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HIV, Hepatitis C, TB, Harm Reduction, and Persons Deprived of Liberty: What Standards Does International Human Rights Law Establish?

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Abstract

HIV, hepatitis C virus (HCV), and TB in prisons and other places of detention are serious public health concerns, with prevalence and incidence considerably higher than in the general community because of the overrepresentation of risky behavior, substandard conditions, overcrowding, people who inject drugs, and the wholly inadequate prevention, care, and treatment of these conditions, including the denial of harm reduction services. This is not only a severe public health crisis but also a serious human rights concern. This article works to clarify the standards established by human rights law with regards to HIV, HCV, TB, and harm reduction in prisons by examining international and regional case law, minimum standards on the treatment of prisoners and public health, as well as the work of UN treaty bodies, Special Rapporteurs, and prison monitoring bodies. It is imperative that urgent steps are taken to close the gap between human rights and public health standards on the one hand, and effective

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Background

HIV, hepatitis C virus (HCV), and tuberculosis (TB) epidemics are a major public health concern around the world. Although all affect the population at large, they have emerged as an especially severe problem in prisons and other places of detention worldwide. Prison populations have a significantly higher prevalence, and in some contexts a higher incidence, of these diseases than the general public. A recent review of the global epidemiology of HIV, HCV, and TB in prisoners estimated that, of the roughly 10 million people detained worldwide on any given day, 3.8% are living with HIV, 15.1% with HCV, and 2.8% with active TB.[1] Throughout this article, the terms 'prison,' 'detention' and 'closed settings' are used interchangeably to refer to all places where people are deprived of their liberty. Similarly, the term 'prisoner,' 'detainee' and 'people deprived of their liberty' are used interchangeably to refer to all persons deprived of their liberty.

Prison settings represent high-risk environments for the transmission of these diseases for a number of reasons. For one, poor and marginalized communities are overrepresented in prison populations worldwide.[2] Many of the factors that contribute to disproportionate levels of incarceration, such as poverty, discrimination, and criminalization of drug use and possession, also put these populations at increased vulnerability to similarly disproportionate rates of HIV, HCV, and TB. For example, people who inject drugs are 24 times more likely to acquire HIV than the rest of the adult population, while HCV and TB prevalence are also much higher among this population.[3]

Punitive approaches to drug use have resulted in the mass incarceration of people who use drugs. Currently, around one in every five prisoners is serving time for a drug offense, and it has been estimated that 56-90% of people who inject drugs will be incarcerated at some stage of their lives.[4] Despite the secure and allegedly drug-free nature of closed custody settings, many people continue to use drugs on an occasional or regular basis while in detention. Injecting drug use is common in prisons in every region of the world, and sharing of injecting equipment—sometimes with 15-20 people—occurs out of necessity.[5] Intensifying this risk of infection and related ill health are the substandard conditions in which detainees are frequently held. Overcrowding, poor sanitation, inadequate ventilation and means for maintaining personal hygiene, and lack of access to clean drinking water and nutritional food are common in prisons and contribute to high rates of disease and death. These poor conditions invariably exist within a climate of violence, humiliation, and discrimination that creates barriers to accessing health care services, which are often weak or inadequate to begin with.

Despite this reality, the provision of HIV, HCV, and TB treatment and prevention programs, including evidence-based harm reduction services such as needle and syringe programs (NSPs) and opioid substitution therapy (OST), remain extremely limited in prisons in comparison to what is available in the broader community. Currently, while 90 countries implement NSPs in the broader community, only eight make the service available in at least one prison. At the same time, while 80 countries provide OST in the broader community, only 52 provide the service in at least one prison, and only 43 countries provide HIV treatment in prisons.[6]

Ill health and poor conditions in prisons do not only concern prisoners and prison staff; they are issues of much wider public health concern. Around one-third of people incarcerated worldwide return to their communities every year, and because recidivism is common, especially among people who use drugs, there is a high degree of mobility between prison and community.[7] Prison health, therefore, is intimately connected to public health.[8] This is not just a public health concern, however, but also a human rights imperative.

Human rights, health, and persons deprived of liberty

Under international human rights law, persons deprived of their liberty retain all fundamental rights and freedoms, apart from those that are unavoidably restricted by the fact of their incarceration.[9]

Like all persons, therefore, detainees have a right to health.

The cornerstone protection of the right to health in international law is found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), but several provisions found in a range of other widely ratified international and regional human rights treaties also protect prisoners' health rights.[10] Some of these specifically articulate the right to health, while others, such as the prohibition of torture and ill treatment, for example, offer indirect protection. The prohibition of torture and ill treatment imposes positive obligations on states to protect the lives and/or well-being of persons deprived of liberty, which has been interpreted by several human rights mechanisms to require government authorities to safeguard the health of prisoners.[11] As will be demonstrated, the right to health and freedom from torture and ill treatment are indivisible and interdependent, particularly in closed settings.[12]

The highly generalized language used to articulate health rights in human rights treaties does not shed much light on the specific entitlements and obligations to which they give rise. UN treaty bodies, however, have provided useful operational guidance in their work to help understand the contours and content of particular rights. According to the UN Committee on Economic, Social and Cultural Rights (CESCR), for example, the right to health is not a right to be healthy; rather, it is an inclusive right that extends not only to timely and appropriate medical care, but also to the underlying determinants of health, such as access to adequate sanitation facilities, healthy environmental conditions, essential drugs, and health-related education and information.[13] This broad understanding of the right to health is important in the context of places of detention.

Clarifying the normative content of detainees' right to health entitlements, and the obligations that these impose on state authorities, requires an examination of international and regional treaty and case law, minimum standards on the treatment of prisoners and public health more generally, as well as the work of UN treaty bodies, Special Rapporteurs, and prison monitoring bodies. The following sections rely on these sources to identify some of the most relevant entitlements and obligations that stem from the right to health of prisoners in the context of HIV, HCV, TB, and harm reduction. Before turning to that, however, a brief word on standards will be helpful. Some standards, such as the absolute ban on torture and ill treatment and the obligation to respect the right to health by refraining from denying or limiting equal access for all persons to health services, are protected by international and regional treaties, as well as national constitutions and laws. Other public health and human rights standards, such as those included in the UN Standard Minimum Rules for the Treatment of Prisoners, codify much more specific entitlements and obligations with regards to, for example, adequate medical care for persons in detention. While the latter do not formally enjoy the status of international law, and are technically non-binding "soft law" instruments, a strong argument can be made that they have become accepted minimum legal requirements for governments to meet.[14]

A right to non-discrimination and equivalence of care

Like with many other socioeconomic rights, the right to health is subject to both resource availability and progressive realization. Yet regardless of their economic situation, states must fulfill minimum core obligations with respect to health, including to prisoners. One of these core obligations, which is both of immediate effect and non-derogable, is to "ensure the right of access to health facilities, goods and services, on a non-discriminatory basis, especially for vulnerable and marginalised groups."[15] Detained against their will, prisoners are at the mercy of the prison authorities, which puts them in a uniquely vulnerable position. Effectively deprived of the ability to provide for themselves, it has been argued that state actors have heightened obligations vis-à-vis prisoners.[16] This is reflected in the CESCR's General Comment 14.[17]

In the context of harm reduction in prisons, the former UN Special Rapporteur on the right to health has stated that "If harm reduction pro-

grammes and evidenced-based treatment are made available to the general public, but not to persons in detention, that contravenes international law."[18] Indeed, the importance of ensuring non-discriminatory access to health facilities, goods, and services in prisons has been widely endorsed in human rights and public health standards, guidelines, and other documents. Several standards of humane treatment of prisoners make reference to non-discrimination in accessing health care, including the European Prison Rules, the UN Basic Principles for the Treatment of Prisoners, and the revised UN Standard Minimum Rules for the Treatment of Prisoners, which state that "Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status."[19] It is also reflected in many international declarations and guidelines, including in the World Health Organization's (WHO) 1993 Guidelines on HIV infection and AIDS in prisons, and various other UN documents and statements.[20]

Very closely related to the obligation of non-discrimination is the principle of equivalence: the obligation to provide a standard of care that is at least equivalent to that available in the community. It is worth mentioning that despite the principle of equivalence enjoying broad consensus among international health and human rights authorities, including UN bodies, the European Union and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or punishment (CPT), it has one notable detractor: the European Court of Human Rights. In *Gladkiy v. Russia*, the Court stated that it "does not always adhere to this standard, at least when it comes to medical assistance to convicted prisoners" and that "[freedom from inhuman or degrading treatment] cannot be interpreted as securing for every detained person medical assistance at the same level as in 'the best civilian clinics.'"[21] While this position flies in the face of well-established international consensus, it is not very surprising given the Court's practice of deferring to the judgment of national authorities, also known as its "margin of appreciation doctrine."[22] The former Special Rapporteur on the right to health has clearly stated that "in the context of HIV and harm reduction, this demands implementation of harm reduction services in places of detention even where they are not yet available in the community, as the principle of equivalence is insufficient to address the epidemic among prisoners."[23]

A right to essential medicines

Another important core obligation vis-à-vis prisoners' right to health, which is also non-derogable and of immediate effect, is to provide essential medicines as defined by WHO's Essential Medicines Programme.[24] According to the latest WHO definition, essential medicines are "those that satisfy the priority health-care needs of the population" and are "selected with due regard to disease prevalence, evidence of efficacy and safety and comparative cost-effectiveness."[25] They are meant to be available at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at an affordable price.[26]

WHO's Model List of Essential Medicines includes morphine, methadone, and buprenorphine, drugs commonly used to treat opioid dependence.[27] Because these are classified as "controlled substances" under the international drug conventions, their availability is often limited. Where these essential medicines are available in the community, they are often of poorer quality, not provided on a continuous basis, or simply unavailable in closed settings.[28] For example, while 80 countries and territories implement OST in the broader community, only 52 countries provide the service in at least one prison.[29] There are several reasons for this, including the common perception that prisons should be "drug-free zones," unfounded concerns about the provision of OST leading to diversion of medication, violence, and/or security breaches, as well as a preference for abstinence-based treatment.[30] Unfortunately, these misconceptions continue to overshadow unequivocal scientific evidence revealing OST to be the most effective treatment in

managing opioid dependence, preventing HIV and HCV transmission, and in caring for drug users living with HIV or other infections.[31]

Again, the obligation to provide essential medicines should be discharged on a non-discriminatory basis, as the Human Rights Council highlighted when it recognized the "responsibility of States to ensure access to all, without discrimination, of medicines, in particular essential medicines, that are affordable and of good quality."[32] From a public health and human rights perspective, it is imperative that essential medicines be equally accessible in places of detention. The former Special Rapporteur on the right to health has called on states to "ensure that all harm reduction measures and drug dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations."[33]

The right to essential medicines also engages the right to humane treatment. The UN Special Rapporteur on torture recently explained that when "the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health, but may also violate an affirmative obligation under the prohibition of torture and ill treatment."[34] The UN Human Rights Committee also recently confirmed that "physical and mental pain and suffering associated with withdrawal symptoms may amount to torture or ill treatment," and that states have an obligation to ensure that drug users deprived of their liberty are effectively protected against this pain and suffering through the provision of timely, adequate and scientifically based medical assistance.[35]

A right to medical care and treatment

The right to medical care and treatment is a critically important element of the right to health and like all other rights, it belongs to everyone, including prisoners. CESCR has explicitly affirmed that "States are under the obligation to respect the right to health by…refraining from denying of limiting equal access for all persons, including prisoners or detainees … [to] curative and palliative health services."[36] On a number of occasions, when reviewing the implementation of state obligations, CESCR has expressed a specific concern about inadequate access to health care in prisons and has explained that medical care and treatment must not only be accessible, but also "timely and appropriate."[37]

This obligation is also expressed regularly within civil and political rights mechanisms. The UN Human Rights Committee, for example, has affirmed that the obligation to "provide appropriate medical care to detainees" is engaged under Article 10 (prohibition of inhuman and degrading treatment) of the International Covenant on Civil and Political Rights.[38] The former Special Rapporteur on torture has also stated that "denial of medical treatment and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law."[39]

The European Court of Human Rights has also recognized the obligation to provide care and treatment specifically for communicable diseases in prisons. In *Gladkiy v. Russia*, the Court held that "the State does have a responsibility to ensure treatment for prisoners in its charge" and that "[a]bsent or inadequate treatment for tuberculosis, particularly when the disease has been contracted in detention, is most certainly subject of the Court's concern."[40] Providing guidance on what "adequate" means, the Court has stated that "The mere fact that a detainee was seen by a doctor and prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance was adequate."[41]

On several occasions, the Court has found that inadequate care and treatment for HIV, HCV, and/or TB has amounted to cruel, inhuman, or degrading treatment.[42] In *Khudobin v. Russia*, the Court found that in the given context, the absence of medical assistance for a prisoner living with HIV amounted to degrading treatment.[43] In *Koryak v. Russia* and *A.B. v. Russia*, the fact that detainees did not receive comprehensive, effective, transparent,

or timely medical assistance for HIV and TB was sufficient for the Court to find that the authorities had failed to comply with their responsibility to ensure the provision of adequate medical treatment, which amounted to inhuman and degrading treatment.[44] In *Kozhokar v. Russia*, the Court found that the applicant did not receive comprehensive, effective, and regular medical assistance for HIV or HCV during detention, which amounted to degrading treatment."[45]

The Court has also found that inadequate treatment of drug dependence violates the prohibition of cruel, inhuman, or degrading treatment. In a very recent case, *Wenner v. Germany*, the Court established that "the refusal to provide the applicant with drug substitution treatment despite his manifest opioid addiction caused him considerable and continuous mental suffering for a long time."[46] The Court concluded that Germany's failure to provide "comprehensive and adequate medical care in detention, at a level comparable to that which the State authorities have committed themselves to provide to persons in freedom, where drug substitution was available," amounted to cruel, inhuman, and degrading treatment.[47] In another especially notable case, *McGlinchey and Others v. UK*, the Court held that the failure of prison health facilities to provide adequate medical care to a prisoner undergoing heroin withdrawal, who subsequently died, constituted ill treatment.[48] Specifically, the Court found that the prisoner's suffering derived not from heroin withdrawal but "the failure of prison authorities to take more effective steps to combat her withdrawal symptoms and [that her] deteriorating condition must have contributed to her pain and distress."[49] International and regional standards relating to the treatment of prisoners reflect this obligation to provide adequate health care and treatment. The Standard Minimum Rules for the Treatment of Prisoners, for example, explicitly state that "the provision of health care for prisoners is a State responsibility," which is reiterated in the European Prison Rules.[50]

An important element of the right to health care and treatment in the context of places of detention is that of continuity of care and treatment. People with health issues who move between detention and the community can find short periods in prison very disruptive to their community-based care and treatment programs. Others who start a particular treatment in prison often do not get connected with appropriate aftercare following release, a concern highlighted by WHO, the UN Office on Drugs and Crime (UNODC), and the Joint United Nations Programme on HIV/AIDS (UNAIDS).[51] This important obligation is also explicitly articulated in the revised Standard Minimum Rules for the Treatment of Prisoners. Rule 24(2) states: "Health-care services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence."[52] Several public health standards also reiterate this important principle.[53]

A right to preventive health services, including harm reduction

Particularly relevant to the context of HIV, HCV, and TB in prisons is the right to preventive health services. In recognition of this, CESCR has identified the obligation to take measures to prevent, treat, and control diseases as being of comparable priority to the core obligations under the right to health.[54] It specifically identifies prisoners and detainees as being entitled to this fundamental right, confirming: "States are under the obligation to respect the right to health by…refraining from denying or limiting equal access for all persons, including prisoners or detainees…to preventive… health services."[55] More specifically, CESCR has on more than one occasion recommended that states take steps to combat infections within prisons, particularly the most severe, such as TB and HIV.[56] The Special Rapporteur on torture has also explicitly stated that "states have an obligation to ensure that drug dependence treatment as well as HIV/hepatitis C prevention and treatment are accessible in all places of detention," and that "needle and syringe programmes should be used to reduce the risk of

infection with HIV/AIDS."[57]

The obligation is also confirmed in international and regional jurisprudence. For example, the UN Human Rights Committee, in its Concluding Observations on Moldova, noted that "Danger to the health and life of detainees as a result of the spread of contagious diseases and inadequate care amounts to a violation of article 10 [prohibition of torture and ill treatment]…and may also include a violation of articles 9 [right to liberty and security of the person] and 6 [right to life]."[58] The European Court of Human Rights has sustained this view in a number of its judgments. In *Melnik v. Ukraine*, the Court found a violation of the prohibition of ill treatment, in part, for the failure to prevent the applicant's tuberculosis while he was in prison.[59] In *Staykov v. Bulgaria*, the Court found the fact that "the applicant fell ill with tuberculosis" while in prison, along with a finding that "the prison authorities' prevention efforts were inadequate" among the factors contributing to a violation of the prohibition of ill treatment.[60]

This legally binding obligation is also reflected in several prison health standards, WHO and World Medical Association declarations, as well as non-binding resolutions of the Council of Europe and Parliamentary Assembly.[61] The CPT has also confirmed that "the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment."[62]

There is unequivocal evidence that the most effective way to prevent HIV and HCV infection within prisons is through the provision of harm reduction services.[63] This has been endorsed by a number of human rights and public health authorities. CESCR, for example, expressed concern at the rapid transmission of HIV in Tajikistan and Mauritius, in particular among prisoners, sex workers, and people who use drugs.[64] The Committee specifically called upon the government of Tajikistan to "establish time-bound targets for extending the provision of free...harm reduction services to all parts of the country" and to implement needle and syringe programs and OST based on international best practice standards in prisons.[65] In a 2009 statement, the UN High Commissioner for Human Rights recognized "the longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV," and stressed that "this is particularly the case for those in detention, who are already vulnerable to many forms of human rights violations."[66] Furthermore, the *Madrid recommendation: Health protection in prisons as an essential part of public health*, which was endorsed by representatives from 65 countries as well as the WHO, UNODC, and the Council of Europe, among many others, recognizes "the urgent need in all prison systems for measures, programmes and guidelines which are aimed at preventing and controlling major communicable diseases in prisons," including "harm reduction measures, including opioid substitution therapy, needle and syringe exchange…and condom distribution."[67]

It is important to briefly mention that human rights and public health standards, as well as minimum standards on the treatment of prisoners, require that testing and treatment, particularly for HIV and drug dependence, be voluntary and carried out only with the free and informed consent of the prisoner.[68] As the Special Rapporteurs on the right to health and torture have both affirmed, "Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity."[69] In the same breath, confidentiality must be protected, particularly in prison settings where the risk of reprisal is high, and information on health status must not be disclosed to third parties without the consent of the prisoner.[70]

A right to the underlying determinants of health

As already mentioned, the right to health extends not only to health care but also to the underlying determinants of health, which have a considerable impact on whether people are healthy or not. This is particularly relevant in the context of prisons and other places of detention, where overcrowding, inadequate sanitary facilities, poor hygiene, poor nutrition, and inadequate access to drinking water

are often the rule rather than the exception. As conditions of detention are integrally linked to the health status of those held within them, it is no wonder that conditions under which detainees are held have been found to favor the spread of diseases.[71]

CESCR has identified housing as "the environmental factor most frequently associated with conditions for disease" and notes that "inadequate and deficient housing and living conditions are invariably associated with higher mortality and morbidity rates."[72] The Standard Minimum Rules for the Treatment of Prisoners also recognize that the failure to provide, among other things, adequate space, lighting, ventilation, nutritious food, drinking water, and appropriate hygiene and sanitary installations can be detrimental to the health of persons in detention.[73]

The Committee Against Torture and the Special Rapporteur on torture have also found that inadequate conditions of detention could amount to ill treatment.[74] Similarly, the European Court of Human Rights has found that health decline, or the contracting of disease, while in detention may also be judged as evidence that the overall prison conditions are inhuman or degrading.[75]

A right to participation

The right to participation, the basic right of people to have a say in matters that affect their lives, has been described as the right of all rights.[76] While the essential role of participation in realizing fundamental human rights has been explicitly recognized in all legally binding human rights treaties, it is particularly important in realizing the right to health. CESCR and the former Special Rapporteur on the right to health have identified participation in all health-related decision-making as an important component of the right to health, as well as one of the underlying determinants of health.[77] One of the core obligations of the right to health is the provision for participation in the development, implementation, and review of the national health plan that focuses on issues affecting the most vulnerable and marginalized, as well as in the health policies and interventions flowing from that plan.[78] In reality, it may not be possible to ensure everyone's participation, but the government has an immediate obligation to obtain a representation of views, particularly of those most vulnerable and marginalized.

Importantly, individuals have a right to "active and informed" participation, which relies on institutional arrangements and specific mechanisms to ensure participation at different stages, as well as capacity-building activities to ensure that people have the ability to participate meaningfully and effectively.[79] In this context, it is important to note that informed participation relies on the right to health-related education and information.

A human rights-based approach to health (HRBA) requires that prisoners participate in the entire process of prison-based HIV, HCV, TB, and harm reduction programming, from identifying priorities, to designing and implementing programmes, to monitoring and evaluating their impact and effectiveness. Considerable benefits to people's participation in health decisions have been identified, including increased sustainability and effectiveness of interventions, improvements in the quality of health care and services, empowerment of individuals, enhanced accountability, and positive health and health-related outcomes.[80]

WHO, UNODC, and UNAIDS have recognized the importance of prisoner participation in the context of the development and implementation of policies and initiatives to address HIV in prisons.[81] There is also recognition of the value of the participation of detainees at the European level. In January 2006, the Committee of Ministers of the Council of Europe adopted Recommendation (2006) 2, which contains the revised European Prison Rules. A new Rule 50 requires that prisoners be allowed and encouraged to discuss matters relating to the general conditions of imprisonment with prison administrations. The commentary to the recommendation states that "it is in the interests of prisoners as a whole that prisons should run smoothly and they may well have suggestions to make."[82] The CPT has also suggested that prisoners' own evaluations of existing health care services might represent one element in determining necessary changes to health care systems for the prison population.[83]

Conclusion

The right to health and the right to be free from ill treatment are increasingly recognized as being interrelated and indivisible, especially in prison contexts, by UN bodies and mechanisms, courts, and prison monitoring bodies. Indeed, as the former Special Rapporteur on the right to health has noted, "The promotion and protection of the right to health…strengthens the prevention of torture and ill-treatment, while the prohibition of torture… reinforces the realisation of the right to health."[84]

People retain their human rights during incarceration, including their right to the highest attainable standard of health. There is an enormous gap, however, between public health and human rights standards on the one hand, and effective implementation in custody settings on the other. Data revealing the high prevalence rates inside places of detention compared to those in the broader community, for example, demonstrate that this is particularly the case with regards to HIV, HCV, and TB. Despite their vulnerability to ill health, persons deprived of liberty are much less likely to have access to adequate prevention, care, and treatment of these diseases, including harm reduction services. Additionally, they are often held in substandard conditions that favor the transmission of diseases. This clearly creates an imperative for increased and ongoing attention to HIV, HCV, and TB in places of detention, including a focus on the urgent need to scale up harm reduction in these settings.

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