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Tuberculosis and prisons

Contracting tuberculosis, and not getting treatment, in prison can be considered cruel and unusual punishment

Michael H. Levy

Throughout the world societies deprive individuals of their liberty in response to real or perceived misdemeanors. Such persons are held in a number of institutions, their names varying from country to country, and according to what stage of the judicial system these persons are passing through. For clarity, I will refer to the sites of incarceration as prisons, and persons in custody as prisoners.

There are no accurate data on the number of persons in the world's prisons - current estimates vary from eight to ten million. The number of persons passing through prisons in a given year is at least four to six times, and the number held in police detention over ten times that number. (i.e. up to 100 million persons annually).

Prisoners are not representative of the general community. Many selective processes operate to transfer a citizen into a prisoner - many of these factors influence the epidemiology of tuberculosis in prisons. Prisoners are predominantly male, young (15-44 years old), and belong to minority groups (with resultant poorer socio-economic status, poorer education and work prospects). It is these community sub-groups who have a high risk of exposure to infection to Mycobacterium tuberculosis.

Human rights derive from the dignity of the individual. They are by definition, universal and indivisible. Minimum levels of healthcare, accommodation and diet for every prisoner are goals that should be pursued by every state. These principles are clearly laid out in the Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (1984). **Contracting tuberculosis, and not getting treatment because of poor prison conditions can be considered "cruel and unusual punishment".**

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Public health and prison health officials face many dilemmas in delivering services that may challenge, or even impinge on, prisoner rights and human rights issues. These dilemmas are more extreme, the poorer the country and the fewer the resources allocated to prison health.

Resource-poor countries with high tuberculosis burdens face many problems which work against the provision of a comprehensive anti-tuberculosis program including, low-level training of health-care workers, provision of poor salaries (or non-payment of salaries), chronic shortages on medications, and high levels of corruption. Prisons accentuate all these circumstances.

In resource-poor countries, where the custodial bureaucracy is often closely aligned to the military-police apparatus and their funds, an independent prison health service may not be achievable. Certainly prisons in resource rich countries would benefit from added independence.

Given that the health of prisoners impacts on that of the general community, the disposition of a health ministry would conceivably be more favourable toward the prison population. Also, prison health finds a place within the national health priorities, on every health indicator where prisoners are certain to be more needy.

What is important is that the prison health service, and particularly its medical staff, has adequate resources and enjoy professional independence. Where resources are limited, those that are available should be distributed to those in greatest need, in a transparent manner.

Prisons and tuberculosis

Prisons present both risks and

opportunities for tuberculosis control. A necessary condition for an effective control program includes a functional health service within the prison, which is accessible to all prisoners.

Prisons are a recognised setting for transmission of tuberculosis. Prisons impose a risk for tuberculosis transmission independent of the predisposing risk factors of the prison population.

There can be no adequate control of tuberculosis within a country, without control of the disease inside the prisons. Prisons are an important source of both tuberculosis disease and tuberculosis transmission. Tuberculosis infection contracted in the community can initiate an epidemic when brought into the prison, while the reverse route of transmission is equally possible.

The high turnover of prisoners can make tuberculosis transmission difficult to demonstrate, and difficult to investigate. Remand prisoners are often held in the most overcrowded conditions. This not only enhances transmission of tuberculosis, but it also makes the detection of cases and their treatment more difficult. All the more important to prevent transmission, as control is extremely difficult in the midst of an epidemic.

Prisons are a setting where HIV and tuberculosis meet. In some countries up to 70 per cent of prisoners with tuberculosis are also infected with HIV. All testing for HIV must be done with the same degree of confidentiality and pre/post-test counseling, irrespective of any imperative to link the results to a tuberculosis programme.

Because of the almost universal criminalization of drugs, drug-users constitute a large, and increasing, proportion of prisoners. Many illicit drug users live on the fringes of society, with little opportunity for regular work and income, have poor access to an adequate diet, excessive alcohol consumption, and have poor access to health care. This complex of factors ensures maximal chance of exposure to tuberculosis, optimal conditions for infection to progress to infectious disease, and minimal opportunity to proper, early diagnosis, and treatment to the point of cure. Prisons are a setting where HIV and tuberculosis meet. As illicit drug-use is directly linked to other activities that result in arrest and detention, these risks are easily transferred into the prison environment.

Prisons, tuberculosis and human rights

The rights accorded to prisoners are codified in the United Nations Standard Minimum Rules for the Treatment of Prisoners. Because proper diagnosis and treatment of tuberculosis are life saving, a tuberculosis control program should be an inseparable component of a prisoner's minimum rights.

No incarcerated individual should bring tuberculosis into the prison; no prisoner should be exposed to tuberculosis while in prison; and no former prisoner should take tuberculosis from the prison environment back to the community. With the re-emergence of tuberculosis as a major health hazard, similar pre-emptive measures, (i.e. prolonging prisoners' sentences in the event that they have not completed anti-tuberculosis treatment when due to be released) could become widespread. Prisoners who know that their effective stay in prison will be prolonged because of their illness will go to great lengths to get "off" a tuberculosis program. This could also be counter-productive, with prisoners falsifying sputum samples in order to avoid the extension of sentences.

The custodial authority needs to provide the facilities and the means to prevent transmission of tuberculosis (prison to the community; community to the prison; within the prison). Because tuberculosis is an infectious disease, the importance of instituting excellent tuberculosis control programs in prisons embraces not only the prison population (prisoners and staff), but also the general community.

Tuberculosis may be the single biggest cause of death among the world's prisoners. But a word of caution. Reports of deaths from "tuberculosis" have been used to conceal other serious human rights abuses, such as malnutrition, murder and deaths from torture. Holger Sawert equated surveillance with accountability. Disease surveillance systems in prisons are at best rudimentary. As a start, all countries should report tuberculosis cases in prisons within their national data. Only then can the "truth" about tuberculosis in prisons be verified.

Public health legislation in many countries includes measures that allow long-term detention of tuberculosis patients who do not comply with treatment. This is a clear contravention of human rights, where incarceration is used to compensate for failures of the public health system.

Tuberculosis has not attracted much attention in the human rights literature, nor has the association between tuberculosis and human rights been examined in detail in the medical literature. This is surprising given the epidemic proportions of the disease, and its disproportionate distribution in resource-poor countries, and within these countries, the disenfranchised poor. This contrasts with extensive work on the area of HIV / AIDS and human rights.

Under human rights law, a state's treatment of its own citizens becomes a subject of international concern. This principle holds that states that treat their citizens poorly would pose a threat to other countries. Even more so, when public health is a concern - as it is with tuberculosis, which neither respects the boundaries of a prison wall, let alone a national boundary. States are accepting international scrutiny - but not yet in the context of tuberculosis control.

Not least because tuberculosis is curable, the emphasis with tuberculosis control is the issue of "equivalence" of access to healthcare.

Conclusion

It is ironic that society condemns transgressors to imprisonment, because they are considered harmful - and by doing so, a greater harm may be reflected back onto the community. Tuberculosis provides another contradiction to imprisonment - one with a public health imperative.

Based on the proceedings of tb.net '99; 'People at Risk, Rights at Risk', a conference on TB and human rights organised by tb.net, the global TB network. For more information contact Upasana Shrestha at tb@mos.com.np