ghana to develop a prison workplace HIV policy. In December 2011, the Ghana Prisons Service adopted the HIV/TB Workplace Policy and Implementation Strategy, which incorporates the key principles of Recommendation No. 200.[52] In addition to addressing the needs and concerns of prison staff, the Ghana policy includes protections against stigma and discrimination for all persons living with HIV and TB (including prisoners); and sets out measures to prevent HIV and TB transmission through information, communication, and education programs for both prison staff and prisoners.

The policy also provides that HIV testing, counseling, and screening, and counseling for TB and sexually transmitted infections, should be offered to all prisoners upon admission. As a workplace policy aiming to respond to HIV and AIDS in and through the workplace setting, the Ghana policy provides for measures to reach the families and dependents of prison employees. It applies to the spouses, immediate family members, and dependents of Prisons Service employees, as well as to prisoners (to the extent permitted under national law). The policy objectives include the provision, "through collaboration with relevant institutions and healthcare providers, treatment, care, support and counseling services for those infected or affected."[53] The fundamental principles of the policy

include confidentiality, non-discrimination, and protection against stigma, and apply to both prison employees and prisoners.

In July 2014, with technical advisory support from the ILO, the Kenya Prisons Services, a Department of the Ministry of Home Affairs, developed an HIV and AIDS workplace policy that integrates the key human rights principles set out in Recommendation No. 200.[54] The foreword to the policy notes that its development was "necessitated by the challenges posed by HIV and AIDS in Kenya Prisons Service." In this regard, the policy states that the epidemic has affected prison staff in numerous ways, including through a reduced workforce due to death, prolonged illnesses, low morale, and interruptions in work schedules to seek medical care. The policy notes that the epidemic has affected the ability of the prison services to achieve their core functions. Prison security is also affected due to absenteeism and physical weakness of officers suffering from opportunistic infections and reduced performance due to stress and stigma associated with an HIV-positive diagnosis. The sector-specific workplace policy seeks to address "the unique environment with curtailed liberties in which prisoners live as well as the poor working conditions under which prison staff work."

Specifically, the Kenya policy reflects the key principles of Recommendation No. 200, which include:

- the recognition of HIV and AIDS as a workplace issue;
- non-discrimination;
- privacy and confidentiality;
- gender-responsive measures;
- social dialogue; and
- access to HIV prevention, treatment, care, and support.

The policy provides guidance for those dealing with day-to-day issues that arise in the prison setting in relation to HIV and AIDS, including human resources management of both HIV-infected and affected prison staff and prisoners and HIV and AIDS programs in prisons. The good practices reflected in both the Ghana and Kenya policies show how integrating a rights-based approach to HIV and TB in prison workplace policies and programs can benefit prison workers directly. In addition, by extending the principle of non-discrimination and respect for the dignity of those living with or affected by HIV and AIDS, or TB, prison workplace policies and programs can contribute to HIV and TB prevention among the prison population, reducing stigma and discrimination while promoting access to HIV-related services. Such an approach serves to protect public health interests, enhancing prevention and access to HIV-related services among prison workers and prisoners, as well as their families and communities.

Conclusion

As evidenced by case law, regional and national courts are progressively recognizing the fundamental health rights of all prisoners. Courts have affirmed that prison authorities have a duty of care to prisoners and must ensure that they have access to HIV and TB prevention measures as well as access to treatment. Prison officials are also under an obligation to ensure that there is no stigma and discrimination against prisoners on the basis of real or perceived HIV status or due to the fact that they belong to at-risk groups.

In addition, by tapping into the enormous potential of workplaces, countries can significantly enhance HIV and TB prevention in prisons and other closed settings, engaging prison authorities, prison employees, their families, and prisoners through workplace policies and programs that integrate the principles of Recommendation No. 200. Such policies and programs will directly benefit prison workers. At the same time, they can contribute to the goal of reducing HIV-related stigma and discrimination and preventing new HIV infections and AIDS-related deaths inside and outside prison environments, among prisoners and the communities where prison facilities are located.

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