

ORIGINAL ARTICLE

The right to health of prisoners in international human rights law

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Abstract

This paper explores the health rights of prisoners as defined in international law, and the mechanisms that have been used to ensure the rights of persons in detention to realise the highest attainable standard of health. It examines this right as articulated within United Nations and regional human rights treaties, non-binding or so-called soft law instruments from international organisations and the jurisprudence of international human rights bodies. It explores the use of economic, social and cultural rights mechanisms, and those within civil and political rights, as they engage the right to health of prisoners, and identifies the minimum legal obligations of governments in order to remain compliant with human rights norms as defined within the international case law.

In addressing these issues, this article adopts a holistic approach to the definition of the highest attainable standard of health. This includes a consideration of adequate standards of general medical care, including preventative health and mental health services. It also examines the question of environmental health, and those poor conditions of detention that may exacerbate health decline, disease transmission, mental illness or death. The paper examines the approach to prison health of the United Nations human rights system and its various monitoring bodies, as well as the regional human rights systems in Europe, Africa and the Americas. Based upon this analysis, the paper draws conclusions on the current fulfilment of the right to health of prisoners on an international scale, and proposes expanded mechanisms under the *UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment* to monitor and promote the health rights of prisoners at the international and domestic levels.

Keywords: *Prisoner health, Human Rights, International Law, United Nations*

Introduction

The late *act for preserving the health of prisoners* requires that an *experienced Surgeon or Apothecary* be appointed to every gaol: a man of repute in his profession. His business is, in the first place, to order the immediate removal of the sick, to the infirmary; and see that they have proper bedding and attendance. Their irons should be taken off; and they should have, not only medicines, but also diet suitable to their condition. He must

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diligently and daily visit them himself; not leaving them to journeymen and apprentices. He should constantly inculcate the necessity of cleanliness and fresh air; and the danger of crowding prisoners together: and he should *recommend*, what he cannot enforce. I need not add, that according to the act, he must report to the justices at each quarter-sessions, the state of health of the prisoners under his care.¹

John Howard
The State of Prisons in England and Wales (1777)

In this excerpt from his most famous work, *The State of Prisons in England and Wales*, the 18th century prison reformer, John Howard, discussed the then newly passed *Act for Preserving the Health of Prisoners in Gaol, and preventing the Gaol Distemper*.² Enacted in 1774, the *Act* was the first Parliamentary legislation in Britain to specifically address health in prisons. As such, it was likely one of the earliest pieces of such legislation in Europe, if not the world.

The principles enshrined in this 230-year-old law are notable for their relevance to a contemporary examination of the right to health of prisoners. Indeed, more than two centuries later, the principles the *Act* outlines continue to form the framework of state obligations in international law to safeguard the health of prisoners.³

For example, the *Act* ordered the appointment of “an experienced Surgeon or Apothecary . . . to attend each Gaol or Prison respectively”. In doing so, it enshrined the legal obligation of the government to provide access to medical care for all prisoners. In specifying that this surgeon or apothecary be “experienced”, it mandated that prison medical staff meet proper qualifications and standards.

The *Act* required that every prison have an acceptable medical infrastructure. It ordered that “Two Rooms in each Gaol or Prison, One for the Men, and the other for the Women, to be set apart for the Sick Prisoners, directing them to be removed into such Rooms as soon as they shall be seized with any Disorder, and kept separate from those who shall be in Health.” These medical units were required to be maintained in a hygienic manner, and were “to be regularly washed and kept clean, and constantly supplied with fresh Air, by Means of Hand Ventilators, or otherwise”.

The *Act* identified the government’s responsibility “for restoring or preserving the Health of Prisoners”, therefore suggesting an obligation to provide both primary medical care for sick prisoners (restoring), as well as taking proactive preventative health measures (preserving). The *Act*’s attention to issues of hygiene, cleanliness and ventilation, as well as the requirement to separate ill prisoners from the rest of the prison population, underlines the responsibility to take measures to prevent the spread of infectious diseases. Indeed, the objective of “preventing the Gaol Distemper” identified in the *Act*’s title speaks to the preventative mandate of the legislation.

The legal obligation of the state to provide medical services in prisons was emphasised by the fact that health care was to be paid for out of taxation. It was reinforced by the stipulation that if “any Gaoler or Keeper of any Prison shall, at any Time, neglect or disobey” the legislation, they were liable for prosecution, fine and possible imprisonment.

Significantly, the *Act* also established a system of external monitoring and oversight that required the prison medical officer “to report to the . . . Justices by whom he is appointed, at each Quarter Session, a State of the Health of the Prisoners under his Care or Superintendance”. In this sense, the *Act* touched upon the modern obligation of states to progressively realise economic, social and cultural rights, including the right to health. Even the *Act*’s title, and its objective of “preserving the health of prisoners”, reflected the concept

in contemporary human rights law of the positive obligations of governments to take action to protect or safeguard the lives and well-being of people in detention.⁴

Background to the issue of health in prisons

In the 200 years since *An Act for Preserving the Health of Prisoners in Gaol, and preventing the Gaol Distemper* defined proper standards of medical care for prisoners in English jails, a comprehensive international legal framework has developed guaranteeing the right to health of all persons deprived of their liberty worldwide. However, the emergence of this international human rights regime has no more resolved the global problem of prison health than Parliamentary legislation in 18th century England assured prisoners of proper medical treatment and living conditions.

The UN Committee on Economic, Social and Cultural Rights, the independent expert body which monitors state compliance with the obligations under the *International Covenant on Economic, Social and Cultural Rights*, has stated, “Health is a fundamental human right indispensable from the exercise of other human rights”.⁵ On this basis, the health status of prisoners is a measure to assess the degree to which the rights of persons in detention are fulfilled or denied in a much broader sense. In reviewing international data on prison health, one can only conclude that the denial of the fundamental human rights of people in prison, including the right to health, is occurring on a global scale.

Today, over nine million people are incarcerated in penal institutions worldwide.⁶ As this figure represents only the prison population at any moment in time, it significantly underestimates the total number of persons who pass through prisons each year, often for short periods of detention. Indeed, annual admissions to prisons in countries across the world are estimated to be at least double, and in some cases 10 times, the actual number of people incarcerated on any single day.⁷

For a great many of these prisoners, the conditions in which they are forced to live differ little in quality than those reported by John Howard 200 years ago. Howard’s investigations revealed prisoners “in loathsome cells”,⁸ “covered (hardly covered) with rags; almost famished; and sick of diseases”,⁹ who were “crowded in close rooms, cells, and subterranean dungeons”¹⁰ where the “Air which has to be breathed, is made poisonous to a more intense degree, by the effluvia from the sick, and what else in prisons is offensive.”¹¹ This assessment is strikingly similar to that described by Human Rights Watch in its 1993 *Global Report on Prisons*, which found:

The great majority of the millions of persons who are imprisoned worldwide at any given moment, and the tens of millions who spend at least part of the year behind bars, are confined in conditions of filth and corruption, without adequate food or medical care, with little or nothing to do, and in circumstances in which violence—from other inmates, their keepers or both—is a constant threat.¹²

A significant proportion of prisoners in most countries are members of groups that suffer social, economic or ethnic/racial discrimination in the broader society. Many of the same factors that make these populations more likely to find themselves in conflict with the law, and therefore incarcerated, also mean that they suffer disproportionately from a poor health status.¹³ According to the World Health Organization (WHO),

In all countries of the world, it is people from the poorest and most marginalized sections of the population who make up the bulk of those serving prison sentences, and many of

them therefore have diseases such as tuberculosis, sexually transmitted infections, HIV/AIDS and mental disorders . . . Penitentiary populations [therefore] contain an over-representation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions.¹⁴

For example, the rate of tuberculosis (TB) infection among incarcerated populations is as much as one hundred times higher than that found outside of prisons,¹⁵ and in many countries is one of the leading causes of mortality among prisoners.¹⁶ According to Dr. Jaap Veen, “There is a clear relation between TB and poverty”.¹⁷ Given that “Prisoners generally come from the most deprived strata of society”, he concludes that it is “no wonder that TB in prisons is generally more prevalent than in civil society in general”.¹⁸

Within prisons, the risk of the spread of TB is heightened by poor and overcrowded prison conditions,¹⁹ illustrating the important relationship between environmental conditions in prisons and the health status of prisoners. Inadequate medical infrastructure, or inconsistent access to medications, heightens the risk of developing multi-drug resistant strains of TB within prison populations.²⁰ As a result, multi-drug resistant TB is common in the prison systems of both high-income and low-income countries.²¹ These multi-drug resistant strains of the disease, which are only treatable with expensive second-line TB therapies whose availability is strictly controlled and which require as much as two years continuous administration, pose an increased risk of illness, or even death, to prisoners and prison staff, as well as to the population outside of prisons.

But TB is just one example of health problems that are magnified within the prison environment. According to the WHO, prisons are places where “Two of the greatest public health problems facing all societies overlap: the epidemic of HIV/AIDS and the pandemic harmful use of psychotropic substances such as alcohol and illegal drugs”.²² In many countries, this intersection fuels very high rates of blood-borne diseases, such as HIV and hepatitis C, among prisoners who share equipment such as needles or syringes to inject drugs. As a result, rates of HIV and hepatitis C infection are significantly higher among prison populations than in the community outside of prisons.²³

As with TB, HIV infection can spread with alarming speed in prisons, particularly among prisoners who inject drugs. For example, in 2002 an HIV outbreak among injecting drug-using prisoners was identified at the Alytus Prison in Lithuania, during which time 263 prisoners tested positive for HIV within the space of a few months. Before this outbreak, testing had identified only 18 HIV infections in Lithuania’s entire prison system, and only 300 persons were known to be living with HIV in the country as a whole.²⁴

High rates of HIV and other infectious diseases in prisons can lead to alarmingly high rates of mortality among prisoners. In South African prisons, where high rates of both HIV and TB infection are evident, officials recorded 1087 “natural deaths” in prison in the year 2000, a 584% increase over the number of similar deaths in 1995. When the Department of Correctional Services examined post-mortem reports on these deaths in 1999, it concluded that 90% were HIV-related.²⁵ Based upon these figures and the continuing growth of the South African prison population, the study predicted that, by 2010, 45,000 people would die in the country’s prisons.²⁶

In addition to infectious diseases, mental health in prison is a growing international concern. The UN Special Rapporteur on the Highest Attainable Standard of Health, who is appointed by the UN Human Rights Council to report on the status of the right to health around the world, has expressed concern that people with mental health problems are often “misdirected towards prison rather than appropriate mental health care or support

services”,²⁷ creating a disproportionately high rate of mental illness within penal institutions. In Europe, the WHO estimates that as many as 40% of prisoners suffer from some form of mental illness,²⁸ and, as a result, are up to seven times more likely to commit suicide than are people outside of prisons.²⁹ The Special Rapporteur has noted that although poor prison conditions “tend to exacerbate mental disabilities . . . there is often little access to even rudimentary mental health care and support services”.³⁰ Prisoners with mental illness are also particularly vulnerable to violence. For example, the UN Special Rapporteur on Violence Against Women has noted that, “mentally ill women are at high risk of sexual abuse in custodial settings. Consequently, it is imperative that prisons have adequate facilities to meet the needs and ensure the protection of such women”.³¹

Despite the demonstrable need for countries to provide proper standards of primary medical and mental health care to fulfil the health rights of people in detention, few prison regimes boast health services that meet international human rights standards. As reported by Human Rights Watch,

Complaints about medical care, or lack thereof were . . . among the most frequent we heard in prisons throughout the world . . . A complaint we heard almost everywhere was that prisoners were denied medical care because of indifference [and] neglect . . . Health care for most of the world’s poor is inadequate; for prisoners, often the poorest of the poor, it is usually miserable.³²

Human Rights Watch also documented consistent problems with environmental health in prisons, including overcrowding, poor sanitary conditions, inadequate lighting and ventilation, extremes of temperature, insect and rodent infestation and insufficient/non-existent personal hygiene supplies. According to the report, any one of these factors can negatively affect a prisoner’s health,³³ and “Inadequate diet and unhygienic living conditions . . . contribute to an extremely high rate of disease and death”.³⁴

While the Human Rights Watch report dates from 1993, little has changed in the intervening years. A 2001 review of international prison conditions noted:

Living conditions in prisons have certainly not improved uniformly in the past decade and in many countries overcrowding has made these conditions even worse. The recognition of the rights of prisoners across jurisdictions has been uneven and progress uncertain.³⁵

The evidence clearly illustrates the degree to which the right to health of prisoners is far from fulfilled. Indeed, in all regions of the world, the people committed to prison are those whose social and economic marginalisation places them at increased risk of physical and mental health problems. They are incarcerated in overcrowded, unsanitary and stressful conditions, alongside others who share the same increased health vulnerabilities. As a result, the prison environment is one marked by disease transmission, environmentally exacerbated health decline and death, and heightened risk of mental illness. In the words of the WHO, “Ill-health thrives in settings of poverty, conflict, discrimination and disinterest. Prison is an environment that concentrates precisely these issues”.³⁶

The problem of poor prison health is not one limited to prisoners and prison authorities. Indeed, health experts and international organisations have consistently emphasised the fact that the issue of prison health cannot be isolated from broader public health concerns, as the vast majority of people in prison are eventually released back into the community.³⁷ Therefore, the fulfilment of the right to health of persons in detention is not only a matter of

pressing concern for persons in detention; it is also integrally linked to state obligations to fulfil the right to health within the population as a whole.

Background to international human rights law

The section will review the various human rights systems and monitoring bodies whose work is described in this article. Rather than a comprehensive overview of the system of international human rights law in its entirety, this section will explain and contextualise the key human rights treaties and bodies that have examined questions of health in prisons.

International human rights law is a consensually based system of treaty law. In ratifying a human rights convention, a state pledges to respect, protect and fulfil the rights it enshrines, and participate in the system(s) of independent monitoring and adjudication the treaty sets out.

There are four systems of international human rights law, falling into two distinct categories. The first is the United Nations system, which itself contains two distinct elements: the treaty system and the Charter-based system.

The treaty-based system is based on nine core international conventions:

- *International Covenant on Civil and Political Rights*
- *International Covenant on Economic, Social and Cultural Rights*
- *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment*
- *Convention on the Elimination of All Forms of Discrimination Against Women*
- *Convention on the Elimination of All Forms of Racial Discrimination*
- *Convention on the Rights of the Child*
- *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*
- *International Convention for the Protection of All Persons from Enforced Disappearance* (not yet in force)
- *Convention on the Rights of Persons with Disabilities* (not yet in force)

In addition to defining specific human rights protections, each treaty also establishes a committee of independent experts (known as a “treaty body”) to monitor the progress of states towards meeting the obligations enshrined in the treaty. The UN Human Rights Committee, for example, monitors the national implementation of the *International Covenant on Civil and Political Rights*. The Committee on the Rights of the Child monitors the implementation at country level of the *Convention on the Rights of the Child*, and so on.

The committees fulfil this mandate through a periodic reporting function, in which countries that have ratified the given treaty must submit a report to that independent expert committee every three to five years and have their human rights record under that treaty reviewed. The underlying principle of the periodic reporting process is one of “constructive dialogue” rather than criticism or confrontation. Following each of these periodic reviews, the committee in question will issue a report, called its Concluding Observations, on the state’s progress, noting areas of good implementation and also recommendations for improvement.

In addition, each committee is mandated to interpret the terms of treaty for which it is responsible in order to provide guidance to states in fulfilling their treaty obligations. These are typically done in the form of General Comments, in essence detailed commentaries on how the committee interprets the scope of the right or treaty article in question. Some of the independent committees, most notably the Human Rights Committee, are also empowered

to consider individual complaints or “communications” from persons who allege to have suffered human rights violations.

Unlike court decisions, none of the recommendations of UN human rights treaty bodies are binding, and there is no direct enforcement mechanism. Rather, the political weight of the treaties themselves is their strongest asset, as all states have agreed the same terms. Lacking any enforcement powers, the independent committees rely on the good will of states to comply with their recommendations.³⁸

The Charter-based system is based on the *Charter of the United Nations*, Articles 1 and 55 of which state that an aim of the UN is to promote fundamental respect for human rights, and which creates the principal organs of the United Nations.

Two of the primary bodies in this system are the UN General Assembly and the Economic and Social Council. The General Assembly is comprised of all 192 UN member states, and is the chief policy-setting body in the UN. It plays a key role in standard setting and the codification of international law. Human rights treaties and declarations are adopted at the General Assembly.

The work of the General Assembly is divided among a number of committees. The Third Committee deals specifically with social, humanitarian and cultural issues, including human rights. It considers reports from the human rights “Special Procedures” (see below) and considers draft human rights conventions and resolutions.

A primary UN body in this context is the Human Rights Council, the most senior political entity in UN system dealing specifically with human rights, and a subsidiary of the General Assembly. It is made up of 47 UN member states, and was created in August 2006 to replace the Commission on Human Rights.

Among the mandates of the Human Rights Council is to oversee the “Special Procedures”. These are independent experts, known as Special Rapporteurs and Working Groups, established to monitor and investigate specific human rights issues. Special Rapporteurs will have either a thematic (e.g. the Right to Health) or a country-specific mandate. They may make country visits on the request of the relevant government, and may also receive individual complaints from victims of human rights abuses.

In addition to the UN human rights system, there are also three regional human rights systems: the European system, the Inter-American system and the African system.

The fundamental treaty within the European system is *Convention for the Protection of Human Rights and Fundamental Freedoms*, more commonly known as the *European Convention on Human Rights*. This treaty is binding over all 47 member states of the Council of Europe. The Convention is enforced by the European Court of Human Rights, which sits in Strasbourg. The European Court considers individual allegations of human rights abuses made against states, and unlike most other international human rights systems, the judgments of the Court are legally binding within European member states. Another key, although lesser-known, European treaty is the *European Social Charter*, which covers economic, social and cultural rights. It is overseen by the European Committee on Social Rights, which operates in much the same way as the UN treaty bodies noted above.

The Inter-American system is comprised of two separate human rights treaties. The earliest of these is the *American Declaration of the Rights and Duties of Man*, which is in force in all 35³⁹ member countries of the Organization of American States (OAS). The rights enshrined in the *American Declaration* are monitored by the Inter-American Commission on Human Rights, which is empowered to both conduct human rights investigations in countries, as well as consider complaints from individuals regarding allegations of human rights abuses.

The second treaty within the Inter-American system is the *American Convention on Human Rights*, which has been ratified by 25 of the OAS states. The Convention's two monitoring bodies are the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. The Commission, an independent body similar to the UN treaty bodies, considers reports from OAS member states and may bring cases to the attention of the Court. The Court is very similar to the European Court, but its jurisdiction is limited in that it may only consider complaints within those states that have accepted the Court's jurisdiction.⁴⁰

The third and newest of the regional human rights system is the African system, in which the fundamental treaty is the *African Charter on Human and Peoples' Rights*. The treaty body created by the *Charter* to ensure its provisions are promoted is the African Commission on Human and People's Rights. Like the UN human rights committees, the African Commission has a periodic reporting function under which states parties must submit a report every two years detailing the actions they have taken to realise and promote the rights enshrined within the *Charter*. In addition, the African Commission may also consider individual complaints of alleged human rights violations. Recently, an additional protocol to the African Charter was adopted, creating an African Court on Human and People's Rights. This Court has now been established but has yet to hear a case.

The standards established in human rights treaties are not ones imposed upon states from the outside. Rather, each national government must, using its own domestic legislative process, choose whether or not to ratify a human rights treaty before the terms of that treaty are enforceable within that country. In this sense, ratifying a human rights treaty is similar to ratifying a trade agreement or an arms control agreement. Unless and until a government ratifies the treaty, it cannot be considered a party to that treaty, or bound by its terms.⁴¹ National governments therefore must provide consent via their own independent political processes before they are bound by the terms of a human rights treaty. However, once providing this consent, states have a legal obligation to uphold the protections and standards the treaty articulates.

International treaties, including international human rights conventions, are best conceptualised as contracts between states. The articles in the convention set out the treaty obligations, which are essentially the terms of the agreement. These obligations are owed by states that have ratified the treaty to the other states that have also ratified the treaty. However, unlike most international treaties, in which states enter into commitments regarding their inter-governmental relations and behaviour, human rights treaties enshrine protections for individuals rather than countries. Under international human rights law, when a state violates an individual's rights as defined within an international treaty, it is in effect breaching its contract with the other states parties to protect that person's rights. The reason that states owe their treaty obligations to each other is because only states are subjects of international law. The individual is merely the subject of the agreement.⁴²

In examining the question of the right to health of prisoners in international human rights law, it is also important to review the protections and legal obligations of states within the framework of international humanitarian law.

In times of armed conflict (war), special legal provisions come into operation to protect those who do not, or who no longer, take part in active hostilities, in particular the sick and injured fighters, civilians and those taken prisoner. These laws are collectively known as international humanitarian law, generally known as the *Geneva Conventions*. The Conventions set out detailed provisions for states to protect the victims of fighting in both

international armed conflicts and non-international armed conflicts (that is, fighting between groups within one country, sometime referred to as civil wars or guerrilla wars).

There is complementarity between international humanitarian law and international human rights law. However, the former lays down very specific protections in times of armed conflict that go beyond the core non-derogable rights such as the right to life and the prohibition of torture. Detailed provisions for protecting the rights of those fighters captured in international armed conflicts, including the right to humane treatment and medical care, are set out in the *Third Geneva Convention of 1949 relative to the Treatment of Prisoners of War*.

The fact that civilians made up the largest proportion of victims of World War II led to increased legal protection for civilians who find themselves either under occupation, or otherwise under the control of the opposition. These protections are contained in the *Fourth Geneva Convention of 1949, relative to the Protection of Civilians*. The *Fourth Geneva Convention* includes detailed provisions to protect the lives and health of civilians who are detained either under house arrest or *en masse* for reasons of security, which is termed internment.

The fact that the majority of armed conflicts in the last 60 years have occurred within states (that is, they are non-international armed conflicts) means that special provisions for protecting the victims of these conflicts is provided for both in Common Article 3 of the all the *Geneva Conventions*, which sets a minimum standard for humane treatment that includes access to medical care, as well as in the *Second Additional Protocol of 1977 relating to the Protection of Victims of Non-international Armed Conflicts*. In those situations of armed conflict where prisoners may not be afforded the special protection of the *Geneva Conventions*, they remain protected by international human rights law, including international standards and guidelines that express the elements of the right to health.

The right to health of prisoners within international human rights treaties

The right of all persons deprived of liberty to the highest attainable standard of health is guaranteed in a wide range of international instruments, including human rights treaties at the international and regional levels, United Nations resolutions and agreed model standards and guidelines for the treatment of prisoners adopted by the UN General Assembly. In some cases, these instruments articulate specific rights and standards, while others are more general and vague.

The right to health of prisoners is articulated within economic, social and cultural rights, under which the right is universal⁴³ and non-discriminatory in application.⁴⁴ It also finds expression within civil and political rights mechanisms. The UN Human Rights Committee, the independent expert body which monitors state compliance with the obligations under the *International Covenant on Civil and Political Rights*, has stated for example that although there is no specific right to health provision within the *Covenant*, questions of health in detention could be raised under the right to life (Article 6) or the right to humane treatment (Article 10).⁴⁵ Indeed both the right to life⁴⁶ and right to humane treatment⁴⁷ impose positive obligations upon countries that have ratified the treaty to protect the lives and/or well-being of persons in custody, which has often been interpreted to require government authorities to take action to safeguard the health of prisoners. As will be explored below, civil and political rights mechanisms within the UN and regional human rights systems provide important protections for the health of persons in detention.

The contemporary concept of the right to “the highest attainable standard of health” is drawn from the Constitution of the World Health Organization in 1946,⁴⁸ language that has since formed the basis for subsequent international instruments that enshrine the right to health.⁴⁹ According to the Preamble of the WHO Constitution, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.⁵⁰ As such, the WHO defines the right to health as universal, and therefore entitled to all persons whether inside or outside of prison. In recent years, the WHO has explicitly applied this universal right to health as the basis for developing prison health guidelines.⁵¹

Article 2 of the WHO Constitution details over 20 areas of necessary action in order to achieve the objective of enabling all persons to attain the highest possible standard of health. Article 2 identifies the need to strengthen health services,⁵² take action to prevent the spread of diseases,⁵³ address mental health issues⁵⁴ and to improve nutrition, housing, sanitation, recreation and other aspects of environmental hygiene.⁵⁵ This broad and universal concept of health is of particular resonance in examining the issue of prisons, and ensuring that prisoners are entitled to adequate medical standards.

The *Universal Declaration of Human Rights*, adopted in 1948, contains reference to health under Article 25.⁵⁶ Although the drafting committee originally recommended that the language of the WHO Constitution be adopted for the *Universal Declaration*,⁵⁷ the final text instead includes the issue with several others under “the right to a standard of living adequate for the health and well-being”.⁵⁸ The language adopted by the *Universal Declaration* in this regard has been characterised as being “very broad and vague”,⁵⁹ yet—given the historical significance and influence of the *Declaration*⁶⁰—the inclusion of even such unspecific language is important in the historical development of the right to health.⁶¹

Based upon the WHO Constitution, the “right to health”, as it has come to be understood in human rights discourse, has been enshrined in human rights treaties and other instruments at both the UN⁶² and regional⁶³ levels. Within the United Nations system, the first treaty to guarantee the right to health is the *International Covenant on Economic, Social and Cultural Rights*, which was adopted in 1966 and entered into force 10 years later. Article 12 of the *Covenant* affirms “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.⁶⁴ As in the WHO Constitution, the right to health is universal and imposes upon states parties to the treaty obligations well beyond the provision of medical services.⁶⁵ According to the UN Committee on Economic, Social and Cultural Rights, the right to health as defined in Article 12 is

an inclusive right extending not only to timely and appropriate 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, including on sexual and reproductive health.⁶⁶

Subsequently, the right to health for children and adolescents has been enshrined within the UN *Convention on the Rights of the Child*. While the *Convention* enshrines a holistic and comprehensive right to health consistent with the approach of the WHO Constitution and *Covenant on Economic, Social and Cultural Rights*, the Committee on the Rights of the Child, the independent expert body which monitors state compliance with the obligations under the *Convention*, “understands the concepts of ‘health and development’ more broadly than being strictly limited to the provisions defined” in the relevant articles.⁶⁷ This would suggest

that the right to health of children and adolescents places increased obligations on countries, due to the age and vulnerability of young people.

The right to health of women is specifically protected under the UN *Convention on the Elimination of All Forms of Discrimination Against Women*, which obligates governments to “take all appropriate measures to eliminate discrimination against women in the field of health care . . . including those related to family planning” for women under Article 12.⁶⁸ As this language refers only to primary health care services, the *Convention’s* conception of the right to health is much less comprehensive than that found in the *Covenant on Economic, Social and Cultural Rights*. However, as women’s rights to health are included under the universal right enshrined in the *Covenant*, it has been suggested that the *Convention’s* language reflects an intent to “highlight only those health-related areas where women need additional protection”.⁶⁹ This is particularly relevant for incarcerated women. The UN Special Rapporteur on Violence Against Women, in her 1999 report on women’s prisons in the United States, noted “women . . . clearly have special medical needs. The mere replication of health services provided for male prisoners is therefore not adequate”.⁷⁰

As mentioned above, protections for the health of all persons—including detainees and prisoners—living in an occupied or partially occupied zone during a time of war or armed conflict are provided for in the 1949 *Geneva Conventions*, in particular *Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*.⁷¹ However, the most detailed protections for the health of prisoners in the *Geneva Conventions* are found in *Convention (III) relative to the Treatment of Prisoners of War*. Article 13 specifies that

Prisoners of war must at all times be humanely treated. Any unlawful act or omission by the Detaining Power causing death or seriously endangering the health of a prisoner of war in its custody is prohibited, and will be regarded as a serious breach of the present Convention.⁷²

Geneva III articulates specific medical and mental health standards and protocols that must be observed by the Detaining Power, including access to free medical services⁷³ in “an adequate infirmary”,⁷⁴ regular medical inspections⁷⁵ and the right to be transferred to a civilian hospital for surgery or special treatment.⁷⁶ Prior to *Geneva III*, health protections in the area of medical care, mental health and environmental health for prisoners of war were articulated in the 1929 *Geneva Convention relative to the Treatment of Prisoners of War*.⁷⁷

Within the regional human rights systems, the European instruments have the weakest health guarantees. While the right to health is guaranteed under Article 11 of the *European Social Charter*,⁷⁸ it has been criticised for its vague articulation of state obligations in this regard.⁷⁹ Health is also addressed under the *Charter of Fundamental Rights of the European Union*.⁸⁰ However, the provision is again equivocal.⁸¹ The *European Convention on Human Rights* contains no explicit right to health. However, as will be explored below, the right to health of persons deprived of liberty is engaged under both the right to life (Article 2) and the prohibition of inhuman or degrading treatment (Article 3).

In the Inter-American system, the right to health was first articulated in 1948 in the *American Declaration on the Rights and Duties of Man*.⁸² The later *American Convention on Human Rights*, which entered into force in 1978, contains no right to health.⁸³ However, in 1988 an *Additional Protocol on Economic, Social and Cultural Rights* was adopted that addresses this issue.⁸⁴ Using language derived from the WHO Constitution and the *Covenant on Economic, Social and Cultural Rights*, Article 10 of the *Additional Protocol* states that, “Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being”.⁸⁵ However, as within the European

system, prisoner health rights within the Inter-American system have most often been engaged under the prohibition of cruel, inhuman or degrading treatment.⁸⁶

Unique among the regional systems, the African system enshrines a holistic protection of the right to health within its primary human rights instrument. The *African Charter on Human and Peoples' Rights* guarantees “the right to enjoy the best attainable state of physical and mental health” under Article 16.⁸⁷ The *African Charter* also requires that states parties “take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick”.⁸⁸ Within the African system, the right to health of prisoners has also been engaged under the right to life and the prohibition of cruel, inhuman or degrading treatment.⁸⁹

Defining lawful health standards in prisons

Although the right to health of prisoners is broadly protected under human rights norms, exercising these guarantees within the context of prisons is difficult. As described by Rieter, “Apart from being especially vulnerable by virtue of being detained, detainees generally are an unpopular political cause . . . Consideration of their rights is not normally included in the political process”.⁹⁰ The health rights of prisoners are therefore rarely a priority for political leaders or the general public. Complicating this situation is the fact that “[n]one of the relevant international or regional conventions define humane or inhumane treatment”.⁹¹ As a result, the generalised language used in the international treaties allows for significant discretion in interpreting standards of humane treatment of prisoners, such as the provision of medical care.

Although specific entitlements, including health guidelines, are codified in numerous international resolutions and model standards, none enjoys the status of international law, and are rather non-binding “soft law” instruments. The 1955 UN *Standard Minimum Rules on the Treatment of Prisoners*,⁹² the 1979 UN *Code of Conduct for Law Enforcement Officials*,⁹³ the 1982 UN *Principles of Medical Ethics*,⁹⁴ the 1988 UN *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*,⁹⁵ the 1990 UN *Basic Principles for the Treatment of Prisoners*⁹⁶ and the 1990 UN *Rules for the Protection of Juveniles Deprived of their Liberty*⁹⁷ all articulate standards of medical care for persons in detention. Each of these instruments, and therefore the standards they define, has been adopted by the UN General Assembly.⁹⁸

While former UN Special Rapporteur on Torture Nigel Rodley suggests that instruments such as the *Standard Minimum Rules* exert a “political or moral” influence,⁹⁹ and others argue that countries have at the very least an ethical obligation to observe such prison health resolutions,¹⁰⁰ none has a binding effect within international law. Ultimately, these are aspirational, rather than prescriptive, standards and guidelines. They articulate neither legally binding norms, nor particularly ambitious or high standards for states to achieve.¹⁰¹

That said, many of the specific principles and standards incorporated within these non-binding instruments have found legal expression within international and domestic case law. The *Standard Minimum Rules*, for example, has been cited by international human rights bodies in finding countries in violation of prisoners’ rights norms, which clearly illustrates the influential position they enjoy with jurists.¹⁰² The *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment* has similarly been cited within the international jurisprudence, and used as a basis for defining standards of detention within international law.¹⁰³ In recent years, the reports of the European

Committee on the Prevention of Torture have been regularly cited in prison jurisprudence of the European Court of Human Rights.¹⁰⁴

The influence of these non-binding instruments on the judgments of international human rights bodies therefore creates the possibility that the standards they embody might evolve from aspirational targets in to accepted legal norms. Indeed, a close review of the jurisprudence on key areas of prison health illustrates a remarkable consistency between the principles and standards articulated in the UN resolutions above, and the judgments of international courts and human rights treaty bodies. This would suggest that, far from articulating non-binding standards, in many cases these guidelines have become accepted minimum legal requirements for governments to meet. The next section will explore this case law, and examine those key areas of consensus on the right to health between non-binding instruments and the international jurisprudence.

A right to medical care

As described in the *Basic Principles for the Treatment of Prisoners*, “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation”.¹⁰⁵ The *UN Principles of Medical Ethics* state that all health personnel working with prisoners “have a duty to provide them with . . . treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained”.¹⁰⁶ This principle is also supported by the non-binding *European Prison Rules*, adopted by the Council of Europe.¹⁰⁷

A review of the international jurisprudence demonstrates that the principle reflected in these and other non-binding instruments also reflects the legal minimum standard within international law under economic, social and cultural rights (the right to health), civil and political rights (the right to life, the right to due process, the right to humane treatment) and international humanitarian law (the *Geneva Conventions*). It is also the consensus view expressed by UN human rights monitors.

The UN Committee on Economic, Social and Cultural Rights has stated explicitly that “States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees . . . [to] curative and palliative health services”.¹⁰⁸ The Committee has expressed specific concern about poor access to health care in prisons in Trinidad and Tobago,¹⁰⁹ Brazil¹¹⁰ and Yemen,¹¹¹ in each case recommending that the countries take measures to improve medical standards in detention to meet their obligations under the *Covenant on Economic, Social and Cultural Rights*.

The right to medical care is guaranteed to young persons in prison under the right to health in Article 24 of the *UN Convention on the Rights of the Child*.¹¹² The *Convention* details a series of areas in which states are obliged to take action in order to fulfil this right, including the provision of primary health services.¹¹³ Although it has not been a major area of the work of the Committee on the Rights of the Child, the right to health of children and young people in detention has been identified as a concern in several of the Committee’s Concluding Observations examining state compliance with the terms of the treaty.¹¹⁴ The Committee has expressed concern at “the lack of adequate basic services such as education and health”¹¹⁵ and called upon the state party to “ensure that all children deprived of their liberty have statutory rights to . . . health”.¹¹⁶

There have been three successful applications by prisoners to the African Commission on Human and Peoples’ Rights, the independent body that monitors state compliance with the *African Charter*, in which countries have been found in violation of the *Charter’s* right to

health. In these cases, the approach of the Commission has been that the state obligation to fulfil the right to health under Article 16 “is heightened in cases where an individual is in its custody”, as the person’s “integrity and well-being is completely dependent upon the actions of the authorities”.¹¹⁷

In the case of *Free Legal Assistance Group and others v. Zaire*, it was alleged that the military engaged in a campaign of persecution against members of the Jehovah’s Witnesses, including arbitrary arrest and detention. The African Commission found a violation of the right to health on grounds including inadequate medical treatment.¹¹⁸ In *International PEN and Others v. Nigeria*, which concerned the case of human rights activist Ken Saro-Wiwa, the Commission found the government in violation of Article 16 for its failure to provide Mr Saro-Wiwa with hospital care, despite the recommendation of a doctor. This failure caused Saro-Wiwa’s “health to suffer to the point where his life was endangered”.¹¹⁹ In the most recent of the African Commission cases, *Malawi African Association and others v. Mauritania*, a violation of the right to health was again found to include poor medical care. In this case, the Commission noted that several prisoners died due to a lack of medical attention.¹²⁰

In domestic law, the South African Constitution enshrines a right to health care, as well as specific guarantees to detainees and sentenced prisoners of the right “to conditions of detention that are consistent with human dignity including ... adequate ... medical treatment”.¹²¹ Based upon these provisions, the right to medical care of prisoners has been litigated before the South African courts.

In the case of *Van Biljon and Others v. The Minister of Correctional Services*, four prisoners living with HIV/AIDS took a case to compel the prison authorities to provide them with HIV anti-retroviral therapies. While the prison service argued that the cost of providing the treatment was prohibitive, the High Court (Cape of Good Hope Provincial Division) ordered that the medications be provided, but only for the two applicants for whom it had been medically prescribed prior to the court action.¹²² In this decision, the Court found that there was a higher obligation on the state to provide medical care for particularly vulnerable prisoners, such as those living with HIV/AIDS, than there was to provide health care for comparable patients outside of prisons.¹²³ More recently, the High Court in Durban in 2006 also found the failure of the state to provide medical care to HIV-positive prisoners violated their right to health, and the judge ordered the authorities to provide HIV anti-retroviral treatment for all medically qualifying prisoners.¹²⁴

The right to medical care of persons in detention is also guaranteed under civil and political rights. The UN Human Rights Committee, for example, has indicated that “the right to ... health of all detained persons” is engaged under Articles 6 (the right to life) and 7 (prohibition of torture) of the *International Covenant on Civil and Political Rights*, and the obligation to “provide appropriate medical care to detainees” is engaged under Article 10 (prohibition of inhuman or degrading treatment).¹²⁵ As a result, the Committee has affirmed that state responsibilities under the *Covenant* include “the provision of adequate medical care during detention”.¹²⁶ It has specified that state obligations to provide medical care to prisoners “extends to persons under the sentence of death”.¹²⁷ Given that even those persons under the most severe penal sanction retain a fundamental right to medical care, it follows that all persons under sentence, or indeed held without charge or in pre-trial detention, must also retain this right. The Committee has been critical of poor standards of prison medical care in a number of its Concluding Observations reviewing the compliance of states with the obligations in the *Covenant*.¹²⁸

The right to medical care in prisons is guaranteed under the right to life. According to the UN Human Rights Committee, “the State party by arresting and detaining individuals takes the responsibility to care for their life”.¹²⁹ Because “the State party remains responsible for the life and well-being of its detainees”,¹³⁰ it is therefore “incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection”.¹³¹ This therefore demands the provision of adequate and pro-active medical care.

The Human Rights Committee has considered several individual complaints addressing prisoner medical care under the right to life. In *Lantsova v. The Russian Federation*, the Committee found a violation of Article 6(1) where a man died in a detention centre in Moscow. The prisoner’s mother, who took the case on behalf of her deceased son, alleged that he was in good health when he entered the prison, but soon fell ill due to poor conditions. It was claimed that the prisoner “received medical care only during the last few minutes of his life” and “that the prison authorities had refused such care during the preceding days and that this situation caused his death”.¹³² The Committee found that the failure of the authorities to provide a “properly functioning medical service” to diagnose and treat the prisoner’s medical condition violated his right to life.¹³³ Based on *Lantsova*, it can be presumed that providing a “properly functioning medical service” in prisons is a legal requirement of countries parties under the right to life in Article 6(1).

While *Lantsova* is the only application before the Human Rights Committee in which a country has been found in violation of the right to health of prisoners based on Article 6 protections, there have been other attempts of note that were ruled inadmissible.¹³⁴ *Fabrikant v. Canada* concerned a life-sentenced prisoner in Québec who had applied for, and been denied, transfer to a prison in British Columbia. The applicant, who had a history of heart problems, claimed the necessary surgical expertise to treat his condition was unavailable in Québec. He argued that the refusal of his transfer constituted a failure “to provide him with necessary and available medical treatment [and] threatens his right to life under article 6”.¹³⁵ Although judging the application inadmissible, the Committee found that under Article 6, “the State party remains responsible for the life and well-being of its detainees”.¹³⁶ It has been suggested that this decision expands the positive obligations of the state under the right to life “beyond taking reasonable steps to preserve a detainee’s life to the taking of such steps to maintain an adequate standard of health”,¹³⁷ which would include providing adequate medical services.

The European Court of Human Rights, the judicial body that considers alleged violations under the *European Convention of Human Rights*, has also used the right to life under Article 2 of the *European Convention* as a mechanism to engage the right to health of prisoners, including the right to medical treatment. According to the Court, the right to life “enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction”.¹³⁸ In *Edwards and another v. United Kingdom*, the failure of the state to provide medical care and health screening systems in prison was found to violate Article 2.¹³⁹ A violation of the right to life was also found in a case of *Tarariyeva v. Russia*, where a prisoner died from post-surgical complications after being transferred back to the prison from the public hospital. In that case, the Court found that:

A further element decisive for the assessment of the adequacy of medical care at the prison hospital is whether it possessed the necessary facilities to perform surgical

interventions successfully and deal with post-operative complications. In the present case it appears that such facilities were conspicuously lacking.¹⁴⁰

In *Malawi African Association and others v. Mauritania*, the African Commission found a violation of the right to life in the *African Charter*, in part, due to lack of medical services for detainees. In the case, in which four prisoners died following a lack of medical attention, the Commission found, “Denying people . . . medical attention . . . constitutes a violation of Article 4”.¹⁴¹

The use of the right to life as a mechanism to engage the right to health has also occurred on the domestic level. The Indian courts have interpreted the right to life in Article 21 of the Indian Constitution in such a manner as to extend health rights to Indian citizens. According to the Supreme Court of India in *Consumer Education and Research Centre And Others v. Union of India and Others*, “The right to health . . . is an integral facet of meaningful right to life . . . Therefore it must be held that the right to health and medical care is a fundamental right under Article 21 . . . and is a minimum requirement to enable a person to live with human dignity”.¹⁴² While there has yet to be a case before the Indian Supreme Court applying this precedent within the prison context, the Court takes the approach that, “prisoners retain all rights enjoyed by free citizens except those that are lost necessarily as an incident of confinement”.¹⁴³ As a result, the right to health—including the provision of medical services—would necessarily extend to persons in detention.

In addition to the right to life, the UN Human Rights Committee has stated that “inadequate care” in detention could also constitute a violation of Article 9 (the right to liberty and security of the person) of the *Covenant on Civil and Political Rights*.¹⁴⁴

The UN Working Group on Arbitrary Detention, the expert body that investigates and reports on deprivation of liberty imposed arbitrarily, has also suggested that the failure of the state to provide a proper standard of health care may violate Article 9, as well as Article 14, which outlines fair trial guarantees.¹⁴⁵ The Working Group’s 2004 Annual Report proposed that the failure to protect the health of pre-trial detainees could breach the right to due process of law. Citing the fundamental legal principle known as “equality of arms”, under which the defence should never be placed at an unfair disadvantage in its ability to present its case, the Working Group raised its concern that

A detainee who has to endure detention conditions that affect his or her health, safety or well-being is participating in the proceedings in less favourable conditions than the prosecution . . . Where conditions of detention are so inadequate as to seriously weaken the pre-trial detainee and thereby impair equality, a fair trial is no longer ensured, even if procedural fair-trial guarantees are otherwise scrupulously observed.¹⁴⁶

In its 2003 report on Argentina, the Working Group specifically cited that health concerns could violate fair trial guarantees. The Working Group observed that, “poor conditions in the areas of . . . health . . . could, and in fact do, restrict the right of persons deprived of their liberty to a proper defence during their trial.”¹⁴⁷

The Working Group’s 2004 Annual Report raised the further concern that holding pre-trial detainees in poor conditions, such as those that promote illness or health decline, violates protections against arbitrary detention. According to the report, “pre-trial detention becomes arbitrary where the conditions are such as to create an incentive for self-incrimination, or—even worse—to make pre-trial detention a form of advance punishment in violation of the presumption of innocence”.¹⁴⁸ Such conditions include

those in which a detainee's health is compromised by a failure to provide adequate medical services.

Support for this interpretation is also found in domestic jurisprudence. The High Court of South Africa (Eastern Cape Division) invoked fair trial guarantees in *S v. Zuba and 23 similar cases*.¹⁴⁹ *Zuba* concerned a group of juvenile detainees who were sentenced to a reform school for youth but, due to the lack of such a facility in the region, spent long periods of detention in prisons or police lock-ups waiting for spaces to become available in reform schools in other regions so they might begin serving their sentences. Among the reasons identified by the Court in ordering the release of the applicants was that their fair trial rights had been violated.¹⁵⁰ According to Judge Plasket, "the right to a fair trial must include the right not to be subjected to a sentence substantially more severe than the one imposed by the trial court".¹⁵¹ Although the judgment did not specifically invoke the right to health, it has been proposed that the Court's reasoning could be used to engage the right to proper medical care in prisons.¹⁵²

As the failure to provide medical treatment to a sick or injured prisoner inevitably and unnecessarily exacerbates his or her pain and suffering, the right to medical care in prisons is also engaged under the prohibition of cruel, inhuman or degrading treatment. For example, the European Committee for the Prevention of Torture, which monitors conditions of detention throughout the countries of the Council of Europe, has expressed the view that "An inadequate level of health care can lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment'".¹⁵³ The UN Human Rights Committee has stated specifically that the right to health of prisoners could be engaged under the right to humane treatment in the *Covenant on Civil and Political Rights*.¹⁵⁴ The related prohibition of torture (Article 7) in the *Covenant* has also been used by the Human Rights Committee to address questions of prison medical care in some cases.¹⁵⁵

Within the international jurisprudence, findings of inadequate medical treatment in this regard are typically found in circumstances where a poor standard of health care is one of a number of issues cumulatively assessed as being cruel, inhuman or degrading. There are two general categories of cases that illustrate this point. The first are torture cases, in which deliberate violence has been inflicted by state actors upon persons in detention. Findings of human rights violations in these cases typically include criticism that the person was denied medical attention to treat the injuries received as a consequence of the physical abuse.

A series of applications to the UN Human Rights Committee in the 1980s concerning the ill-treatment of detained persons in Uruguay illustrates this type of case. The Committee's findings of violations of the *Covenant on Civil and Political Rights* cited physical abuse or torture, as well as the failure of prison authorities to provide subsequent medical assistance. For example, in *Setelich/Sendic v. Uruguay*, the Committee found violations "of article 7 and article 10 (1) because Raul Sendic . . . was subjected to torture for three months in 1978 and is being denied the medical treatment his condition requires".¹⁵⁶ Many other cases fall into this category. *Pennant v. Jamaica*, for example, found a violation where the applicant "was beaten while in police custody and did not receive medical treatment until the committing magistrate ordered the police to take him to hospital".¹⁵⁷

All the African Commission cases in which denial of medical care is cited in a finding of cruel, inhuman or degrading treatment occur in the context of physical abuse or beatings of persons in detention.¹⁵⁸ This is also true of much of the Inter-American human rights case law, where "very deficient"¹⁵⁹ or "inadequate or unresponsive"¹⁶⁰ medical attention has been cited by the Inter-American Court of Human Rights, along with deliberate physical abuse, as contributing to a finding of cruel, inhuman or degrading treatment.

The work of both the UN Committee against Torture, the independent expert body which monitors state compliance with the obligations under the UN *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, and the UN Special Rapporteur on Torture have focused on issues related to medical care for victims of torture. The Special Rapporteur, for example, recommended that “Victims of torture and ill-treatment receive . . . adequate medical treatment and rehabilitation”.¹⁶¹ The Committee has identified “lack of health care staff” among those “[p]oor prison conditions that affect the health of both inmates and wardens”.¹⁶² The Committee’s Concluding Observations on state compliance of Belgium specifically recommended that the country “Improve the system of access to health care in prisons”.¹⁶³

In addition to the torture cases, the other category of applications that generally cite inadequate medical care are those in which health services are one of a list of prison conditions that are cumulatively assessed to constitute inhumane or degrading treatment. Much of this case law focuses on the issue of capital punishment.

A series of UN Human Rights Committee applications examining the death penalty in Jamaica and in Trinidad and Tobago, for example, identified poor medical care as one of many unacceptable conditions on death row cumulatively judged to violate the protections in the *Covenant on Civil and Political Rights*.¹⁶⁴ Absent deliberate physical abuse found in the torture cases, lack of medical treatment in these cases was usually found to constitute inhumane treatment rather than torture. In the jurisprudence of Inter-American human rights system, there are also a significant number of death row cases in which poor conditions of confinement, including deprivation of medical care, were found to constitute cruel, inhuman or degrading treatment.¹⁶⁵

The *European Convention’s* Article 3 prohibition of inhuman or degrading treatment has been used extensively to engage the right to health of prisoners. Like the right to life, the prohibition of inhuman or degrading treatment imposes positive obligations on states, and the European Court has articulated these obligations in very clear terms.¹⁶⁶ The Court has affirmed that “the authorities are under an obligation to protect the health of persons deprived of liberty and the lack of appropriate medical care may amount to treatment contrary to art 3”.¹⁶⁷ According to *Kudla v. Poland*, Article 3 obligates the state to ensure a prisoner’s “health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance”.¹⁶⁸ In *Melnick v. Ukraine*, the failure of prison authorities to “diagnose and cure the applicant’s tuberculosis” was among the factors contributing to a violation of Article 3.¹⁶⁹

The prohibition of cruel, inhuman or degrading treatment has also been used by domestic courts to require the authorities to provide medical care in prisons. In *Estelle v. Gamble*, the United States Supreme Court found that under “the evolving standards of decency” that characterise the Court’s approach to interpreting Eighth Amendment guarantees against cruel and unusual punishment, the state is obliged to provide medical care for people in prison.¹⁷⁰ Writing for the majority, Justice Thurgood Marshall affirmed

[T]he government’s obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical “torture or a lingering death,” . . . In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose.¹⁷¹

The international case law shows that the right to medical care of prisoners includes not just general medicine, but also access to specialist treatment whether in the place of imprisonment, or through transfer to a community health facility. The jurisprudence of the UN Human Rights Committee includes cases where prison authorities have been obligated to provide ophthalmologic and dental treatment,¹⁷² dermatology¹⁷³ and treatment for allergies and asthma.¹⁷⁴ This obligation also includes provision of medicines,¹⁷⁵ including medications to relieve pain.¹⁷⁶

The Special Rapporteur on Health has sent a number of individual communications to countries expressing concern over the failure to provide treatment for diabetes,¹⁷⁷ “chronic asthma”,¹⁷⁸ kidney conditions,¹⁷⁹ a “critical” heart condition,¹⁸⁰ tuberculosis¹⁸¹ and dental problems.¹⁸² The Special Rapporteur on Violence against Women has called for “timely referrals and easy access to gynaecologists” for incarcerated women.¹⁸³

The state must also provide prisoners with access to specialised medical treatment outside of the prisons. In *Levy v. Jamaica*, the UN Human Rights Committee found a violation of Article 10(1) where the applicant “should have had an operation on his jaw and throat, but that the prison authorities made it impossible for him to keep his appointment”.¹⁸⁴ In *Simpson v. Jamaica*, a prisoner was “refused specialized treatment” despite “an undiagnosed and untreated medical condition giving rise to symptoms of great pain and swelling in his testicle”, among other ailments.¹⁸⁵ In *Matthews v. Trinidad and Tobago*, “between 1990 and 1993, [the applicant] was denied attendance at an eye clinic . . . on 14 occasions”.¹⁸⁶ On the other hand, in *Henry and Douglas v. Jamaica*, no violation of Articles 7 or 10(1) was found because the prison authorities enabled the applicant to “visit various hospitals and receive medical treatment for his cancer, including chemotherapy”.¹⁸⁷

Where the prison is unable to provide an adequate standard of medical care, the European Court has found that—in exceptional cases—the person should be released. This was the judgment in *Price v. United Kingdom*, in which the applicant was “four-limb deficient as a result of phocomelia due to thalidomide”¹⁸⁸ and *Mouisel v. France*, in which the prisoner was suffering from leukaemia.¹⁸⁹ Indeed, the European Court takes the approach that the state’s positive obligations to protect the well-being of detainees are heightened when a prisoner is at increased vulnerability due to severe health concerns such as physical disability.¹⁹⁰

The UK courts have touched on the right to health of prisoners in considering the question of the right to correspondence. In *R (Szuluk) v. Governor, HMP Full Sutton*, a prisoner who had undergone surgery following a brain haemorrhage requested that medical correspondence between himself and his external specialist be exempted from screening by prison staff. Although the prison initially granted this request, it subsequently changed its position and required the prison medical officer to read all such correspondence. As a result, the prisoner took a case to the UK courts alleging an infringement of his rights under Article 8 (the right to respect for private and family life, home and correspondence) of the *European Convention on Human Rights*.¹⁹¹

The applicant won an initial case in 2004, when the judge ruled that the unique nature of the case warranted prison authorities to invoke the discretion allowed within the prison correspondence policy.

What makes this case special is the fact that this prisoner is suffering from a life-threatening condition and is undergoing treatment outside the prison, and is in the need of continual medical care In those circumstances, and making clear that this is a case

which, in my view, turns specifically on its own exceptional facts, it is appropriate to grant the relief sought.¹⁹²

Although not specifically invoking a right to health, the reasoning of the judgment is clear that the decision to allow the private correspondence was, in part, to ensure that the prisoner was receiving a proper standard of medical treatment.

In this case the claimant is suffering from a life-threatening condition. He is undoubtedly, in those circumstances, and understandably concerned to ensure that his treatment in prison does not in any way affect him adversely. He wants, and understandably wants, to obtain, if necessary, reassurance from his specialist and from other medical practitioners, if there are any, who are involved in treating him.¹⁹³

However, this judgment was later overturned on appeal, where the Court found “the requirement that Mr Szuluk’s correspondence with Dr Renowden be read by the prison medical officer was a proportionate interference with his Art 8 rights”.¹⁹⁴ However, the appeals Court did not conclude that the prison has the right in all cases to screen a prisoner’s medical correspondence, and left open “the possibility that in another case Art 8 will make it disproportionate to refuse to waive [the policy] in relation to medical correspondence . . . [However] we do not consider that this is such a case”.¹⁹⁵

Medical care for detainees and prisoners, including interned civilians, is also guaranteed in international humanitarian law under the *Geneva Conventions*, particularly in *Convention (III) relative to the Treatment of Prisoners of War* and *Convention (IV) relative to the Protection of Civilians in Time of War*. Article 13 specifies that *Geneva III* articulates specific medical standards and protocols that must be observed by the Detaining Power, including access to free medical services¹⁹⁶ in “an adequate infirmary”,¹⁹⁷ regular medical inspections¹⁹⁸ and the right to be transferred to a civilian hospital for surgery or special treatment.¹⁹⁹

Inadequate medical care for detainees in this regard was recently examined in the *Limaj Case* before the International Criminal Tribunal for the former Yugoslavia.²⁰⁰ In addition to physical abuse and torture of detainees and the Llapushnik/Lapusnik prison camp, the defendants were accused of “maintaining and enforcing the inhumane conditions . . . which included inadequate . . . medical care”.²⁰¹ Although medical care was “readily available” at the camp,²⁰² treatment was not provided, even to those who were injured while being taken into custody, or beaten in detention.²⁰³ The Tribunal found that these conditions were illegal, and contributed to the offence of cruel treatment.²⁰⁴

A right to timely medical attention

According to the *Standard Minimum Rules*, “The medical officer . . . should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed”.²⁰⁵ The *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment* specifies that “medical care and treatment shall be provided whenever necessary”.²⁰⁶

The right to have medical attention provided to prisoners in a timely fashion is one broadly supported as a legal requirement. Indeed, it is clear from the jurisprudence that medical care for prisoners is only compliant with international law if it is available when needed.

The UN Human Rights Committee has stated that under the *Covenant on Civil and Political Rights*, “Appropriate and *timely* medical care must be available to all detainees”.²⁰⁷

[Emphasis added.] The Committee found that in order to be compliant with obligations under the right to life, health care must be available to diagnose and treat prisoners when they are ill or otherwise in need of attention, as anything less than this does not constitute a “properly functioning medical service” within the terms of Article 6(1).²⁰⁸

Medical services found cruel, inhuman or degrading generally occur in a context where the applicant is clearly in need of medical attention, such as following beatings or torture, or when he or she is ill or injured. The failure to provide medical attention in this context, which unnecessarily exacerbates the pain and suffering of the prisoner, may quickly lead to treatment deemed inhuman or degrading.

In *Leehong v. Jamaica*, for example, the UN Human Rights Committee found violations of Articles 7 and 10(1) of the *Covenant on Civil and Political Rights*, in part, because the applicant had “only been allowed to see a doctor once, despite having sustained beatings by warders and having requested medical attention”.²⁰⁹ In *Kalenga v. Zambia*, Article 10(1) was breached, in part, because of the “failure to provide medical assistance *when needed*”.²¹⁰ [Emphasis added.] In *Bennett v. Jamaica*, the Human Rights Committee was critical of the fact that the applicant had not seen a doctor for several years.²¹¹

The obligation to provide timely medical attention can also be inferred from the regional case law. In the *Cantoral Benavides Case*, the Inter-American Court of Human Rights found an Article 5 violation (the right to humane treatment), in part, because, “While being transferred to these cells [the applicant] was beaten . . . [and] Upon his arrival, he received no medical attention”.²¹² In *Caesar v. Trinidad and Tobago*, the prisoner “was not given the necessary surgery until five or six years after the pertinent medical recommendation”.²¹³ The Inter-American Commission on Human Rights provided more specificity in characterising a standard of “inadequate medical care” as occurring when “visits from the doctor are not regular and it is not clear whether [the applicant] will be able to see a doctor when necessary”.²¹⁴

The European Court of Human Rights has stated that “lack of medical assistance in circumstances where such assistance was not needed cannot, of itself, amount to a violation of Article 3” (prohibition of inhuman or degrading treatment).²¹⁵ That said, the Court’s jurisprudence is clear that a failure to provide timely medical assistance when needed may violate the *European Convention*.

For example, the Court found an Article 3 violation, in part, where a prisoner had not seen a doctor for 18 months, even after taking part in a hunger strike. “In the Court’s view, this cannot be deemed to be adequate and reasonable medical attention, given the hunger strike and the diseases from which the applicant was suffering”.²¹⁶ In *McGlinchy and Others v. United Kingdom*, the Court found a violation based on a much shorter delay in treatment, when “a gap in the monitoring of [the prisoner’s] condition by a doctor over the weekend” resulted in a rapid decline of her health status, and later death.²¹⁷ *Iorgov v. Bulgaria* cited “an unwarranted delay in providing adequate medical assistance” as contributing to a violation of Article 3.²¹⁸

In *Istrath and Others v. Moldova*, the Court found that the prisoner “was not given timely medical assistance”²¹⁹ and that “the failure to provide immediate medical assistance to the applicant in an emergency situation” contributed to a violation of Article 3.²²⁰ On the other hand, in *Aliev v. Ukraine*, the Court found that the health standards in the prison did not violate Article 3 because, in part, “the applicant received medical assistance when he complained about health problems”.²²¹

The European Court has also found that, where a prisoner has a serious medical condition, timely medical care can include regular access to specialised diagnostic care. In

the case of *Popov v. Russia*, where the prisoner had a history of bladder cancer and had previously undergone chemotherapy, the Court concluded “that the minimum scope of medical supervision required . . . included regular examinations by a uro-oncologist and cystoscopy at least once a year”.²²² In that case, the fact that the prisoner had received neither examination in the one year and nine months of his incarceration was found to contribute to inhuman and degrading treatment, and therefore a violation of Article 3.²²³

Timely medical attention in the European Court’s jurisprudence also extends to access to treatment. In *Paladi v. Moldova*, the Court expressed concern at the delay in initiating recommended treatment, and found that the interruption of the treatment once it had been initiated amounted to a violation of Article 3.²²⁴

The Special Rapporteur on Health has expressed concern over the failure of prison authorities to provide “prompt and adequate medical treatment”.²²⁵ The Special Rapporteur on Violence Against Women has specifically recommended “timely referrals and easy access to gynaecologists” for incarcerated women.²²⁶

This principle is also supported within international humanitarian law. In the *Limaj Case*, the International Criminal Tribunal for the former Yugoslavia found that although medical care was “readily available” at the Llapushnik/Lapusnik prison camp, the failure to make it available to treat detainees in need of medical assistance was illegal.²²⁷

A right to preventative health

Prison health standards and declarations of the WHO²²⁸ and the World Medical Association²²⁹ state that prisoners must be provided with measures to prevent the transmission of disease. Non-binding resolutions of the Council of Europe also state that, “respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment”.²³⁰ The UN *Rules for the Protection of Juveniles Deprived of their Liberty* specifies that all juvenile detainees shall receive preventive health care.²³¹ This agreed medical standard found throughout the non-binding instruments is also reflected as a legal norm in the international case law, one which obligates states to take measures to prevent the spread of disease within prisons.

In its 1997 Concluding Observations on the Russian Federation, the Committee on Economic, Social and Cultural Rights expressed specific concern “over the re-emergence of tuberculosis . . . particularly in prisons, where the health and social conditions of detention are unacceptable.”²³² This concern was repeated in the Committee’s 2003 Concluding Observations.²³³ In its 2003 report on Moldova, the Committee expressed “alarm” about TB in prisons, citing an “infection rate . . . more than 40 times higher than the national average”.²³⁴ In both cases, the Committee recommended that the states take steps to “combat” the spread of TB in prisons, which indicates an obligation under the *Covenant on Economic, Social and Cultural Rights* to implement preventative health programmes in prisons.²³⁵

Article 24 (the right to health) of the *Convention on the Rights of the Child* obligates states to implement preventative health initiatives in order to fulfil the right to health of children and adolescents, a universal right that extends to children and young people in detention.²³⁶

The right to preventative health measures is also engaged under civil and political rights mechanisms. The UN Human Rights Committee’s jurisprudence indicates that the failure to take steps to prevent the spread of diseases in prisons, such as tuberculosis, may violate Articles 6, 7, 9 and 10 of the *Covenant on Civil and Political Rights*.²³⁷ For example, in its 2002 Concluding Observations on Moldova, the Committee noted that the “the spread of

contagious diseases” could amount to a violation of Article 9 (the right to liberty and security of the person).²³⁸

This issue has also been addressed in the domestic jurisprudence of some countries. The Irish Courts have engaged this question in considering whether poor conditions of confinement render the detention itself unlawful under Article 40 of the Irish Constitution. In *The State v. Frawley*, for example, the Court found that prisoners enjoy the right to have their health protected.²³⁹ According to the Court, “When the executive . . . imprisons an individual in pursuance of a lawful warrant of a court then it seems to me to be a logical extension of the principle . . . that it may not, without justification or necessity, expose the health of that person to risk or danger.”²⁴⁰ This would imply the obligation to take measures to protect prisoners from being exposed to or contracting contagious diseases.

In the South African jurisprudence, the judgment on *S v. Zuba and 23 similar cases* may also be interpreted to engage the right to preventative health measures under rights of due process. Using principle articulated in the decision that “the right to a fair trial must include the right not to be subjected to a sentence substantially more severe than the one imposed by the trial court”,²⁴¹ Steinberg suggests that, “An HIV-positive accused might argue that being detained in an overcrowded facility would expose him to an unreasonable risk of contracting opportunistic infections such as tuberculosis.”²⁴²

However, not all domestic courts have been proactive in enforcing the right to preventative health. Both the UK²⁴³ and Australian²⁴⁴ courts have failed to order prison officials to provide condoms to prisoners as an HIV prevention measure. The Scottish courts also dismissed an attempt by a prisoner to compel prison authorities to provide access to sterile injecting equipment such as syringes to prevent the spread of HIV and hepatitis C among people who inject drugs in prisons.²⁴⁵ These cases illustrate that in the controversial area of HIV prevention, which necessitates action to address health risks resulting from sexual activity and drug use in prisons, the domestic courts may be less inclined to force sweeping policy changes upon state authorities.²⁴⁶

State obligation to provide preventative health measures in prisons has also been engaged under the right to life. In *Cabal and Pasini Bertran v. Australia*, the applicants claimed their right to health was placed in “serious jeopardy” as a result of incarceration alongside prisoners with communicable diseases, including those suspected of having tuberculosis.²⁴⁷ Although finding the application inadmissible, the UN Human Rights Committee affirmed that “a failure to separate detainees with communicable diseases from other detainees could raise issues primarily under articles 6, paragraph 1”.²⁴⁸ This indicates a state responsibility to take steps to protect non-infected prisoners from contracting contagious diseases.

The UN Human Rights Committee’s 2002 Concluding Observations on Moldova noted that it was “particularly disturbed at the prevalence of disease, notably tuberculosis” in prisons and, in that context, reminded the government of “its obligation to ensure the health and life of all persons deprived of their liberty” and that the “[d]anger to the health and lives of detainees as a result of the spread of contagious diseases . . . amounts to a violation of article 10 of the Covenant and may also include a violation of articles 9 and 6.”²⁴⁹ This suggests that taking action to prevent disease transmission in prisons is part of state obligations under the *Covenant on Civil and Political Rights*.

The European Court has also indicated that states are under an obligation to prevent the spread of disease in prisons. In *Pantea v. Romania*, the Court stated that Article 3 of the *European Convention* “compels the authorities . . . to take the practical preventive measures necessary to protect the physical integrity and the health of persons who have been deprived of their liberty.”²⁵⁰ In *Melnick v. Ukraine*, the European Court found an Article 3 violation,

in part, for the failure to “prevent ... the applicant’s tuberculosis” while he was in prison.²⁵¹ In *Staykov v. Bulgaria*, the Court found the fact that “the applicant fell ill with tuberculosis” while in prison, along with a finding that “the prison authorities’ prevention efforts were inadequate” among the factors contributing to a violation of Article 3.²⁵²

Health decline, or the contracting of disease, while in detention may also be judged as evidence that the overall prison regime is inhuman or degrading.²⁵³ Therefore, it can be argued that countries have an obligation to prevent the transmission of diseases in prisons in order to remain human rights compliant.

In *Benediktov v. Russia*, the European Court found it “most probable” that the applicant was infected with hepatitis C while in prison. While this in and of itself did not constitute a violation of Article 3, particularly as the prisoner was given effective treatment, the Court considered it a contributing factor to its finding that the overall conditions of confinement were degrading.²⁵⁴

In *Kalashnikov v. Russia*, the fact that the applicant contracted a series of skin and fungal infections while incarcerated was an element cited by the Court in finding the state in violation of Article 3.²⁵⁵ Similarly, in *Neumerzhitsky v. Ukraine*, the Court found that the applicant’s contracting scabies and eczema in prison “demonstrate[s] that he was detained in an unsanitary environment, with no respect for basic hygiene”.²⁵⁶ The UN Human Rights Committee²⁵⁷ and the Inter-American Court of Human Rights²⁵⁸ have also cited health decline or the contracting of diseases in detention as contributing to overall prison conditions that are cruel, inhuman or degrading.

A right to mental health care

The *Standard Minimum Rules* specify that all prisons should have a psychiatric service to diagnose and treat mental illness.²⁵⁹ The requirement that mental health services be provided to prisoners is codified in a number of non-binding instruments on prison health, including the *European Prison Rules*²⁶⁰ and *Recommendation 1235 (1994) on Psychiatry and Human Rights* of the Council of Europe.²⁶¹

The Special Rapporteur on Health has expressed concern that prisoners with mental illness are particularly vulnerable to human rights violations.²⁶² Indeed, international courts and treaty bodies have articulated clear legal standards for the humane treatment of persons with mental illness in detention. Many of the standards for mental health care in prisons outlined in the non-binding instruments above are reflected within this jurisprudence.

Given the unique vulnerability of persons with mental illness in detention, the state’s positive obligations to ensure their humane treatment, and to protect their well-being, are heightened. The European Court, for example, has stated that, “the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with”.²⁶³ As a result,

[T]he assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.²⁶⁴

The Inter-American Commission on Human Rights also takes the approach that the state’s obligations to ensure the well-being of persons in detention are heightened when a prisoner is mentally ill.²⁶⁵

The UN Human Rights Committee has stated that under the *Covenant on Civil and Political Rights*, “the State party is under an obligation to provide . . . appropriate . . . psychiatric care”.²⁶⁶ As with general medical care, mental health care must be available and provided in a timely fashion in order to be consistent with human rights law. The Committee has found violations where “no psychiatric treatment was available in the prison”²⁶⁷ and where there was a failure to provide an adequate psychiatric examination despite the evidence of the prisoner’s declining state.²⁶⁸ In its Concluding Observations on Belgium, the Committee criticised delays in providing mentally ill prisoners with proper care. “The practice of keeping psychiatric patients in prison psychiatric annexes for several months before transferring them to hospitals that treat mental disorders is incompatible with articles 7 and 9 of the Covenant and should be discontinued”.²⁶⁹

In the European system, the failure of the state to provide adequate standards of mental health care in detention was found to violate the right to life in Article 2 of the *European Convention*. In *Edwards and another v. United Kingdom*, two mentally ill persons were arrested separately and placed in the same prison cell. One of the men was later beaten to death by the other. In finding that the applicant’s Article 2 rights had been violated, the Court cited “the failure of the agencies involved in this case (medical profession, police, prosecution and court) to pass on information . . . to the prison authorities and the inadequate nature of the screening process” in the police station and the prison.²⁷⁰

[T]he Court considers that it is self-evident that the screening process of the new arrivals in a prison should serve to identify effectively those prisoners who require for their own welfare or the welfare of other prisoners to be placed under medical supervision. The defects in the information provided to the prison admissions staff were combined in this case with the brief and cursory nature of the examination carried out by a screening health worker who was . . . inadequately trained and acting in the absence of a doctor to whom recourse could be made in the case of difficulty or doubt.²⁷¹

Based upon *Edwards*, the failure to provide adequate mental health screening procedures to identify vulnerable prisoners, and then place them under psychiatric supervision appropriate to their needs, violates the *European Convention*.

The European Court has gone further in identifying lawful standards of mental health provision. Proper mental health care in prisons must include adequate written record keeping and monitoring of patients, and be carried out by properly qualified staff. According to the European Court, a “lack of effective monitoring of [the applicant’s] condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person”.²⁷² In *Rohde v. Denmark*, a standard of monitoring found consistent with state obligations under Article 3 was described as one where the applicant “was attended to by medical staff automatically and regularly”, and that the staff “reacted promptly and increased their observation . . . whenever he showed any change in mood or behaviour”.²⁷³

As is the case with general health decline, deterioration of mental health while in custody may be considered an indication that the overall prison conditions are cruel, inhuman or degrading, and therefore in violation of international law. In *Williams v. Jamaica*, the UN Human Rights Committee’s finding of an Article 10 violation was, in part, based on the fact that the applicant’s “mental condition seriously deteriorated during his incarceration on death row”.²⁷⁴ In the 2006 report on conditions for detainees held in Guantanamo Bay, the UN Special Rapporteurs involved in the investigation similarly found the decline in mental health of the prisoners to be an indicator of broader human rights violations. According to

the report, “The totality of the conditions of their confinement at Guantanamo Bay constitute a right-to-health violation because they derive from a breach of duty and have resulted in profound deterioration of the mental health of many detainees”.²⁷⁵

The Special Rapporteur on Health has expressed concern on several occasions about poor standards of mental health care in prisons. The Special Rapporteur’s 2004 Annual Report generally criticised “abusive treatment of mental health patients” in prison.²⁷⁶ In the Report of his 2005 Mission to Peru, the Special Rapporteur specifically recommended that, “Appropriate mental health services be made available to persons in detention”.²⁷⁷ The Special Rapporteur has expressed concern about inadequate mental health care, as well as prison conditions that exacerbate mental illness including the use of restraints, in several individual communications with states.²⁷⁸

A right to a professional standard of care

The *Standard Minimum Rules* specify that “at least one qualified medical officer” will be available in every prison,²⁷⁹ a requirement echoed in the *European Prison Rules*.²⁸⁰ The *Principles of Medical Ethics*²⁸¹ and Council of Europe *Recommendation 1235 (1994) on Psychiatry and Human Rights*²⁸² specify that standards of mental health care must meet acceptable professional standards. A review of the jurisprudence makes clear that prisoners have a right to a professional standard of health service provided by qualified medical personnel. States that fall short of this threshold in the provision of medical or mental health care risk violating their obligations under international law.

In *Robinson v. Jamaica*, the UN Human Rights Committee criticised the fact “that there is no doctor, leaving warders with very limited training to treat medical problems”.²⁸³ In this case, the provision of unqualified “medical” staff with limited training was insufficient to meet state obligations to ensure humane treatment. In its Concluding Observations on Portugal, the Committee recommended that “[The State] should guarantee that detainees are monitored daily by fully qualified medical staff during solitary confinement”.²⁸⁴ The Committee is again clear that the qualifications of the staff are relevant in considering whether a state party is meeting its obligations under the *Covenant on Civil and Political Rights*. On the other hand, the European Court has found that the health care received by a prisoner did not violate Article 3 prohibitions on inhuman or degrading treatment, in part, because “medical examinations were carried out by qualified and authorised professionals”.²⁸⁵ This again indicates that the provision of professional and qualified medical staff is necessary to meet human rights obligations.

The UN Committee on the Rights of the Child has identified “the lack of adequate basic services such as education and health, [including] the absence of adequately trained staff” as a matter of concern in its Concluding Observations on state compliance with the treaty.²⁸⁶ This would indicate that the obligation to provide qualified medical staff includes juvenile detention facilities.

Lack of qualified staff has also been highlighted by UN Special Rapporteurs. The Special Rapporteur on Health has expressed concern where “the prison [medical] clinics are too poorly equipped in terms of staff, equipment and medicines to deal with even basic complaints”.²⁸⁷ Following her mission to US prisons, the Special Rapporteur on Violence Against Women recommended that, “A qualified doctor should be on the premises for 24 hours”.²⁸⁸

A right to informed consent and to refuse treatment

Given the vulnerability of persons in detention to coercion, the issue of informed consent to medical treatment and the right to refuse treatment are particularly resonant. Non-binding standards of prison health care are clear that people in prison must provide informed consent before undergoing treatment. The WHO states that, "Prisoners should have access to information on treatment options and the same right to refuse treatment as exists in the community".²⁸⁹ This includes not only medical and drug treatments, but also undergoing medical testing, such as that for HIV infection.²⁹⁰ This position was recently affirmed in a joint policy framework on addressing HIV/AIDS in prisons produced by the WHO in collaboration with UNAIDS and the UN Office of Drugs and Crime.²⁹¹

The 1988 UN *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment* state that prisoners have the right to request a second medical opinion, although the granting of such a request is discretionary and subject to "reasonable conditions to ensure security and good order in the place of detention or imprisonment".²⁹² The 1990 UN *Rules for the Protection of Juveniles Deprived of their Liberty* indicate that informed consent is preferable "when possible" before administering medicines, although due to the varying levels of competence among juveniles, it may not be absolutely obligatory, in particular where a treatment is considered by health staff acting independently as being in the best interest of the juvenile patient.²⁹³

Within the international human rights case law, issues of consent to treatment have been considered under the right to health and the prohibition of cruel, inhuman or degrading treatment. The consensus is that while people in prison have a right to consent and a right to refuse treatment, these rights are subject to some specific limitations.

According to the UN Committee on Economic, Social and Cultural Rights, the right to health includes the "right to be free from ... non-consensual medical treatment".²⁹⁴ The Committee articulates a limited qualification to this right, specifically in the case of mental illness and disease control. It describes the

State's obligation to refrain from ... applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.²⁹⁵

In his 2004 Annual Report, the Special Rapporteur on Health specifically highlighted concerns over "non-consensual medical treatment".²⁹⁶ In a 2005 communication with the Government of North Korea, the Special Rapporteur raised concern over allegations of forcible abortions on pregnant incarcerated women.²⁹⁷ This would indicate that women prisoners have the right to refuse such invasive medical procedures. The UN Committee on the Elimination of Discrimination Against Women has also been critical of coerced gynaecological examinations of women prisoners.²⁹⁸

The UN Special Rapporteurs investigating conditions at Guantanamo Bay take a position consistent with that of the UN Committee on Economic, Social and Cultural Rights. In their joint report, the Rapporteurs state that:

From the perspective of the right to health, informed consent to medical treatment is essential, as is its 'logical corollary' the right to refuse treatment. A competent detainee,

no less than any other individual, has the right to refuse treatment. In summary, treating a competent detainee without his or her consent—including force-feeding—is a violation of the right to health, as well as international ethics for health professionals.”²⁹⁹

In its use of the qualification “competent detainee”, the Special Rapporteurs suggest that, in keeping with the Committee’s view, the right to refuse treatment may be limited in cases where the person is judged “incompetent”, presumably as a result of mental illness. However, in such a case the human rights protections afforded prisoners with mental illness would be engaged.

This approach taken under the right to health in the case of persons judged mentally incompetent is mirrored in the Article 3 jurisprudence of the European Court of Human Rights, which contains the most detailed examination of this issue. The European Court adopts the approach that “a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading”;³⁰⁰ however, “The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist”.³⁰¹

Therefore, according to the interpretation of the Court, if a physician can sufficiently justify that the treatment of the person judged mentally incompetent is both necessary and in conformity with established medical practice, it can be administered without consent. According to the Court in *Herczegfalvy v. Austria*,

The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3.³⁰²

However, the method by which the compulsory treatment takes place must be consistent with Article 3 protections against torture and inhuman or degrading treatment.³⁰³

This is also the Court’s approach to force-feeding of prisoners, as the practice “is aimed at saving the life of a particular detainee who consciously refuses to take food”.³⁰⁴ However, like medical treatments, the state has an obligation to show that the force-feeding is “medically necessary” otherwise it can amount to torture under Article 3.³⁰⁵ Indeed, in both *Nevmerzhitsky v. Ukraine*³⁰⁶ and *Ciorap v. Moldova*³⁰⁷ the state was found guilty of torture for force-feeding the applicants without proving medical necessity. This raises the possibility that non-consensual treatment, particularly if administered in a forceful or violent manner, could be found to reach the threshold of torture.³⁰⁸

Questions of informed-consent to medical procedures in prisons has also been examined in domestic case law. For example, in *C v. Minister of Correctional Services*, the South African Court found that the rights of a prisoner had been violated where he had been tested for HIV without providing proper consent.³⁰⁹ This reinforces the right of prisoners to refuse medical treatments, including medical testing.

A right to environmental health

In addition to medical care and mental health services, a third element affecting the fulfillment of the right to health of prisoners is the environment within the prison itself. Indeed, the issue of healthy or unhealthy living conditions has particular resonance in considering the issue of prisoners' health, as overcrowding, inadequate sanitary conditions and poor food and water standards are common in prisons worldwide. While such conditions are typically considered to be violations of the right to dignity or humane treatment, they clearly have implications on the right to health. As described by the World Medical Association,

Overcrowding, lengthy confinement within closed, poorly lit, badly heated and consequently poorly ventilated and often humid spaces are all conditions frequently associated with imprisonment and which contribute to the spread of disease and ill-health. Where these factors are combined with poor hygiene, inadequate nutrition and limited access to adequate health care, prisons can represent a major public health challenge. Keeping prisoners in [such] conditions . . . expose them to substantial medical risk.³¹⁰

As with medical care and mental health care, questions of environmental health are engaged under economic, social and cultural rights as well as civil and political rights.

According to the UN Committee on Economic, Social and Cultural Rights, the right to health as defined in Article 12 is:

an inclusive right extending not only to timely and appropriate 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, [and] healthy . . . environmental conditions.³¹¹

Some legal scholars have suggested the right to health, as it has come to be codified, includes not only the right to healthcare services, but also to the "underlying preconditions of health, such as occupational health, environmental health, clean drinking water, and adequate sanitation",³¹² a conclusion shared by the Committee on Economic, Social and Cultural Rights³¹³ and found within the *Universal Declaration of Human Rights*.³¹⁴

The right to a healthy living environment in prisons is also engaged by Article 11(1) of the *Covenant on Economic, Social and Cultural Rights*, which enshrines the right to adequate housing.³¹⁵ As described in *General Comment No. 4* of the UN Committee on Economic, Social and Cultural Rights, which provides a detailed and authoritative interpretation of the meaning of Article 11, housing is "the environmental factor most frequently associated with conditions for disease . . . [and] inadequate and deficient housing and living conditions are invariably associated with higher mortality and morbidity rates".³¹⁶ The Committee defines "adequate housing" to include adequate privacy, space, security, lighting and ventilation,³¹⁷ safe drinking water, heating, sanitation and washing facilities,³¹⁸ and protection from dampness or "other threats to health".³¹⁹ All of these factors have particular relevance to the relationship between prison conditions and the health status of prisoners, as the lack of any of these factors has the potential to negatively affect the physical and/or mental health of people in detention.

The right to a healthy living environment is also engaged under civil and political rights mechanisms. Some legal scholars have argued that that the right to life inherently includes a

requirement to provide the necessary elements for survival, such as food, water and shelter.³²⁰ Such an approach would therefore imply a positive obligation to address environmental health issues under the right to life.

The UN Human Rights Committee has expressed concern about environmental health issues in a number of Concluding Observations on state compliance with the terms of the *Covenant on Civil and Political Rights*.³²¹ In these cases, the Committee has made clear that it views issues such as overcrowding and poor sanitation within a health context. The Committee's Concluding Observations on Moldova, for example, noted that it was "particularly disturbed at the prevalence of disease, notably tuberculosis, which is a direct result of prison conditions", adding that such conditions potentially violate Articles 6, 9 and 10 of the *Covenant on Civil and Political Rights*.³²² The European Court recently found that the obligation to provide proper environmental conditions is heightened when a prisoner has health conditions that required "extensive medical treatment".³²³ The Special Rapporteur on Torture has also addressed the impact of poor environmental conditions, noting that "overcrowding, inadequate sanitation and hygiene, lack of food and medical assistance, not only may put at risk the physical integrity of detainees, but have far-reaching consequences on their mental integrity".³²⁴

International humanitarian law also addresses the right to a healthy environment for Prisoners of War and for Civilian internees. Both *Geneva III* (Prisoners of War) and *Geneva IV* (Civilians) contains numerous prohibitions against housing prisoners in conditions detrimental to their health, and obligates the Detaining Power "to take all sanitary measures necessary to ensure the cleanliness and healthfulness of camps and to prevent epidemics".³²⁵ Under the terms of *Geneva III*, prisoners are entitled to adequate food, water and clothing,³²⁶ facilities to maintain personal cleanliness and hygiene,³²⁷ and are to be protected against overcrowding³²⁸ and extremes of climate.³²⁹

According to the *Standard Minimum Rules on the Treatment of Prisoners*, the failure to provide prison accommodation that provides, among other things, adequate space, lighting, ventilation, food and hygiene can be detrimental to the health of persons in detention.³³⁰ There is also a growing body of international jurisprudence finding that poor environmental conditions in prisons, with potential negative consequences on the health of detainees, constitute a violation of international law.

A right to adequate living space

People in prison have the right to an amount of living space sufficient to safeguard their health. The UN Human Rights Committee considers that a lack of adequate living space not only contributes to a violation of the right to dignity and humane treatment, but also to conditions that breach the rights to life and health. For example, the Committee has noted concerns over, "The recurring problems of overcrowding and poor health and sanitary conditions in many prisons, which are incompatible with article 10, paragraph 1, of the Covenant" and the resultant need "to reduce overcrowding and to upgrade prison facilities as quickly as possible".³³¹

The Human Rights Committee has identified "overcrowding" as a condition "which contribute[s] to a high level of death in custody".³³² In its Concluding Observations on Georgia, the Committee listed "crowding" among those factors that "have resulted in a high rate of infectious disease and a very alarming mortality rate, particularly among juvenile detainees".³³³ In Concluding Observations on Mongolia, the Committee cited lack of "adequate space" among those conditions that should be improved "to ensure that imprisonment does not damage prisoners' health".³³⁴

The Committee has found state violations in a number of individual applications related to overcrowded prison conditions.³³⁵ In *Lantsova v. The Russian Federation*, overcrowding was found to violate Article 10(1), and therefore also Article 6(1), as the prisoner “lost his life as a direct result of the existing prison conditions”.³³⁶

The UN Committee against Torture has also identified “serious overcrowding” as one of the “[p]oor prison conditions that affect the health of both inmates and wardens”.³³⁷ The Special Rapporteur on Torture has noted the impact of overcrowding on health, stating that, “overcrowding exacerbates the inability of the staff to provide adequate . . . health care to the detainees. It also makes it difficult to prevent the spread of infectious diseases”.³³⁸ Overcrowding was included among the environmental factors described by the Special Rapporteur as “health-damaging conditions” that “effectively subjects inmates to disease”.³³⁹ The Special Rapporteur on Health has also expressed concern that “Prison conditions—such as overcrowding, [and] lack of privacy . . . tend to exacerbate mental disabilities”.³⁴⁰

The African Commission on Human Rights has expressed concerns about insufficient living space in prisons in several cases,³⁴¹ including *John D Ouko v. Kenya* in which it cited detention in “a two by three metre basement cell” as constituting inhumane treatment.³⁴² The Inter-American Court of Human Rights has found Article 5 (the right to humane treatment) violations where detainees were held “in a damp underground cell measuring approximately 15 square meters with 16 other prisoners”³⁴³ and where a prisoner was held in a cell “with 4 or 5 other men”, forcing him to sleep on the floor.³⁴⁴ Trinidad and Tobago was found in breach because, among other things, the “victims suffered from serious overcrowding, which forced them to sleep sitting or standing up”.³⁴⁵ The Inter-American Commission on Human Rights has also found prison overcrowding to constitute a component of an Article 5 violation.³⁴⁶

The European Court has cited overcrowding in a series of Article 3 cases from States including Russia,³⁴⁷ Bulgaria,³⁴⁸ Lithuania,³⁴⁹ Estonia,³⁵⁰ Greece³⁵¹ and Ukraine.³⁵² The Court has stated that a situation of “continuously, severely overcrowded [cells] . . . in itself raises an issue under Article 3”.³⁵³ In *Karalevičius v. Lithuania*, the Court was clear that it “considers the extreme lack of space as a central factor in its analysis of compliance of the applicant’s detention conditions with Article 3”.³⁵⁴ The Court has also been clear that a lack of resources or other systemic factors do not absolve the state from its obligations to house prisoners in conditions compliant with Article 3.

Irrespective of the reasons for the overcrowding, the Court considers that it is incumbent on the respondent Government to organise its penitentiary system in such a way as to ensure respect for the dignity of detainees, regardless of financial or logistical difficulties.³⁵⁵

In the *Limaj Case*, the International Criminal Tribunal for the former Yugoslavia identified overcrowding as one of the “cause[s] of serious mental and physical suffering” for detainees, and therefore contributing to the offence of cruel treatment.³⁵⁶

A right to hygienic living conditions

The failure of the state to provide proper toilet or washing facilities, or clean living conditions, can not only negatively affect the health of detainees, but potentially breach international law.

The African Commission on Human Rights has found that such poor environmental conditions in prisons can violate the right to health under the *African Charter*. In *Malawi African Association and others v. Mauritania*, a violation of Article 16 was found, in part, due to inadequate hygiene in the prison.³⁵⁷ The UN Special Rapporteur on Health expressed concern about unhygienic living conditions that contributed to the death of 12 prisoners and the hospitalisation of 40 others in Myanmar. The Special Rapporteur specifically identified a “sewage system in the prison [that] may have facilitated the spread of disease” among the causes of the poor health conditions.³⁵⁸

However, the majority of the cases where poor standards of hygiene and sanitation have been found to violate international law have engaged civil and political rights mechanisms, particularly the right to humane treatment. “Lack of” or “poor” sanitary facilities in prisons have been cited by the UN Human Rights Committee as contributing to both deaths in custody and high rates of infectious diseases.³⁵⁹ It has also identified “lack of . . . sanitation” as a condition that might “damage prisoners’ health”.³⁶⁰ In its Concluding Observations on Georgia, the Committee noted that where environmental conditions are so poor as to violate Article 10, the state party might also potentially breach Articles 6 (the right to life) and 7 (the prohibition of torture).³⁶¹

The Human Rights Committee has cited unhygienic conditions that affect health as contributing to findings of cruel, inhuman or degrading treatment in a number of individual applications.³⁶² In *Marshall v. Jamaica*, for example, the conditions described were “unsanitary, with waste sewage and a constant smell pervading the prison . . . and that the inmates are required to share utensils which are not cleaned properly . . . The author contends that the conditions have caused serious detriment to his health”.³⁶³ In *Sextus v. Trinidad and Tobago*, specific hygiene concerns cited included “The location of the prison food-preparation area, around 2 metres from where the prisoners empty their slop pails [which] creates an obvious health hazard.”³⁶⁴ The Inter-American Commission on Human Rights cited a similar concern where the placement of “the prisoners’ washing facilities and ‘excrement well’ . . . in the same location”.³⁶⁵

“[D]irty”³⁶⁶ or “airless and dirty”³⁶⁷ cells, or forcing detainees to live “in very bad conditions of hygiene”³⁶⁸, have been condemned by the African Commission Human Rights in Article 5 petitions. Prison conditions described as “unhygienic” have been found to contribute to breaches by the Inter-American Court³⁶⁹ and Commission,³⁷⁰ while detention in an “unsanitary environment, with no respect for basic hygiene” has been found to contribute to Article 3 violations by the European Court.³⁷¹ In *Melnick v. Ukraine*, the European Court specific found “that the applicant’s conditions of hygiene and sanitation were unsatisfactory and would have contributed to the deterioration of his poor health”.³⁷² The presence of insects, rodents or other vermin has been singled out for criticism by the European Court,³⁷³ the African Commission³⁷⁴ and the UN Human Rights Committee³⁷⁵ in this context.

The failure to provide proper and sanitary toilet facilities is another prison condition that has been found to contribute to unhygienic conditions, and treatment deemed cruel, inhuman or degrading. The UN Human Rights Committee has found violations in a number of applications that concern the use of “a bucket”,³⁷⁶ “a plastic pail”³⁷⁷ or “a hole in the ground”³⁷⁸ as a toilet. In *Marshall v. Jamaica*, the applicant complained of the “unhygienic practice of using slop buckets which are filled with human waste and stagnant water and only are emptied in the morning.”³⁷⁹ In its Concluding Observations on Mongolia, the Committee included poor sanitation among the conditions that should be improved “to ensure that imprisonment does not damage prisoners’ health”.³⁸⁰ Similar

violations have been cited in cases before the Inter-American Commission³⁸¹ and Court,³⁸² the European Court³⁸³ and the African Commission.³⁸⁴

As discussed above, the UN Working Group on Arbitrary Detention has cited environmental health issues, including poor sanitation, as potentially violating fair trial guarantees. In the Working Group's estimation, "A detainee who has to endure detention conditions that affect his or her health, safety or well-being is participating in the [court] proceedings in less favourable conditions than the prosecution".³⁸⁵ Within domestic jurisprudence, poor hygiene and lack of proper sanitation facilities sufficient to engage the right to health have been cited in challenges to the lawfulness of detention under Article 40 of the Irish Constitution. In *The State (Richardson) v. The Governor of Mountjoy Prison*, the applicant alleged that her detention was unlawful due to the poor conditions in which she was confined, particularly the inadequate toilet and sanitary facilities. In the case, the Court found that the government has a "duty under the Constitution ... to protect the [applicant's] health and to provide her with appropriate facilities to maintain proper standards of hygiene and cleanliness".³⁸⁶

In *Pedro Orlando Ubaque v. Director, National Model Prison*, the Constitutional Court of Colombia found that the sanitary and environmental conditions in which a prisoner living with HIV/AIDS was housed violated his right to health and right to life.³⁸⁷ The Court found the prisoner's rights had been violated despite the fact he was held in a special unit designed to care for people living with HIV/AIDS in the prison. Although the Court agreed that the state had implemented special medical provision for the prisoners in this unit, it still found that the overall sanitary and environmental conditions violated the right to health and right to life.³⁸⁸

A Right to Food and Water

The failure to provide detainees with reasonable quality food or water in sufficient quantity has an obvious negative impact on health. The *Standard Minimum Rules* specify that all prisoners shall be provided with "food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served", as well as "Drinking water ... whenever he needs it".³⁸⁹ The failure to provide safe and adequate food and drinking water has been found to contribute to violations of international law in all human rights systems.

The UN Committee on Economic, Social and Cultural Rights has expressed concern about access to health care in prisons in its Concluding Observations on Trinidad and Tobago,³⁹⁰ Brazil³⁹¹ and Yemen,³⁹² identifying lack of access to adequate food and drinking water in all three cases. In *Malawi African Association and others v. Mauritania*, the African Commission on Human Rights found a violation of the right to health on grounds including insufficient food.³⁹³ In that case, the Commission found that detainees in Mauritania "only received a small amount of rice per day, without any meat or salt. Some had to eat leaves or grass".³⁹⁴

In an individual communication with the Government of Myanmar, the Special Rapporteur on Health expressed concern about unhygienic living conditions, and their negative health effects which had led to the death of 12 prisoners and the hospitalisation of 40 others. The Special Rapporteur specifically identified "rotten" food and "unclean drinking water" among his concerns.³⁹⁵

However, most of the case law on this issue is again found under civil and political rights mechanisms. In Nigeria, the UN Human Rights Committee cited "lack of adequate food [and] clean water" among the factors contributing to "a high level of death in custody".³⁹⁶ Poor quality or insufficient food and/or water have been cited as contributing to Article

10(1) violations in numerous individual applications to the Committee.³⁹⁷ The European Court reached a similar conclusion in *Alver v. Estonia*, finding the “[f]ood had been provided only once a day” and that “the quality of the food had been poor”.³⁹⁸ In the *Malawi African Association and others v. Mauritania* case, the African Commission found that the failure to provide adequate food not only violated the right to health, but also contributed to a violation of the right to life.³⁹⁹

Adequate food and water for detainees is also guaranteed under international humanitarian law. Under Article 26 of *Geneva III*, the Detaining Power must provide “basic daily food rations . . . in quantity, quality and variety to keep prisoners of war in good health” as well as “[s]ufficient drinking water”.⁴⁰⁰ In the *Limaj Case* before the International Criminal Tribunal for the former Yugoslavia, the fact that “food and water were not provided regularly”⁴⁰¹ at the Llapushnik/Lapusnik prison camp contributed to “inhumane conditions”⁴⁰² and the offence of cruel treatment.⁴⁰³

Fulfilling the Right to Health of Prisoners: The Need for an Enhanced Role for the United Nations Committee against Torture

There is consensus in international law that the state has an obligation to protect the lives and well-being of people it holds in custody. Prisoners have the right to health, including medical care, mental health care and living conditions that do not jeopardise their health or promote disease. As reviewed above, the international jurisprudence exhibits clear areas of consensus, and therefore direction to states, on the minimum legal standards they must meet to remain human rights compliant.

The right to health of prisoners is enshrined under both economic, social and cultural rights as well as civil and political rights. Indeed, the issue of the right to health of prisoners offers a unique intersection of these two groups of rights, and one might argue is an illustration of interconnectedness of these rights that highlights the artificial separation of them into different categories.

A comparison of the jurisprudence from United Nations and regional human rights bodies, as well as key national case law, shows that the different systems have adopted a remarkably similar approach when engaging the right to health of persons in detention. Yet despite this legal direction, it is clear from the investigations of human rights monitors and non-governmental organisations that the failure to fulfil the right to health of prisoners affects millions of people worldwide.⁴⁰⁴ This vividly illustrates that—as was the case in the 18th century England of John Howard—the recognition of this right in law does not mean that people in prison are necessarily able to avail of the protections it provides.

As described by one legal scholar who focuses on health rights, “the problem with the right to health is not so much a lack of codification but rather an absence of a consistent implementation practice through reporting procedures and before judicial and quasi-judicial bodies”.⁴⁰⁵ Enhancing the mechanisms to enforce state compliance with human rights obligations is therefore the central challenge, one made more difficult by the negative public attitudes towards prisoners worldwide.

The stigmatisation of this already marginalised population is not without effect on the enforcement mechanisms themselves. Traditionally, human rights bodies have been reluctant to wade into the contentious area of prison conditions, and instead to allow states wide discretion in matters that are essentially viewed as domestic policy. Commenting in 2000 on the approach of European human rights bodies to prison conditions up to that time, Professor Stephen Livingston of Queen’s University, Belfast concluded,

Strasbourg has done little more than legitimate the existing practice of most States. Commission decisions give the impression that, except in the most egregious cases, such matters are seen as too detailed and too threatening to the authority of prison staff for a court to tamper with.⁴⁰⁶

While Nigel Rodley, the former UN Special Rapporteur on Torture, has suggested that the “Regulation of prison conditions is quite properly the province of domestic legislation”, there is a legitimate question as to whether national courts effectively fulfil this role.⁴⁰⁷ As noted in a recent UNAIDS review of litigation on HIV/AIDS by prisoners, “the ultimate success of strategies using courts and tribunals to defend and promote human rights will depend in part on whether there is a culture of respect for the rule of law in the jurisdiction in question, as well as the watchdog agencies”.⁴⁰⁸ However, the social and political stigmatisation of prisoners means that efforts to enforce their rights are challenging even in countries with a strong constitutional law tradition.

In the United States, it is “recognized that prison officials are vested with wide discretion in controlling prisoners . . . and that hence, unless an infringement upon constitutional or fundamental rights is involved, federal courts are naturally disinclined to interfere with a prison’s internal discipline”.⁴⁰⁹ In South Africa, the government recently refused to comply with an order of the High Court to provide HIV anti-retroviral therapies to a group of prisoners. This delay resulted in the death of at least one of the litigants in the case.⁴¹⁰

These two examples demonstrate the limitations of leaving the question of prisoner health rights solely within the realm of the domestic courts, and illustrate the need for vigorous international oversight and enforcement mechanisms to complement domestic human rights advocacy. The engagement of prisoner health rights under civil and political rights mechanisms creates an important opportunity for an enhanced role for the relevant treaty bodies in fulfilling the right to health of prisoners.

As has been explored, the jurisprudence in all the human rights systems takes the position that inadequate medical care, or conditions of confinement negatively affecting the mental or physical health of prisoners, may constitute cruel, inhuman or degrading treatment, and in some egregious instances reach the threshold of torture. Indeed, the prohibition of cruel, inhuman or degrading treatment—a protection generally recognised as binding within customary international law⁴¹¹—has been the mechanism most commonly used before international human rights courts and treaty bodies to engage the right to health of prisoners. As the treaty body mandated to monitor and prevent torture and cruel, inhuman or degrading treatment worldwide, can the UN Committee against Torture become an effective agent to monitor prison medical care, and promote improved health standards, on an international scale?

The Committee has numerous mechanisms to monitor and promote state compliance with the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, including both a periodic reporting function to review state compliance with the terms of the treaty⁴¹² as well a mechanism to receive individual complaints from victims.⁴¹³ The *Convention* also contains an innovative mechanism that allows the Committee to consider ex-officio enquires into systematic torture under Article 20.⁴¹⁴

The recent adoption of the *Optional Protocol to the UN Convention against Torture*⁴¹⁵ creates two new and complementary mechanisms for independent inspection of places of detention. The first is an international Sub-Committee for the prevention of torture, which can conduct its own visits to countries who have adopted the *Optional Protocol*. The second mechanism mandates that each state adopting the *Optional Protocol* establish an

independent national body to monitor places of detention, a so-called National Preventive Mechanism.

With the addition of a Special Rapporteur on Torture, the monitoring and enforcement mechanisms to prevent torture are more robust than those found with many other UN treaties.⁴¹⁶ The comprehensive nature of monitoring and enforcement mechanisms provided for under the *Convention against Torture*, including the new inspection regimes established under the *Optional Protocol*, would significantly strengthen the options currently available for promoting the right to health of prisoners. Yet while both the Committee and Special Rapporteur have made occasional comment on prison health issues, as described above, their work in this regard has been far from exhaustive, and indeed is far less developed than a number of other treaty bodies and human rights courts and commissions.

However, there is scope to expand the Committee's work in this regard, and to more rigorously address the right to health of prisoners under Article 16 on cruel, inhuman or degrading treatment in the *Convention against Torture*,⁴¹⁷ which states that

Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.⁴¹⁸

Article 16 expands the remit of the Committee to include ill-treatment falling short of torture. Indeed, the Committee has stated, "Allegations that prisoners were . . . not provided with medical treatment . . . cannot be considered as instances of torture, although they amount to cruel and degrading treatment".⁴¹⁹ The 2007 Annual Report of the Special Rapporteur on Torture also identifies "restricted access to medical services" in prison as contributing to inhumane treatment.⁴²⁰

There is room for evolution of the approach of the Committee against Torture in this regard. Professor William A. Schabas of the Irish Centre for Human Rights writes, "It is now well-accepted that international human rights norms must receive a dynamic and 'evolutive' construction" and therefore "[t]he concept of what is cruel, inhuman, or degrading ought to change over time to reflect contemporary thinking and values".⁴²¹ This evolutive principle has been embraced by human rights courts and treaty bodies in expanding the definition of cruel, inhuman or degrading treatment to include health related matters in prisons.

The European Court, for example, takes the view that the "living nature"⁴²² of *European Convention* requires it apply to an "increasingly high standard . . . in the area of the protection of human rights and fundamental liberties."⁴²³ This process of evolving norms and standards creates "the possibility . . . that certain acts previously falling outside the scope of Article 3 might in future attain the required level of severity" to constitute *Convention* violations.⁴²⁴ Based upon this principle, there is clearly room for the Committee against Torture to take a more expansive role in monitoring prisoner health rights, and promoting improved standards.

It is now well established in the Article 3 case law of the European Court that intent is not necessary for a breach of the prohibition of inhuman or degrading treatment to occur. According to *Price v. United Kingdom*,

In considering whether treatment is "degrading" within the meaning of Article 3, one of the factors which the Court will take into account is the question whether its object was to

humiliate and debase the person concerned, although the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3.⁴²⁵

The approach adopted in *Price*, and in numerous subsequent Article 3 applications before the European Court,⁴²⁶ clearly creates scope for examining prisoner health issues under the *Convention against Torture* by removing the issue of intent as an obstacle to engaging protections against cruel, inhuman or degrading treatment.

Further scope for an evolutive interpretation of the Committee's role *vis-à-vis* prison health is found in the interpretation of the definition of "lawful punishment" under the *Convention against Torture*. Under Article 1, torture "does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions".⁴²⁷ The UN *Declaration against Torture*, from which the *Convention against Torture* was broadly drawn,⁴²⁸ defines "lawful sanctions" as those that do not violate the *Standard Minimum Rules on the Treatment of Prisoners*.⁴²⁹ Rodley suggests that treatment that violates the *Rules* could therefore be seen as violating the *Convention*.⁴³⁰ As discussed above, medical, mental health and environmental health conditions have often been found by human rights courts and treaty bodies to contravene standards set out in the *Rules*, and human rights bodies have used the *Rules* as a basis for findings of state violations. Therefore, this raises the possibility of defining conditions that violate established prison health standards as being "unlawful", and therefore open for scrutiny by the Committee against Torture.

Clearly, then, the scope exists for the Committee against Torture to substantially expand its remit in the area of prisoner health rights, and incorporate specific monitoring of conditions that constitute cruel, inhuman or degrading treatment. However, this function could be further enhanced and strengthened through the adoption of an international instrument specifically codifying the rights of prisoners to health care within international law.

It has been suggested that the development of an international treaty to specifically define the humane standards of treatment of prisoners at the level of international law, along with comprehensive mechanisms for periodic reporting and receiving individual complaints, would be the most effective mechanism to improve prison conditions worldwide. According to Bernard in 1994,

Widespread abuse of prisoners' human rights will continue unless, inter alia, clear and, at least basically, precise definitions of those rights are promulgated and accepted. The current standards of humane treatment, even though they are generally accepted, are abysmally inadequate because they lack definition.⁴³¹

As reviewed above, in the decade since Bernard's proposal to develop a *UN Convention on the Humane Treatment of Prisoners*, lawful standards of prison health, and the integrally related issue of prison living conditions, have been quite clearly defined in the international jurisprudence. Regional differences in socio-economic and political environments have not resulted in differing standards of acceptable prison health regimes between UN and regional human rights bodies. African, Latin American and European jurists, as well as the UN Human Rights Committee and UN Committee on Economic, Social and Cultural Rights, have developed a remarkably consistent approach on what conditions of detention are in violation of international human rights law on issues related to the right to health of prisoners. Therefore, these significant areas of consensus on the issue of health could form the basis of a new international instrument, for example a *Second Optional Protocol to the UN Convention against Torture*.

Building upon the already defined lawful health standards in prisons, a *Second Optional Protocol* focusing specifically on health standards could clearly define the rights of prisoners and responsibilities of states at the level of international law, and outline monitoring and enforcement mechanisms under the *Convention against Torture*. Given the comprehensive regime of independent national and international monitoring of places of detention that entered into force under the *Optional Protocol to the Convention against Torture*, a *Second Optional Protocol* on the right to health would allow for the active promotion of clear international standards of lawful health care.

Given the ongoing failure of states to fulfil the right to health of prisoners, such new enforcement mechanisms could significantly improve access to, and standards of, health care and environmental conditions in places of detention around the world. As the failure of states to provide adequate health standards in prisons poses a significant risk to the health of the general public, enhanced enforcement mechanisms, such as a *Second Optional Protocol*, would be a powerful statement of the important link between prison health and public health, and the need to address both before the right to the highest attainable standard of health is realised by all.

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Notes

- 1 Howard (1792), p. 29.
- 2 *An Act for preserving the Health of Prisoners in Gaol, and preventing the Gaol Distemper* 14 Geo.3 c.59 (1774).
- 3 For the purposes of this paper, the term "prisoner" is used to refer to individuals detained in criminal justice and correctional facilities during the investigation of a crime; while awaiting trial; after conviction and before sentencing; after sentencing; and those held without charge. The term is used interchangeably with others including "person(s) in detention", "incarcerated person(s)" and "person(s) deprived of liberty". Unless specifically noted otherwise, the term is a general one used broadly to refer to adult and juvenile males and females.
- 4 Human Rights Committee 'General Comment No. 6: The Right to Life Article 6' (30 April 1982) UN Doc HRI/GEN/1/Rev.1 para 5.; Joseph also notes that the Human Rights Committee "has confirmed a broad positive element to the right to life". S. Joseph et al. (2004), p. 155; Human Rights Committee "General Comment 21: Humane treatment of persons deprived of liberty (Art. 10)" (10 April 1992) Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies UN Doc.HRI/

- GEN/1/Rev.6 para 3. Even prior to the 1774 UK *Act*, the Italian philosopher and penal reform advocate, Caesar Beccaria, implied a responsibility of States to refrain from inflicting unnecessary harm upon persons in prison. “[T]he purpose of punishment”, according to Beccaria, “is not that of tormenting or afflicting any sentient creature . . . The end of punishment . . . is no other than to prevent the criminal from doing further injury to society, and to prevent others from committing the like offence. Such punishments, therefore, and such a mode of inflicting them, ought to be chosen, as will make the strongest and most lasting impressions on the minds of others, with the least torment to the body of the criminal”. Beccaria (1776), p. 31.
- 5 Committee on Economic Social and Cultural Rights ‘General Comment No. 14: The right to the highest attainable standard of health’ (11 August 2000) UN Doc E/C.12/2000/4 para 1.
- 6 Walmsley (2005), p. 1.
- 7 Human Rights Watch (1993), p. 127.
- 8 Howard, *op. cit.*, p. 4.
- 9 Howard, *op. cit.*, p. 5.
- 10 Howard, *op. cit.*, p. 7.
- 11 *Ibid.*
- 12 Human Rights Watch (1993), p. xv.
- 13 Bone and others (2000), p. 11. *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* (UNODC/WHO/UNAIDS New York 2006), p. 12.
- 14 *Moscow Declaration: Prison Health as part of Public Health* (World Health Organization Europe 2003), p. 2.
- 15 International Committee of the Red Cross (2006), Press Release (22 March).
- 16 International Committee of the Red Cross (2006), Interview with Dr Eric Burnier.
- 17 Veen (2006), p. 1.
- 18 *Ibid.*
- 19 Maher and others (1998), pp. 22–23.
- 20 Bone and others, *op. cit.*, p. 22.
- 21 Research cited by the WHO on multi-drug resistant TB in prisons as a percentage of total TB infections among prisoners found high rates in prisons in New York, USA (32%), the Russian Federation (22.56%), Azerbaijan (23%) and the Republic of Georgia (13%). Bone and others, *op. cit.*, p. 21.
- 22 World Health Organization Europe (2005), p. 3.
- 23 Jürgens (2006), p. 2.
- 24 Jürgens (2002), p. 19. For more information on this outbreak see Caplinskas & Likatavicius (2002).
- 25 Goyer (2003), chapter 1.
- 26 *Ibid.*
- 27 Commission on Human Rights ‘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’ (11 February 2005) UN Doc E/CN.4/2005/51 para 11.
- 28 World Health Organization Europe *Health in Prison Factsheet* (WHO Regional Office for Europe), p. 2.
- 29 *Ibid.*
- 30 Commission on Human Rights (2005), *op. cit.*.
- 31 Commission on Human Rights (1999), para 67.
- 32 Human Rights Watch (1993), pp. 21–22.
- 33 Human Rights Watch (1993), chapter 2.
- 34 Human Rights Watch (1993), p. 22.
- 35 van Zyl Smit & Dunkel (2001), p. viii.
- 36 Bone and others, *op. cit.*, p. 11.
- 37 For example, *The Moscow Declaration: Prison Health as part of Public Health* (note 14); *Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia* (23 February 2004) prin 1, 3; *HIV/AIDS Prevention, Care, Treatment and Support in Prison Setting* (note 13), p. 8.
- 38 Barrett (2008).
- 39 Although Cuba is a member of the OAS, it has been suspended from participation since 1962, leaving 34 countries actively participating.
- 40 To date, 22 OAS member states have accepted the Court’s jurisdiction. See Inter-American Commission on Human Rights, <http://www.cidh.org/Basicos/English/Basic4.Amer.Conv.Ratif.htm>
- 41 All members of the UN are, however, bound by the Charter of the United Nations.
- 42 Barrett, *op. cit.*
- 43 International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR) art 12(1).
- 44 *Ibid.*, art 2.2.

- 45 *Cabal and Pasini v. Australia* (7 August 2003) UN Doc CCPR/C/78/D/1020/2002 para. 7.7.
- 46 Human Rights Committee 'General Comment No. 6' (note 4) para 5.
- 47 Human Rights Committee 'General Comment 21' (note 4) para 3.
- 48 Constitution of the World Health Organization (adopted by the International Health Conference New York 19–22 June 1946 signed on 22 July 1946 entered into force on 7 April 1948) Official Records of the World Health Organization No. 2, p. 100 (WHO Constitution) preamble.
- 49 Toebe (1999), p.16.
- 50 WHO Constitution (n48) preamble.
- 51 For example, World Health Organization (1993); WHO Europe (note 14), p. 1; Bone, op. cit.
- 52 WHO Constitution (note 48) art 2(c).
- 53 *Ibid.*, art 2(g).
- 54 *Ibid.*, art 2(m).
- 55 *Ibid.*, art 2(i).
- 56 "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control". Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III) (UDHR) art 25.
- 57 Toebe, op. cit., p. 40.
- 58 UDHR (note 56) art 25(1).
- 59 Toebe, op. cit., p. 40.
- 60 *Ibid.*
- 61 *Ibid.*
- 62 ICESCR (note 43) art 12(1); Convention on the Elimination of All Forms of Discrimination against Women (entered into force 3 September 1981) UNGA Res 34/180 UN Doc A/34/46 (CEDAW) art 12; Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC) art 24.
- 63 European Social Charter (Revised) (adopted 3 May 1996, entered into force 3 July 1999) ETS 163 art 11; American Declaration of the Rights and Duties of Man, OAS Res XXX adopted by the Ninth International Conference of American States (1948) reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OEA/Ser L V/II.82 Doc 6 Rev 1 at 17 (1992) (American Declaration) art XI; Additional Protocol to the American Convention on Human Rights in the Area of Economic Social and Cultural Rights (entered into force 16 November 1999) OAS Treaty Series No. 69 (1988) reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OEA/Ser.L.V/II.82 doc.6 rev.1 at 67 (1992) (Protocol of San Salvador); African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (African Charter) art 14(1); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (adopted 11 July 2003, entered into force 25 November 2005) reprinted in 1 Afr Hum Rts LJ 40 (African Women Protocol); African Charter on the Rights and Welfare of the Child (entered into force 29 November 1999) OAU Doc CAB/LEG/24.9/49 (African Children Charter).
- 64 ICESCR (note 43) art 12(1).
- 65 Committee on Economic Social and Cultural Rights (note 5) para 4.
- 66 *Ibid.*, para 11.
- 67 Committee on the Rights of the Child 'General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child' (2003) UN Doc CRC/GC/2004/4 para 4.
- 68 CEDAW (note 62) art 12.
- 69 Toebe, op. cit., p. 55.
- 70 Commission on Human Rights (note 31) para 64.
- 71 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (12 August 1949, entered into force 21 October 1950) (Geneva I).
- 72 Geneva Convention Relative to the Treatment of Prisoners of War (12 August 1949) 6 UST 3316 75 UNTS 135 (Geneva III) art 13.
- 73 *Ibid.*, art 15.
- 74 *Ibid.*, art 30.
- 75 *Ibid.*, art 31.
- 76 *Ibid.*, art 30.
- 77 Geneva Convention relative to the Treatment of Prisoners of War (27 July 1929) arts 4, 5, 9, 14, 15, 32, 58, 69.

- 78 European Social Charter (note 63) art 11.
- 79 Toebes, *op. cit.*, p. 69. Rather than the comprehensive language of the WHO Constitution or *Covenant on Economic, Social and Cultural Rights*, for example, the *Social Charter* requires only that States “remove as far as possible the causes of ill-health” [Article 11(1)] and “prevent as far as possible epidemic, endemic and other diseases”. [Article 11(3)]. Toebes suggests that the inclusion of the term “as far as possible” in this context “detracts from the mandatory character of such an obligation”.
- 80 Charter of Fundamental Rights of the European Union (18 December 2000) OJ (C 364) 01 art 35.
- 81 Under Article 35, “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices”. This wording suggests a wide discretion to States in defining for themselves the parameters of the scope of the right to health care services. The equivocal nature of the language used in Article 35 stands in contrast to other public services guaranteed within the *Charter*, such as the guarantee that in Article 14, “Everyone has the right to education”.
- 82 Article XI guarantees “the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources”. American Declaration (note 63), art XI.
- 83 American Convention on Human Rights (entered into force 18 July 1978) OAS Treaty Series No. 36 1144 UNTS 123 reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OEA/Ser.L.V/II.82 doc.6 rev.1 at 25 (1992) (American Convention).
- 84 Protocol of San Salvador (note 63).
- 85 *Ibid.*, art 10(1).
- 86 See below.
- 87 African Charter (note 63), art 16.
- 88 *Ibid.*, art 14(2); Separate instruments within the African system define health rights for women and for children. See African Women Protocol (note 63) art 14; African Children Charter (note 63) art 14.
- 89 See below.
- 90 Rieter (2002), pp. 83, 86.
- 91 Bernard (1994), pp. 759, 787.
- 92 Standard Minimum Rules for the Treatment of Prisoners (adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, approved 31 July 1957 ESC Res 663C(XXIV), amended 12 May 1977 ESC Res 2076(LXII)) (Standard Minimum Rules).
- 93 Code of Conduct for Law Enforcement Officials (adopted by 17 December 1979) UNGA Res 34/169 art 6.
- 94 Principles of Medical Ethics (18 December 1982) UNGA Res 37/194 art 6.
- 95 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988) GA Res 43/173, annex 43 UN GAOR Supp (No. 49) at 298, UN Doc A/43/49 prin 24.
- 96 Basic Principles for the Treatment of Prisoners (1990) GA Res 45/111, annex, 45 UN GAOR Supp. (No. 49A) at 200, UN Doc A/45/49 para 9.
- 97 Rules for the Protection of Juveniles Deprived of their Liberty (14 December 1990) GA Res 45/113 art 31.
- 98 See also, United Nations Standard Minimum Rules for the Administration of Juvenile Justice (1985) GA Res 40/33, annex, 40 UN GAOR Supp (No 53) at 207, UN Doc A/40/53 (The Beijing Rules); United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990) GA Res 45/113, annex, 45 UN GAOR Supp (No. 49A) at 205, UN Doc A/45/49.
- 99 Rodley (1999), p. 280.
- 100 Betteridge (2004), p. 14.
- 101 Rodley, *op. cit.*, p. 279.
- 102 For example, *Greek Case* (1969) 12 YB 170 EcomHR.
- 103 For example, *John D Ouko v. Kenya* (2000) African Commission on Human and Peoples’ Rights Comm No 232/99 paras 24–25; *Media Rights Agenda v. Nigeria* (2000) African Commission on Human and Peoples’ Rights Comm No. 224/98 para 70.
- 104 For example, *Henaf v. France* (2005) 40 EHRR 44; *Kalashnikov v. Russia* (2003) 36 EHRR 34; *Poltoratskiy v. Ukraine* (2003) ECHR 2003–V; *Kehayov v. Bulgaria* App No. 41035/98 (judgment of 18 January 2005); *I. I. v. Bulgaria* App. No. 44082/98, (judgment of 9 June 2005).
- 105 Basic Principles for the Treatment of Prisoners (note 96) para 9.
- 106 Principles of Medical Ethics (note 94) art 1.
- 107 ‘Recommendation Rec (2006) 2 of the Committee of Ministers to member states on the European Prison Rules’ (adopted 11 January 2006 by the Committee of Ministers at the 952nd meeting of the Ministers’ Deputies) (European Prison Rules) art 40.3.
- 108 Committee on Economic Social and Cultural Rights (note 5) para 34, emphasis in original.

- 109 Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Trinidad and Tobago’ (2002) UN Doc E/2003/22 45 paras 274, 297.
- 110 Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Brazil’ (2003) UN Doc E/2004/22 28 paras 144, 177.
- 111 Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Yemen’ (2003) UN Doc E/2004/22 55 paras 361, 380.
- 112 CRC (note 62) art 24(1).
- 113 *Ibid.*, art 24(2).
- 114 Committee on the Rights of the Child ‘Concluding Observations: Argentina’ (2002) UN Doc CRC/C/121 8 para 87; Committee on the Rights of the Child ‘Concluding Observations: United Kingdom of Great Britain and Northern Ireland’ (2002) UN Doc CRC/C/121 23 para 154; Committee on the Rights of the Child ‘Concluding Observations: Côte d’Ivoire’ (2001) UN Doc CRC/C/108 59 paras 311–312.
- 115 Committee on the Rights of the Child ‘Concluding Observations: Argentina’ (note 114) para 87.
- 116 Committee on the Rights of the Child ‘Concluding Observations: United Kingdom of Great Britain and Northern Ireland’ (note 114) para 154.
- 117 *International PEN and Others v. Nigeria* (1998) African Commission on Human and Peoples’ Rights Comm Nos. 137/94, 139/94, 154/86, 161/97 para 112. See also *Malawi African Association and others v. Mauritania* (2000) African Commission on Human and Peoples’ Rights Comm Nos. 54/91, 61/91, 98/93, 164/97 à 196/97 and 210/98 para 122. “The State’s responsibility in the event of detention is even more evident to the extent that detention centres are its exclusive preserve, hence the physical integrity and welfare of detainees is the responsibility of the competent public authorities”.
- 118 *Free Legal Assistance Group, Lawyers’ Committee for Human Rights, Union Inter africaine de l’Homme, Les Témoins de Jehovah v. Zaïre* (1996) African Commission on Human and Peoples’ Rights Comm Nos. 25/89, 47/90, 56/91, 100/93 para 47.
- 119 *International PEN and Others v. Nigeria* (note 117) para 112.
- 120 *Malawi African Association and others v. Mauritania* (note 117) para 122.
- 121 Constitution of the Republic of South Africa 1996 Art 35(2)(e).
- 122 *Van Biljon and Others v. Minister of Correctional Services and Others* (1997) 50 BMR 206. Ngwenya and Cook in Brand & Heyns (2005), p. 133; Canadian HIV/AIDS Legal Network/UNAIDS (2006), pp. 113–116.
- 123 *Van Biljon and Others v. Minister of Correctional Services and Others* (note 122) para 54; Gutto (1998), 79 fn 68; Canadian HIV/AIDS Legal Network/UNAIDS, op. cit., p. 115.
- 124 *EN and others v. The Government of the RSA and others* (Case No. 4576/2006, Durban and Local Coast Division, judgment of 22 June 2006) paras 31, 35.
- 125 Human Rights Committee ‘Concluding Observations: Georgia’ (2002) UN Doc A/57/40 vol I 53 para 78(7).
- 126 *Pinto v. Trinidad and Tobago* (Communication No. 232/1987) Report of the Human Rights Committee vol 2 UN Doc A/45/40 p. 69 para 12.7; see also *Kelly v. Jamaica* (2 April 1991) UN Doc CCPR/C/41/D/253/1987 para 5.7.
- 127 *Pinto v. Trinidad and Tobago* (note 126) para 12.7. This position was also argued by Lord Steyn in his partial dissent in the Privy Council case of *Thomas and Hilaire v. Trinidad and Tobago* (27 January 1999) Privy Council Appeal No. 60 of 1998 19. Lord Steyn stated, “There are irreducible minimum standards of treatment of condemned men which a state must observe. Those obligations fall into two categories. First there are negative obligations. Thus prisoners may not be assaulted. Secondly, there are positive obligations. Thus there is an obligation on the State to ensure that even a condemned man is afforded necessary medical care.”
- 128 For example, Human Rights Committee ‘Concluding Observations: Portugal’ (2003) UN Doc A/58/40 vol I 56 para 83(11); Human Rights Committee ‘Concluding Observations: Cambodia’ (1999) UN Doc A/54/40 vol I 57 para 306; Human Rights Committee ‘Concluding Observations: Congo’ (2000) UN Doc A/55/40 vol I 43 para 282; Human Rights Committee ‘Concluding Observations: Mongolia’ (2000) UN Doc A/55/40 vol I 49 para 332; Human Rights Committee ‘Concluding Observations: Syrian Arab Republic’ (2001) UN Doc A/56/40 vol I 70 para 81(13).
- 129 *Lantsova v. Russian Federation* (26 March 2002) UN Doc CCPR/C/74/763/1997 para 9.2.
- 130 *Fabrikant v. Canada* (6 November 2003) UN Doc CCPR/C/79/D/970/2001) para 9.3.
- 131 *Lantsova v. Russian Federation* (note 129) para 9.2. In *Barbato v. Uruguay*, the Committee found the State in violation of Article 6, in part, “because the Uruguayan authorities failed to take appropriate measures to protect his [the applicant’s] life while he was in custody”. *Barbato v. Uruguay* (27 November 1982) UN Doc CCPR/C/OP/2 para 10(a).
- 132 *Lantsova v. Russian Federation* (note 129) para 9.2.
- 133 *Ibid.*

- 134 For example, *Galina Vedeneyeva v. Russian Federation* (15 April 2005) UN Doc CCPR/C/83/D/918/2000; *Romans v. Canada* (23 August 2004) UN Doc CCPR/C/81/D/1040/2001.
- 135 *Fabrikant v. Canada* (note 130) para 3.1.
- 136 *Ibid.*, para 9.3.
- 137 Joseph et al., *op cit.*, p. 183.
- 138 *Edwards and another v. United Kingdom* (2002) 35 EHRR 417 para 54; see also *Osman v. United Kingdom* (1999) 29 EHRR 45.
- 139 *Edwards and another v. United Kingdom* is examined in more detail below.
- 140 *Tarariyeva v. Russia* Application No. 4353/03 (judgment of 14 December 2006) para 87.
- 141 *Malawi African Association and others v. Mauritania* (note 117) para 120.
- 142 *Consumer Education and Research Centre And Others v. Union of India and Others—Supreme Court of India* (27 January 1995) para 26, reprinted in Ramcharan (2005), p. 163.
- 143 *Sobraj v. The Superintendent, Central Jail Tihar* [1979] 1 SCR 512 para 518.
- 144 Human Rights Committee ‘Concluding Observations: Republic of Moldova’ (2002) UN Doc A/57/40 vol I 76 para 84(9).
- 145 Although it does not possess a remit to consider prison conditions *per se*, the Working Group on Arbitrary Detention has noted that it “cannot disregard that . . . inadequate conditions of detention have a negative impact on the exercise of rights that squarely fall within its mandate”. Commission on Human Rights ‘Civil and Political Rights, including the Question of Torture and Detention: Report of the Working Group on Arbitrary Detention’ (1 December 2004) UN Doc E/CN.4/2005/6 para 68.
- 146 *Ibid.*, para 69.
- 147 Commission on Human Rights ‘Civil and Political Rights, including the Question of Torture and Detention: Report of the Working Group on Arbitrary Detention—Addendum: Visit To Argentina’ (23 December 2003) UN Doc E/CN.4/2004/3/Add.3 para 62.
- 148 Commission on Human Rights (note 145) para 70.
- 149 *S v. Zuba and 23 similar cases* (cases no CA40/2003 and 207/2003, Eastern Cape Division, judgment handed down on 2/10/2003).
- 150 *Ibid.*, para 21.
- 151 *Ibid.*, fn 18.
- 152 Steinberg (2005).
- 153 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1993), para 31.
- 154 *Cabal and Pasini v. Australia* (note 45) para. 7.7.
- 155 For example, *Womah Mukong v. Cameroon* (Communication No. 458/1991) UN Doc CCPR/C/51/D/458/1991.
- 156 *Setelich/Sendic v. Uruguay* (28 October 1981) UN Doc A/37/40 para 20. See also *Vasilskis v. Uruguay* (31 March 1983) UN Doc A/38/40; *Viana v. Uruguay* (29 March 1984) UN Doc A/39/40.
- 157 *Pennant v. Jamaica* (20 October 1998) UN Doc CCPR/C/64/D/647/1995 para 8.3.
- 158 For example, *Constitutional Rights Project and Civil Liberties Organisation v. Nigeria* (1999) African Commission on Human and Peoples’ Rights Comm Nos 143/95, 150/96 para 5; *Malawi African Association and others v Mauritania* (note 117) paras 12, 116; *International PEN and Others v Nigeria* (note 117) para 80; *Krishna Achuthan (On behalf of Aleke Banda), Amnesty International (On behalf of Orton and Vera Chirwa), Amnesty International (On behalf of Orton and Vera Chirwa v. Malawi* (1994) African Commission on Human and Peoples’ Rights Comm Nos. 64/92, 68/92, 78/92 para 7.
- 159 *Cantoral Benavides Case (Judgment)* Inter-America Court of Human Rights Ser C No. 69 (18 August 2000) para 85.
- 160 *Caesar v. Trinidad and Tobago (Judgment)* Inter-American Court of Human Rights Ser. C (11 March 2005) para 50(p).
- 161 Commission on Human Rights ‘Report by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak: Mission to Mongolia’ (20 December 2005) UN Doc E/CN.4/2006/6/Add.4 para 55(i).
- 162 Committee against Torture ‘Concluding Observations: Zambia’ (2002) UN Doc A/57/44 34 para 65(b).
- 163 Committee against Torture ‘Concluding Observations: Belgium’ (2003) A/58/44 49 para 131(j).
- 164 For example, *Shaw v. Jamaica* (2 April 1998) UN Doc CCPR/C/62/D/704/1996 para 7.2; *Marshall v. Jamaica* (3 November 1998) UN Doc CCPR/C/64/D/730/1996; *Leehong v. Jamaica* (13 July 1999) UN Doc CCPR/C/66/D/613/1995.
- 165 For the Inter-American Court see *Hilaire, Constantine and Benjamin et al. v. Trinidad and Tobago Case (Judgment)* Inter-American Court of Human Rights Ser C No. 94 (21 June 2002) para 84(m); for the

- Inter-American Commission see *Lallion v. Grenada (Judgment)* Inter-American Commission on Human Rights Case 11.765 (21 October 2002) para 87; *Jacob v. Grenada (Judgment)* Inter-American Commission on Human Rights Case 12.158 (21 October 2002) para 94; *McKenzie, Downer and Tracey, Baker, Fletcher, Rose v. Jamaica (Judgment)* Inter-American Commission on Human Rights Cases 12.023, 1112.044, 12.107, 12.126, 12.146 (13 April 2000) para 289; *Victor Rosario Congo v. Ecuador (Judgment)* Inter-American Commission on Human Rights Case 11.427 (13 April 1999) para 68; *Rudolph Baptiste v. Grenada (Judgment)* Inter-American Commission on Human Rights Case 11.743 (13 April 2000) paras 137–138.
- 166 Article 3 imposes a “duty to protect” the well being of people in detention. [*Keenan v. United Kingdom* (2001) 33 EHRR 38 para 91.] This encompasses “a positive obligation to protect the physical well-being of persons deprived of their liberty” [*Hurtado v Switzerland* (1994) Ser A 280A para 79.], a duty “to take the practical preventive measures necessary to protect the physical integrity and the health of persons who have been deprived of their liberty”, and a duty to “do everything that could reasonably [be] expected . . . to prevent the occurrence of a definite and immediate risk to [a prisoner’s] physical integrity, of which [the authorities] knew or should have known” [*Pantea v. Romania* (2005) 40 EHRR 26 paras 189, 190].
- 167 *Rohde v. Denmark* Application No. 69332/01 (judgment 21 July 2005) para 99.
- 168 *Kudla v. Poland* (2000) 35 EHRR 11 para 94.
- 169 *Melnik v. Ukraine* Application No 72286/01 (judgment of 28 March 2006) paras 2 103(b), 106.
- 170 *Estelle v. Gamble* 429 US 97, 105 (1976) paras 26–27.
- 171 *Ibid.*, para 11.
- 172 *Pinto v. Trinidad and Tobago* (note 126) para 12.7.
- 173 “although appointments were made for a medical doctor to see him, these appointments were not kept, and that his skin condition has been left untreated” *Lewis v. Jamaica* (18 July 1996) UN Doc CCPR/C/57/D/527/1993 para 10.4.
- 174 “the author is allergic to dust and to the paint used in St. Catherine Prison and . . . his allergy provokes attacks of asthma and burning eyes, for which he does not receive any treatment”. *Whyte v. Jamaica* (27 July 1998) UN Doc CCPR/C/63/D/732/1997 para 9.4
- 175 *Free Legal Assistance Group and others* (note 112) para 47; *EN and others v. The Government of the RSA and others* (note 124) paras 31, 35.
- 176 “the author was stabbed in the face by an inmate . . . He received twenty stitches, but was denied follow-up medical treatment. He submits that he suffered much pain the following three days, but that he was denied pain killers.” *Leslie v. Jamaica* (31 July 1998) UN Doc CCPR/C/63/D/564/1993 para 3.2.
- 177 Commission on Human Rights ‘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, Addendum: Summary of communications sent to and replies received from Governments and other actors, December 2004–December 2005’ (22 December 2005) UN Doc E/CN.4/2006/48/Add.1 paras 10–11.
- 178 *Ibid.*, paras 26–27.
- 179 *Ibid.*, paras 28, 43.
- 180 *Ibid.*, para 40.
- 181 *Ibid.*, para 44.
- 182 Commission on Human Rights ‘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: Addendum, Summary of cases transmitted to Governments and replies received (2 February 2005) UN Doc E/CN.4/2005/51/Add.1 para 41.
- 183 Commission on Human Rights (note 31) para 218
- 184 *Levy v. Jamaica* (3 November 1998) UN Doc CCPR/C/64/D/719/1996 para 7.4.
- 185 *Simpson v. Jamaica* (31 October 2001) UN Doc CCPR/C/73/D/695/1996 para 2.7.
- 186 *Matthews v. Trinidad and Tobago* (31 March 1998) UN Doc CCPR/C/62/D/569/1993 para 3.1.
- 187 *Henry and Douglas v. Jamaica* (25 July 1996) UN Doc CCPR/C/57/D/571/1994 para 9.5.
- 188 *Price v. United Kingdom* (2001) 34 EHRR 53 para 7.
- 189 *Mouisel v. France* (2004) 38 EHRR 34.
- 190 For example, *Price v. UK* (n 188).
- 191 “Everyone has the right to respect for his private and family life, his home and his correspondence”. Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 8(1).
- 192 *R (Szuluk) v. Governor, HMP Full Sutton* [2004] 1 PLR 386 para 37.
- 193 *Ibid.*, para 33.
- 194 *R (Szuluk) v. (1) Governor, HMP Full Sutton (2) Home Secretary* [2005] 2 PLR 42 para 23.
- 195 *Ibid.*, para 27.

- 196 Geneva III (note 72) art 15.
- 197 *Ibid.*, art 30.
- 198 *Ibid.*, art 31.
- 199 *Ibid.*, art 30.
- 200 *Limaj Case (Judgment)* IT-03-66-T (30 November 2005).
- 201 *Ibid.*, para 283.
- 202 *Ibid.*, 288.
- 203 *Ibid.*, 286.
- 204 *Ibid.*, 289.
- 205 Standard Minimum Rules (note 92) art 25(1).
- 206 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (note 95) prin 24.
- 207 Human Rights Committee (note 122) para 83(11).
- 208 *Lantsova v. Russian Federation* (note 129) para 9.2.
- 209 *Leehong v. Jamaica* (note 164) para 3.11.
- 210 *Kalenga v. Zambia* (27 July 1993) UN Doc CCPR/C/48/D/326/1988 para. 6.5.
- 211 *Bennett v. Jamaica* (25 March 1999) UN Doc CCPR/C/65/D/590/1994) para 10.8
- 212 *Cantoral Benavides Case* (note 159) para 43(a).
- 213 *Caesar v. Trinidad and Tobago* (note 160) para 51(k).
- 214 *Lallion v. Grenada* (note 165) para 88; see also *Jacob v. Grenada* (note 166) para 95.
- 215 *Istrath and Others v. Moldova* Application Nos. 8721/05, 8705/05, 8742/05 (judgment of 27 June 2007) para 49.
- 216 *Neomerzhitsky v. Ukraine* Application No. 54825/00 (judgment of 5 April 2005) para 105.
- 217 *McGlinchy and Others v. United Kingdom* (2003) 37 EHRR 41 para 57.
- 218 *Iorgov v. Bulgaria* Application No. 40653/98 (judgment of 11 March 2004) para 85.
- 219 *Istrath and Others v. Moldova* (note 215) para 54.
- 220 *Ibid.*, para 58.
- 221 *Aliiev v. Ukraine* Application No. 41220/98 (judgment of 29 April 2003) para 143.
- 222 *Popov v. Russia* Application No 26853/04 (judgment of 13 July 2006) para 211.
- 223 *Ibid.*, paras 219–220.
- 224 *Paladi v. Moldova* Application No. 39806/05 (judgment 10 July 2007) paras 81, 85.
- 225 Commission on Human Rights (note 182) paras 39, 41.
- 226 Commission on Human Rights (note 31) para 218.
- 227 *Limaj Case* (note 200) para 288.
- 228 “All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination ... with respect to their legal status”. WHO (note 51) art 1.
- 229 World Medical Association ‘Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases’ (adopted October 2000).
- 230 ‘Recommendation No. R (98)7 Concerning The Ethical And Organisational Aspects Of Health Care In Prison’ (adopted 8 April 1998 by the Committee of Ministers) preamble; see also ‘Recommendation No. R (93) 6 of the Committee of Ministers to Member States Concerning Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and related Health Problems in Prison’ (adopted 18 October 1993 by the Committee of Ministers) preamble.
- 231 Rules for the Protection of Juveniles Deprived of their Liberty (note 97) para 49.
- 232 “Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Russian Federation’ (1997) UN Doc E/1998/22 para 112.
- 233 Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Russian Federation’ (2003) UN Doc E/2004/22 64 para 33.
- 234 Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Moldova’ (2003) UN Doc E/C.12/1/Add.9 para 25.
- 235 Committee on Economic, Social and Cultural Rights (note 233) para 61; Committee on Economic, Social and Cultural Rights (note 234) para 47.
- 236 CRC (note 62) art 24(a–f).
- 237 Human Rights Committee (note 144) para 84(9).
- 238 *Ibid.*, para 84(9).
- 239 ‘Core Document forming part of the Reports of States Parties: Ireland’ (1 July 1998) UN Doc HRI/CORE/1/Add.15/Rev.1 para 42(b); Irish Council for Civil Liberties ‘ICCL Submission to the Government’s Consultation on the Content of its First Report under the United Nations Convention Against Torture’ (January 2006) 4.

- 240 *The State (C) v. Frawley* [1976] IR 365 para 373.
- 241 *S v. Zuba* (note 149) fn 18.
- 242 Steinberg, op.cit.
- 243 *R v. Secretary of State of the Home Department ex parte Glen Fielding* (1999) EWHC Admin 641 (High Court of Justice, Queen's Bench Division).
- 244 *Prisoners A–XX Inclusive v. State of New South Wales* (1995) 38 NSWLR 622.
- 245 *John Shelley v. The Secretary of State for the Home Department* (2005) Case No. CO/5613/2004. This case has been accepted to be heard by the European Court of Human Rights.
- 246 For a discussion of this issue at the domestic level, see *HIV/AIDS Prevention, Care, Treatment and Support in Prison Setting* (note 13), pp. 15–16.
- 247 *Cabal and Pasimi Bertran v. Australia* (note 45) para 3.
- 248 *Ibid.*, para 7.7.
- 249 Human Rights Committee (note 144) para 84(9).
- 250 *Pantea v. Romania* (note 166) para 189.
- 251 *Melnik v. Ukraine* Application No. 72286/01 (judgment of 28 March 2006) paras 2 103(b), 106.
- 252 *Staykov v. Bulgaria* Application No. 49438/99 (judgment of 12 January 2007) para 81.
- 253 For example, *Neumerzhitsky v. Ukraine* (note 216) para 87; *I.I. v. Bulgaria* Application No. 44082/98 (judgment of 9 June 2005) para 76; *Alver v. Estonia* Application No. 64812/01 (judgment of 8 November 2005) para 54.
- 254 *Benediktov v. Russia* Application No. 106/02 (judgment of 10 May 2007) para 40.
- 255 *Kalashnikov v. Russia* (note 104) para 98.
- 256 *Neumerzhitsky v. Ukraine* (note 216) para 87.
- 257 For example, *Kellv v. Jamaica* (note 126) para 5.7; “increased the incidence of influenza among inmates” *Matthews v. Trinidad and Tobago* (note 186) para 3.3.
- 258 “Mr. Caesar has suffered from serious health problems, which have included contracting tuberculosis and chronic hemorrhoids”. *Caesar v. Trinidad and Tobago* (note 160) paras 50(p), 99.
- 259 Standard Minimum Rules (note 92) para 22(1).
- 260 European Prison Rules (note 107) paras 47.1, 47.2.
- 261 For example, ‘Recommendation 1235 (1994) on Psychiatry and Human Rights’ (adopted 12 April 1994 by the Parliamentary Assembly).
- 262 Commission on Human Rights (note 27) para 8.
- 263 *Herczegfalvy v. Austria* (1992) 15 EHRR 437 para 82.
- 264 *Keenan v. United Kingdom* (note 166) para 111; see also *Pantea v. Romania* (note 166) para 191; *Rohde v. Denmark* (note 167) para 99.
- 265 “[T]he Commission considers that ... the guarantees established in article 5 of the American Convention must be interpreted in light of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care”. *Victor Rosario Congo v. Ecuador* (note 165) para 54.
- 266 *Sahadath v. Trinidad and Tobago* (2 April 2002) UN Doc CCPR/C/684/1996 para 9.
- 267 *Ibid.*, para 7.3.
- 268 *Williams v. Jamaica* (4 November 1997) UN Doc CCPR/C/61/D/609/1995 para 6.5.
- 269 Human Right Committee ‘Concluding Observations: Belgium’ (1999) UN Doc A/54/40 vol I 26 para 88.
- 270 *Edwards and another v. UK* (note 139) para 64.
- 271 *Ibid.*, para 62.
- 272 *Keenan v. UK* (note 166) para 116.
- 273 *Rohde v. Denmark* (note 167) para 106.
- 274 *Williams v. Jamaica* (note 269) para 6.5.
- 275 Commission on Human Rights ‘Situation of detainees at Guantanamo Bay’ (27 February 2006) UN Doc E/CN.4/2006/120 para 92.
- 276 Commission on Human Rights ‘The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt’ (16 February 2004) UN Doc E/CN.4/2004/49 para 5.
- 277 Commission on Human Rights ‘Report submitted by the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt: Addendum Mission to Peru’ (4 February 2005) UN Doc E/CN.4/2005/51/Add.3 para 71(d).
- 278 Commission on Human Rights (note 177) para 43, 73.
- 279 Standard Minimum Rules (note 92) para 22(1).
- 280 European Prison Rules (note 107) para 41.1.
- 281 Principles of Medical Ethics (note 94) prin 1.

- 282 Recommendation 1235 (note 261) para 7(vi)(b).
- 283 *Robinson v. Jamaica* (29 March 2000) UN Doc A/55/40 vol. II 116 paras 10.1.
- 284 Human Rights Committee (note 128) para 83(16).
- 285 *Aliev v. Ukraine* (note 221) para 143.
- 286 Committee on the Rights of the Child ‘Concluding Observations: Argentina’ (note 114) para 62.
- 287 Commission on Human Rights (note 182) para 23.
- 288 Human Rights Commission (note 31) para 218.
- 289 WHO (note 51) prin 36.
- 290 *Ibid.*, prin 11.
- 291 *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings* (note 13) actions 21, 46, 66, 68.
- 292 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (note 95) prin 25.
- 293 Rules for the Protection of Juveniles Deprived of their Liberty (note 97) para 55.
- 294 Committee on Economic, Social and Cultural Rights (note 5) para 8.
- 295 *Ibid.*, para 34.
- 296 Commission on Human Rights (note 276) para 5.
- 297 Commission on Human Rights (note 182) para 23.
- 298 Committee on the Elimination of Discrimination Against Women ‘Concluding Observations: Turkey’ (1997) UN Doc A/52/38/Rev.1 part I 24 para 178.
- 299 Commission on Human Rights (note 275) para 82.
- 300 *Neumerzhitsky v. Ukraine* (note 216) para 94.
- 301 *Herczegfalvy v. Austria* (note 263) para 82.
- 302 *Ibid.*
- 303 *Ibid.*, paras 80–82.
- 304 *Neumerzhitsky v. Ukraine* (note 216) para 94.
- 305 *Ibid.*, para 97.
- 306 *Ibid.*, paras 98–99.
- 307 *Ciorap v. Moldova* Application No. 12066/02 (judgment of 19 June 2007) paras 76–83.
- 308 Under the revised *Declaration of Malta* on hunger strikes of the World Medical Association, the body that establishes ethical guidance for doctors around the world, force-feeding by any means is considered as unethical and as cruel, inhuman and degrading treatment. World Medical Association ‘Declaration on Hunger Strikers’ (Adopted by the 43rd World Medical Assembly Malta, November 1991 and editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992 and revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006).
- 309 *C v. Minister of Correctional Services* 1996 (4) SA 292 (T).
- 310 World Medical Association (note 229) preamble, para 4.
- 311 Committee on Economic Social and Cultural Rights (note 5) para 11.
- 312 Toebes (1999b), pp. 661, 663.
- 313 “[T]he right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation . . . and a healthy environment”. Committee on Economic Social and Cultural Rights (note 5) para 4.
- 314 UDHR (note 56) art 25(1).
- 315 ICESCR (note 43) art 11(1).
- 316 Committee on Economic Social and Cultural Rights ‘General Comment No. 4: The right to adequate housing’ (13 December 1991) UN Doc E/1992/23 annex III at 114 (1991) reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies* UN Doc HRI/GEN/1/Rev.6 at 18 (2003) para 8(d).
- 317 *Ibid.*, para 7.
- 318 *Ibid.*, para 8(b).
- 319 *Ibid.*, para 8(d).
- 320 See Ramcharan (1983), p. 297. In this regard, Ramcharan notes that “more people die on account of hunger and disease than are killed”. at p. 305.
- 321 For example, Human Rights Committee ‘Concluding Observations: Togo’ (2002) UN Doc A/58/40 vol I 36 para 78(15); Human Rights Committee ‘Concluding Observations: Nigeria’ (1996) UN Doc A/51/40 vol I 37 para 285.; Human Rights Committee ‘Concluding Observations: Georgia’ (1997) UN Doc A/52/40 vol I 40 para 243.
- 322 Human Rights Committee (note 144) para 84(9).

- 323 *Labzov v. Russia* Application No. 62208/00 (judgment of 16 June 2005) para 47.
- 324 Commission on Human Rights ‘Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General’ (1 September 2004) UN Doc A/59/324 para 46.
- 325 Geneva III (note 72) art 29.
- 326 *Ibid.*, arts 25, 26.
- 327 *Ibid.*, art 29.
- 328 *Ibid.*, art 21.
- 329 *Ibid.*, art 22.
- 330 Standard Minimum Rules (note 92) rules 10, 15, 20.
- 331 Human Rights Committee ‘Concluding Observations: Senegal’ (1998) UN Doc A/53/40 para 64.
- 332 Human Rights Committee (note 321) para 285.
- 333 *Ibid.*, para 243.
- 334 Human Rights Committee (note 128) paras 332, 333.
- 335 For example, the fact that the applicant “was kept in a hut measuring 5 m by 10 m” with 100 other prisoners contributed to violations of Articles 7 and 10(1) *Masiotti v. Uruguay* (26 July 1982) UN Doc A/37/40 para 11; “being kept in a 9 × 6’ cell together with five other inmates . . . is not in compliance with the requirement that prisoners be treated with humanity and with respect for the inherent dignity of the human person” *Henry v. Trinidad and Tobago* (note 187) para 7.4; “cells measuring approximately 9’ × 6’ with between 9 and 12 other prisoners. Each cell consists of 2 bunks, therefore only 4 men can sleep at any one time” *Sahadath v. Trinidad and Tobago* (note 267) para 2.7; see also *Sextus v. Trinidad and Tobago* (16 July 2001) UN Doc A/56/40 vol II (16 July 2001) 111 para 2.4; “the prison population was . . . five times the allowed capacity” *Lantsova v. Russian Federation* (note 129) para 9.1; see also *Shaw v. Jamaica* (note 165); *Francis et al. v. Trinidad and Tobago* (25 July 2002) UN Doc CCPR/C/75/D/899/1999; *Zheludkov v. Ukraine* (29 October 2002) UN Doc CCPR/C/76/D/726/1996.
- 336 *Lantsova v. Russian Federation* (note 129) para 10.
- 337 Committee against Torture (note 126) para 65(b).
- 338 Commission on Human Rights ‘Report of the Special Rapporteur, Mr. Nigel S. Rodley, submitted pursuant to Commission on Human Rights resolution 1994/37 Addendum: Visit by the Special Rapporteur to the Russian Federation’ (16 November 1994) UN Doc E/CN.4/1995/34/Add.1 para 41.
- 339 *Ibid.*, para 85.
- 340 Commission on Human Rights (note 27) para 11.
- 341 For example, see also *Malawi African Association and others v. Mauritania* (note 158) paras 12, 116; *Krishna Achuthan et al. v. Malawi* (note 158) para 7.
- 342 *John D Ouko v. Kenya* (note 103) para 5.
- 343 *Suarez Rosero Case* (Judgment) Inter-American Court of Human Rights Ser C No. 44 (20 January 1999) para 98.
- 344 *Caesar v. Trinidad and Tobago* (note 160) para 49(16).
- 345 *Hilaire Case* (note 165) para 154; see also *Cantoral Benevides Case* (note 159) para 85.
- 346 *McKenzie et al. v. Jamaica* (note 165) para 286.
- 347 “the applicant spent the entire six-month term of his detention in cells that measured 42 m² and accommodated up to 51 inmates, for whom 28 or 30 bunk beds were available. He was thus afforded less than 1 m² of personal space and shared a sleeping place with other inmates, taking turns with them to get a rest” *Novoselov v. Russia* Application No. 66460/01 (judgment of 2 June 2005) para 41.
- 348 “detained in a cell of 10.5 square metres occupied by four detainees” *Kehayov v. Bulgaria* (note 105) para 67; “the applicant was detained for three months in a cell of six square metres apparently occupied by three to four detainees”. *I.I. v. Bulgaria* Application (note 253) para 72.
- 349 “For most of that time the applicant was afforded less than 2 square metres of space, of which more than one year and a half was spent by the applicant being restricted to 1.51 m of space, in a cell of 16.65 m together with 10 other inmates” *Karalevičius v. Lithuania* Application No. 53254/99 (judgment of 7 April 2005) para 36.
- 350 “there were periods where this amount [of personal living space] was limited to 1.81 sq. m in Jõgeva and 2.36 sq. m in the Central Prison” *Alver v. Estonia* (note 253) para 52.
- 351 *Dougoz v. Greece* (2001) ECHR 2001—II para 48.
- 352 “his cell measured 44.7 m. Between 15 prisoners (according to the Government) and up to 60 prisoners (according to the applicant) were held in it”. *Melnik v. Ukraine* (note 169) para 102. See also *Dvoynykh v. Ukraine* Application No. 72277/01 (judgment of 12 October 2006).
- 353 *Dvoynykh v. Ukraine* Application No. 72277/01 (judgment of 12 October 2006) para 66.
- 354 *Karalevičius v. Lithuania* (note 349) para 39; see also *Novoselov v. Russia* (note 347) para 43.

- 355 *Benediktov v. Russia* Application No. 106/02 (judgment of 10 May 2007) para 37. See also *Mamedova v. Russia* Application No. 7064/05 (judgment of 1 June 2006) para 63.
- 356 *Limaj Case* (note 200) paras 288, 289.
- 357 *Malawi African Association and others v. Mauritania* (note 117) para 122.
- 358 Commission on Human Rights (note 177) para 45.
- 359 Human Rights Committee ‘Concluding Observations: Georgia’ (note 321) para 243; Human Rights Committee ‘Concluding Observations: Nigeria’ (note 321) para 285.
- 360 Human Rights Committee (note 128) para 332, 333.
- 361 Human Rights Committee (note 125) para 78(7).
- 362 For example, *Kelly v. Jamaica* (note 126) para 3.8; *Shaw v. Jamaica* (note 164) para 7.2; *Bozize v. Central African Republic* (7 April 1994) UN Doc CCPR/C/50/D/428/1990 para 2.2; *Leslie v. Jamaica* (note 176) para 3.8.
- 363 *Marshall v. Jamaica* (note 164) para 6.7; see also *Bennett v. Jamaica* (note 211) para 10.8 where the applicant had “close to his cell a large pipe carrying waste water with foul odour”.
- 364 *Sextus v. Trinidad and Tobago* (note 335) para 2.4.
- 365 *McKenzie et al. v. Jamaica* (note 165) at para 286.
- 366 *Constitutional Rights Project and Civil Liberties Organisation v. Nigeria* (note 158) para 5.
- 367 *International PEN and Others v. Nigeria* (note 117) para 80.
- 368 *Malawi African Association and others v. Mauritania* (note 117) para 12.
- 369 *Hilaire Case* (note 165) para 84(m).
- 370 *Lallion v. Grenada* (note 165) para 88.
- 371 *Nevmerzhiysky v. Ukraine* (note 216) para 87. See also *Dvoynykh v. Ukraine* Application No. 72277/01 (judgment of 12 October 2006) para 67, “the applicant ... was not provided with adequate amounts of personal hygiene products and cleaning products”.
- 372 *Melnik v. Ukraine* (note 251) para 109.
- 373 “The punishment cells had been cold and damp and rats had come out from the hole used as a toilet” *Alver v. Estonia* (note 253) para 53. The cells “were dirty and infested with cockroaches, bed-bugs and lice” *Mayzit v. Russia* Application No. 63378/00 (judgment of 20 January 2005) para 41.
- 374 “Cells were infested with lice, bedbugs, and cockroaches”. *Malawi African Association and others v. Mauritania* (note 117) para 12.
- 375 “his cell was infested with ants and other insects” *Pennant v. Jamaica* (note 158) para 8.4.; “the prison is infested by vermin” *Robinson v. Jamaica* (note 283) para 10.1.
- 376 *Perkins v. Jamaica* (30 July 1998) UN Doc CCPR/C/63/D/733/1997 para 11.7; *Sahadath v. Trinidad and Tobago* (note 266) para 2.7.
- 377 *Sextus v. Trinidad and Tobago* (note 335) para 2.1; see also *Sahadath v. Trinidad and Tobago* (note 266) para 2.7; *Francis et al. v. Trinidad and Tobago* (note 335) para 2.3.
- 378 *Griffin v. Spain* (4 April 1995) UN Doc CCPR/C/53/D/493/1992 para 3.1.
- 379 *Marshall v. Jamaica* (note 164) para 6.7; see also *Wilson v. The Philippines* (30 October 2003) UN Doc CCPR/C/79/D/868/1999 para 2.4; *Simpson v. Jamaica* (note 185) para 2.1.
- 380 Human Rights Committee (note 128) paras 332, 333.
- 381 “there is no integral sanitation in the cells and therefore that the victims must use buckets for toilets”. *McKenzie et al. v. Jamaica* (note 165) para 271.
- 382 “There were no toilet facilities and a ‘slop pail’ was used by everyone in the cell”. *Caesar v. Trinidad and Tobago* (note 160) para 49(16).
- 383 *Kehayov v. Bulgaria* (note 104) para 71; see also *I.I. v. Bulgaria* (note 253) para 73.
- 384 *John D Ouko v. Kenya* (note 103) para 5.
- 385 Commission on Human Rights (note 147) para 62.
- 386 *The State (Susan Richardson) v. The Governor of Mountjoy Prison* [1980] ILRM 82 1979 No 498.
- 387 *Pedro Orlando Ubaque v. Director, National Model Prison* Constitutional Court of Colombia Decision No T-502/94 (1994); cited in Canadian HIV/AIDS Legal Network/UNAIDS (note 122), p. 101.
- 388 *Ibid.*
- 389 Standard Minimum Rules (note 92) rule 20.
- 390 Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Trinidad and Tobago’ (2002) UN Doc E/2003/22 45 paras 274, 297.
- 391 Committee on Economic, Social and Cultural Rights ‘Concluding Observations: Brazil’ (2003) UN Doc E/2004/22 28 paras 144, 177.
- 392 Committee on Economic, Social and Cultural Rights (note 111) paras 361, 380.
- 393 *Malawi African Association and others v. Mauritania* (note 158) para 122.
- 394 *Ibid.*, para 12. See also *Krishna Achuthan et al. v. Malawi* (note 158) para 7.

- 395 Commission on Human Rights (note 177) para 45.
- 396 Human Rights Committee (note 321) para 285
- 397 For example, “The author contends that the prison diet and conditions of detention have contributed to a worsening of his situation. He claims that the prison diet consists of two slices of (mostly dry) bread and a cup of ‘sugar water’ in the morning, and 1/4 pound of rice and peas and flour at lunch time” *Matthews v. Trinidad and Tobago* (note 186) para 3.2; “abysmal quality of the food” *Pennant v. Jamaica* (note 158) para 8.4; “the quality of food and drink is very poor” *Robinson v. Jamaica* (note 283) para 10.1; “the provision of inadequate food to detained individuals . . . does not . . . meet the requirements of article 10” *Kelly v. Jamaica* (note 126) para 5.7; the applicant “stated that poor food had resulted in significant weight loss” *Francis et al. v. Trinidad and Tobago* (note 335) para 2.3; “the running water in the prison is polluted with insects and human excrement” *Marshall v. Jamaica* (note 164) para 6.7.
- 398 *Alver v. Estonia* (note 253) para 53.
- 399 *Malawi African Association and others v. Mauritania* (note 158) para 120.
- 400 Geneva III (note 72) art 26.
- 401 *Limaj Case* (note 200) para 288.
- 402 *Ibid.*, para 283.
- 403 *Ibid.*, para 289.
- 404 See Human Rights Watch (note 5).
- 405 Toebes (1999b), p. 665.
- 406 Livingstone (2000), pp. 309, 321.
- 407 Rodley, *op. cit.*, p. 14.
- 408 Canadian HIV/AIDS Legal Network/UNAIDS (note 122), p. 130.
- 409 Dreschler (2006), p. 2(a).
- 410 Berger (2006).
- 411 Bernard, *op. cit.*, 789.
- 412 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85 art 19 (CAT).
- 413 *Ibid.*, art 22.
- 414 Rodley, *op. cit.*, p. 157.
- 415 Optional Protocol to the Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (adopted 18 December 2002, entered into force 22 June 2006) GA Res A/RES/57/199.
- 416 Rosas and Scheinin in Eide et al. (2001), p. 428.
- 417 *Ibid.*
- 418 Committee against Torture (note 413) art 16(1).
- 419 Committee against Torture ‘Concluding Observations: New Zealand’ (1998) UN Doc A/53/44 19 para 175.
- 420 ‘Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment’ (13 August 2007) UN Doc No A/62/221 para 9.
- 421 Schabas (2004), pp. 417, 426.
- 422 *Tyrer v. United Kingdom* (1978) 2 EHRR 1 para 31.
- 423 *Selmouni v. France* (1999) 29 EHRR 403 para 101.
- 424 *Henaf v. France* (note 105) para 55. This evolutive interpretation of inhuman or degrading treatment is also reflected in the approach of the Inter-American Court. “The European Court has pointed out . . . that certain acts that were classified in the past as inhuman or degrading treatment, but not as torture, may be classified differently in the future . . . since the growing demand for the protection of fundamental rights and freedoms must be accompanied by a more vigorous response in dealing with infractions of the basic values of democratic societies”. *Cantoral Benevides Case* (note 159) para 99.
- 425 *Price v. UK* (note 188) para 24.
- 426 For example, *Peers v. Greece* (2001) ECHR 2001—III para 74; *Mayzit v. Russia* (note 373) para 36; *Poltoratskiy v. Ukraine* (note 104) para 131.
- 427 Committee against Torture (note 412) art 1(1).
- 428 Rodley, *op. cit.*, p. 49.
- 429 Declaration in the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted by the UN General Assembly 9 December 1975) UNGA Res 3452 (XXX) (Declaration against Torture) art 1.
- 430 Rodley states, “Clearly . . . a punishment which does not violate the Rules . . . cannot be seen as torture”. Rodley, *op. cit.*, p. 278. This suggests the possibility that treatment that contravenes the *Standard Minimum Rules* could constitute torture or ill-treatment under the terms of the Committee against Torture.
- 431 Bernard (note 91) 790.

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