Health care of prisoners: ethical and organizational aspects

Professional paper

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Abstract

The author of the paper analysed the ethical and the organizational aspects of the health care in prison. The respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community in general. The health care of prisoners is a continuing challenge for the prison systems. An inadequate level of health care can lead rapidly to situations falling within the scope of the term "inhuman and degrading treatment". Poor health care of prisoners as noted by the Committee for Prevention of Torture is due to the lack of independence, lack of resources, lack of properly trained health care staff, low standard of hygiene and low standard of prison facilities. The author draw attention to the United Nations Standard Minimal Rules for the Treatment of Prisoners (the Nelson Mandela Rules), the European Prison Rules, and the Recommendation No. R (98) 7 Concerning the Ethical and Organisational Aspects of Health Care in Prison and other international documents regarding health care of prisoners. The author discussed the growing trend of integrating prison health care into community health-care services, which is a development that has been seen as a step in the right direction by the Council of Europe. In brief, the author analysed the health care in the Macedonian prisons and the legislation regarding this issue with suggestions and proposal for its improvement.

Keywords: prisoner, health care, Nelson Mandela Rules, European Prison Rules, Committee for Prevention of Torture.

1. Introduction

"Prisoners represent an underserved, vulnerable population. Vulnerability can be defined as an increased likelihood of incurring additional harm or greater prejudice. Truly, prisoners are by nature, vulnerable patients, given the stresses and trauma of their daily confinement to an institutional living situation. Prisoners frequently have limited access to healthcare due to social and economic disadvantages, family dysfunction, and high rates of school dropout and lack of appropriate support in the early years of life. The accumulation of these negative social determinants of health explain why detainees have such a high burden of disease. The detention setting has been identified as a significant opportunity to address the health needs of vulnerable groups. Modern prison health services should aim to reduce inequalities by providing a range and quality of health care equivalent to that available in the community, according to the principles outlined by the Council of Europe" (Wolff *et al*., 2012).

"Health-care services for persons deprived of their liberty are directly relevant to the CPT's mandate. Inadequate health care can lead rapidly to situations of inhuman and degrading treatment, whereas medical and non-medical staff in prisons with better professional knowledge and skills mean a healthier and safer environment for prisoners and prison staff and better

protection of the public by reducing the risks of transfer of health problems from prisons to the community" (Lehtmets and Jörg, 2014).
Further in the paper the health care of prisoners *de jure* and *de facto* is analysed. Namely, the most important international documents dealing with this issue are analysed, such as, the International Covenant on Economic, Social and Cultural Rights, the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), the European Prison Rules and the Recommendation No. R (98) 71 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison. Next, the health care of prisoners according to the Law on Execution of Sanctions of the Republic of Macedonia is analysed, as well as, the health care of prisoners in Republic of Macedonia *de facto* according to the reports of the Committee for prevention of torture.

2. Health care of prisoners (international and domestic legislature and the health care of prisoners in the North Macedonian prisons)

Several international standards define the quality of health care that should be provided to prisoners. In the first place, the provision in Article 12 of the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966) establishes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". This applies to prisoners just as it does to every other human being. Those who are imprisoned retain their fundamental right to enjoy good health, both physical and mental, and retain their entitlement to a standard of health care that is at least the equivalent of that provided in the wider community (Moller Lars *et al*., 2007).
"The United Nations (1990) Basic Principles for the Treatment of Prisoners indicate how the entitlement of prisoners to the highest attainable standard of health care should be delivered: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (Principle 9). In other words, the fact that people are in prison does not mean that they have any reduced right to appropriate health care. Rather, the opposite is the case. When a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary. Prison administrations have a responsibility not simply to provide health care but also to establish conditions that promote the well-being of both prisoners and prison staff. Prisoners should not leave prison in a worse condition than when they entered. This principle is reinforced by Recommendation No. R (98) 7 of the Committee of Ministers of the Council of Europe (1998) concerning the ethical and organizational aspects of health care in prison and by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), particularly in its 3rd general report (Council of Europe, 1993). The European Court of Human Rights is also producing an increasing body of case law confirming the obligation of states to safeguard the health of prisoners in their care. The argument is sometimes advanced that states cannot provide adequate health care for prisoners because of shortage of resources. In the 11th general report on its activities (Council of Europe, 2001), the CPT underlined the obligations state governments have to prisoners even in times of economic difficulty (Moller Lars *et al*., 2007)."

2.1 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)

The Standard Minimum Rules for the Treatment of Prisoners (SMRs) were adopted in 1955, and constitute since then the universally acknowledged minimum standards for the management of prison facilities and the treatment of prisoners, and have been of tremendous value and influence in the development of prison laws, policies and practices in Member States all over the world (Arnaudovski and Gruevska Drakulevski, 2011).[1]

Considering the advances in international law and correctional science, the UN General Assembly decided, in 2011, to establish an open-ended intergovernmental Expert Group to review and possibly revise the SMRs. After an analysis process that involved five years of intense work by government experts, civil society and academics, the UN General Assembly adopted in December 2015, the revision of the Standard Minimum Rules for Treatment of Prisoners, which are now called the Nelson Mandela Rules (NMRs).

The `Nelson Mandela Rules` (NMRs) have 122 Rules (unlike the SMRs with 95 Rules) divided into two major parts. The first part is "Rules of general application" (Rules 1-85) and the second part is "Rules applicable to special categories" (Rules 86-122).

A special attention in the rules has the provisions relating to the health care of prisoners. These rules are provided in the ninth section, *"Health-care services"*. These rules are subject of the revision in the NMRs, and are provided in Rules 24-35 compared to five rules in the previous SMRs.

Among other provisions, it is stipulated that the provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence (Rule 24, NMRs).

Particular attention shall be paid to prisoners with special healthcare needs or with health issues that hamper their rehabilitation. The health-care service shall consist of an interdisciplinary team. Also, the services of a qualified dentist shall be available to every prisoner (Rule 25, NMRs).

Each prisoner should have accurate, up-to-date and confidential individual medical file which upon a request should be granted to the prisoner or to a third party appointed by the prisoner (Rule 26, NMRs).

All prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals (Rule 27, NMRs).

Considering the special needs for health care for woman, the NMRs stipulate that in women's prisons, there shall be special accommodation for all necessary prenatal and postnatal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the prison. If a child is born in prison, this fact shall not be mentioned in the birth

[1]https://www.unodc.org/ropan/en/PrisonReform/the-nelson-mandela-rules--an-updated-guide-for-prison-management-in-line-with-human-rights.html

https://www.unodc.org/documents/justice-and-prison-reform/Brochure_on_the_UN_SMRs.pdf Accessed on 10.5.2017.

certificate (Rule 28, NMRs). A decision to allow a child to stay with his or her parent in prison shall be based on the best interests of the child concerned (Rule 29, NMRs).
A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary (Rule 30, NMRs).
The physician shall report to the prison director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment (Rule 31, NMRs).

The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community (Rule 32, NMRs).
If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority (Rule 33-34, NMRs).
The physician or competent public health body shall regularly inspect and advise the prison director on several issues (food, hygiene of the institution and of prisoners, sanitation, temperature, lighting and ventilation and other conditions) (Rule 35, NMRs).
To summarize, as the state bears responsibility for those it deprives of their liberty, healthcare must be provided in prison and offered at the same level of care as in the community. In line with good practice, prison healthcare should be organised in close cooperation with community health services, including to ensure continuity of care. The Rules elaborate on what prison healthcare services should consist of, including for any children housed in prison with their parent. The role of healthcare professionals in prison must be clearly separate from that of the prison administration. The same ethical and professional standards apply to prison healthcare staff as those outside prison. Their role in prison is to evaluate, promote and treat the physical and mental health of their patients - prisoners. This includes treatment and care for infectious diseases, substance dependencies, mental health and dental care. Healthcare staff must not be involved in prison management issues, such as disciplinary measures, and their clinical decisions must not to be overruled or ignored by non-medical prison staff. Prison healthcare staff have a duty to report any signs of torture or other inhuman treatment (Penal Reform International, 2016).
When prisoners see a doctor they are patients just like they would be in the community. Patients must give their informed consent to any medical interventions and examinations, and their medical records are confidential. The protection of staff and other prisoners from infectious diseases, for example, can be achieved by only disclosing the information necessary so the required measures can be taken whilst still upholding medical confidentiality. The competent public health body should regularly inspect and advise the prison director on a variety of issues impacting on the health and well-being of prisoners - as well as prison staff. This includes food, hygiene of the institution and of prisoners, sanitation, temperature, lighting and ventilation and other conditions (Penal Reform International, 2016).

2.2 European Prison Rules

Prison standards reflect the commitment to treat prisoners justly and fairly. They need to be spelt out clearly, for the reality is that public pressure may easily lead to the violation of the fundamental human rights of this vulnerable group. The first attempt to set such standards in Europe was made in 1973 with the introduction of the European Standard Minimum Rules for the Treatment of Prisoners by Resolution No. R (73) 5 of the Committee of Ministers. They sought to adapt the United Nations Standard Minimum Rules for the Treatment of Prisoners, which were initially formulated as far back as 1955, to European conditions. In 1987 the European Prison Rules were thoroughly revised to allow them, in the words of the Explanatory Memorandum "to embrace the needs and aspirations of prison administrations, prisoners and prison personnel in a coherent approach to management and treatment that is positive, realistic and contemporary".

Part III of the EPRs (rules 29-48) refer to the health care of prisoners.
According to the rule 39, prison authorities shall safeguard the health of all prisoners in their care. This rule is a new one and has its basis in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which establishes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Alongside this fundamental right, which applies to all persons, prisoners have additional safeguards as a result of their status. When a state deprives people of their liberty it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary. Prison administrations have a responsibility not simply to ensure effective access for prisoners to medical care but also to establish conditions that promote the well-being of both prisoners and prison staff. Prisoners should not leave prison in a worse condition than when they entered. This applies to all aspects of prison life, but especially to health care.
This principle is reinforced by Recommendation No. R (98) 7 of the Committee of Ministers to member states concerning the ethical and organisational aspects of health care in prison and also by the CPT, particularly in its 3rd General Report (CPT/Inf (93) 12). There is also an increasing body of case law coming from the European Court of Human Rights, which confirms the obligation of states to safeguard the health of prisoners in their care.
Rule 40 refers to the organisation of prison health care. It stipulates that medical services in prison shall be organised in close relation with the general health administration of the community or nation. This is a case in a number of European countries. If this is not the case, then there should be the closest possible links between the prison health care providers and health service providers outside the prison (Council of Europe, Commentary to the EPS, June 2006).
It is also an important principle that prisoners should have access to health care free of charge. A number of countries experience great difficulty in providing health care of a high standard to the population at large. Even in these circumstances prisoners are entitled to the best possible health care arrangements and without charge. The CPT has stated that even in times of grave economic difficulty nothing can relieve the state of its responsibility to provide the necessities of life to those whom it has deprived of their liberty. It has made clear that the necessities of life include sufficient and appropriate medical supplies. Nothing in these rules prevents a state from allowing prisoners to consult their own doctor at their own expense (Council of Europe, Commentary to the EPS, June 2006).

A basic requirement to ensure that prisoners do have access to health care whenever required is that there should be a medical practitioner appointed to every prison. The medical practitioner referred to should be a fully qualified medical doctor. In large prisons a sufficient number of doctors should be appointed on a full-time basis. In any event, a doctor should always be available to deal with urgent health matters. Also, every prison shall have personnel suitably trained in health care. 41.5 The services of qualified dentists and opticians shall be available to every prisoner (Rule 41, EPR).

The idea of rule 42 of the EPR underlying the duties of prison doctors is that they should give appropriate medical care and advice to all the prisoners for whom they are clinically responsible. In addition, their clinical assessments of the health of prisoners shall be governed solely by medical criteria. The task of the medical practitioner begins as soon as any person is admitted to a prison.

Rule 43 implies that individual prisoners are entitled to regular, confidential access to appropriate levels of medical consultation, which is at least the equivalent to that available in civil society.

Rules 44 and 45 address the medical practitioner's duties to inspect and to advise upon the conditions of detention. Rule 46 requires the prison administration to ensure that it has, in addition to facilities for general medical, dental and psychiatric care, suitable arrangements in place to provide specialist consultation and in-patient care. The next rule, addresses mental health issues since the conditions of imprisonment may have a serious impact on the mental well-being of prisoners. Prison administrations should seek to reduce the extent of that impact and should also establish procedures to monitor its effects on individual prisoners. Steps should be taken to identify those prisoners who might be at risk of self-harm or suicide. Staff should be properly trained in recognising the indicators of potential self-harm. Where prisoners are diagnosed as mentally ill they should not be held in prison but should be transferred to a suitably equipped psychiatric facility.

Prisoners shall not be subjected to any experiments without their consent. Experiments involving prisoners that may result in physical injury, mental distress or other damage to health shall be prohibited (Rule 48, EPR).

To conclude, the revised European Prison Rules, adopted on 11 January 2006 by the Committee of Ministers of the Council of Europe (2006), contain a significantly expanded section on health care in the prison setting. For the first time, the European Prison Rules specifically refer to the obligation of prison authorities to safeguard the health of all prisoners and the need for prison medical services to be organized in close relationship with the general public health administration (Moller Lars *et al*., 2007).

2.3 Recommendation No. R (98) 71 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison

The health profile of prisoners compared to the community as a whole is very poor. Health care is a major concern in European prisons and in many states deficiencies in the provision of health care have been noted. In 1998, the Committee of Ministers of the Council of Europe adopted a recommendation on prison health care. The recommendation stresses the requirement that prison health care should be of a standard equivalent to that in the outside community; it calls for the same ethical principles to guide practice in prison as in general practice; it emphasises that the primary concern of medical staff should be the health needs of the prisoner

and that all their decisions should be based solely on medical judgements (Council of Europe, Revision of the EPR, June 2006).
The Appendix to Recommendation No. R (98) 7 consists of 74 rules, divided in three parts. The first part refers to the main characteristics of the right to health care in prison; the second part implies to the specific role of the prison doctor and other health care staff in the context of the prison environment and the third part refers to the organisation of health care in prison with specific reference to the management of certain common problems.
The first part implies to: A. Access to a doctor; B. Equivalence of care; C. Patient's consent and confidentiality and D. Professional independence.
The second part refers to A. General Requirements; B. Information, prevention and education for health; C. Particular forms of pathology and preventive health care in prison and D. The professional training of prison health care staff.
The third part has rules for: Transmitted diseases, in particular: HIV infection and Aids, tuberculosis, hepatitis; B. Addiction to drugs, alcohol and medication: management of pharmacy and distribution of medication; C. Persons unsuited to continued detention: serious physical handicap, advanced age, short term fatal prognosis; D. Psychiatric symptoms, mental disturbance and major personality disorders, risk of suicide; E. Refusal of treatment, hunger strike; F. Violence in prison: disciplinary procedures and sanctions, disciplinary confinement, physical restraint, top security regime; G. Health care special programmes: socio-therapeutic programmes, family ties and contacts with the outside world, mother and child and H. Body searches, medical reports, medical research.
The need for adopting the Recommendation No. R (98) 7 is due to the fact that medical practice in the community and in the prison context should be guided by the same ethical principles. Next, the respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community in general. The medical practitioner in prison often faces difficult problems which stem from conflicting expectations from the prison administration and prisoners, the consequences of which require that the practitioner should adhere to very strict ethical guidelines;
Not of less importance is the fact that it is in the interests of the prison doctor, the other health care staff, the inmates and the prison administration to proceed on a clear vision of the right to health care in prison and the specific role of the prison doctor and the other health care staff. Also, it was taken in consideration the specific problem situations in prisons such as overcrowding, infectious diseases, drug addiction, mental disturbance, violence, cellular confinement or body searches require sound ethical principles in the conduct of medical practice.
In the course of its regular visits the CPT pays particular attention to the provision of medical services and evaluates these against the international human rights standards on prison health care. Medical staff have important roles relating to the human rights obligations of states to prisoners. They may play a part in preventing torture by ensuring that when prisoners arrive from police custody with injuries or sustain injuries in prison these are fully recorded and reported to the appropriate authorities. There are particular health problems in prisons in a number of member states in central and Eastern Europe. In many of them tuberculosis is a major issue, although recent interventions from the World Health Organisation, the European Union, the Council of Baltic Sea States, the International Committee of the Red Cross and other organisations have brought the problem under control in some states. Multi-drug resistant tuberculosis (MDRTB) is a more severe form of TB, which can occur as a consequence of inconsistent prescribing practices or transmission from an infected person. The proportion of HIV infected prisoners is a major problem in some member states, as are Hepatitis B and C. In a

number of member states, prisoner suicides are a cause for concern due to the lack of proper medical help, lack of psychiatric monitoring and segregation incompatible with the proper treatment of a mentally ill person. The WHO and the Council of Europe argue for close links between prison and public health services and it is worth noting in this context that several countries started a process of placing the management of prison health services under the public health services. The results suggest that this transfer of responsibility has improved the quality of health care given to prisoners (Council of Europe, Revision of the EPR, June 2006). This is very encouraging since Macedonia is in a process of major reforms in regard to the health care of prisoners in this line.

3. The health care of prisoners according to the Law on Execution of Sanctions of the Republic of North Macedonia (LES*)*

According to the current North Macedonian legislation, prisoner is provided with a health care. He cannot be exposed to medical or other experiments which disturb their physical, psychological and moral integrity and the agreement of the prisoner for their participation in an experiment does not exclude the responsibility of the person who approved it (Article 46, LES).
The necessary medical assistance and hospital treatment shall be provided to the convicted and detained persons in accordance with the regulations in the field of health care and health insurance. Novelty in the LES is that the healthcare workers employed in public healthcare institutions that perform primary health care in the network of healthcare institutions on the territory of the head office of the institution shall provide health services to prisoners and detained persons. The expenses for the health protection of the convicted person shall be covered by the Budget of Republic of North Macedonia (Article 124, LES). Before the amendments of the LES, employment of a physical doctor in the institutions who shall take care of the convicts' health conditions was obligatory.
Next, the doctor has to check-up each convict and to determine the convict's personal state of health at his reception for serving the sentence and at his leaving the institution (Article 125, LES). The convicts with determined physical and mental disturbances, as well as certain addictions, shall be subject to medical treatment in the institution, and when it is necessary, upon medical findings of a doctor, they shall be referred in an appropriate medical institution (Article 126, LES). The convicts suspected of being ill of a contagious disease, or noticed to suffer physical or mental disturbances which may prevent them from their adaptation in the milieu, shall be accommodated in special premises of the institution, upon both medical findings and referral by the doctor (Article 127, LES). The convicts who, during their serving the sentence, will get hold of mental illness, or demonstrate a severe psychological disturbance determined by a doctor-psychiatrist, shall be sent by the institution to the appropriate health institution for treatment and keeping until there is no longer a need for their further keeping and treating as determined according to the general regulations (Article 128, LES). An ill convict may request a specialist medical check-up at his expense, if the institution's doctor has not determined such check-ups. The institution's director shall decide the convict's request after receiving an opinion by the institution's doctor (Article 129, LES). The time spent by the convict for his healing shall be included in the time being spent at serving his sentence of imprisonment (Article 130, LES). If the convict endangers his health or life by refusing food or by refusing medical treatment, necessary medical measures to feed and heal him may be undertaken even without his consent. The institution's director, according to the institution's house rules, shall decide the expenses of the undertaking the necessary medical measures referred to in paragraph 1 of this Article (Article

131, LES). Upon every heavier disease and harder disturbance of the convict's state of health, the institution shall inform the convict's family about it (Article 132, LES). The young adults shall be subjected to systematic check-up at least once a year (Article 133, LES).
As to the leave of absence from work, the general regulations shall be applied upon the convicts-females during their pregnancy, parturition and maternity. Convicted pregnant females and nursing mothers shall be provided with an expert medical care. As a rule, the convicted pregnant females, upon a proposal by the doctor, shall be referred to the maternity section four weeks prior to their parturition. As a rule, the convicted pregnant females shall give a birth in a general health institution, except in the cases when the necessary conditions for safe parturition of the convicted pregnant female are provided within the institution. As a rule, the convict-nursing mother shall stay in the maternity section until her child has become one year aged, if before it she has not been released from the serving her sentence. The birth registry must not include the data which shall imply that the child has been born in a penal-correctional institution (Article 134, LES).

3.1 Health care of prisoners in Republic of Macedonia according to the CPT

After the last visit of the Republic of North Macedonia, the CPT published a highly critical report on the prisons in the Republic of North Macedonia.
According to the Report, published on October 12, 2017, to the Government of "the former Yugoslav Republic of Macedonia" on the visit to "the former Yugoslav Republic of Macedonia" carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 6 to 9 December 2016, The CPT's delegation was informed that the process of transferring the responsibility for health care in prisons to the Agency for public health administration under the Ministry of Health will be completed by March 2017. This step is to be welcomed. The challenges facing health care in prisons are enormous including a woeful lack of staff, inadequate screening of new arrivals in prison which has consequences both for the prevention of ill-treatment and public health, inadequate dental and psychiatric care and poor drug treatment practices. The CPT recommends that health care staff constitute an autonomous department within prisons and not subordinate to any other department within the prison. A step forward has been made in order to solve this problem, namely the obligation for health services is undertaken by the Ministry of Health and a positive outcome from such a measure is expected.
The level of health care for convicts in the country is below the level of what is required by the best practices and on many occasions the CPT has made negative remarks. Once again, this is largely due to insufficient number of employees (especially qualified medical staff) but also due to inadequate conditions for accommodating convicts in need of ambulatory treatment. The number of doctors and qualified nurses should be substantially increased as soon as possible. At least one psychologist should also be recruited. For example, in the Idrizovo Penitentiary, the team consisted of two doctors (a general practitioner and a psychiatrist) and two nurses for a prison population of over 1,800 prisoners.
The material conditions of the medical institutions remained inadequate and in a state of neglect and decay. They need to be completely renovated and re-equipped. Furthermore, dental equipment should be repaired so that the dentist can work full time.
The CPT (2017) reiterates its recommendation that the national authorities remind all prison health care staff that every newly-arrived prisoner should be properly interviewed and physically examined as soon as possible, and no later than 24 hours after admission by a doctor or by a

fully-qualified nurse reporting to a doctor (for example, cases of examination were noticed in the Idrizovo Penitentiary after 7 or 10 days after admission), and that any allegations of ill- treatment and signs of injury should be fully recorded, in accordance with the relevant Instructions. Further, the screening of inmates for infectious diseases, notably hepatitis and HIV, should be offered along with voluntary counselling.

The CPT (2017) reinforces that there should be no filtering of prisoners' access to a doctor. The delegation received many complaints about access to health care, which is a little surprising. Officially, prisoners make a request to the director to see the doctor, and the requests are filtered by prison officers. A couple of weeks may pass before the doctors come, and even then it is not certain that the doctor will call the prisoner. Therefore, the CPT proposes that prisoners deliver medical examination requests in a sealed envelope.

Another illicit practice is that the medical team in the Idrizovo Penitentiary was supported by six "assistant" prisoners who essentially performed work on nurses, such as, maintenance of registers for health care, drug distribution and care for other prisoners when no member of the health care team was present. In the opinion of the CPT, prisoners should never be involved in health obligations. Therefore, the CPT reiterates its recommendation that immediate steps be taken to replace prisoners performing nursing duties with qualified health care staff.

The CPT (2017) recommends that the number of nurses be increased. For example, the health care team decreased in the Skopje prison from 2014 and consisted of one doctor and one nurse for 198 detainees and 117 convicted prisoners. In the Stip Penitentiary, there was one general practitioner and one nursing assistant for 359 prisoners. The CPT recommends that in both prisons the number of nurses should increase to at least five.

The CPT (2017) calls upon the national authorities to take steps to ensure that medical confidentiality is fully guaranteed in all prisons.

The CPT (2017) reiterates its recommendation that the national authorities take urgent action to review the management of the methadone maintenance program at Idrizovo Prison and a methadone dispenser should be purchased immediately. Further, any preventive measures must also be accompanied by a genuinely multidisciplinary therapeutic programme to help drug addicted prisoners and an effective drug awareness training should be offered to prison staff, which would provide a basis for establishing constructive, helping relationships with prisoners.

The CPT reiterates its recommendation that the national authorities introduce a clear policy and comprehensive procedure on the identification of the causes of death of detained persons – including when the death occurs in (or on the way to) hospital – and clear criteria on the classification of deaths as suicides. In particular, every death of a prisoner should be the subject of a thorough investigation to ascertain, inter alia, the cause of death, the facts leading up to the death, including any contributing factors, and whether the death might have been prevented. Further, whenever a person dies in prison (or soon after transfer from prison), an autopsy should be carried out and the prison's management and medical services should be informed of the outcome.

4. Conclusions

All prisons are different, but they share common challenges. Public health can no longer afford to ignore prison health. Health care in custody is complex, and health services in these settings need to be better prioritised by governments all over the world.

Regarding the organisation of prison health care, "one method of ensuring that prisoners have access to an appropriate quality of health care is by providing close links between prison-

administered health services and public health. In recent years, some countries have begun to create and strengthen such relationships. However, many prison and public health reformers argue that a close relationship is not enough and that prison health should be part of the general health services of the country rather than a specialist service under the government ministry responsible for the prisons. There are strong arguments for moving in this direction in terms of improving the quality of health care provided to prisoners (Moller Lars *et al*., 2007)."

Provision of health care in custody, and particularly, the doctor-patient relationship are under pressure within the detention setting. Variable and inconsistent organisation of prison health care by countries is unethical and is a detriment to these vulnerable patients. Respect for the seven fundamental principles of prison health care should be incorporated into national poli- cies and legislations, worldwide. The improvement of these patients' health care translates into an elevation of human rights for a vulnerable population (Wolff et al., 2012).

Given the numerous challenges (systematic, patient level) that physicians are up against in treating these vulnerable patients, several fundamental principles of prison health care should be incorporated into the legislation for prisoner rights of all countries. Measures should be taken to ensure strict adherence to these guidelines. Ignoring these principles or an unawareness of their importance is a barrier to the trustful doctor-patient relationship – an aspect of health which is at the core for the provision of high quality medical care for patients detained in prison. These principles are: confidentiality, communication and partnering with allophonic patients, better integration into national and global public health strategies of health care centres in prison, health care policies focusing on prison health prevention and treatment, stewardship of prison health centres (it is recommended that stewardship be transferred from the Ministry of Justice to the Ministry of Health).

Finally, to conclude, people who are in prison have the same right to health care as everyone else; prison administrations have a responsibility to ensure that prisoners receive proper health care and that prison conditions promote the well-being of both prisoners and prison staff; health care staff must deal with prisoners primarily as patients and not prisoners; health care staff must have the same professional independence as their professional colleagues who work in the community; health policy in prisons should be integrated into national health policy, and the administration of public health should be closely linked to the health services administered in prisons; this applies to all health matters but is particularly important for communicable diseases; the European Prison Rules of the Council of Europe provide important standards for prison health care (Moller Lars *et al*., 2007).

Regardless of the circumstances, the ultimate goal of health care staff in prisons must remain the welfare and dignity of the patients.

References

1. Arnaudovski, Lj. and Gruevska Drakulevski, A. 2011. *Law on Execution of Sanctions: integral text with an introduction, brief explanations and registry of terms with appendix.* Skopje: "Studiorum" - Center for Regional Studies and Cooperation. [Арнаудовски, Љ. и Груевска-Дракулевски А. 2011. *Закон за извршување на санкциите: интегрален текст со предговор, кратки објаснувања и регистар на поимите со прилози*. Скопје: „Студиорум"-Центар за регионални истражувања и соработка].

2. Council of Europe, Commentary on Recommendation Rec (2006) 2 of the Committee of Ministers to member states on the European Prison Rules, European Prison Rules, Council of Europe Publishing, June 2006. https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae. Page 63-70.

3. Council of Europe, Committee of Ministers, Recommendation No. R (98) 71 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison (Adopted by the Committee of Ministers on 8 April 1998 at the 627th meeting of the Ministers' Deputies). (https://rm.coe.int/09000016804fb13c). (Accessed: 25.9.2018).

4. Council of Europe, Committee of Ministers, *Recommendation Rec (2006)2 of the Committee of Ministers to member states on the European Prison Rules*. Adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers'Deputies. (https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae). (Accessed: 5.2.2018).

5. Council of Europe, Revision of the European Prison Rules, a contextual report by Andrew Coyle, scientific expert, European Prison Rules, Council of Europe Publishing, June 2006. https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae. Page 119-121.

6. Dubois C, Linchet S, Mahieu C, Reynaert J-F, Seron P. *Organization models of health care services in prisons in four countries*. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2017. KCE Reports 293. D/2017/10.273/69.

7. International Covenant on Economic, Social and Cultural Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, in accordance with article 27. https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx. (Accessed: 25.9.2018).

8. Law on Execution of Sanctions of the Republic of Macedonia, Official Gazette of the Republic of Macedonia, No. 2/2006, 57/2010, 170/2013, 43/2014, 166/2014, 33/2015 and 98/2015.

9. Lehtmets Andres, Pont Jörg. 2014. *Prison health care and medical ethics: A manual for health-care workers and other prison staff with responsibility for prisoners' well-being*. Council of Europe, November 2014.

10. Moller Lars, Stöver Heino, Jürgens Ralf, Gatherer Alex and Nikogosian Haik, 2007. *Health in prisons: A WHO guide to the essentials in prison health.* World Health Organization 2007.

11. Penal Reform International. 2016. Short guide to the revised United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules). www.penalreform.org. (Accessed: 5.2.2017).

12. Restellini Jean-Pierre, Restellini Romeo. *Prison-specific ethical and clinical problems* in Prison and Health. World Health Organization (http://www.euro.who.int/__data/assets/pdf_file/0009/249192/Prisons-and-Health,-3-Prison-specific - ethical-and-clinical-problems.pdf) (Accessed: 25.9.2018).

13. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) Resolution adopted by the General Assembly on 17 December 2015 [*on the report of the Third Committee (A/70/490)*]. (Accessed: 5.2.2018).

14. United Nations. 1990. Basic Principles for the Treatment of Prisoners, Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990.

15. Wolff Hans, Casillasa Alejandra, Riedera Jean-Pierre, Gétaza Laurent. 2012. *Health care in custody: Ethical fundamentals*. Bioethica Forum / 2012 / Volume 5 / No. 4. (http://www.bioethica-forum.ch/docs/12_4/06_Wolff.pdf). (Accessed: 25.9.2018).