HIV, HCV, TB AND HARM REDUCTION IN PRISONS

Human Rights, Minimum Standards and Monitoring at the European and International Levels

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Gen Sander

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HARM REDUCTION INTERNATIONAL

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Abbreviations and acronyms

AIDS	acquired immune deficiency syndrome
CESCR	UN Committee on Economic, Social and Cultural Rights
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
NPM	National preventive mechanisms
NSP	Needle and syringe programmes
OPCAT	Optional Protocol to the Convention against Torture
OST	Opioid substitution therapy
SPT	United Nations Subcommittee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	UN Office on Drugs and Crime
WHO	World Health Organization

Glossary

Gender-responsive:	Health care, treatment and services that are gender-responsive are respectful, and informed by knowledge and understanding, of the particular lived experiences, inequalities, preferences, concerns and needs of individuals based on their distinct genders (or sexes/sex characteristics), gender identities and forms of gender expression. They also take into consideration the interrelationship between gender and a range of other factors (social, economic, etc.) that impact on people's wellbeing.
Harm reduction	Policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs among people who choose to actively use. For more information, visit: http://www.ihra.net/what-is-harm-reduction
Needle and syringe programme (NSP)	These programmes supply sterile needles/syringes and related injecting equipment to people who are actively injecting for safer drug use.
Opioid substitution therapy (OST)	Prescribed medication supplied to people who use drugs as a replacement therapy for opioid dependence. OST decreases or eliminates injecting practice among people who use drugs, thus significantly reducing HIV and hepatitis C transmission in this group, an outcome for which there is a well-established evidence base.
Prison	The term "prison" is used throughout this tool to refer to all detention facilities. Although the tool does not explicitly focus on issues particular to juveniles/youth detention centres, or migrants/migrant detention centres, it still applies to them.
Prisoner	The terms "prisoner" and "detainee" are used interchangeably throughout this tool to refer to adults deprived of their liberty.

Introduction

ABOUT THIS REPORT

This report is part of the European Union co-funded project "Improving Prison Conditions by Strengthening Infectious Disease Monitoring", led by Harm Reduction International. The project aims to reduce ill treatment of people in detention and improve prison conditions through more comprehensive and standardised monitoring of the human immunodeficiency virus (HIV), hepatitis C virus (HCV), tuberculosis (TB) and harm reduction. The research element of the project has two components. The first includes mapping the current situation relating to HIV, HCV, TB and harm reduction in prisons in seven European countries (Greece, Ireland, Italy, Latvia, Poland, Portugal and Spain), as well as the working practice of human rights-based prison monitoring mechanisms in these countries, with particular reference to HIV, HCV, TB and harm reduction. The second research component is the subject matter of this report, which maps the existing regional and international public health and human rights standards relating to HIV, HCV, TB and harm reduction in prisons, along with the mandate and practice of regional and international human rights-based prison monitoring mechanisms in this regard.

This research was used to develop a user-friendly tool, *Monitoring HIV, HCV, TB and Harm Reduction in Prisons: A Human Rights-Based Tool to Prevent Ill Treatment* (available on Harm Reduction International's website) to help generate better informed, more consistent, and sustained monitoring of HIV, HCV, TB and harm reduction in prisons by national, regional and international human rights-based prison monitoring mechanisms, such as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the UN Subcommittee for the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), and National Preventive Mechanisms (NPMs) or National Human Rights Institutions. These mechanisms, not yet engaged by the harm reduction sector, are therefore the main target of this report.

The parameters of this project were purposely kept narrow to ensure feasibility. As such, the focus is on issues specifically relating to HIV, HCV, TB and harm reduction in the context of prisons that accommodate adults, and the standards that relate to these. Juveniles and other places of detention - including police cells, psychiatric hospitals and immigration detention centres - are not specifically addressed in this research. While this work certainly remains applicable to these populations and settings, they also require specific attention, provisions and measures; more research and monitoring tools in these areas are therefore needed and encouraged.

This report is not meant to be prescriptive, nor is it a revision of existing standards on health in prisons. It is an overview of prisoners' health rights in relation to HIV, HCV, TB and harm reduction, as well as a broader collection of minimum standards and guidelines - drawn from both the public health and human rights fields - than what is normally applied by human rights-based prison monitoring mechanisms.

HIV, HCV, TB and harm reduction in prisons: public health and human rights

THE IMPORTANCE OF FOCUSING ON HIV, HCV, TB AND HARM REDUCTION IN PRISONS: A PUBLIC HEALTH PERSPECTIVE

HIV, HCV and TB epidemics are a major public health concern around the world, including in high-income countries. Although HIV, HCV and TB affect the population at large, they have emerged as an especially severe problem in prison systems worldwide. Global HIV prevalence, for example, is up to 50 times higher among the prison population than in the general public,[1] while one in four detainees worldwide is living with HCV,[2] in comparison to, for example, one in 50 people in the broader community in Europe.[3] TB is one of the leading causes of mortality in many countries' prisons,[4] with rates up to 81 times higher in prisons than in the broader community.[5] Prisons represent high-risk environments for the transmission of these diseases for a number of reasons, including the over-incarceration of vulnerable and disadvantaged groups who are more likely to suffer from poor health; the criminalisation of people who use drugs; risky behaviour in prisons, such as unsafe injecting drug use; substandard prison conditions and overcrowding; inadequate health care; and the denial of harm reduction services.

Members of poor and marginalised groups are overrepresented in the prison population worldwide.[6] Many of the factors that make these groups more likely to be incarcerated, including poverty, discrimination and drug use, also mean that they tend to carry a disproportionately high burden of disease and ill-health, including a higher prevalence of HIV, HCV and TB. Due to unequal access to appropriate health care services prior to their incarceration, many begin their prison sentence with untreated cases of HIV, HCV and TB, while those who enter prison relatively healthy have a higher chance of infection for several reasons, including increased risky behaviour, such as unsafe injecting drug use.

Punitive approaches to drug use have resulted in the mass incarceration of people who use drugs. According to global figures, 10-48% of male and 30-60% of female prisoners are using or dependent on illicit drugs upon entry to prison,[7] and every sixth prisoner is thought to be using drugs to a problematic extent.[8] In Europe, crimes related to the use, possession or supply of illicit drugs are the main reason for incarceration of between 10% and 25% of all sentenced prisoners.[9] Despite being prohibited, drugs always find their way into prisons. While some prisoners stop using and injecting drugs during incarceration, others will either continue or begin using while in prison.

With people who inject drugs making up about one third to one half of prison populations, levels of injecting drug use in prisons are high.[10] Despite this reality, however, the provision of harm reduction interventions, such as needle and syringe programmes (NSPs) and opioid substitution therapy (OST), remains extremely limited in comparison to what is available in the broader community. As of 2015, there are only seven countries or territories in the world who implement NSPs, while 44 implement OST, in at least one prison.[11] As needles and syringes are so scarce in prison, injecting drug users are often forced to make their own injecting equipment, and sharing or reusing occurs out of necessity. Sometimes up to 15 or 20 individuals inject with the same equipment,[12] which has been found to be the easiest and most effective way of transmitting HIV and HCV.[13] The combination of high rates of HIV, HCV and shared injecting equipment create a high-risk environment for the transmission

of these diseases. Additional behavioural risk factors for the transmission of HIV and HCV include consensual and non-consensual unprotected sexual activity,[14] the sharing or re-use of tattooing or piercing equipment, and the sharing of razors.

Intensifying this risk of infection and related ill-health are the substandard prison conditions in which prisoners are frequently accommodated. Overcrowding, poor sanitary conditions, inadequate ventilation and lighting, extreme temperatures, inadequate means for maintaining personal hygiene, a lack of access to clean drinking water, and the provision of nutritionally inadequate food are common in prisons and contribute to an exceptionally high rate of disease and death. Furthermore, 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 being with. With prison health still typically falling under the jurisdiction of the Ministry of Justice or the Ministry of Interior, rather than the Ministry of Health, there is often not only a disjunction, but also a marked disparity, between the health care provided to prisoners and the health care provided to the broader community.

Ill health and poor conditions in prisons do not just concern detainees and prison staff, they are also issues of much wider public concern. Illnesses transmitted or exacerbated in prison never remain in situ. It is estimated that more than 10.2 million people, including sentenced and pre-trial detainees, are held in detention centres worldwide,[15] 6 million of which are held in Europe alone.[16] About one third of these return to their communities every year.[17] Because recidivism to prison is common, especially among those who have a drug dependency,[18] there is a high degree of mobility between prison and community. Furthermore, there is substantial daily interaction between prisons and the broader community for prison staff and visitors. Prison health, therefore, is intimately connected to public health.[19] But as the following section will demonstrate, it is not just a public health concern, it also a human rights imperative.

HIV, HCV, TB AND PRISONERS' HEALTH RIGHTS: ENTITLEMENTS AND OBLIGATIONS

Under international human rights law, prisoners retain all their fundamental rights and freedoms during incarceration, except those that are unavoidably limited or restricted by the fact of their incarceration.[20] Like all persons, therefore, prisoners have a right to the highest attainable standard of physical and mental health (hereafter the '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, but several provisions found in a range of other, widely ratified, human rights treaties also protect prisoners' health rights.[21] Some of these specifically articulate the right to health,[22] while others, for example, offer indirect protection, such as the prohibition of torture and ill treatment, which, as confirmed by the Human Rights Committee, engages the right to health of all detained persons.[23] The right to humane treatment imposes positive obligations on states to protect the lives and well-being of prisoners, which has been interpreted by several human rights mechanisms to require government authorities to safeguard the health of prisoners.[24] As will be demonstrated

throughout the remainder of this section, the right to health and the freedom from torture and ill treatment are indivisible and interdependent, particularly in prison settings.[25]

Importantly, the right to health is an inclusive right that extends not only to timely and appropriate medical care, but also to the underlying determinants of health.[26] The following section identifies some of the most relevant entitlements and obligations emanating from the right to health of prisoners in the context of HIV, HCV, TB and harm reduction.

A right to non-discrimination and equivalence of care

One of the core obligations of the right to health is to ensure "the right of access to health facilities, goods and services, on a non-discriminatory basis, especially for vulnerable and marginalised groups",[27] which, as already discussed, includes prisoners. Several standards of humane treatment of prisoners make reference to the importance of non-discrimination in accessing health care,[28] an obligation that is also confirmed in many public health declarations and guidelines.[29] In the context of HIV and HCV in prisons, the former UN Special Rapporteur on the right to health, Anand Grover, has stated that "[i]f harm reduction programmes and evidenced-based treatment are made available to the general public, but not to persons in detention, that contravenes international law."[30]

Very closely related to the obligation of non-discrimination is the internationally recognised obligation to provide a standard of care in prisons that is at least equivalent to that available in the community, commonly known as the "principle of equivalence". Some experts, however, have questioned whether the aim should not be equivalence of care, but rather equivalence of objectives and results,[31] which would involve a higher standard of care for prisoners. This opinion is supported by the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment,[32] as well as the former Special Rapporteur on the right to health.[33]

A right to essential medicines

Another important core obligation with regards to the right to health of prisoners is the provision of essential medicines as defined by the World Health Organization (WHO) Essential Medicines Programme.[34] Essential medicines are "those that satisfy the priority health-care needs of the population"[35] and should be available at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at an affordable price.[36]

The WHO's Model List of Essential Medicines[37] includes morphine, methadone and buprenorphine, drugs commonly used to treat opioid dependence. These and other drugs on the list, such as antiretroviral drugs, are also essential for the treatment of HIV, HCV and TB, and for pain management and relief. As some are classified as "controlled substances" under the international drug conventions, their availability for medical purposes is often excessively limited or restricted despite there being no basis for this in international law.[38] Where these medicines are available in the broader community, they tend to be of poorer quality, provided sporadically, or are simply unavailable in prison settings. As the obligation to provide essential medicines is to be discharged on a non-discriminatory basis, these shortfalls represent a breach of international law.[39] Indeed, the former Special

Rapporteur on the right to health and the Human Rights Committee have both confirmed there is an obligation on states to ensure that people who use drugs deprived of their liberty are provided with essential medicines, and that the pain and suffering of prisoners associated with withdrawal symptoms could amount to ill treatment, [40] as found by the European Court of Human Rights in *McGLinchey and Others v UK*.[41]

A right to medical care and treatment

The right to medical care and treatment is a critical element of the right to health of prisoners. The Committee on Economic, Social and Cultural Rights (CESCR) has affirmed that "[s]tates 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] curative and palliative health services."[42] This obligation is also regularly expressed within civil and political rights mechanisms. The Human Rights Committee, for example, has confirmed 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,[43] a view echoed by the former Special Rapporteur on torture, Manfred Nowak.[44] Standards relating to the treatment of prisoners[45] also reflect this obligation and the European Court of Human Rights has found, on several occasions, that inadequate care and treatment for HIV, HCV or TB has amounted to cruel, inhuman or degrading treatment.[46]

An important element of this particular right in the context of prisons is that of continuity of care and treatment. People with health issues who move between prison and the community can find short periods in prison very disruptive to their community-based care and treatment programmes. Others who start a particular treatment in prison often do not get connected with the appropriate aftercare following release. This principle is explicitly articulated in the revised Standard Minimum Rules for the Treatment of Prisoners,[47] and enjoys support in a number of WHO, UNODC, and UNAIDS documents,[48] as well as other public health standards.[49]

A right to preventive health services, including harm reduction

Particularly relevant to the context of infectious diseases in prisons is the right to preventive health services. The CESCR confirms that "[s] tates 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.[50] More specifically, the Committee has recommended that states take steps to "combat" the spread of diseases in prisons, particularly with such serious diseases as TB[51] and HIV.[52]

The Human Rights Committee has 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)."[53] Both the former Special Rapporteur on torture[54] and the European Court of Human Rights[55] have supported this view, while the European Committee for the Prevention of Torture has confirmed that, "the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention".[56]

This legally binding obligation is also reflected in prison health standards,[57] WHO[58] and World Medical Association declarations,[59] as well as non-binding resolutions of the Council of Europe[60] and Parliamentary Assembly.[61]

There is unequivocal evidence confirming that one of the most effective ways of preventing the spread of HIV and HCV in prisons is through the provision of harm reduction services.[62] This has been endorsed by numerous human rights[63] and public health authorities.[64] Navi Pillay, the former High Commissioner for Human Rights, for example, recognised in 2009, "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".[65] Indeed, the provision of harm reduction services for people who use drugs is now recognised as a component element of the right to health and constitutes a legal obligation under international human rights law, which states must progressively realise.[66]

A right to the underlying determinants of health

According to the CESCR, the right to health is an inclusive right that extends not only to health care but also 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."[67] These and other underlying determinants have a considerable impact on whether people are healthy or not. This is particularly relevant in the context of prisons.

The CESCR has identified housing as "the environmental factor most frequently associated with conditions for disease", pointing out that "inadequate and deficient housing and living conditions are invariably associated with higher mortality and morbidity rates."[68] The Standard Minimum Rules for the Treatment of Prisoners also explicitly recognise that conditions are integrally linked to a prisoner's health status.[69] Furthermore, the Committee Against Torture and the former Special Rapporteur on Torture have consistently argued that inadequate conditions of detention could amount to ill treatment,[70] while the European Court of Human Rights has found that decline in health, or the contraction of disease, while in detention may be judged as evidence that the overall prison conditions are inhumane or degrading. [71]

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".[72] The CESCR and the former special Rapporteur on the right to health, Paul Hunt, have identified participation in all health-related decision-making at the community, national and international level as an important component of the right to health, as well as one of the underlying determinants of health.[73] 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 meaningfully and effectively participate.[74] In this context, informed participation relies in part on the right to seek, receive and impart health-related information and the right to basic health education.

The WHO, UNODC and UNAIDS have recognised the importance of prisoner participation in the context of the development and implementation of policies and initiatives to address HIV in prisons.[75] There is also recognition of the value of prisoner participation in health matters within the Council of Europe[76] and the European Committee for the Prevention of Torture.[77] Importantly, significant benefits to people's participation in health decisions have been identified, including increased sustainability and effectiveness of interventions, improvements in health outcomes and the quality of health care and services, empowerment of individuals and enhanced accountability.[78]

Minimum standards relating to HIV, HCV, TB and harm reduction in prisons

WHAT ARE MINIMUM STANDARDS AND HOW ARE THEY USED?

Standards are typically understood as agreements on appropriate or desirable levels of quality or attainment. In the field of public health, they generally derive from evidence or best practice. In the context of human rights, standards are derived from the law and help outline the necessary minimum pre-conditions for compliance with legal requirements. For example, while prisoners' health rights are protected by law, the law itself does not provide sufficient clarity in terms of what exactly is required of states to meet their obligations in relation to a particular right. By defining some of the specific steps and benchmarks required to respect, protect and fulfil human rights, standards help to ensure state responsibility and accountability in a structured way. They are also very useful tools for monitoring state compliance with their human rights obligations. It is important to note, however, that while meeting standards is often a necessary pre-condition for compliance with legal requirements, they only provide a minimum level of protection. Authorities, therefore, should strive to provide conditions that exceed the minimum standards identified in this report and elsewhere.

Some standards, like 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, like 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.[79]

MINIMUM STANDARDS RELATING TO HIV, HCV, TB AND HARM REDUCTION IN PRISONS

The following standards have been identified as some of the most significant for preventing, treating, and caring for HIV, HCV and/or TB in prisons in a human rights compliant manner. They are not new, but rather derive from pre-existing standards from both the human rights and public health fields. Some may look unfamiliar to health professionals because a human rights angle has been added, and the reverse is also true.

They were selected by carefully combing through human rights treaties, declarations, general comments, commitments, recommendations, rules, principles, policy papers, reports, regional and international judicial decisions, standards on humane treatment, monitoring body reports, and public health guidelines and best practice relating to HIV, HCV, TB, drug use, harm reduction, and human rights in prisons.

The first five sections focus specifically on issues identified as the most pressing and currently overlooked with regards to the prevention of ill treatment in the context of HIV, HCV, TB and harm reduction in prisons. The remaining sections identify standards relating to HIV, HCV, TB and harm reduction with regards to national context (sections 6-8), the prison health system (sections 9-16), and

accountability for prisoners' health and human rights (sections 17-19).

Importantly, the standards that follow incorporate a human rights-based approach to health, which aims to realise the right to the highest attainable standard of physical and mental health and other health-related rights within prisons. It is based on seven key principles: participation, equality and non-discrimination, accountability, and availability, accessibility, acceptability and quality of facilities goods and services. These principles should guide not only service delivery, but also programming in all health-related sectors and at all stages of the process. A human rights-based approach to health is not only about the achievement of certain goals or health outcomes, it is about their achievement through a participatory, inclusive, transparent and responsive process.

1. PREVENTION/HARM REDUCTION SERVICES	
a)	All prisoners should have equal, easy and confidential access to sterile injecting equipment through needle and syringe programmes. Prisoners and staff should receive information and education about the programmes and be involved in their design and implementation.
b)	Needle and syringe programmes should be available at relevant times to meet the needs of prisoners, should be accessible on a confidential basis, and be offered free of charge.
c)	All prisoners should have equal, free, easy and discreet access to condoms and lubricants. These should be available at all times, in various locations, and without prisoners having to request them.
d)	Women should have equal, free, easy, and discreet access to female condoms.
e)	Post-exposure prophylaxis should be offered to all prisoners and staff for exposure that has the potential for HIV transmission. This must be initiated within 72 hours.
f)	Pregnant women should have access to the full range of interventions for the prevention of mother-to-child transmission, including family planning and antiretroviral prophylaxis for pregnant and breastfeeding women.
g)	Prisoners should have access to the materials necessary for sterile tattooing and piercing.
h)	All preventive/harm reduction services should be relevant to the needs of individual prisoners.
i)	Naloxone should be available within prisons to reverse opioid overdoses.

2. EVIDENCE-BASED DRUG DEPENCENCE TREATMENT AND CARE	
a)	Prisoners should have access to the same evidence-based drug dependence treatment and counselling programmes that are available to the broader community.
b)	Prisoners should have equal, easy, confidential, and uninterrupted access to opioid substitution therapy (OST) during their detention.
c)	OST should be available on a voluntary basis, free of charge, gender-responsive, and accompanied by relevant information and support.

d)	Prisoners should be involved in developing their own treatment plans.
e)	Detoxification programmes should be available to prisoners on a voluntary and confidential basis, and should be supervised by trained health professionals.
f)	Prisoners participating in drug dependence programmes should have access to counselling and psychosocial services.
g)	Prison health services should provide or facilitate, if necessary, specialised drug treatment programmes designed especially for women.
h)	A functioning system of referral and cooperation between medical services inside and outside prisons should be in place to ensure continuity of drug dependence treatment between correctional institutions and jurisdictions, and following release.

3. HIV TREATMENT AND CARE

a)	At each stage of HIV-related illness, prisoners should receive appropriate medical and psychosocial treatment at least equivalent to that given to other members of the community.
b)	Treatment for HIV should be provided by prison medical services, applying the same quality, clinical and accessibility criteria as in the broader community.
c)	Authorities should ensure that prisoners are provided with accessible information on HIV treatments and therapies sufficient to enable them to make an informed choice about their treatment options, and that they are able to refuse treatment if they so choose.
d)	HIV treatment and care should be gender-responsive.
e)	Authorities should ensure that prevention, diagnosis and treatment of STIs, TB, hepatitis and other opportunistic infections are provided as key components of comprehensive HIV care.
f)	Prisoners should have access to diagnostics, antiretroviral treatment, a proper diet, health promotion options, and adequate pain management medications.
g)	Prisoners should have access to effective, appropriate, and compassionate palliative care that meets standards available in the wider community.

h)	Antiretroviral therapy should be provided to prisoners to reduce the progression, mortality and transmission of the disease.
i)	Post-exposure prophylaxis (PEP) should be offered on a confidential basis and within 72 hours, to all prisoners and staff for exposure that has the potential for HIV transmission.
j)	Antiretroviral prophylaxis should be available to pregnant prisoners to prevent mother-to-child transmission.
k)	The medicine necessary for HIV treatment should be of good quality.
l)	All prisoners undergoing HIV treatment should be offered support services, including counselling.
m)	Options for the early release of prisoners with advanced stages of HIV-related illness should be available.
n)	All costs associated with HIV treatment and care should be covered by the state or the prison authorities.
o)	A functioning system of referral and cooperation between medical services inside and outside the prison should be in place to ensure continuity of HIV treatment and care between correctional institutions and jurisdictions, and following release.

4. HCV TREATMENT AND CARE

a)	All prisoners living with HCV should be evaluated for the presence or severity of liver damage and the need for treatment.
b)	All prisoners living with HCV should be vaccinated for hepatitis A and B if not already protected, to prevent co-infection.
c)	All prisoners living with HCV should be provided with the most up-to-date and evidence based treatment.
d)	All prisoners living with HCV should be provided with sufficient accessible information on HCV treatment and therapies to enable them to make an informed choice about their treatment options.
e)	HCV treatment and care should be gender-responsive.

f)	All costs associated with HCV treatment and care should be covered by the state or the prison authorities.
g)	The medicine needed to treat HCV should be of good quality.
h)	There should be a functioning system of referral and cooperation between medical services inside and outside the prison in place to ensure continuity of HCV care and treatment between correctional institutions and jurisdictions, and following release.

5. TB TREATMENT AND CARE

a)	TB treatment should be initiated immediately upon detection to interrupt transmission and prevent emergence of drug resistance.
b)	Drug susceptibility testing should be performed at the start of treatment for all previously treated TB patients.
c)	All prisoners found to have infectious TB should be isolated, in a human rights-compliant way, in properly ventilated facilities while contagious.
d)	All prisoners should receive adequate treatment in line with national TB programme guidelines, including for those with multiple drug-resistant TB and TB-HIV co-infection, using directly observed treatment, short-course (DOTS) and an uninterrupted supply of drugs of guaranteed quality.
e)	Prisoners with multiple drug-resistant TB should be treated with specialised regimens containing second-line anti-tuberculosis drugs.
f)	TB treatment and care should be gender-responsive.
g)	TB treatment should be administered under the direct observation of health care staff in line with national TB programme guidelines.
h)	All prisoners undergoing TB treatment should be offered support services, including counselling.
i)	Voluntary HIV testing and counselling should be part the routine management of all TB patients.
j)	All costs associated with TB treatment and care should be covered by the state or prison authorities.

k)	All prisoners receiving TB treatment should be provided with sufficient accessible information on TB treatments and therapies to enable them to make an informed choice about their treatment options, and refuse treatment if they so choose.
l)	A functioning system of referral and cooperation between medical services inside and outside the prison should be in place to ensure continuity of TB treatment and care between correctional institutions and jurisdictions, and following release.

6. POLICY MEASURES

a)	Policies and guidelines on communicable diseases should be devised at the national level.
b)	Authorities should devise policies or guidelines for the prevention, care and treatment of HIV, HCV and TB.
c)	Authorities should draw up a comprehensive drug policy for prisoners which incorporates harm reduction and evidence-based drug treatment.
d)	All health related policies, at the national and prison level, should be based on evidence and best practice.
e)	All prison health policy should be informed by the assessed needs of the specific prison population.
f)	The specific needs of key groups that are most at risk, including women, people who inject drugs and sex workers, should be taken into account in prison health policies and guidelines.
g)	Representatives of the prison sector should meaningfully participate in the development prison health policies and guidelines.
h)	Former and current prisoners, or appropriate representatives, should meaningfully participate in the development and implementation of all policies and guidelines relating to their health.

7. RESOURCES

a)	Adequate financial and human resources should be made available within the prison health system to adequately address HIV, HCV and TB.

b)	National authorities should increase prison health budget allocations.
c)	Funding and resources for interventions that demonstrate a needs and evidence base, such as harm reduction interventions, should be prioritised.

8. INTEGRATION AND EQUIVALENCE

a)	Medical services in prisons should be organised in close relation with the general health administration of the community or nation.
b)	Health policy in prisons should be integrated into, and compatible with, national health policy.
c)	Prison health services should be integrated into public health structures and collaboration between public health, social services, drug services and prison health systems and staff should be enhanced.
d)	National programmes on HIV, HCV and TB should consider prisons when planning and budgeting.
e)	Prisoners are entitled to at least the same standards of health care that are available in the broader community during their incarceration.

9. PRISON CONDITIONS

a)	Every prisoner should be provided with food at the usual hours which satisfies in quality and quantity the standards of diet and modern hygiene and takes into account their age, health, the nature of their work, and so far as possible, religious or cultural requirements.
b)	Drinking water should be available to every prisoner whenever it is needed.
c)	Prisoners should always have access to natural light and fresh air (ventilation) in the places where they are required to live and work.
d)	Every prisoner should have ready access to proper toilet and sanitation facilities, as well as the ability to maintain good standards of personal hygiene.

e) Temperatures should be regulated to suit the climate of the season in places where prisoners are required to live, work and bathe.

f) Prisoners' clothing and bedding should be changed and washed regularly, so that these are in clean and good condition.

g) Each detainee must have an individual mattress and bedframe in the cell, and be able to move freely between the furniture.

h) All prisoners should have access to regular outdoor exercise.

i) Prisoners and staff should be ensured protection from discrimination on all prohibited grounds including sex, gender, race, ethnicity, sexual orientation, and health status.

10. MEDICAL SCREENING

a) All prisoners must be seen by a fully qualified health professional to assess their health and medical needs within 24 hours of arrival into custody.

b) The initial medical examination should be systematic, comprehensive, and use up-to-date methods. It should include a physical examination, screening for TB, screening for potential withdrawal symptoms resulting from the use of drugs, medication or alcohol, and voluntary, confidential and free testing for HIV and HCV.

c) All examinations should be accompanied by relevant information, including information on the objectives of each exam/test, communicable disease prevention, and safer drug use and sex. If free and informed consent is given for voluntary tests, appropriate pre- and post-test counselling should be provided.

d) All medical examinations should be conducted out of the hearing of prison officers and all patient-related information, including test results, should be protected by medical confidentiality.

11. EDUCATION AND INFORMATION

a) Prisoners should be given a leaflet or booklet on their arrival informing them of the existence and operation of health care services.

b)	All prisons should have a health education programme in place, which includes education on healthy lifestyles (nutrition, exercise, smoking, safer behaviour and practices) and mental health promotion.
c)	A prison health care service should ensure that accurate and non-judgemental information about HIV, HCV and TB, including methods of transmission, means of protection, and the application of adequate preventive measures, is regularly circulated to prisoners and prison staff.
d)	Health information should be coordinated and consistent with that disseminated in the general community, and all prisoners should have an opportunity to discuss the related information with qualified people.
e)	Prisoners should have the opportunity to participate in the development of health education programmes and materials.
f)	All written materials distributed to prisoners should be appropriate for the educational level in the prison population. Information should be made available in a language and form that prisoners can understand, and presented in an attractive and clear format.
g)	Information and counselling should be provided to prisoners who use drugs to promote harm reduction and to facilitate their access to appropriate harm reduction services.
h)	The content and message of educational materials relating to HIV, HCV and TB should respect and be relevant to differences in, for example: sex, gender, gender identity, health status, age, race, ethnicity, culture, religion, language, literacy level, and sexual orientation.
i)	The content of health education programmes for prisoners should combat HIV related discrimination, homophobia and any stigma associated with same-sex sexual relationships, and discrimination and stigma associated with sex work and drug use.
j)	Prisoners and prison staff should be involved in disseminating information (peer education) on communicable diseases and harm reduction.

12. INFORMED CONSENT

a)	Every prisoner is free to refuse treatment or any other medical intervention.
b)	Prisoners should be informed of their right to refuse before any medical intervention.

c) In order to be able to provide informed consent, prisoners should be informed of the clinical and prevention benefits of testing for HIV, HCV and TB, the objectives of every medical exam or test, as well as the follow-up services that will be available to them.

d) Prisoners should be provided with all relevant information concerning their condition, the course of the treatment and medication prescribed to them.

e) Prisoners who refuse any medical interventions should not be subjected to disciplinary measures, i.e. segregation.

13. MEDICAL RECORDS

a) Forms should be designed for recording all prisoner medical examinations. The forms should include a record of the prisoner's name, age and cell number; the doctor's name; the date, time and focus of all examinations; a record of the prisoner's infectious disease and vaccination history; and diagnostic information.

b) All medical records should be securely held to protect the patient's right to confidentiality. Only medical personnel should have access to prisoner medical files.

c) Prisoners should be able to access and/or obtain a copy of their medical files upon request.

d) In the event of a transfer, medical files should be forwarded to the doctors in the receiving establishment.

e) Upon release, prisoners' medical information should be forwarded to the community doctor of their choice.

f) Protocols should be in place to ensure secure information sharing between service providers in the community and in prisons.

14. MEDICATION

a) Prisoners should receive a regular, uninterrupted supply of the essential medicines required for their treatment.

b) Prisoners should have access to all the medicine included in the WHO list of essential medicines, including methadone, buprenorphine, naloxone and antiretrovirals.

c)	Qualified staff should be available to ensure that prisoners take the prescribed medicines in the correct doses and at the correct intervals.
d)	Only qualified health care staff members should dispense medicine.
e)	The state or prison authorities should cover the purchase of any medication.
f)	All medication should be of good quality, and stored in appropriate locations and at appropriate temperatures.

15. GENERAL TREATMENT AND CARE

a)	Prisoners should receive the same quality of care, treatment and support as persons living in the broader community.
b)	All prisoners should have access to a member of the health care staff at any time, regardless of their type of detention.
c)	Prisoner requests to consult a doctor should be met without undue delay.
d)	Prisoner requests to be examined by a health care staff member of the same sex or gender should be respected.
e)	Prisoners in need of diagnostic examination and/or hospital treatment should be promptly transferred to appropriate medical facilities.
f)	Prisoners should be involved in planning their own care and treatment.
g)	Women should receive the same standard of care and treatment as men.
h)	Gender-responsive health care services at least equivalent to those available in the broader community should be available to prisoners who need them.

16. PRISON STAFF (HEALTH CARE AND CUSTODIAL)

a)	Prison staff should receive HIV, HCV and TB prevention information during their initial training and thereafter on a regular basis.

b)	National authorities should develop specialised courses for staff that provide health care services in prisons, covering topics such as communicable diseases, harm reduction, epidemiology, hygiene, and medical ethics and human rights, including the right to health and freedom from ill treatment.
c)	Prison authorities should support the training of health care staff leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug use.
d)	Prisoners should be treated by staff who receive regular and ongoing training, supervision and support to maintain their professional registration, and who continue their professional development. Staff credentials should be regularly checked.
e)	All prison staff should receive gender-responsive training.
f)	Health care staff should be integrated into the public health service, including with regard to access to goods, services, information and training.
g)	Health care staff should be independent from the prison system.
h)	Working hours of medical staff should be appropriate to the needs of the prison.
i)	Members of health care staff should be on duty day and night, and on weekends.
j)	All staff should receive domestically competitive salaries and benefits, and should be allowed to have a healthy work-life balance.

17. MONITORING

a)	Authorities should establish mechanisms to oversee, supervise and inspect the administration of prisons, including in relation to health.
b)	A routine health data collection system should be in place that collects, among other things, disaggregated data on HIV, HCV and TB in prisons.
c)	Indicators and benchmarks measuring compliance with, and progress towards, human rights and public health standards should be developed for all interventions relating to HIV, HCV and TB harm reduction.

d)	The implementation of any form of intervention relating to HIV, HCV or TB should be accompanied by precise studies monitoring progress and evaluating effectiveness, while taking into consideration informed consent, confidentiality, respect for human rights, available scientific evidence and scientific integrity.
e)	Health indicators should be disaggregation on the prohibited grounds of discrimination to identify any particular or intersecting disparities in levels of enjoyment of the right to health and to ensure appropriately targeted interventions.
f)	All measures should be taken to ensure that human rights violations do not inadvertently occur in the process of data collection, i.e. discrimination or violation of confidentiality and consent.
g)	Prisoners should participate in the monitoring and evaluation of all health-related interventions.

18. REVIEW

a)	There should be easily accessible and confidential avenues for prisoners to make comments/complains about their health care and treatment, and systems should be in place to support those who may need assistance in doing this.
b)	Responses to health-related complaints should be timely, easy to understand, dealt with by a health professional and deal directly with the prisoner's concerns.
c)	Prisoners who make complaints against staff or other prisoners should not be discriminated against and must be protected from possible recrimination.

19. REMEDIES

a)	Mechanisms and institutions should be empowered to provide remedies to prisoners in the event of violations of health or other rights.

Monitoring HIV, HCV, TB and harm reduction in prisons

The journey from standard setting to effective implementation or operationalisation is often a long and difficult one. Prisons are rarely the subject of public attention or concern, not only because they are closed settings, making them difficult to monitor, but also because they accommodate individuals and groups that tend to be stigmatised by the rest of society. The lack of public attention to prison issues makes it very easy for governments to ignore their obligations and violate prisoners' rights.[80] This is where the work of independent prison monitoring bodies, such as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the UN Subcommittee for the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), and National Preventive Mechanisms (NPMs) is crucial. Empowered with extensive mandates to prevent torture and ill treatment,[81] and granted unrestricted access to people and information, the CPT, SPT and NPMs visit places of detention the world over to examine whether conditions of detention are in conformity with minimum standards. In the context of HIV, HCV, TB and harm reduction, which are increasingly found to engage the right to be free from torture and ill treatment, there is an important role for such monitoring bodies to play. The following section explores the current mandates and working practice of the CPT and SPT, particularly in relation to HIV, HCV, TB and harm reduction in prisons, to assess the degree to which they can and do consider matters relating to these issues in their work, as well the important role they can and ought to play in improving prisoners' health in the course of their work. For an evaluation of the work of national monitoring bodies in this respect, please see the reports produced by our national partners in this project.*

THE CPT AND SPT: MANDATES AND WORKING METHODS

The CPT was established under the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which came into force in 1989 and has since been ratified by all 47 member states of the Council of Europe. It is not an investigative body, but rather "provides a non-judicial preventive mechanism to protect persons deprived of their liberty against torture and other forms of ill-treatment" in Europe.[82] The CPT's mandate is set in Article 1 of the Convention, which provides that "[t]he Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment".[83]

The Committee currently consists of 47 members, one from each state that has ratified the Convention. Each member is elected by the Council of Europe's Committee of Ministers, and serves a four-year term with the possibility of being re-elected only once.[84] The Convention affirms that the members much be chosen "from among persons of high moral character" and must be "known for their competence in the field of human rights or having professional experience in the areas covered by this Convention."[85] The members, who are independent and impartial, include experts from a variety of backgrounds, including medical professionals, lawyers, human rights practitioners, and specialists in prison or police matters.

* These reports are available on the Harm Reduction International website.

The CPT implements its preventive function through periodic and ad hoc visits to places of detention. It enjoys unlimited access to all places of detention, as well as all information and documents, and is entitled to conduct private interviews with detainees and to communicate freely with anyone whom it believes can supply relevant information, including lawyers and medical doctors. Delegations comprised of two to five members are formed for each visit or mission, and efforts are taken to ensure a gender and professional balance.[86] The Committee may also be assisted by experts, including medical experts, on an ad hoc basis to provide particular or specialised skills, in addition to those of the Committee members. In practice, experts have accompanied almost all the CPT's missions, and there are on average two experts per delegation.[87] Visits are typically organised around the examination of a few substantive issues, including treatment of prisoners, conditions of detention, and health care services. In its 3rd General Report, the CPT explicitly affirmed that "[h]ealth care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate."[88] When visiting prison health care services, the CPT is typically guided by consideration of: access to a doctor, equivalence of care, consent and confidentiality, preventive health care, humanitarian assistance, as well as professional independence and competence.[89]

All CPT visits must be followed up by an analysis of the problems encountered and recommendations to resolve them, which are incorporated into a report. While these recommendations are not legally binding, under the principle of cooperation, states are required to give them serious consideration and to try to implement them as far as possible. States are also required to formally respond to the Committee's report. Furthermore, six months after receiving the report, the state must generally submit an interim report, and within one year it must send in a follow-up report on the measures taken to implement the recommendations. In this way an on-going dialogue is established between the Committee and the authorities with the aim of improving the conditions of detention as well as the treatment of people deprived of their liberty.[90]

The SPT started operating in February 2007, having been established by the Optional Protocol to the Convention Against Torture (OPCAT), which entered into force in 2006 and, as of January 2016, is ratified by 80 countries. Like the CPT, it is not an investigative body, but is rather "focused on an innovative, sustained and proactive approach to the prevention of torture and ill treatment."[91] Also like the CPT, it is mandated to undertake regular visits to places where people are deprived of their liberty and make recommendations to states concerning the protection of persons deprived of their liberty against torture and ill treatment.[92] Unlike the CPT, however, it also has another important function, which is to advise and provide assistance to states parties on the establishment of National Preventive Mechanisms (NPMs), which OPCAT requires that they establish, as well as provide advice and assistance to both the NPMs and state parties regarding the working of the NPM. In addition, the SPT must cooperate, for the prevention of torture in general, with relevant UN organs and mechanisms, as well as with international, regional and national institutions and organisations.[93]

The SPT currently consists of 25 independent and impartial experts from various regions of the world, that are elected by states parties

to the OPCAT for one four-year term, with the possibility of being re-elected once. Like the CPT, members come from a wide variety of professional backgrounds, including health, law and human rights.

Similar to the CPT, the SPT visits places of detention to examine whether or not conditions of detention are in conformity with the relevant national and international minimum standards. It has unrestricted access to all places where people may be deprived of their liberty, their installations and facilities and to all relevant information. They can also privately interview persons deprived of their liberty and any other person who might be able to provide relevant information. They also undertake NPM and OPCAT advisory visits, during which guidance is provided with regards to establishing a NPM and their effective operational practices, etc. All visits are conducted by at least two members of the SPT, accompanied, if necessary, by experts with relevant professional experience and knowledge. In the SPT's visit guidelines, it is specifically stated that the delegation shall consist of at least one lawyer and one medical doctor.[94]

During each of its visits to date, the SPT has looked at issues relating to health care and conditions of detention. After each visit, a report is drawn up and concrete recommendations are made to assist the state party in improving conditions and protection against torture and ill treatment. Again, these recommendations are not legally binding, but States are expected to begin implementing them just as soon as possible. In some cases, the SPT conducts follow-up visits to check on the progress being made in relation to their recommendations.

Overall, both the CPT and SPT have demonstrated that prisoners' health is a priority. Not only does each body consist of medical experts and examine issues relating to health and the underlying determinants of health during each visit, but both have also established ad hoc working groups on medical issues. Considering this, it is certainly within the mandate and capacity of both the CPT and SPT to look at the inter-related issues of HIV, HCV TB, harm reduction and ill treatment in places of detention. The following section will evaluate the extent to which they do in practice, the coherence of any recommendations made and standards promoted in relation to these issues, and the role both mechanisms could play in the promotion of prisoners health and human rights by focusing more of their efforts on HIV, HCV, TB and harm reduction while fulfilling their preventive mandates.

CPT AND SPT MONITORING PRACTICE IN THE CONTEXT OF HIV, HCV, TB AND HARM REDUCTION

The CPT and SPT have similar mandates and working methods, which enable them to prioritise prisoners' health in their work. The two bodies have, however, differed in their attention and approach to HIV, HCV, TB and harm reduction in places of detention. Although both bodies have identified the transmission of these diseases as a serious problem in prisons and consistently look at issues that relate to health and have a bearing on communicable diseases, the CPT has devoted much more attention to HIV, HCV, TB and harm reduction in both the standards it has developed over the years, as well as in its recommendations. This is certainly partially due to the fact that it has been in operation for much longer, has undertaken many more visits and has a more

focused mandate. Nevertheless, more could be done by both monitoring bodies to contribute to the prevention of ill treatment in the context of HIV, HCV, TB, and harm reduction, while improving prisoners' health and enjoyment of human rights in the process.

The CPT has explicitly recognised that the transmission of HIV, HCV and TB is a serious problem in certain prison systems.[95] On several occasions, it has expressed serious concerns about the inadequacy of the measures taken to tackle this, as well as the conditions under which prisoners are held, which the Committee has "found to be such that they can only favour the spread of these diseases."[96] In light of its findings and drawing from existing regional and international standards, the CPT has developed several standards of its own, some of which specifically address HIV, HCV, and TB. For example, it has affirmed that, regardless of economic difficulties, "the act of depriving a person of [their] liberty always entails a duty of care which calls for effective methods of prevention, screening and treatment."[97] It has explained that,

> The use of up-to-date methods for screening, the regular supply of medication and related materials, the availability of staff ensuring that prisoners take the prescribed medicines in the right doses at the right intervals, and the provision when appropriate of special diets, constitute essential elements of an effective strategy to combat [HIV, HCV, and TB] and to provide appropriate care to the prisoners concerned.[98]

In order to dispel misconceptions surrounding communicable diseases, the CPT has made it clear that national authorities are also obliged to ensure that there is a full educational programme about them, in particular HIV, HCV and TB, for both prisoners and prison staff that addresses methods of transmission, means of protection, and the application of adequate preventive measures.[99] The CPT has also affirmed that appropriate information and counselling should be provided before and, in the case of a positive result, after any screening test, and that non-discrimination, confidentiality and informed consent should always be taught, promoted and respected.[100] With regards to the underlying determinants of health, the CPT has stated that conditions of accommodation for prisoners with communicable diseases must be conducive to the improvement of their health, and authorities must ensure natural light, good ventilation, satisfactory hygiene and the absence of overcrowding. In order to ensure that HIV, HCV and TB are effectively controlled, everyone working in this field in a given country must co-ordinate their efforts as best as possible. In this respect, the CPT has stressed that the continuation of treatment after release from prison must be guaranteed.[101] These and other standards more generally related to health, such as the ability to access a doctor at any time, are raised continuously throughout the CPT's reports.

The CPT has also made several recommendations regarding drug policies and harm reduction in prisons, which have a significant bearing on the prevention of HIV and HCV. In 2002, it drafted a list of issues to be examined when evaluating arrangements for the treatment of drug users detained in prisons, which includes considerations of equivalency, availability and accessibility of harm reduction services and continuity of care.[102] On a number of occasions it has called upon authorities to

draw up a comprehensive strategy for the provision of assistance to prisoners with "drug-related problems" and to institute a harm reduction policy.[103]

After visiting detention facilities in Ireland, the CPT recommended that "all prisoners admitted while on methadone maintenance programmes in the community should be able to continue such maintenance within prisons as part of a comprehensive drug treatment programme" and that "prisoners undergoing drug withdrawal should be provided with the necessary support to alleviate their suffering."[104] Following up on this recommendation four years later, the CPT observed that in one prison visited, "the prison doctor…refused to provide methadone treatment and that the "methadone doctor" only visited twice a week resulting in a haphazard and incomplete treatment programme," and recommended that authorities take the necessary steps to remedy these deficiencies.[105] The CPT has also stressed that management of prisoners who use drugs must be varied – combining harm reduction and detoxification programmes, substitution therapy, psychological support, socio-educational programmes and rehabilitation.[106] Attention has also been drawn to the importance of providing specific training on drug-related issues to all health care and prison staff.[107]

In contrast to the CPT's rather detailed attention to HIV, HCV and TB and other issues that specifically increase the risk of their transmission, the SPT has not yet turned its attention to these in a comprehensive way. When considering issues of health care, the SPT has tended to focus on medical examinations on arrival, conditions of detention (including food, sanitation, drinking water and hygiene), cost of services and medication, availability and training of doctors, specialised care for women, pregnant women and children, and medical confidentiality. While these are important and clearly relevant to HIV, HCV and TB, specific focus on these diseases has been minimal.

The SPT has stated that medical examinations upon admission are extremely important, first, as a safeguard against ill treatment, but also because they "provide a good opportunity to assess the state of health and medical needs of prisoners, to carry out voluntary tests and to offer advice on sexually transmitted diseases as well as information on the prevention of such diseases and other infectious diseases or drug addition."[108] In the context of HIV, the SPT has recommended that all prisoners be provided with a free and voluntary HIV test, which should be confidential, accompanied by advice and be administered only with the prisoners' informed consent.[109] In the context of TB, the SPT has recommended that all prisoners should have the opportunity to be X-rayed for TB using mobile X-ray units and that treatment should commence for inmates who have tested positive.[110] Echoing the CPT, the SPT has also recommended that the state authorities develop specialised courses on, among other things, communicable diseases for physicians who provide medical services in prisons.[111] Following its visit to the Maldives, the SPT remarked that since most prisoners were sentenced for drug related crimes, authorities should introduce programmes for treatment and rehabilitation of "drug abusers".[112] Aside from these examples, there is rarely any attention paid to HIV, HCV and TB or issues relating to drug use or harm reduction in prisons. And it is worth observing that while the CPT refers to several human rights and public health documents when reporting on health, the SPT refers to the Standard

Minimum Rules for the Treatment of Prisoners, which are crucial but far from comprehensive, especially in the context of HIV, HCV, TB and harm reduction.

It is important to mention that while the SPT has the mandate and the professional expertise to monitor HIV, HCV, TB and harm reduction in prisons, it struggles significantly from a shortage of both human and financial resources, which inhibits the fulfilment of its mandate.[113] In 2012, for example, the SPT was only able to conduct two visits while having 65 states parties. This suggests a rate of one country visit every twenty years, which, in its own words, "is not compatible with the spirit of conducting regular visits and on-going dialogue".[114] This lack of resources, both financial and human, will need to be addressed in a sustainable manner for the SPT to be able to effectively fulfil its mandate, including in the context of HIV, HCV, TB and harm reduction.

Conclusions and recommendations

Prisoners 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 and effective implementation in places of detention. Statistics revealing the high incidence rates inside prisons 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, prisoners are much less likely to have access to adequate prevention, care and treatment of these diseases, including harm reduction services. Additionally, prisoners are often held in substandard conditions that favour the transmission of diseases.

As this report has demonstrated, the right to health and the right to be free from ill treatment are increasingly recognised as being interrelated and indivisible, especially in prison contexts, by UN mechanisms, courts and prison monitoring bodies. Indeed, as the former Special Rapporteur on the right to health has noted, "[t]he 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."[115] With a broad preventive mandate and unrestricted access to all places of detention, prison monitoring bodies such as the CPT and SPT, as well as National Preventive Mechanisms, are in a unique position to help prevent ill treatment while promoting and protecting prisoners' right to health.

On the whole, the CPT and the SPT both have the mandate and the expertise to monitor issues relating to HIV, HCV, TB and harm reduction in prisons. In practice, while concrete steps are being taken to fulfil this part of their mandate, especially with regards to the CPT which has more resources, capacity and experience, more could be done by both mechanisms to strengthen protection from ill treatment in this particular context, while contributing to improved health and enjoyment of human rights for prisoners.

RECOMMENDATIONS FOR THE CPT AND SPT

1. **Ensure consistency when setting rules and standards with regards to HIV, HCV, TB and harm reduction in recommendations**.
   More could be done to ensure cohesion between the CPT and SPT with regards to the examination of, and recommendations on, HIV, HCV, TB and harm reduction in prisons. While there do not appear to be any conflicting recommendations or standards promoted, the SPT does not ever go as far as the CPT. The SPT echoes many of the CPT's recommendations in the context of health more generally but, as already discussed, the SPT could follow the CPT's example and focus more of its attention on issues relating to HIV, HCV, TB and harm reduction in particular. The CPT and SPT should consult and cooperate to promote their objectives in an effective way, as encouraged by the OPCAT.[116]

2. **Undertake targeted visits on HIV, HCV, TB and harm reduction in prisons.**
   Targeted visits examining these and related issues in depth would be one of the most effective ways of adopting a systematic and comprehensive approach to monitoring HIV, HCV, TB and harm reduction in prisons. This supports a statement expressed by the CPT that "there is a generally held view within the Committee that it must seek to give sharper focus to many of its visits and

make them more targeted."[117] However, given the magnitude of the problem posed by HIV, HCV and TB in prisons, in both public health and human rights terms, these targeted visits should be undertaken with the intent of becoming integrated into regular visits with time.

3. **Use Harm Reduction International's monitoring tool, *Monitoring HIV, HCV, TB and Harm Reduction in Prisons: A Human Rights-Based Tool to Prevent Ill Treatment,* in part or in whole, during targeted or regular visits.**
   This could be beneficial for several reasons. First, it would help to ensure that a systematic and comprehensive approach to monitoring these issues is taken, and that recommendations stemming from visits are more consistent. Second, it would allow for the standardised collection of objective, reliable and comparable data on HIV, HCV and TB and harm reduction in prisons, which is currently sparse, on a national, regional and global scale. Third, it would simplify the identification of situations that could amount to ill treatment in the context of HIV, HCV, TB and harm reduction, while also contributing to the progressive realisation of other human rights, including the right to health. As a human rights-based approach requires the disaggregation of data, this monitoring tool would also allow the identification of especially vulnerable groups or any situations of discrimination. Further, it would send a strong message to government and prison authorities about the importance of harm reduction in prisons, as well as preventing, treating and caring for HIV, HCV, TB in a human rights-compliant manner.

References

1. Mariner J and Schleifer R (2013) "The Right to Health in Prisons", Advancing the Human Right to Health. Zuniga J et al (Eds), Oxford: Oxford University Press.
2. Lamey S et al 'Incidence and prevalence of hepatitis C in prisons and other closed settings: results of a systematic review and meta-analysis' (October 2013) *Hepatology* vol 58 no 4:1215-1224.
3. World Health Organization (July 2015) *Hepatitis C in the WHO European Region: Fact Sheet*. Geneva: WHO.
4. Lines R 'The right to health of prisoners in international human rights law' (March 2008) *International Journal of Prisoner Health* vol 4 no 1.
5. Word Health Organization (2014) *Prisons and Health – WHO Guide.* Geneva: WHO.
6. World Health Organization (24 October 2003) *Moscow Declaration: Prison Health as part of Public Health*. Geneva: WHO.
7. Fazel S, Bains P, and Doll H 'Substance abuse and dependence in prisoners: a systematic review' (2006) *Addiction* vol 101:181-191.
8. Word Health Organization (2014) *Prisons and Health – WHO Guide.* Geneva: WHO.
9. European Monitoring Centre for Drugs and Drug Addiction (2012) *Prisons and Drugs in Europe – Problem and Responses*. Lisbon: EMCDDA, p 9.
10. Dolan K, et al 'People who inject drugs in prison: HIV prevalence, transmission and prevention' (2015) *International Journal of Drug Policy* vol 26:S12-S15.
11. The *Global State of Harm Reduction* identifies 43 countries or territories that implement OST in at least one prison. Since 2014, however, Vietnam has started providing OST in at least one prison, so the total is now at 44. See Harm Reduction International (2014) *Global State of Harm Reduction.* London: HRI; and UNODC (2 October 2015) *Viet Nam opens the first Methadone Maintenance Therapy Service Unit for Prisoners.* Available at https://www.unodc.org/southeastasiaandpacific/en/vietnam/2015/10/prisoners/story.html (date of last access 29 January 2016).
12. Dolan K, et al 'People who inject drugs in prison: HIV prevalence, transmission and prevention' (2015) *International Journal of Drug Policy* vol 26:S12-S15.
13. International Federation of the Red Cross (2010) *Out of Harm's Way: Injecting Drug Users and Harm Reduction*. Geneva: IFRC.
14. This is in relation to HIV. The sexual transmission of HCV is rare, although the risk is increased if sexually transmitted infections (STI) are present or sex is particularly violent, i.e. transmission through blood rather than other bodily fluids.
15. Prison Reform International (2015) *Global Prison Trends.* London: PRI.
16. World Health Organization (2014) *Prisons and Health – WHO Guide.* Geneva: WHO, p xi.
17. Ibid.
18. Dolan K, et al 'People who inject drugs in prison: HIV prevalence, transmission and prevention' (2015) *International Journal of Drug Policy* vol 26:S12-S15.
19. See, for example, Declaration on Prison Health as Part of Public Health (Moscow Declaration), adopted in Moscow on 24 October 2003.
20. Humane treatment of persons deprived of their liberty, General Comment No. 21: Article 10, Report of the UN High Commissioner for Human Rights (10 April 1992) UN Doc No. CCPR/C/21, para. 3.
21. These include the International Covenant on Civil and Political Rights (ICCPR); the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); the Convention on the Elimination of Discrimination Against Women (CEDAW); the Convention on the Rights of the Child (CRC); the Convention on the Rights of People with Disabilities (CRPD); the European Convention for the Protection of Human Rights and Fundamental Freedoms; The European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment; the European Social Charter; the African Charter on Human and Peoples' Rights; and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.
22. Including the Universal Declaration of Human Rights, article 25(1); Convention on the Rights of the Child, article 24; Convention on the Elimination of All Forms of Discrimination Against Women, article 12; International Covenant on the Elimination of Racial Discrimination, article 5; Convention on the Rights of Persons with Disabilities, article 25; the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, article 28; the European Social Charter, article 11, the African Charter on Human and Peoples' Rights, article 16, the African Charter on the Rights and Welfare of the Child, article 14; and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, article 10.
23. Concluding Observations: Georgia, Human Rights Committee (2002) UN Doc No. A/57/40, para 78(7).
24. Lines R 'The right to health of prisoners in international human rights law' (March 2008) *International Journal of Prisoner Health* vol 4 no 1:11.
25. Grover A and Gaziyev J 'A Contribution by the Special Rapporteur on the Right to Health: Right to Health and Freedom from Torture and Ill-Treatment in Healthcare Settings' (No date provided) *Torture in Healthcare Settings: Reflection on the Special Rapporteur on Torture's 2013 Thematic Report*, Centre for Human Rights and Humanitarian Law Anti Torture Initiative, p 17. Available at: http://antitorture.org/wp-content/uploads/2014/03/PDF_Torture_in_Healthcare_Publication.pdf (date of last access 29 January 2016).
26. General Comment 14: The right to the highest attainable standard of physical and mental health, Committee on Economic, Social and Cultural Rights (2000) UN Doc No. E/C.12/2000/4, para 11.
27. Ibid., para 43(a).
28. See, for example: Recommendation Rec (2006) 2 of the Committee of Ministers to member states on the European Prison Rules of the Council of Europe (11 January 2006) para 40.3; Basic Principles for the Treatment of Prisoners, General Assembly of the Council of Europe (14 December 1990) principle 9.
29. See, for example: UNODC, WHO and UNAIDS (2006) *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response*. Vienna: UN Office on Drugs and Crime; UNAIDS (1997) *Prisons and AIDS*. Vienna: UN Office on Drugs and Crime; WHO (1993) *Guidelines on HIV infection and AIDS in prisons*. Geneva: World Health Organization.

30. Report of the Special Rapporteur on the Right to the highest attainable standard of physical and mental health, Anand Grover, General Assembly (6 August 2010) UN Doc No. A/65/255, para 60.
31. Lines R 'From equivalence of standards to equivalence of objectives: The entitlements of prisoners to health care standards higher than those outside prisons' (December 2006) *International Journal of Prisoner Health* vol 2 no 4:269-280.
32. Council of Europe, *Background Paper for Conference: The CPT at 25: taking stock and moving forward*, 2 March 2015, p 10. Available at: http://www.cpt.coe.int/en/conferences/cpt25-background_paper.pdf (date of last access 29 January 2016).
33. Report of the Special Rapporteur on the Right to the highest attainable standard of physical and mental health, Anand Grover, General Assembly (6 August 2010) UN Doc No. A/65/255 para 60.
34. General Comment 14: The right to the highest attainable standard of physical and mental health, Committee on Economic, Social and Cultural Rights (2000) UN Doc. E/C.12/2000/4.
35. Hogerzeil H (2006) Essential medicines and human rights: what can they learn from each other? - *WHO Bulletin* [emphasis added]. Geneva: World Health Organization. Available at: http://www.who.int/bulletin/volumes/84/5/371.pdf (date of last access 29 January 2016).
36. WHO (2006) *The Selection and use of essential medicines*: *Report of the WHO Expert Committee 2005.* Geneva: World Health Organization Technical Report Series, No. 933.
37. WHO, (2015) *Model List of Essential Medicines*, *19th List, April 2015 (Amended June 2015).* Geneva: World Health Organization. Available at: http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_JUN2015.pdf?ua=1 (date of last access 29 January 2016).
38. See: International Harm Reduction Association (2010) *Controlled Essential Medicines, Human Rights and Drug Policy: Briefing 5*. London: Harm Reduction International; and Lohman, Diederik, Ezer, and Tamar (2014) *Denial of Pain Treatment and the Prohibition Against Torture and Ill-Treatment*, *Torture in Healthcare Settings: Reflection on the Special Rapporteur on Torture's 2013 Thematic Report*. Washington, DC: American University George Washington College of Law Centre for Human Rights and Humanitarian Law Anti Torture Initiative, p 137. Available at: http://antitorture.org/wp-content/uploads/2014/03/PDF_Torture_in_Healthcare_Publication.pdf (date of last access 29 January 2016).
39. Access to medicine in the context of the right of everyone to the highest attainable standard of physical and mental health, UN Human Rights Council (12 October 2009) UN Doc No. A/HRC/RES/12/24.
40. See: Report of the Special Rapporteur on the right to health, Anand Grover, UN General Assembly (6 August 2010) UN Doc No. A/65/255; Concluding observations of the seventh periodic report of the Russian Federation, Human Rights Committee (31 March 2015) UN Doc No. CCPR/C/RUS/CO/7, para 16; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Méndez, Human Rights Council (1 February 2013) UN Doc No. A/HRC/22/53, para 55.
41. European Court of Human Rights, *McGlinchey and Others v. UK*, Application no. 50390/99, 29 July 2003, para 71.
42. General Comment 14: The right to the highest attainable standard of physical and mental health, Committee on Economic, Social and Cultural Rights (2000) UN Doc No. E/C.12/2000/4, par. 34. The Committee has on several occasions expressed a specific concern about inadequate access to health care in prisons. See, for example: Concluding observations: Ukraine, Committee on Economic, Social and Cultural Rights (4 January 2008) UN Doc No. E/C.12/UKR/CO/5.
43. Concluding Observations: Georgia, UN Human Rights Committee (2002) UN Doc A/57/40, para 78(7).
44. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, UN Human Rights Council (14 January 2009) UN Doc No. A/HRC/10/44, para 71.
45. See, for example, the Revised UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) (2015) UN Doc No. 5/CN.15/2015/L.6/Rev.1, Rule 24; Recommendation Rec (2006)2 of the Committee of Ministers to member states on the European Prison Rules, Council of Europe, (11 January 2006), para 39.
46. See, for example, the following European Court of Human Rights cases: *M.S. v. Russia*, Application no. 8589/08, 10 July 2014; *Koryak v. Russia*, Application no. 24677/10, 13 November 2012; *Glakiy v. Russia*, Application no. 3242/03, 21 December 2010; *Kozhokar v. Russia*, Application no. 33099/08, 16 December 2010; *Menchenkov v. Russia*, Application no. 35421/05, 7 February 2008; *Khudobin v. Russia*, Application no. 59696/00, 26 October 2006; and *McGlinchey and Others v. UK*, Application no. 50390/99, 29 July 2003.
47. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), UN General Assembly (29 September 2015) UN Doc No. A/C.3/70/L.3, rule 24(2): "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."
48. See, for example: UNODC, WHO and UNAIDS (2006) *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response*. Vienna: UN Office on Drugs and Crime, para 48.
49. See, for example, World Medical Association (October 2011) *Declaration of Edinburgh on Prison Conditions and The Spread of TB and Other Communicable Diseases*. Ferney-Voltaire, France: World Medical Association.
50. General Comment 14: The right to the highest attainable standard of physical and mental health, Committee on Economic, Social and Cultural Rights (2000) UN Doc No. E/C.12/2000/4, (2000), para 34 [emphasis added].
51. Concluding Observations to Moldova, Committee on Economic, Social and Cultural Rights (2003) UN Doc No. E/2004/22, para 337.
52. Concluding Observations to the Russian Federation, Committee on Economic, Social and Cultural Rights (2011) UN Doc No. E/C.12/RUS/CO/5, para 29.
53. Concluding observations: Moldova, Human Rights Committee (2002) para 9.
54. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, UN Human Rights Council (14 January 2009) UN Doc No. A/HRC/10/44, para 74.
55. European Court of Human Rights, *Melnik v. Ukraine*, Application no. 72286/01, 28 March 2006, paras 104-106. See also: *Staykov v. Bulgaria,* Application no. 49438/99, 12 October 2006, paras. 81-82.

56. 11th General Report on the CPT's activities, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or punishment (3 September 2001) CPT/Inf (2001), para 31 [emphasis added].
57. The Madrid Recommendation, Health Protection in Prisons as an Essential Part of Public Health, October 2009, Spain.
58. WHO (1993) *Guidelines on HIV infection and AIDS in prisons*. Geneva: World Health Organization; UNODC, WHO and UNAIDS (2006) *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response*. Vienna: UN Office on Drugs and Crime.
59. See, for example: World Medical Association, Declaration of Edinburgh on Prison Conditions and the Spread of TB and Other Communicable Diseases, Adopted by the 52nd WMA General Assembly, Edinburough, Scotland, October 2000, and revised by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011.
60. Recommendation No. R (98) 7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison, Council of Europe, Committee of Ministers (adopted 8 April 1998).
61. Resolution 1536 (2007)1 on HIV in Europe, Parliamentary Assembly of the Council of Europe (2007) para 9.4.
62. See, for example: UNODC, WHO and UNAIDS (2006) *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response*. Vienna: UN Office on Drugs and Crime.
63. See, for example: Concluding Observations on Mauritius, UN Committee on Economic, Social and Cultural Rights (10 December 2012) UN Doc No. E/C.12/MUS/CO/4, para 27.
64. See, for example, the Madrid Recommendation, Health Protection in Prisons as an Essential Part of Public Health, October 2009, Spain.
65. High Commissioner calls for focus on human rights and harm reduction in international drug policy, United Nations Press Release (10 March 2009). Speech available at: http://www.unhchr.ch/huricane/huricane.nsf/view01/3A5B668A4EE1BBC2C12575750055262E?opendocument (date of last access 29 January 2016).
66. Some justification for this has already been provided throughout this section. See also: OHCHR (7 December 2015) Open Letter by the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Dainius Puras, in the context of the preparations for the UNGASS on drugs which will take place in New York in April 2016; Harm Reduction International et al (15 May 2015) OHCHR Submission: Impact of the world drug problem on the enjoyment of human rights. London: Harm Reduction International; Hunt P (2008) 'Human Rights, Health and Harm Reduction: States' amnesia and parallel universes'. Address at Harm Reduction International's 19th Annual Conference in Barcelona, Spain, 11 May; and Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Mission to Sweden, General Assembly (28 February 2007) UN Doc No. A/HRC/4/28/Add.
67. General Comment 14: The right to the highest attainable standard of physical and mental health, Committee on Economic, Social and Cultural Rights (2000) UN Doc No. E/C.12/2000/4, para 11.
68. General Comment 4: The right to adequate housing, Committee on Economic, Social and Cultural Rights (2000) UN Doc No. E/C.12/2000/4, para 8(d).
69. Revised UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), UN General Assembly (2015) UN Doc No. 5/CN.15/2015/L.6/Rev.1, Rules 13, 14, 18, and 22.
70. See: Report of the Committee Against Torture, UN Committee Against Torture (1998) UN Doc No. A/53/44; Special Rapporteur on Torture, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak, U.N. Doc. A/62/221 (2007), para. 9.
71. See the following European Court of Human Rights cases: *Benedictov v. Russia*, Application No. 106/02, 10 May 2007 and *Kalashnikov v. Russia,* Application no. 47095/99, 15 July 2002. See also: *Ananyev and Others v. Russia*, Application nos 42525/07 and 60800/08, 10 January 2012.
72. Waldron J 'Participation: The right of rights' (1998) *Proceedings of the Aristotelian Society* vol 98:307-337.
73. See: *General Comment 14: The right to the highest attainable standard of physical and mental health*, Committee on Economic, Social and Cultural Rights (2000) UN Doc No. E/C.12/2000/4, para 11; Potts H and Hunt P (2008) *Participation and the Right to the Highest Attainable Standard of Health.* Colchester, UK: University of Essex Human Rights Centre, foreword.
74. See: Potts H and Hunt P (2008) *Participation and the Right to the Highest Attainable Standard of Health.* Colchester, UK: University of Essex Human Rights Centre.
75. See, for example, UNODC, WHO and UNAIDS (2006) *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response*. Vienna: UN Office on Drugs and Crime, p 13; From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA), UNAIDS (1999) UN Doc No. UNAIDS/99.43E.
76. *Commentary to Recommendation Rec(2006) 2 of the Committee of Ministers to Member States on the European Prison Rules*, Council of Europe. Available at: http://www.coe.int/t/dghl/standardsetting/prisons/E%20commentary%20to%20the%20EPR.pdf (date of last access 29 January 2016).
77. Background Paper for Conference: The CPT at 25: taking stock and moving forward, Council of Europe (2 March 2015), p 11. Available at: http://www.cpt.coe.int/en/conferences/cpt25-background_paper.pdf (date of last access 29 January 2016).
78. Potts H and Hunt P (2008) *Participation and the Right to the Highest Attainable Standard of Health.* Colchester, UK: University of Essex Human Rights Centre.
79. Lines R 'The right to health of prisoners in international human rights law' (March 2008) *International Journal of Prisoner Health* vol 4 no 1, p 14.
80. Mariner J and Schleifer R (2013) 'The right to health in prison' Advancing the Human Right to Health. Zuniga J M et al (eds). Oxford: Oxford University Press.
81. Hajek, Z (2009) 'New Partnerships for Torture Prevention in Europe'. CPT Conference Presentation, p 59.
82. See the European Committee for the Prevention of Torture's website: http://www.cpt.coe.int/en/about.htm (date of last access 29 January 2016)
83. European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987), article 1.

84. Ibid., article 5(3).
85. Ibid., article 4(2).
86. Bernath B (1999) *The CPT: History, Mandate and Composition*. Geneva: The Association for the Prevention of Torture, Brochure No. 3, p 41.
87. Ibid.
88. 3rd General Report, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (1992) para 30.
89. Ibid., para 32.
90. See: the CPT's website; and Bernath B (1999) *The CPT: History, Mandate and Composition*. Geneva: The Association for the Prevention of Torture, Brochure No. 3.
91. See the UN Office of the High Commissioner for Human Right's webpage on the SPT: http://www.ohchr.org/EN/HRBodies/OPCAT/Pages/OPCATIntro.aspx (date of last access 29 January 2016).
92. Optional Protocol to the Convention Against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (22 June 2006) article 11. 1(a).
93. Ibid., article 11. 1) b).
94. Guidelines of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to visits to States parties, UN Subcommittee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (20-24 February 2012) UN Doc No. CAT/OP/13/4, para 6.
95. 11th General Report, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (2001) para 31.
96. Ibid.
97. Ibid.
98. Ibid.
99. See: CPT Standards, Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2013) CPT/Inf/E (2002) 1 – Rev 2013, para 54; and 11th General Report, CPT (2001).
100. See: CPT Standards, Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2013) CPT/Inf/E (2002) 1 – Rev 2013, para 55; and 11th General Report, CPT (2001).
101. Ibid.
102. Drugs in Prisons: Draft list of issues to be examined when evaluating arrangements for the treatment of drug users detained in prisons, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (14 October 2002).
103. See, for example, the following European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment's reports: Greece (2013), para 129; Montenegro (2013), para 67; Estonia (2012), para 87; Lithuania (2012), para 71; Greenland (2012), para 33; Serbia (2011), para 71; and Greece (2011), para 75.
104. Ireland Report, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (2010), para 74-78.
105. Ireland Report, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (2010), para 57.
106. See, for example, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment's reports: Macedonia (2011), para 44; and Poland (2013), para 81.
107. Lithuania Report, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (2012), para. 71.
108. Report on the visit to the Republic of Paraguay, UN Subcommittee on Prevention of Torture (7 June 2010) UN Doc No. CAT/PP/PRY/1, para 171.
109. Ibid., para 180.
110. Ibid., para 179.
111. Report on the visit to Mexico, UN Subcommittee on Prevention of Torture (21 May 2010) UN Doc No. CAT/OP/MEX/1, para. 173.
112. Report on the visit to the Maldives, UN Subcommittee on Prevention of Torture (26 February 2009) UN Doc No. CAT/OP/MDV/1, para 235.
113. *7th Annual Report*, UN Subcommittee on Prevention of Torture (20 March 2014) UN Doc No. CAT/C/52/2, para 104.
114. 6th Annual Report, UN Subcommittee on Prevention of Torture (23 April 2013) UN Doc No. CAT/C/50/1, para 102.
115. Grover A and Gaziyev J (2013) *A Contribution by the Special Rapporteur on the Right to Health: Right to Health and Freedom from Torture and Ill-Treatment in Healthcare Settings - Torture in Healthcare Settings: Reflection on the Special Rapporteur on Torture's 2013 Thematic Report.* Washington, DC: Centre for Human Rights and Humanitarian Law Anti Torture Initiative, p 6. Available at: http://antitorture.org/wp-content/uploads/2014/03/PDF_Torture_in_Healthcare_Publication.pdf (date of last access 1 February 2016).
116. Hajek, Z (2009) 'New Partnerships for Torture Prevention in Europe'. CPT Conference Presentation, p 59.
117. 11th General Report, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (2001), para 10.

People who inject drugs make up about one third to one half of prison populations globally, and prisons have a much higher prevalence of HIV, hepatitis C (HCV) and TB than the broader community. Yet the provision of harm reduction services continues to remain extremely limited in prisons in comparison to what is available in the broader community. This has serious public health and human rights implications, which should be considered by human rights-based prison monitoring mechanisms.

This report identifies some of the most important human rights and public health standards relating to HIV, HCV, TB and harm reduction in prisons, demonstrating the indivisibility and interdependence of the right to the highest attainable standard of physical and mental health and the freedom from torture or cruel, inhuman or degrading treatment or punishment. A review of the mandate and working practice of European and international human rights-based prison monitoring mechanisms highlights that they are in a unique and critical position to consider these important issues, although this is not yet occurring in an adequately systematic or comprehensive manner.

Harm Reduction International is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights based approaches to drug policy through an integrated programme of research, analysis, advocacy and civil society strengthening. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

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