Treatment and detention regime of detainees suffering from tuberculosis
May 2019

This paper provides some guidance regarding the detention regime and treatment of persons deprived of liberty and suffering from tuberculosis. It was prepared following a request for assistance by the Seimas Ombudsman (which is also the National Preventive Mechanism under the Option Protocol to the Convention against Torture) of Lithuania on this subject matter, dated 15 February 2019.

The paper briefly outlines the situation presented by the Seimas Ombudsman, listing the main issues at stake. It then provides basic information on tuberculosis (TB) to inform the subsequent analysis on existing rules, principles, recommendations and jurisprudence on the matter.

I. Situation overview

The Lithuanian Ombudsman received a complaint, whereby the applicants reported that during their treatment at Lithuanian Prison Hospital for pulmonary-positive (Open) TB, they had not been enrolled in any rehabilitation programs, had not been able to attend any social activities, had not been offered religious services, and had not been allowed direct (close) contacts with their relatives. Some have been kept indoors to be treated for pulmonary TB for approximatively two years.

The Ombudsman concretely asked the APT the following questions:

a) Is the prohibition for prisoners to have direct contacts with relatives or private contacts with partners justified?
b) Is the prohibition to attend social activities and participate in social rehabilitation programs proportional and justified?
c) Is the complete isolation of detainees infected with pulmonary-positive (Open) TB justified?
d) What technical, medical, organisational (or other) measures can be put in place to allow individuals with TB to participate in social programmes, activities, meet and have close contacts with their relatives?

Additionally, the question of precautionary measures that members of monitoring teams should take when conducting visits to facilities housing persons suffering from tuberculosis will also be addressed in this paper.

Two paramount responsibilities shall inform and guide any detaining authority handling similar situation: they shall (1) uphold the rights and protect the dignity of prisoners suffering from tuberculosis, and (2) protect the overall detained population, as well as the population at large, from contamination. While some restrictions to the detention regime can be justified to prevent contamination, a balance must be struck, and neither of these two objectives should be compromised.

II. Some basic facts on TB

> *TB is a treatable and curable disease. Active, drug-susceptible TB disease is treated with a standard six-month course of four drugs that are provided with information, supervision and support to the patient by a health worker or trained volunteer. Without such support, treatment adherence can be difficult and the disease can spread. The vast majority of TB cases can be cured when medicines are provided and taken properly. […]*
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> *Multidrug-resistant tuberculosis (MDR-TB) is a form of TB caused by bacteria that do not respond to the two most powerful, first-line anti-TB drugs. MDR-TB is treatable and curable by using second-line drugs. However, second-line treatment options are limited and require extensive chemotherapy (up to two years of treatment) with medicines that are expensive and toxic.*
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> *In some cases, more severe drug resistance can develop. Extensively drug-resistant TB (XDR-TB) is a more serious form of MDR-TB caused by bacteria that do not respond to the most effective second-line anti-TB drugs, often leaving patients without any further treatment options.*
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> World Health Organisation[1]

In 2012, Lithuania had the second highest rate of TB in the European Union (59.2 per 100 000 inhabitants). The World Health Organization (WHO) placed Lithuania among the high TB burden countries in 2007 and since 2008 among high MDR-TB burden countries.[2]

Persons deprived of liberty find themselves at a much higher risk to contract tuberculosis. In the European Region, the WHO reports numbers 30 times higher among prisoners than among

[1] World Health Organisation (WHO), Tuberculosis Factsheet, accessible at: https://www.who.int/en/news-room/fact-sheets/detail/tuberculosis

[2] Greta Musteikienėa et al., Multidrug-resistant tuberculosis in Lithuania – Still a long way ahead, Medicina, Vol. 52, Issue 2, 2016, 69-78, p. 70.

the general population.[3] While TB is a preventable and most often curable disease, in prison TB threatens the health and life of many detainees because of discrimination in access and quality of care.[4] Similarly, treatment success rates are 20 percentage points lower in prison than in the general population.[5]

III. General principles applicable to this situation

While not specifically elaborated in the context of health-related isolation/confinement, there exist a number of general principles on the treatment of detainees, which provide useful guidance. These principles represent the baseline against which the treatment and detention regime of persons deprived of their liberty should be analysed.

Life in prison must approximate the positive aspects of life in the community, as closely as possible.[6] The objective of detention must be to facilitate the reintegration into society.[7] States must respect the dignity of persons deprived of their liberty under the same conditions as for that of free persons. As such, no person deprived of their liberty should be subjected to "hardship or constraint other than that resulting from the deprivation of liberty",[8] and all prisoners should be accommodated in conditions with the "least restrictive security arrangements compatible with the risk of their escaping or harming themselves or others".[9]

Also relevant to the subject matter, is the fundamental right to the highest attainable standard of health, without discrimination. In fact, the Committee on Economic Social and Cultural Rights has stated that States are under the obligation to refrain from "denying or limiting equal access for all persons, including prisoners or detainees [...] to preventive, curative and palliative health services".[10]

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[3] WHO, 'Good Practices in the Prevention and Care of Tuberculosis and Drug-Resistant Tuberculosis in Correctional Facilities', 2018, p. 3.
[4] WHO Europe, Preventing the spread of tuberculosis in prisons – sharing lessons from Azerbaijan, published on 17.07.2018. accessible at: http://www.euro.who.int/en/countries/azerbaijan/news/news/2018/7/preventing-the-spread-of-tuberculosis-in-prisons-sharing-lessons-from-azerbaijan
[5] WHO, 'Good Practices in the Prevention and Care of Tuberculosis and Drug-Resistant Tuberculosis in Correctional Facilities', 2018, p. 3.
[6] Council of Europe, European Prison Rules, June 2006, accessible at: https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae, Rule 5.
[7] *Ibid*, Rule 6.
[8] CCPR General Comment 21, on Art. 10 Human Treatment of Persons Deprived of Their Liberty, §3.
[9] European Prison Rules, Rule 18.10.
[10] See CESR General Comment 14 (2000) on Art. 12 on the right to the highest attainable standard of health, para. 34; For more on the right to health in the context of confinement and deprivation of

IV. Specific issues

Following these general principles, the following sections look into the specific issues raised by the Seimas Ombudsman, outlining standards and practice, and providing some basic guidance.

a. Isolation and restrictions to the detention regime

Restrictions to the detention regime should follow the principles of Proportionality, Lawfulness, Accountability, Necessity, and Non-discrimination (PLANN).[11] Any form of involuntary segregation or separation from the general population should always be subject to authorisation by law or by the competent administrative authority.[12] No such separation or segregation should lead to automatic withdrawal of rights to visit, or of access to resources and activities normally available to persons deprived of their liberty.[13]

The prolonged isolation of patients for lengthy treatment of drug-resistant tuberculosis has shown to create feelings of anger, fear, self-blame, depression and suicide.[14] Such feelings are already associated with prolonged incarceration, and thus amplified by such isolation regimes. In the prison context, the segregation of contagious tuberculosis patients should therefore be kept to a minimum. When the clinical evolution is satisfactory, segregation is not necessary beyond the first 3-4 weeks of treatment.[15]

b. Direct Contact with relatives and private contact with partners

In situations of deprivation of liberty, the right to private and family life can be subject to certain restrictions. However, as stated by the European Court of Human Rights, "it is an essential part of a prisoner's right to respect for family life that the prison authorities assist him in maintaining contact with his close family".[16] Detention regimes should seek to

liberty, see report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/38/36 (2018).

[11] CPT, 21st General Report (2011), §55; See also European Prison Rules, Rule 3, and Mandela Rules, Rule 37.

[12] Mandela Rules, Rule 37.

[13] CPT, 21st Report (2011), §55(d); See also Sharon Shalev, A sourcebook on Solitary Confinement, Mannheim Centre for Criminology LSE, October 2008, pp. 44-46.

[14] A/HRC/38/36, §91 (cited above, see footnote 7)

[15] Hernan Reyes (ICRC), 'Pitfalls of TB management in prisons, revisited', International Journal of Prisoner Health, 2007; 3(1): 43-67, p. 50.

[16] ECtHR, Messina v. Italy (no. 2) Application no. 25498/94, Judgment 28 September 2000, §61; See also Kurkowski v. Poland (Application no. 36228/06), Judgment 9 April 2013, §95; See also European

compensate the desocialising effects of long-term imprisonment in a proactive and positive manner, including by facilitating family contact.[17] More specifically, the European Committee for the Prevention of Torture (CPT) states that prison health care services should support "measures that foster prisoners' contacts with the outside world, such as properly equipped visiting areas, family or spouse/partner visits under appropriate conditions".[18] While precautionary measures must be put in place, the TB status of detainees does not exempt the detaining authorities and prison health care services from their responsibilities to foster contact with the outside world and create the conditions for adequate family visits to occur.

The detaining authorities should make arrangements to facilitate contact between infected patients and family members, while protecting the latter from contagion. Such arrangements can range from precautions such as personal masks (both for patients and visitors), to visits without physical contact (including behind glass).[19] Ventilation technologies, set up of visiting rooms for adequate airflow and air change, and UV germicidal irradiation are examples of measures to reduce the risk of TB contamination. For example, the CPT noted in its 2002 report on a visit to Azerbaijan, that in a specialised establishment for prisoners suffering from TB, "visits by relatives were allowed in accordance with the type of regime to which the prisoner was sentenced, and prisoners in the terminal phase could receive unlimited visits".[20] Though a medical opinion should be sought when adapting the visiting modalities for prisoners suffering from TB, it seems reasonable to ask that arrangement to prevent contamination do not compromise the right of prisoners to maintain meaningful family contact. To complement these arrangements, detaining authorities can also make use of effective virtual communication (video calls for example).[21]

On various occasions, the CPT has made recommendations regarding the treatment and right to receive visits of terminally ill detainees. Such recommendations include encouraging detaining authorities to consider accommodating terminally ill patients in single rooms

Prison Rules, Rule 24, which speaks of the prison authorities' duty to make the necessary arrangements for such visits and contact.

[17] CPT, 11th General Report (2001), §33; See also Khoroshenko v. Russia [GC] (Application no. 41418/04), Judgment 30 June 2015, § 67, 144.

[18] CPT, 3rd General Report (1993), §63.

[19] Hernan Reyes (ICRC), 'Pitfalls of TB management in prisons, revisited', International Journal of Prisoner Health, 2007; 3(1): 43-67, p. 50.

[20] CPT, Report of Country visit, Azerbaijan: Visit 2002 CPT/Inf (2004) 36, Section: 33/53, §120.

[21] Detaining authorities should neither consider virtual communication systems to be the default option, nor the only available mode of communication for detainees suffering from TB.

allowing for regular visits from close relatives, and in some cases, 'compassionate release'.[22] The CPT passed on these recommendations specifically for prisoners in the terminal stages of TB in the Ukrainian context.

c. Activities and social rehabilitation

In detention, persons deprived of their liberty should benefit from a balanced programme of educational, vocational, professional, recreational, and physical activities.[23] Persons deprived of their liberty must be allowed at a minimum one hour of exercise in the open air (if the weather permits).[24]

Through its visit reports, the CPT has developed further guidance (including in the Lithuanian context). The CPT considers a satisfactory programme of activities to be of crucial importance for the well-being of persons deprived of their liberty.[25] Therefore, it considers "unacceptable for prisoners simply to be left languishing in their cells for weeks, months, or even years" [26] This statement also applies to the prison hospital context. In its 2004 visit to the Prison Hospital of Lithuania, the CPT recommended that the detaining authorities offer a wider range of activities to patients (particularly those staying for prolonged periods). Already at the time, the CPT considered the access to activities insufficient for the prisoners in the Prison Hospital.[27]

The observations of the CPT in other contexts provide some examples of other detention regimes for persons deprived of their liberty and suffering from tuberculosis. In a 2005 visit to Ukraine, the CPT went to a 'colony' for prisoners suffering from tuberculosis. There it found that all prisoners were allowed two hours of open-air exercise a day and recommended measures to ensure that all patients can *de facto* enjoy this right. In this same establishment, the detaining authorities "provided paid work for up to thirty prisoners at a work-rate scaled back in line with medical advice",[28] but did not offer a satisfactory variety of activities. Here the CPT expressed the need for a wide offer of activities, and reaffirmed the need to provide *all* detainees with access to open-air exercise. In 2002, the CPT visited a specialised medical establishment for prisoners suffering from tuberculosis, in Azerbaijan. In that establishment a group of MDR-TB patients had no contact with the rest of the prison population but could

[22] See CPT, Report of Country visit, Latvia: Visit 1999 CPT/Inf (2001) 27, Section 52/76, §§168-9; CPT, Report of Country visit, Ukraine: Visit 2005 CPT/Inf (2007) 22, Section 29/35, §§ 136-7; CPT, Report of Country visit, Ukraine: Visit 2012 CPT/Inf (2013), Section 17/20, § 61.
[23] European Prison Rules Rules 25 – 28; Mandela Rules, Rule 23, 42.
[24] European Prison Rules, Rule 27.1; Mandela Rules, Rule 23.1.
[25] CPT, Report of Country visit, Lithuania: Visit 2000 CPT/Inf (2001) 22, Section: 28/51, §72.
[26] *Ibid.*
[27] CPT, Report of Country visit, Lithuania: Visit 2004 CPT/Inf (2006) 9, Section: 26/45, §82.
[28] CPT, Report of Country visit, Ukraine: Visit 2005 CPT/Inf (2007) 22, Section: 29/35, §131

move freely in the prison and the yard, and had access to the same regime and activities as other detainees.[29] This was considered an acceptable detention regime by the monitoring body. Such accommodations by the detaining authorities constitute positive examples of balancing the rights of detainees suffering from TB to have access to activities and social rehabilitation with the public health considerations. It is worth noting here that while detention regimes or conditions were not ideal, these are examples of detaining authorities in States with limited resources, in the early 2000s, making efforts to strike an acceptable balance between public health precautions and the rights and well-being of the detained population.

d. Right to manifest one's religion and to be offered religious services

Persons deprived of their liberty should enjoy their right to manifest their religion (or belief) to the fullest extent compatible with the specific constraint.[30] The Nelson Mandela Rules further stipulate that access to a qualified representative of any religion shall not be refused to any prisoner[31]". Detention regimes so as far as practicable, should make arrangements to allow prisoners to practice their religion, including by attending services or meetings led by approved representatives, or to ensure that chaplains hold dedicated religious services, for example directly at the prison hospital.[32]The same balancing logic should be adopted with this particular issue. In this case, it does not appear that preventing contagion can justify denying prisoners the right to participate in dedicated religious services or benefit from the services of a religious representative, when accommodations can be made.

V. Specific considerations and precautionary measures regarding monitoring visits[33]

Monitoring bodies, in particular those operating in countries/regions with high prevalence of TB, should duly consider precautionary measures before embarking on visits to places of deprivation of liberty. It is essential that monitoring bodies seek the advice and expertise of medical health professionals specialised in infection diseases, when planning visits to places where persons suffering from TB are being treated. Monitoring bodies should also be aware that persons suffering from tuberculosis may not be necessarily confined to dedicated places. It is also worth mentioning that monitoring bodies may come in contact with persons suffering with TB who have yet to be diagnosed and treated.

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[29] CPT, Report of Country visit, Azerbaijan: Visit 2002 CPT/Inf (2004) 36, Section: 33/53, §120.
[30] CCPR, General Comment 22, on Art. 18 freedom of thought, conscience and religion, §8.
[31] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Rule 65.3.
[32] European Prison Rules, Rule 29.2.
[33] This section was in part informed by a conversation with a staff member of the CPT Secretariat.

The involvement of medical professionals seems essential to ensure both the adequate monitoring of such places of detention[34], and the health and safety of the members of the visiting team. A medical doctor would be best positioned to ask the adequate questions – including on treatment and medical practices – and to formulate recommendations. In some circumstances, it may be best for medical doctors within the NPM to conduct individual interviews with detainees suffering from the most resistant forms of TB.

The risk of TB infection can be reduced by a conjunction of administrative, environmental, and respiratory protection controls.[35] Here are some precautionary measures monitoring bodies can take, or ensure the detaining authorities have taken when preparing and conducting visits (this is of course not an exhaustive list):

When conducting visits to places where persons infected by TB are detained, monitoring bodies should:[36]

- Include a healthcare specialist in the visiting team and ensure everyone has received the same briefing ahead of the visit
- Advise patients to wear surgical masks, and carers/visitors to wear adequate and well-fitted respirators (i.e. more protective face masks), *if appropriate*.[37]
- Maintain some distance between the visitor and the detainee being interviewed, and favour individual interviews over group interviews.

Some precautionary measures outlined above carry the risks of affecting the *rapport* between the monitor and the detainee. For example, detainees may perceive wearing a respirator as

[34] APT, Visiting places of detention. What role for physicians and other health professionals, 2008, p. 13.

[35] Center for Disease Control and Prevention, 'Core Curriculum on Tuberculosis: What the Clinician Should Know', 2013 (6th ed.), p. 214.

[36] Monitoring bodies should also check whether detaining authorities have enacted measures to prevent contagion. Precautionary measures to mitigate contagion in a detaining facility include: ensuring early and effective screening, including in police stations; disseminating information on respiratory hygiene and cough etiquette; ensuring appropriate ventilation technologies are in place; ensuring UV germicidal irradiation are in place; ensuring adequate airflow and air change by rearranging furniture and opening windows. For reference, see CPT, Report of Country visit, Moldova: Visit 2015 CPT/Inf (2016) 16,Section: 22/41, §119-120.

[37] See also Dharmadhikari et. al. 'Surgical Face Masks Worn by Patients with Multidrug-Resistant Tuberculosis - Impact on Infectivity of Air on a Hospital Ward', in Am J Respir Crit Care Med. 2012 May 15; 185(10): 1104–1109. Published online 2012 May 15. doi: 10.1164/rccm.201107-1190OC, accessible at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359891/; and TB facts, TB prevention, precaution, vaccine, masks, accessible at: https://www.tbfacts.org/tb-prevention/.

being dismissive or disrespectful. As such, it should be up to the monitoring body to decide what measure to prioritise to both ensure the safety of its members and ensure a positive relationship with the detainees interviewed. Further, monitoring bodies should be under close medical attention and undergo regular medical examinations. Members of monitoring bodies with immunodeficiency should take particular precautions, including if deemed necessary exclude themselves from such visits. Finally, the participation to monitoring visits of facilities for TB patients should be on voluntary bases for the members of monitoring bodies.

VI. Conclusions

The established principles and rules on the treatment of persons deprived of their liberty set a general framework, which must guide States when implementing policies affecting such populations. While it is undeniable, that tuberculosis in a detention context poses serious public health threats for the prison community and beyond, restrictions to the detention regime of tuberculosis patients must be legitimate and proportionate to the objective for which they are enacted. As shown by the findings of the CPT, detaining authorities have been able to better balance their duty to protect others from contagion, with the rights of detainees suffering from tuberculosis.