THE IMPACT OF IMPRISONMENT ON THE HEALTH RIGHTS OF FEMALE INMATES. A COMPARATIVE STUDY. A CASE STUDY OF SOROTI PRISON – UGANDA

SUBMITTED
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APPROVAL BY SUPERVISOR

I certify that I have supervised and read this Study and that in my opinion; it conforms to acceptable standards of scholarly presentation and is fully adequate in scope and quality as a Dissertation in partial fulfillment for the Award of Degree of Bachelor of Laws of Kampala International University.

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ABSTRACT

KEY WORDS; Prisoner Health Rights, Health Care Service Provision, Nutrition, Activity, Hygiene and Sanitation.

BACKGROUND: Female inmates tend to suffer poor health on a range of indicators. This Study sought to explore Female and Male Inmates' perceptions of the Impact of Imprisonment on their Health Rights and Well-being.

METHOD: This Qualitative Study involved both adult Female (20) and male inmates (10) who were either Remands or Convicts at Soroti Prison in Eastern Uganda. Participant Observation, Individual, and Focus Group Interviews were conducted.

RESULTS: Both female and male inmates reported that imprisonment mainly the manner of health care service provision, poor nutrition, sharing of basins, urinary, and shaving equipments in prison impacted negatively upon their health. Inadequate and improper medical care, poor nutrition, hard manual labour, separation from families (in particular biological children), cruelty of prison staff, enforced living with other inmates living with HIV/AIDS that puts them at risk of contracting TB, and lack of physical exercise affected their own health. Both the female and male inmates complained of under dosage and being forced to dig and do other manual work while sick. Female inmates reported that the use of worn out pieces of their prison uniform during menstrual cycle made them vulnerable to Candida, lack of privacy and the loss of their role as mother are additional 'pains' suffered by them. Male inmates on the other hand, described responses to imprisonment that were also health negating as sleeping bed-bed on the floor, using one blanket to lay as well as for covering, sleeping without mosquito

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CHAPTER ONE:

THE NEED TO STUDY THE IMPACT OF IMPRISONMENT ON THE HEALTH RIGHTS OF FEMALE INMATES.

1.0. INTRODUCTION

Little research has been conducted to understand the Impact of Imprisonment on the Health Rights of Female Inmates. More research is needed to find out the impact of Imprisonment on the Health Rights and well-being of Female Inmates in general. The purpose of this study is to explore, investigate and analyse the Impact of Imprisonment on the Health Rights and well-being of Female Inmates. This research studies both adult female and male Inmates.

1.1. BACKGROUND TO THE STUDY

The Impact of Imprisonment on women's health is mixed but is largely perceived to be negative. Despite policy initiatives to introduce health promotion in prisons, there is little evidence of the extent to which it has been effective.

The current policy climate in Uganda makes it especially timely to examine the reported experience of female inmates themselves about the Impact of Imprisonment on their health rights.

The fact that prisoners have higher rates of psychological distress and mental health problems when compared to the general population are well established (Fazel & Danesh, 2000). Needless to say, the rates are much higher in the case of women in custody.

According to the fact sheet of Amnesty International of Women in Prison, women are denied essential medical resources and treatments, especially during pregnancy. There are studies which have reported high prevalence of Syphilis among women prisoners as compared to general population. HIV infection is also high (M.C.De Azearaga Urteaga et al., 2010). Women prisoners suffer menstrual disorders, stress, and depression.

A round the developed world, a growing and changing prison population has given rise to renewed interest in the effects of imprisonment on the health of inmates. This is a population with many complex and often co-morbid health needs and the difficulty in separating and determining causal links has led many to conclude that health needs are 'imported' by inmates rather than being a product of their experience of incarceration. The truth is almost certainly a combination. Prisoners comprise a number of more vulnerable population groups such as young people, older people, people with intellectual or physical impairments and women. Each group has particular health vulnerabilities and needs that must be met within an institutional environment designed, by and large, for adult men.

Although prison is sometimes a setting for health improvement, the environment is in many ways a severe risk to the prisoner. Suicide and self-harm can be more likely among inmates. mental health problems and addictions are prevalent and often co-morbid in prisons. Prisoners are at far greater risk of death immediately after release supporting the view that the health of prisoners must be treated within a broader context.

Communicable diseases and the behaviours that spread them are commonly developed within the prison environment. The conditions of prison can exacerbate deterioration in older prisoners and

economically disadvantaged and 'powerless' of society. The majority of the inmates in any country, including Uganda, are those who come from a context already shaped by social exclusion.

Among other things, they are likely to be members of an ethnic minority, have limited education and a history of instability, unemployment or underemployment, substandard diet and housing conditions and inferior medical access (Smith & Robinson, 2006). Their health reflects this disadvantage and like them tends to be poor (Marshall et al., 2000).

Loucks (2005) argues "women in prison are already an extremely vulnerable population, characterized by addiction, depression, anxiety, suicidal and self-harming behaviour, backgrounds of abuse and deprivation. Young (1996) notes that their health tends to reflect a lifetime of exclusion, marginalization and particularly oppression. She states that these all too frequently equates to limited access to health care and exposure to risks such as blood borne viruses or sexually transmitted infections (STIs).[1] Many of these factors have been found to be more prevalent among women prisoners than among men in prison.

Information on the state of prison health around the world is incomplete and largely inadequate. In 1993, Human Rights Watch (HRW) conducted a major review of prison conditions worldwide and found that the great majority of prisoners were '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'.

[1] Cited in Robert, Frigon & Belzile (2007).pg. 178; They also cite Stoller Shaw (1981), Smith (2000) & Ingram Fogel (1991).

- Levels of distress, anger, depression and frustration are high.

In the international literature, there is also a rekindled acknowledgement of the distinct social context that exists within the prisons and the role this plays in the health and well being of those who are forced to live there. The work of Sykes (1958) drew attention to the significance of the 'Prison Code'; the normative value that exists within prisons. He observed that "prisoners could display 'self centered and egoistical alienative modes' of behaviour that arose from being forced to conform to roles commensurate with prison regimes and having to fit in with prison social life (De Viggiani N, 2006).

Internationally, the ideas of inmate subculture include doing one's own time (i.e. keep your own emotions to yourself) and the belief that the line between prisoner and 'authority' must always be maintained. Contemporary Commentators, notably De Viggiani (2007), Ireland (2000, 2007), and Haney (2002), are revising the social aspects of incarceration and have pointed to a number of socio-environmental factors which influence health and well being. These include:

- The role of external social influences: e.g. support networks, the ability to retain 'street' roles and relationships
- The prison code, its enforcement and an individual's ability or strategy to conform or adopt to it, and
- Unequal power relationships and rigid hierarchies.

Sykes (1958) coined the phrase "pains of imprisonment" to describe the particular 'types' of suffering caused by incarceration and argues that they ultimately contribute to an erosion of self.

imprisonment can be conducive to the spread of disease with overcrowding, poor ventilation, risk behaviours and pre-existing vulnerabilities all contributing to potential transmission.

International literature on prison health effects focuses heavily on communicable diseases and highlights their link to prison practices such as tattooing, piercing, sexual behaviour and drug use. In Uganda, information is limited, but the findings of this study as reported by male inmates reveal sharing of shaving equipments and needles.

Other potential effects suggested by International literature include:

- A worsening of chronic conditions or other ailments due to lack of care or resources, poor or unsuitable environment, overcrowding, rigidity of prison rules, conflicts between prison practices and health needs, and distress
- Behavioural, psychological and developmental adaptations to prison life which do not translate well upon re-entry into the community and family (these include an inability or unwillingness to express emotion, hyper-vigilance, increased aggressiveness, gang
- membership, atrophied autonomy and distrust of authority (Aday, 1994 & Edwards, 1998)[3]
- Problems upon re-entry including stigma, limited housing and / or employment opportunities, increased debt, a breakdown in relationships and further social exclusion, and disintegration of one's sense of identity and roles in the family / community (Travis & Waul (eds), 2003).

[3] Cited in Smyer & Gragert (2006).

environment of inequality and disadvantage. Prisoners may therefore be more susceptible to preventable health problems and more likely to resort to drug miss-use, self-harm or disorderly conduct (Singleton et al.1997, Smith, 1998, Home Office, 2000). These importation factors are therefore highly significant in terms of explaining the health status of inmates and can help explain how broader health determinants impact on the prison population.

Ronal Braithwaite et al (2005) note that 'women's medical concerns related to reproductive health and the psychological mater surrounding the imprisonment of single female heads of households are often overlooked[4]'.

The serious health and social problems present a challenge to prison and local detention facilities that have been created, organised and managed for men, leaving the diverse needs of women forgotten and neglected (King's College London,2004; Nurman & Parrish,2002). The supreme court of the US in **Estelle V. Gamble**[5] mandated health care for prisoners, recognising indifference to their serious health problems as a violation of the Eighth Amendment of the US Constitution, prohibiting cruel and unusual punishments.

Historically the provision of health care in prisons and local detention facilities has been problematic, but the unprecedented number of imprisoned women worldwide has created a crisis. As noted by the Chairperson of Uganda Human Rights Commission (UHRC), while there is a remarkable improvement in the conditions of living in prisons and other places of detention, which are attributable to the efforts and god will of the government and the prison administration, as well as other interests and support, the living conditions of inmates remain far from good.

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[4] p.1679
[5] 1976

retains responsibility for good health of prisoners in order not to aggravate the afflictions that naturally come with imprisonment.

Health of inmates in a prison is a public health issue and it is the responsibility of the public authorities to provide for the health of detainees as they would to that of any citizen. They are also responsible for efficient and sufficient medical and nursing provisions and procedures.

Sanitation conditions in most prisons are tragic. In most cells there are a few basins, if at all, shared by all? The basins are used for everything. At night, they act as buckets for both long and short calls. During the day, they are used for bathing and cleaning the wards.

Principle 12 SMR says: "*the sanitary installations shall be adequate to enable every prisoner to comply with the needs of nature when necessary and in a clean and decent manner*[6]".

The Uganda Prison Service Policy Document provides for a health promotion strategy for prisons in Uganda based on a "healthy setting" approach. However, it is unclear what impact, if any, this has had on prisons and prisoners health. The Policy advocates holistic and integrated health and Criminal Justice solutions for women at risk of offending, to reduce levels of imprisonment, and women Centered Custodial regimes for those who need to be detained. However, the Uganda Government and the Uganda Prison Service has been criticised for delays in implementing the recommendations. Moreover, there is some ambiguity about what effect imprisonment has on health.

[6] Prisons Update Vol.8 Issue.1. January – June 2002; A Newsletter on the Police And Reform Project of the FHRI

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 with the implementation practice through reporting procedures and before judicial and quasi-judicial bodies (Toebes, 1996b),p.665). Enhancing the mechanisms to enforce state compliance with health rights obligations is therefore the central challenge, one made more difficult by the negative public attitude towards prisoners worldwide.

The health rights of inmates are therefore rarely a priority for political leaders or the general public. Complicating this situation is the fact that "none of the relevant International or Regional Conventions define humane or inhumane treatment (Bernard, 1994,pp. 759, 787). As a result, the generalised language used in the International Treaties allows for significant discretion in interpreting standards of humane treatment of inmates, such as the provision of medical care, nutrition, activity, hygiene and sanitation.

Although specific entitlements, including health guidelines, are codified in numerous International resolutions and model Standards, they are rather non-binding "soft law" instruments. Ultimately, these are aspirational, rather than prescriptive standards and guidelines.

They articulate neither legally binding norms, nor particularly ambiguous or high standards for states to achieve. On this basis, the health status of inmates is a measure to assess the degree to which the rights of persons in prison are fulfilled or denied in a much broader sense.

These characteristics perhaps fuel my desire to take a critical look at the Impact of Imprisonment on the Health Rights and well-being of Female Inmates.

1.4. RESEARCH QUESTIONS

1. How has Imprisonment in general affected your health rights and general well-being?

2. How has the general medical care provision in prison affected your health rights and well-being?

3. How do you think the nutrition in prison has impacted on your health rights and well-being?

4. How has the general hygiene and sanitation in prison affected your health rights and well-being?

1.5. RESEARCH MEASURES

The Researcher obtained information containing demographic information for the Research participants.

Interview measures consisted of participants' responses to open ended questions or prompts addressing risk factors for imprisonment (health and well-being).

Individual interviews lasted approximately 2 hours- 21/2 hours each.

Interview transcript were analysed through systematic reading, re-reading, sifting and coding data into categories, themes and sub themes.

1.6. IMPLICATION OF THE STUDY FOR THE PRACTICE AND POLICY.

It is important to better understand female inmates as the number of women incarceration continues to increase. Women comprise a small percentage of the national prison population and are often ignored in correction research.

Legislators and Justice Policymakers: the Research has implications for refinement of state laws concerning women.

Findings of this study are useful to the individuals who have power and authority to allocate funding for gender specific programming for girls and women.

Prevention and Education Programmers: information on context and impact of imprisonment can be applied for both professional and members of the lay public. In this way, those who come into contact with the victims (children, youth, and families) would have the requisite knowledge to build support, recognise dangers, and help link the girls and women to valuable resources as needed across the life span.

1.7. LIMITATIONS OF THE STUDY

One of the limitations of this Study was the paucity of Research or Literature available on the Topic of the Impact of Imprisonment on the Health Rights of Female inmates, in Uganda and Africa as a whole.

A small Sample Size inhibited the Researcher's ability to generalise to the large population of female inmates in Regional Jails across the country.

The location of the prison, being that it was a small Women's Unit which received autonomy two years ago and only accommodates female inmates on Remand and those convicted for a period of less than five years.

Non-response by some of the selected Participants affected the quantity and quality of data that was obtained. The reasons for non-response included ill health or deliberate refusal of the participant to participate due to trauma or other prison related distresses.

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 (ESCR Art. 12 (1)), under which the right is Universal and non- discriminatory in application (ESCR Art. 22). It also finds expression within Civil and Political Rights (CPR) mechanisms. The UN Human Rights Committee (HRC), the independent expert body which monitors state compliance with the obligations under the ICCPR, 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 to life (Art.6) or the right to humane treatment (Art.10)[7]. Indeed both the right to life[8] and the right to humane treatment[9] impose positive obligations upon countries that have ratified the treaty to protect the lives and / or well-being of person in custody, which has often been interpreted to require government authorities to take action to safeguard the health of prisoners.

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, and political belief, economic or social condition[10]. 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[11].

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[7] Cabal & Pasini V Australia (7 August 2003) UN Doc CCPR/C/78/D/1020/2002)para 7.7
[8] HRC 'General Comment No. 6' (Note 4) para 5
[9] HRC 'General Comment 21' (Note 4) para 3
[10] WHO Constitution (N 48) Preamble
[11] Foe example, WHO (1993); WHO Europe (Note 14), P.1; Bone Op. Cit

attention when they are sick"[16]. 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.

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 fulfill 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"[17]. In **Free Legal Assistance Group & 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 adequate medical treatment[18]. In **International PEN & 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"[19]. In the most recent of the African Commission cases, **Malawi African Association & Others V Mauritania**, a violation of the

[16] African Women Protocol (Note 63) Art.14
[17] International PEN & Others V Nigerai (1998) African Commission on Human & Peoples Rights Comm Nos.137/94, 139/94, 154/86, 161/97 para 112
[18] (1996) African Commission on Human & People' Rights Comm Nos. 25/89, 47/90, 56/91, 100/93 para 47
[19] (Note 117) para 122.

state responsibilities under the Covenant include "the provision of adequate medical care during detention[24]. It has specified that state obligations to provide medical care to prisoners "extends to persons under the death sentence[25]". 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-trail detention, must also 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[26].

The right to medical care in prisons is guaranteed under the right to life. According to the UN HRC, "State Party by arresting and detaining individuals takes the responsibility t care for their health[27]". Because "the State Party remains responsible for the life and well-being of its detainees[28]", it is therefore "incumbent on states to ensure the right of life of detainees, and not incumbent on the latter to request protection[29]. This therefore demands the provision of adequate and pro-active medical care.

The HRC has considered several individual complaints addressing medical care under the right to life. For example 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. It was claimed that the prisoner "received medical care only during the last few minutes of his life" and "that the prison

[24] Pinto V Trinida & Tobago (Communication No. 232/9187) Report of the HRC Vol.2 UN DocA/45/40 p.69 para 12.7
[25] Ibid (Note 126) para12.7
[26] For example, HRC 'Concluding Observations: Portugal' (2003) UN Doc A/58/40 Vol 156 para 83 (1)
[27] Lantsova V Russian Federation (26 March 2002) UN Doc CCPR/74/763/1997 para 9.2.
[28] Fabrikant V Canada (6 November 2003) UN Doc CCPR/C/79/D/970/2001) para 9.3.
[29] Barbato V Uruguay (27 November 1982) UN Doc CCPR/C/OP/2 para 10 (a)

A further element decisive for the assessment of 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[34].

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.

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 HRC includes cases where authorities have been obligated to provide ophthalmologic and dental treatment[35], dermatology[36] and treatment for allergies and asthma[37]. This obligation also includes provision of medicines[38], including medications to relieve pain[39].

The UN HRC has made clear that it views issues such as overcrowding and poor sanitation within a health context. The Special Rapporteur on Torture has also addressed the impact of poor environmental conditions, noting that "overcrowding, inadequate sanitation and hygiene, lack of

[34] Application NO.4353/03 (Judgment of 14 December 2006) para 87
[35] Pinto V Trinidad & Tobago (Note 126) para 12.7
[36] Lewis V Jamaica (18 July 1996) UN Doc CCPR/C/57/D/527/1993 para 10.4; "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".
[37] Whyte V Jamaica (27 July 1998) UN Doc CCPR/C/63/D/732/1997 para 9.4.
[38] EN & Others V The Government of the RSA & Others (Note 124) para 31, 35
[39] Leslie V Jamaica (31 July 1998) UN Doc CCPR/C/63/D/564/1993 para 3.2

such as following a beatings or torture, or when he or she is ill or injured. The failure to provide medical attention in this context, which unnecessarily exacerbated the pain and suffering of the prisoner, may quickly lead to treatment deemed inhuman or degrading. In **McGlinchy & Others V UK**, 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[46].

The European Court has also found that, where a prisoner has a serious medical condition, timely medical care can include regular access to specialized diagnostic care. In the case of **Popou 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 Gystoscopy at least once a year"[47]. The Special Rapporteur on Violence Against Women has specifically recommended "timely referrals and easy access to gynecologists" for incarcerated women[48].

Prison Health Standards and Declaration of WHO and the World Medical Association[49] state that prisoners must be provided with measures to prevent the transmission of disease. The right to preventive health measures is also engaged under CPR mechanisms. The UN HRC jurisprudence indicates that the failure to take steps to prevent the spread of diseases in prisons, such as TB, may violate Articles 6, 7, 9 and 10 of the CCPR[50]. However, not all domestic courts have been proactive in enforcing the right to preventive health. The European Court has also indicated that

[46] (2003) 37 EHRR
[47] Application No. 26853/04 (Judgment of 13 July 2006) para 211
[48] Commission on HR (Note 31) para 218
[49] World Medical Association 'Declaration of Edinburg on Prison Conditions & the Spread of TB & Other Communicable Diseases' (Adopted October 2000)
[50] HRC (Note 144) para 84 (9)

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. 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"[57]. This includes not only medical and drug treatments, but also undergoing medical testing, such as that for HIV infection[58]. The UN Special Rapporteurs in their joint report state that:

From the perspective of the right to health, informed consent to medical treatment is essential, as it 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"[59].

2.2. THE RIGHT TO FOOD AND WATER (NUTRITION)

The failure to provide detainees with reasonable quality food or water in sufficient quantity has an obvious negative impact on health. The SMR 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"[60]. In **Malawi African Association & Others V Mauritania**, the African Commission on HR found a violation of the

[57] WHO (Note 51) Prin 36
[58] Ibid, Prin 11
[59] Commission on HR (Note 275) para 23
[60] SMR (Note 92) Rule 20

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[64].

The failure of the state to provide proper toilet or washing facilities, or clean living conditions, cannot only negatively affect the health of detainees, but potentially breach International Law. In

Malawi African Association & Others V Mauritania, a violation of Article 16 was found, in part, due to inadequate hygiene in the prison[65]. The UN Special Rapporteur on Health expressed concern about unhygienic living conditions that contributed to the death of 12 prisoners and hospitalization 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 other causes of the poor health conditions[66]. "Dirty"[67] or "airless and dirty"[68] cells or forcing detainees to live "in very bad conditions of hygiene"[69], have been condemned by the African Commission on HR in Article 5 petitions.

The failure to provide proper sanitary toilet facilities is another prison condition that has been found to contribute to unhygienic conditions, and treatment deemed cruel, inhuman or degrading.

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[64] Committee on ESCR (Note 5) para 11
[65] Note 117) para 122
[66] Commission on HR (177) para 45
[67] Constitutional Rights Project & Civil Liberties Organisation V Nigeria (Note 158) para 5
[68] International PEN & Others V Nigeria (Note 117) para 80
[69] Malawi African Association & Others V Mauritania (Note 117) para 12

psychologically and socially stimulating treatment of the prisoners are also matters of health (Chirwa, 2002).

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 with the implementation practice through reporting procedures and before judicial and quasi-judicial bodies (Toebes (1996b) p.665)". Enhancing the mechanisms to enforce state compliance with human rights obligations is therefore the central challenge, one made more difficult by the negative public attitude towards prisoners worldwide.

The stigmatization 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 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 (Livingstone, 2000), pp. 309, 321).

2.4. HEALTH CARE SERVICE PROVISION (MEDICAL CARE)

The prison health care services in Uganda particularly upcountry prisons comprise Outpatients Primary Care Clinics which handle both adult and juvenile detainees. Prison health staffs in Uganda consist of nurses and Clinical Officers.

In its Ottawa Charter for Health Promotion (1986), the WHO argues that "health is created by caring of one self and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates the conditions that allow the attainment of health by all its members". Health here is defined in more holistic terms, extending beyond a purely medicalised conception to take into account the role social context plays in the wellbeing of an individual.

The Standard Minimum Rules (SMR) R.22 provides that specialist treatment needs should be met in either specialist prison facilities or civilian hospitals. Particularly important in relation to prison health care is access to suitable psychiatric care, including adequate supervision to prevent suicidal behaviour (**Keenan V UK (2001)**[72].

Primary Care Physicians and frontline workers (nurses) play a central role in prisons and share a direct responsibility to ensure that detainees can expert their right to health as they do for other patients outside the penitential setting (Roger Watson, Anne Simpson, Tony Hotstick, 2004) 119-28), although medical workers in general do not require them to assume the role of advocates on behalf of their patients. This is particularly true in closed and isolated environment of prisons, where human rights abuses occur with impunity and where health workers are sometimes the first witnesses of such violations. This said, health professionals are often unaware of the ethical and human rights framework in which their activity takes place. Moreover, they tend to underestimate the use of legal instruments and litigation as a way to enforce the right to life and health. Developing an understanding of the right to health does not necessarily entail adopting a different way of working. On the contrary, the right to health could

[72] Prison Law Reports 180, (2001)33 EHRR 914;

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. It identifies the need to strengthen health services[73], take action to prevent the spread of diseases[74], address mental health issues[75] and to improve nutrition, housing, sanitation, recreation and other aspects of environment hygiene[76]. This broad and universal concept of health is of a particular resonance in examining the issue of prisons, and ensuring that prisoners are entitled to adequate medical standards.

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 categories of cases that illustrate this point. The first are torture cases, in which deliberate violence has been inflicted by the state actors upon persons in detention. Findings of human rights violation 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.

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[77]. This is also true of much of the Inter-American Human Rights Case Law, where

[73] WHO Constitution (Note 48) Art.2 (c)
[74] Ibid Art.2 (g)
[75] Ibid Art.2 (m)
[76] Ibid Art. 2(i)
[77] For example, Constitutional Rights Project & Civil Liberties Organisation V Nigeria (199) African Commission on Human & Peoples Rights Comm Nos 143/95, 150/96 para 5

punishment, the state is obliged to provide medical care for people in prison[83]. Writing for the majority, Justice Thurgood Marshall affirmed:

The government has obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical need; if authorities fail to do so, those needs will not be met. In those 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[84].

The Special Rapporteur on Health has sent a number of individual communications to countries expressing concern over the failure to provide treatment for diabetes, "chronic asthma", kidney conditions, a "critical" heart condition, TB and dental problems[85].The Special Rapporteur on Violence Against Women has called for "timely referrals and easy access to gynecologists" for incarcerated women[86].

The state must also provide prisoners with access to specialized medical treatment out side of the prisons. In **Simpson V Jamaica**, a prisoner was "refused specialized treatment despite

[83] 429 US 97, 105 (1976) paras 26-27
[84] Ibid, para 11
[85] 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 & Replies Received from Governments & other Actors, December 2004 – December 2005' (22 Decemeber 2005) UN Doc E/CN-4/2006/48/ASS.1 Paras; 10-11; 26-27; 28, 43; 40;44
[86] Commission on Human Rights (Note) para 218

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 fulfill this role (Rodley, Op. Cit, p.14). 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. The question of prisoners' health rights is solely best with the realm of the domestic courts, and illustrates the need for vigorous international oversight and enforcement mechanisms to complement domestic Human Rights advocacy. The engagement of prisoner rights under CPR mechanisms creates an important opportunity for an enhanced role for the relevant treaty bodies in fulfilling the right to health of prisoners.

On the other hand, while providing access to health care to all detainees, health professionals working in prisons need to regulate health demands and avoid manipulation by both detainees (over use) and security staff (limiting access by the regulation of escorts for example). Moreover, all aspects of health care provision (prevention, diagnosis and treatment) need to be grounded in good medical evidence. This implies integrating evidence-based medicine and the concept of equivalent, rationalizing and taking into account the resources available.

Achieving health care continuity is another important objective of health professionals working in prison. It requires that a prisoner with a given health problem or disability achieves continuity of health care as he or she moves back to the community.

The WHO guidelines on HIV Infection and AIDS in Prisons (WHO, 1993) contain the following recommendations specific to women in prison:

CHAPTER THREE:

METHODOLOGY

3.0. INTRODUCTION

The focus of this Qualitative Research Study was to gather, investigate and analyse the female inmates' perceptions of the Impact of Imprisonment on their Health Rights and Well-being.

A Qualitative Design was utilized in order to obtain a greater understanding of the lives of female inmates. Bogdan and Biklen (1998) suggest that qualitative researchers seek to understand the meaning of their participants' lives. Merriam (2001) notes that qualitative researchers try to better understand human experiences and how the participants understand their world.

Henrique (1982) suggests that "perceptions help determine identification of the problem, attempt to remedy the problem and to determine the resources employed in the problem solution. Perceptions help to validate viewpoints" (p.33).

The Research combined three Qualitative Research Methods; Participant Observation, Focus Group Discussion and Individual (one-to-one), Semi-Structured Interviews with inmates, with the aim of generating theory through an inductive, 'organic' process.

An official permission to undertake the Study was obtained from the Commissioner General of Uganda Prisons Service.

confidentiality and anonymity, subject to the provisos that I would be required to report to prison authorities disclosures of intention to self –harm, harm another, to escape or if child protection concerns were raised.

This Methodology is helpful in striving to generate theories that, on the one hand, do not overstate or generate about perceptions and beliefs of inmates, yet, on the other hand, enable the researcher to be reasonably confident in interpreting and coding themes arising from the data.

Research participants were called by their fellow female or male inmate or warder to the visitors' reception where they were left alone with the researcher.

The researcher (author) was free to move about the wing and talk to or interview inmates undisturbed. The participants were generally more free, settled and chatted with the researcher.

The Researcher had a prior orientation visit to the prison in February 2011 where two meetings were held; one with In-Charge Women's Prison and another with the In-Charge Male Prison to learn about prison life.

An interaction was also held with few female inmates during the orientation visit.

Once trust, rapport and mutual respect had been established with inmates and prison staff, it was easier to access and interview inmates in the more formal sense, and their by try to elicit accurate and fair interpretations of their values and perceptions of prison and its impact on health rights. Using in-depth interviewing allowed the inmates the opportunity to express their own feelings, beliefs and experiences.

Miller and Glassner (1997) suggest that researchers cannot provide a minor reflection of the social world but they can provide access to the meanings people attribute to their experiences and social words.

The aim of the research was to identify female and male inmates own perceptions of the Impact of Imprisonment on their Health Rights and Well-being. Obtaining female and male inmates perspectives was important because it could result in a deeper conceptualization and understanding of their perception of the Impact of Imprisonment on their Health Rights and Well-being.

Subsequent data analysis was based on the transcribed Semi-Structured Interview Data.

Data Analysis was done through systematic reading, re-reading, and sifting, sorting and coding data into categories, themes and sub themes.

Six data categories emerged from this process, which related to the inmates bio-data, health, healthcare service, nutrition, activity, hygiene and sanitation in prison-which have major implications for inmate health rights.

4.1. SUMMARY OF FEMALE INMATES BIO DATA (DEMOGRAPHICS)

TABLE A. AGE RANGE

RANGE	NUMBER	PERCENTAGE
17 - 20	5	25%
21 - 35	8	40%
36 - 50	3	15 %
60 - 80	4	20 %
TOTAL	**20**	**100%**

TABLE B. LITERACY LEVEL

EDUCATION STATUS	NUMBER	PERCENTAGE
P1 – P4	6	30 %
P5 – P7	3	15 %
S1 – S3	2	10 %
S4 – S6	1	5 %
ZERO EDUCATION	8	40 %
TOTAL	**20**	**100 %**

TABLE C. MARITAL STATUS

RESPONSE	NUMBER	PERCENTAGE
Married	5	25 %
Widowed	5	25 %
Divorced / Separated	3	15 %
Single	7	35
TOTAL	**20**	**100 %**

TABLE H. LEGAL STATUS

RESPONSE	NUMBER	PERCENTAGE
Remands	12	60 %
Convicts	8	40 %
TOTAL	**20**	**100 %**

4.2. SUMMARY OF MALE INMATES DEMOGRAPHICS

TABLE I. AGE RANGE

RANGE	NUMBER	PERCENTAGE
17 - 20	2	20 %
21 - 35	7	70 %
36 - 50	1	10 %
60 - 80	0	0 %
TOTAL	**10**	**100%**

TABLE J. LITERACY LEVEL

EDUCATION STATUS	NUMBER	PERCENTAGE
P1 – P4	1	10 %
P5 – P7	2	20 %
S1 – S3	1	10 %
S4 – S6	4	40 %
TERTIARY	2	20 0 %
TOTAL	**10**	**100 %**

TABLE O. LEGAL STATUS

RESPONSE	NUMBER	PERCENTAGE
Remands	4	40 %
Convicts	6	60 %
TOTAL	**10**	**100 %**

From the above tables, 80 % of the female and 100 % of the male inmates were of reproductive and productive age. The majority of the females had lower literacy levels (they either knew to write or could not either write or read) compared to their male counterparts who had a fair literacy level (100 % of the male inmates could read, write and spoke English fairly). 65 % of the females and 40 % of the male inmates had ever been or were in a marital relationship. 80 % of the female and 50 % of the male inmates had biological children; 37 % of the female and 20 % of the male inmates had more than 5 biological children each. 20 % of the female inmates were pregnant (80 % of these were due to give birth in September while the 20 % was only 4 months pregnant). 45 % of the females were charged with theft, 35 % with murder while 70 % of the males were charged with defilement. 60 % of the females were Remands, 40 % Convicts whereas 60 % of the males were convicts and 40 % Remands.

Generally, the offences committed by the females arose out of domestic violence while those committed by their male counterparts were sexual in nature. The majority of the males had spent more months and years in custody while a majority of their female counterparts had spent few months and years. For example, the longest convicted male at the time of the Study had been in custody for 9 years and the longest convicted female had only been in custody for 21/2 years.

4.3.1. IMPACT OF IMPRISONMENT ON THE HEALTH RIGHTS OF INMATES

HOW IMPRISONMENT HAS GENERALLY AFFECTED THE HEALTH RIGHTS AND WELL-BEING OF INMATES.

TABLE.P. TERMINAL DISEASES REPORTED BY FEMALE INMATES

DISEASE	NUMBER	PERCENTAGE
HIV/AIDS	5	25 %
Leprosy	1	5 %
Epilepsy & Asthma	1	5 %
High Blood Pressure	3	15 %
Unknown	10	50 %
TOTAL	**20**	**100 %**

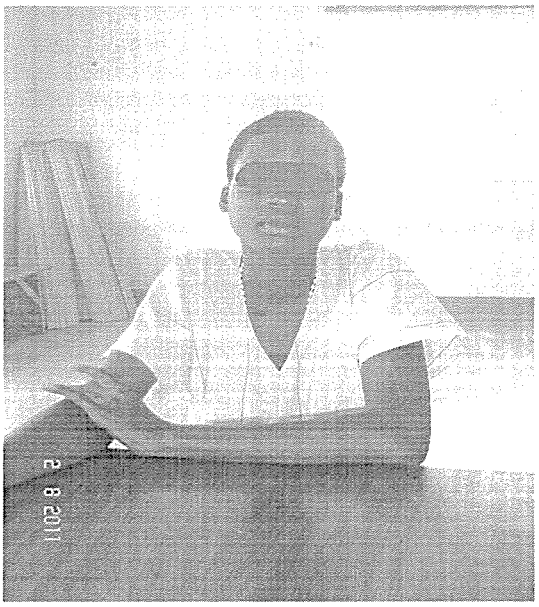
60 % (3/5) of the HIV/AIDS infected female inmates interviewed were pregnant and due to give birth. These findings indicate that majority of the terminal diseases of females are imported into the prison. The Respondents had known of their conditions before imprisonment.

However, they reported that imprisonment had worsened their health and general well-being due to improper medical care and poor nutrition.

An inmate with Leprosy remarked:

"Ever since I was arrested and brought here two and half months ago, I have missed collecting my Leprosy drugs from Kumi Hospital. The Madams here are advising me to get money for two people (myself & the Wardress accompanying me) in order for me to be accompanied to collect the drugs. Iam always in severe pain, feeling like screaming out loud. The under dose of panadol Iam given

PHOTO OF EPILEPTIC INMATE



4.3.2 COMMON DISEASES ENCOUNTERED BY FEMALE INMATES WHILE IN PRISON

1. Skin Rash (Scabies & Ringworm

2. Candida

3. Syphilis

4. Tuberculosis

5. Ulcers

6. Eye and Memory problems

7. Kidney disease

I was generally healthy before I was imprisoned; I delivered all my 9 children normally, but since I was imprisoned, I worry a lot and now I regularly vomit blood and frequently get my menstrual cycle twice a month. I now have stomach ulcers and the doctors told me from Soroti hospital that ulcers have eaten all my stomach and that I should stop worrying so that I do not die and leave my children.

PHOTO OF JANET

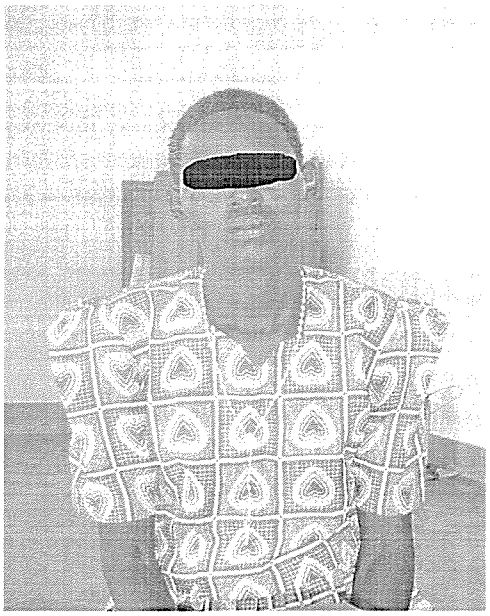


TABLE Q. TERMINAL DISEASES REPORTED BY MALE INMATES

DISEASE	**NUMBER**	**PERCENTAGE**
HIV/AIDS	3	30 %
Kidney disease	1	10 %
Unknown	6	60 %
TOTAL	**10**	**100 %**

positive later. Some of us men get HIV here in prison. We stay in prison longer than the women and end up developing habits that we would not have developed if we were at liberty.

Another male inmate feeding on only beans also stated:

Here, if you have a health condition that does not allow you to eat either posho or beans, then you shall leave prison with severe kidney disease as eating beans January to January affects kidneys and the eye sight.

The findings on Tables O & P reveal that male inmates tend to be at risk of contracting terminal diseases like HIV/AIDS in prison than their female counterparts who report to prison already knowing their HIV status. Female inmates seem to import terminal diseases into prison. For example, all the female inmates who had terminal diseases had spent less than 6 months in prison.

4.3.4. COMMON DISEASES ENCOUNTERED BY MALE INMATES WHILE IN PRISON

1. HIV/AIDS

2. Gonorrhea

3. Syphilis

4. Skin Rash (Scabies, Chicken Pox & Ringworm)

5. Malaria

6. Kidney disease

7. Tuberculosis

many respondents as ulcers) caused by worries of the general state of their biological children, dependants and property back home.

Among both Remand and Convicted female inmates, common emotional responses were unhappiness, feelings of worthlessness, worry, and somatic symptoms. All these were aggravated during crises points in prison such as uncertainty of the state of their biological children, inability to afford a lawyer, missing Case Files in Court, illness or death of a family member, cruelty of prison staff, lack of family support, and irregularity of complainants at court. During the Study, it was noted that most female inmates; had never been visited either by a relative or friend in the last 3 months, had no money, depended on prison food, prison medical care and prison welfare officer for legal issues as they could not afford to arrange for Bail. While in prison, nearly all inmates experience depressed moods or stress symptoms. Anxiety and sleep disorders were some of the frequent complaints.

Both females and males reported wounds or injuries arising from manual work, prisoner – prisoner and prisoner – askari (guard). They stated that the most common causes of injury were being struck by a person or object, and cutting, piercing or stabbing. They further said that those male inmates who attempt to escape and were caught during the escape were severely beaten, tortured, and isolated.

These findings therefore confirm previous Research Survey of the Health of Female prisoners in Queensland, Hockings et al (2002) found that 67.9 % f the injuries had by the women occurred whilst in protective custody. In this Study, sprains / strains and open wounds were the most reported injury by female inmates. In my Study findings, the most commonly causes of injury for the female

said available in their Wing was a room designated for a Sick Bay and not equipped with any medical equipment except beds.

However, the male respondents stated that they had a Medical Clinic in their wing which is equivalent to Health Centre 111 but further stated that it was not well equipped to cater for any serious ailments. They reported that there were only 4 Nurses and 1 Clinical Officer for over 300 male inmates and the female inmates. Both the female and male inmates reported that the medical team mostly worked when there were sick inmates.

Both female and male inmates reported that they have extensive and diverse health needs that the prison health care services were rarely able to address. That the nurses heavy focus was bent towards providing primarily to immediate, short-term problems rather than longer-term.

The respondents said that any medical act by the prison nurses could only take place if the inmate raised his or her hand during the morning parade as unwell and she or he had to wait for the nurses to report on duty to see them. That although the medical staff could come and go to the clinic, they could not enter a ward (dormitory) without a guard accompanying them, a situation that may compromise confidentiality.

The male participants further stated that once they were in the main hospital (Soroti Regional Referral Hospital) admitted, one hand was cuffed on a bed and it was either the wardress or warder with any available family member to provide physical care. That if they were in the prison medical unit, they were locked up while waiting for a turn to see the health staff, or to return to their ward.

Esther (fictive name) was arrested from their home in Katakwi for alleged theft of a friend's phone. She was taken to a police cell where she spent two weeks and was later transferred to Women Prison Soroti. She became familiar to the prison medical team as she had been brought in a poor health state. She is 4 months pregnant, asthmatic and epileptic, for which she is on medication, but with poor compliance as obtaining asthma and epilepsy drugs solely, depends on availability at the main hospital. Esther stated that she came to prison with a pregnancy and asthma but due to too much manual work of long hours, she begun collapsing from the garden during hot hours. Because of the continuous collapsing, she was referred to the main hospital where she was diagnosed with epilepsy. She complained of poor access to medications and irregular reviews by the health care staff and of being asked to sweep the compound daily since she was relieved from garden work. Esther also failed to appear in court for mention of her case due to lack of a cloth to wear since they are not allowed to go to court in prison uniform. She is a total orphan and comes from a destitute family.

This case illustrates how inmates with chronic or terminal illnesses, poor literacy and from destitute families are more prone to fail to access effective health care and may be subject to isolation, abusive acts or indifference by medical and security staff.

The findings of this study therefore indicate that the nature of medical care received by the female inmates was short-term as there was no permanent clinic within their Wing.

What I have learnt is that the drugs are there but the nurses and store man get for the diseases they can treat and not for those the Clinical Officer prescribes because the nurses get only 100 tablets of panadol; it is the store man who decides what to give out.

Another female respondent remarked:

We only receive drugs when they are available and when not available and your condition is worse, they refer you to Soroti hospital and when you are not too ill, they tell you to wait until the drugs are available.

The findings above indicate the current state of health of inmates and the inadequacy of the current response by the prison medical and administrative staff to the health needs of inmates. It was further stated by the respondents that 99 % of them hardly completed prescribed treatment due to lack of medications hence affecting their recovery rate of any ailment.

It is therefore clear from the above findings that the inmates had been deprived of the right to timely medical attention and thus imprisonment impacting on their health rights and well-being.

4.4.4. AVAILABILITY OF MEDICAL CARE STAFF

Both the female and male respondents stated that the nurses were mainly available during day time and when the drugs were available within the prison clinic and store.

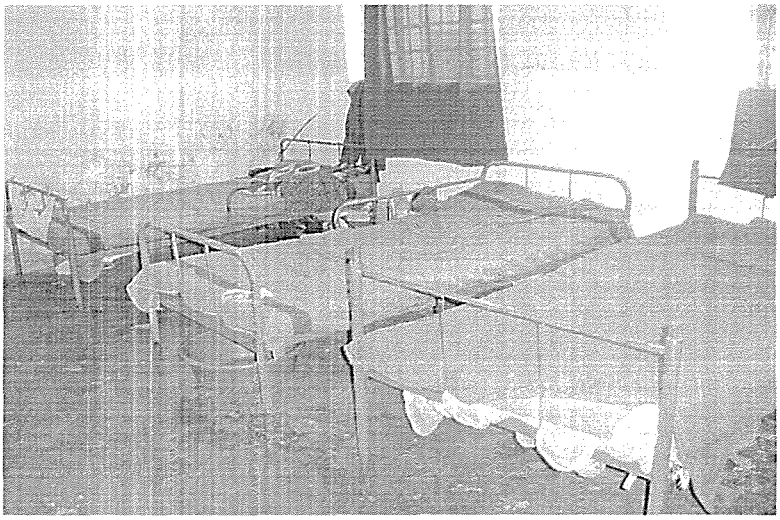
A female inmate who is 8 months pregnant and HIV positive had this to say:

The medical team is very reluctant; they come at their own time like if you were to be treated in the morning, they come in the afternoon; if having diarrhea, they give you panadol or having

The findings above illustrate that the inmates were deprived of the right to a professional standard of care. SMR (Note 92) Para 22(1) provides that *"at least one qualified medical officer" will be available in every prison.* Imprisonment had therefore negatively affected the health rights and well-being of both the female and male inmates.

4.4.5. CARE FOR THE SICK INMATES IN GENERAL

FEMALE INMATES SICK BAY



100 % of the female participants responded that the inmates who were sick and not bed bound were taken to dig and where they refused to go to the garden, they would be locked up and denied to cook their private food brought by their relatives on Visitation Days. That when an inmate was seriously ill, either the nurses would put them on drip in the Sick Bay or refer them to Soroti Hospital. That incase a sick inmate was admitted, the Wardresses look after them and sometimes, they contact their relatives who would be with them in hospital. They further reported that the sick were mostly transported to hospital on foot by the wardresses unless there was a free prison van.

The male inmates on the other hand reported that sick inmates take porridge twice; morning and midday. That the only difference is that when you are sick, they do not take you to the garden immediately and your people are allowed to come and take care of you in the hospital. They further stated that there are only Two Askaris (guards) responsible of accompanying sick inmates to the Soroti Regional Hospital; one guard for general health care and another for ART Centers like TASO, AIC, and Uganda CARES. That where the sick male inmates referred to Soroti Hospital are more than 4, then the rest must wait for the 4 taken to return or forfeit treatment for that day as the guards are strictly allowed to move with only Two inmates each if one and 4 inmates if Two.

Ezekiel (fictive name), a male respondent charged with impersonation and feeding on only beans remarked:

Referral to main hospital is a challenge; transport is a problem because there are only 2 Askaris for main hospital and HIV/AIDS Centers; you miss the appointment and if there are more than 2, only 2 must go because Askari is to take only 2 and this affects our health because CD4 drops and sickness comes in because of improper drug adherence; you fail to comply with the commandments of HIV/AIDS. When they take your Card, they bring drugs but you do not get reviewed by your doctor if for instance there is need to change the drug since the Askari cannot be feeling what you are feeling as an HIV/AIDS patient with a health complaint.

The male respondents living with HIV/AIDS reported that this had compromised their ART treatment, drug adherence and generally affected their CD4 Count. They also reported that the habit of warders collecting for them their ARVs had completely incapacitated them as they could not be physically reviewed by their ART doctors. That some of them who had known their HIV status in

The findings above confirm Research Findings reported in Young's (2000) Study that showed that 14/15 women she interviewed said that they had received inadequate medical care while in prison and all of them described care that was non-empathetic, including being treated as if they were "undeserving of care"[94]. Reed and Lyne (1997) reviewed the health practices in the UK prisons and found examples of this.

These findings show a clear contravention Principle 24 of the Body of Principles for the Protection of All Persons under Any Form of Detention which specifies that "*medical care and treatment shall be provided whenever necessary*". The UN HRC has stated that under the CCPR, "*Appropriate and timely medical care must be available to all detainees*"[95]

4.4.6. ROUTINE GENERAL MEDICAL CHECK UPS

100 % of both the female and male participants reported that routine general check ups for all the inmates was rarely done. However, they stated that the key focus of the medical staff are those inmates reported to them by the In-Charge or guard on duty to be sick and that general check ups of all the inmates was done only if there was an outbreak. They further stated that Malaria, TB, HIV/AIDS and Syphilis were the only diseases checked during any check ups and this was done in short notice.

Ben (fictive name), a male participant remarked:

There are no routine check ups within the wards; we just follow the medical team in the clinic; they never follow the patient; it is as they say that it is a patient to look for the doctor.

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[94] Young DS (2000) Women's Perceptions of Health Care in Prison. Health Care For Women International 21: 219-234 Pg. 219.

[95] **HRC (Note 122) Para 83 (11)**

The male respondents chorused that the issue of being followed up by the nurse after treatment does not happen, it is the inmate himself to return to the clinic if not feeling well to be given more medicine.

The male participants further chorused this during a Focus Group Discussion:

We have lice here in plenty and the administration has just over looked at it. It is the administration that rules everything not the medical team. The good Clinician was transferred. Our problem is one tablet and inadequate treatment.

Under Case Law for example, in **McGlinchy & Others V UK**, the Court found a violation of the inmate's health right based on a much shorted delay in treatment, when a "gap in the monitoring of the prisoner's condition by a doctor over a weekend" resulted in a rapid decline of her health status, and later her death.[96] Irregularity in the follow-up of sick inmates after treatment therefore impacted negatively upon their health right and well-being.

4.4.8. CARE OF PREGNANT INMATES

100% of the female respondents stated that there was no special care whatsoever provided for pregnant women except accompanying them for Antenatal Care; that they (pregnant women), dug equally like their unexpectant colleagues, no special exercise or teaching or meals as they ate posho and beans daily.

A female Atikiro (prefect) had this to say regarding the care of pregnant inmates:

[96] (2003) 37 EHRR 41 Para 57

4.4.9. RELATIONSHIP WITH THE MEDICAL AND PRISON SECURITY STAFF

It was clear from talking to inmates that the traditional prison code to some extent governed how they related to one another. The female inmates upon reaching near the wardress removed their slippers or shoes, knelt down before her and upon being called just came running.

The male inmates on the other hand also removed their slippers or shoes and squirted. The female inmates addressed the wardresses as "madam" and the male inmates called the warders "afande".

100 % of both the female and male respondents complained that the prison staff particularly guards (wardresses and warders) treated them like children and house maids or boys.

One female inmate who is also a prefect (Atikiro) remarked:

The madams here treat us like their little children at home; they shout at us, beat us sometimes and take us to their homes to do all their domestic work as if we are their house girls.

Two male respondents chorused:

The Afandes here always displace their anger from either quarreling with their wives or being commanded by their boss at administration on us. When they have wakened up from the bad side of the bed, they can even parade and lock us up at 2 P.M, shout at us and beat us when uncalled for... Any way, they too have their own frustrations just like us here.

Generally, inmates felt at worst victimized and at best neglected, particularly by prison staff (guards), which effect undermined their confidence, self-esteem and self-worth. The inmates mistrusted prison staff (guards).

Gerald (fictive name), a male respondent stated that:

Sometimes, they are very hostile and transfer their annoyance; they tell us that you people we are not the ones who brought you here, we did not send you to steal or murder or defile.

Regarding the medical staff, 99 % of both the male and female inmates reported that the nurses in particular attended to them with compassion and always made them feel as people of worth. They further stated that whenever drugs were not available, they endeavoured to collect for them drugs at their own cost from the main hospital.

The Research conducted by Belzile and Frigon (2003) highlighted the varying support roles prison nurses were playing for female inmates and how the "clinical space becomes a space for validation where women feel they can be themselves, and be listed to and learn about who they are". They found that the prison nurses most able and most likely to offer this kind of support were those who answered to health rather than to custodial authorities.

While we lack the depth research to be able to make similar claims in Uganda, some of the female and male interviewees had this to say about the prison medical team:

A 30 year old pregnant and HIV positive inmate said:

The nurses treat us fairly well and keep telling the madams not to engage pregnant women in heavy work.

Regarding the Nutritional status of female inmates, 1 in 10 was underweight but the rest looked generally well nourished with some reasonable normal weight compared to their male counterparts where 6/10 were weak and sick looking and complained of great weight loss.

100 % of the female inmates said that they were fed on posho and beans on daily basis; that the beans was fried on visitation days only; that either Egg plant or Green Vegetables grown by them on the Bed Shamba (vegetable garden) was occasionally mixed; that 2 Kilograms of beans was prepared for 25 inmates for lunch and supper and that they had 2 meals a day plus a cup of porridge without sugar every morning. They further reported that no special meals were provided for the sick or pregnant women or children. That only those lucky ones whose relatives visited had special meals as they were all allowed cooking any dry or fresh food brought by their relatives and friends on visitation days.

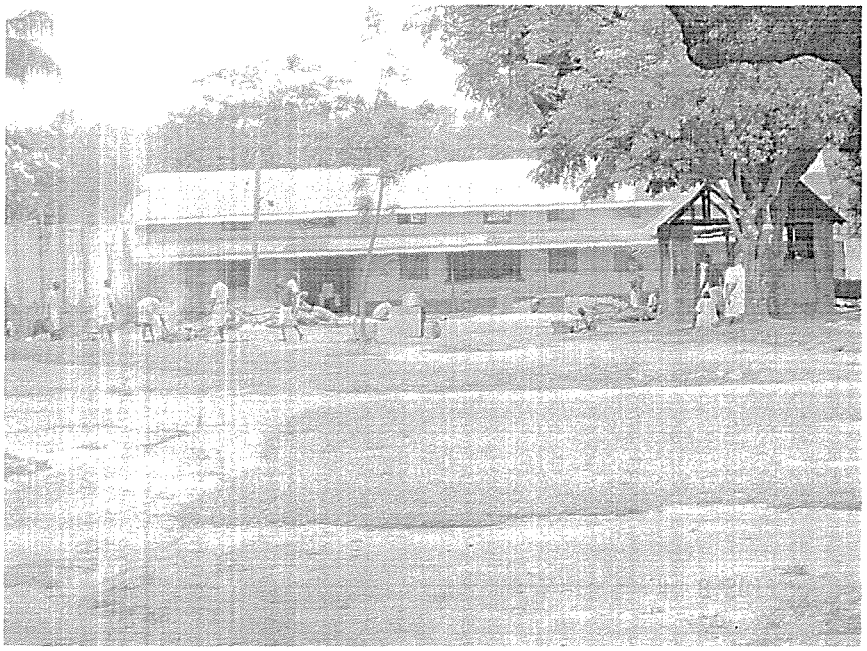
The female inmates attributed their well nourishment to fairly good feeding as the food is prepared and served by fellow female inmates and that all of them were permitted to individually cook any local food brought to them by friends and relatives during visitation and that the In-Charge Women once in a while gave them a balanced diet.

However, the male respondents stated that they only had posho and beans daily and had meat once a year on Christmas Day.

Mauritania cited above, the African Commission on Human Rights found a violation of the right to health on grounds including insufficient food. In this 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". Article 26 of the Geneva 111 further provides that 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 "sufficient drinking water". Imprisonment therefore had negatively affected the inmates' right to food and water thus contributing to inmates' poor health and well-being.

4.6. IMPACT OF ACTIVITY ON THE HEALTH RIGHTS AND WELL-BEING OF INMATES

MALE INMATES COOKING



It was evident from talking to both the female and male inmates that they were willing to sign up and participate in any educational or vocational training because they saw this as an opportunity for them when released.

A Female Convict left with only 3 months to be released had this to say:

I came to this prison when I did not know how to read, write and speak any English, but for the 21/2 years I have been here, I now can read the Ateso Bible, write my name, speak and understand English. If vocational training was available like tailoring, crocheting and reproductive health education, I would have returned home in November more enlightened than I had been before.

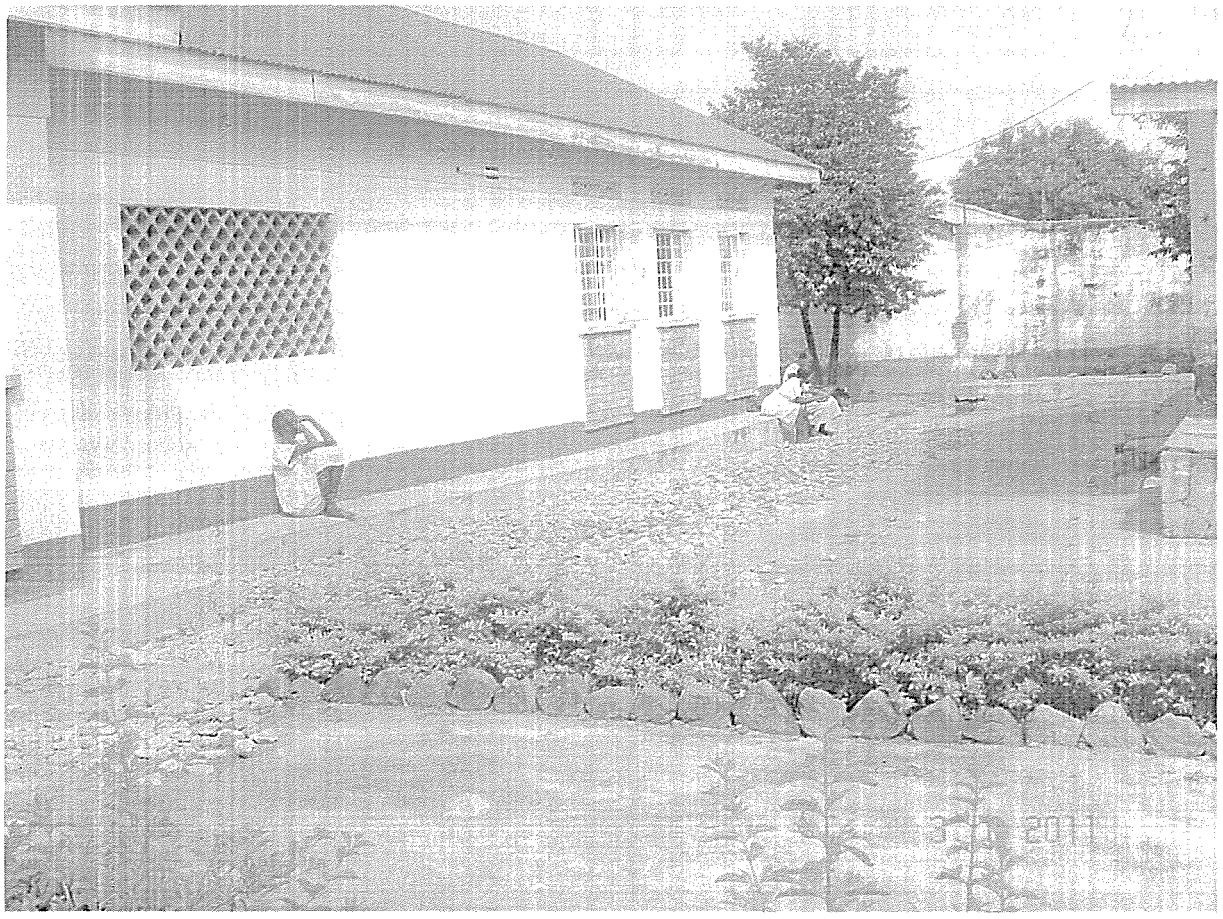
Inmates with families were worried of their inability to support their children or dependants financially after release from prison. 95 % of the female respondents claimed to have lost their property to in-laws and their accusers and that their children were left at the 'mercy of God and good Samaritans' within their communities.

A mother of 9 living biological children charged with the murder of her husband remarked:

I completely do not know where I shall start from when Iam released from here. My sister-in-law who accused me of murdering her brother who was a known thief in the area and was poisoned by unknown people, broke into my home where I had always been a man and a woman, removed all the food I had harvested, cows, goats, pigs and left my children with nothing. Now I hear my children are moving home to home in search of food and parental help, but some unkind neighbours beat them for food...Iam just going to build a home again...My community admired

4.7. IMPACT OF HYGIENE AND SANITATION ON THE HEALTH RIGHTS AND WELL – BEING OF INMATES

PHOTO OF FEMALE WARD



60 % of the male inmates used tooth brushes and toothpaste while only 40 % used sticks without toothpaste. Both the female and male respondents said that they wash their uniforms at least twice a week.

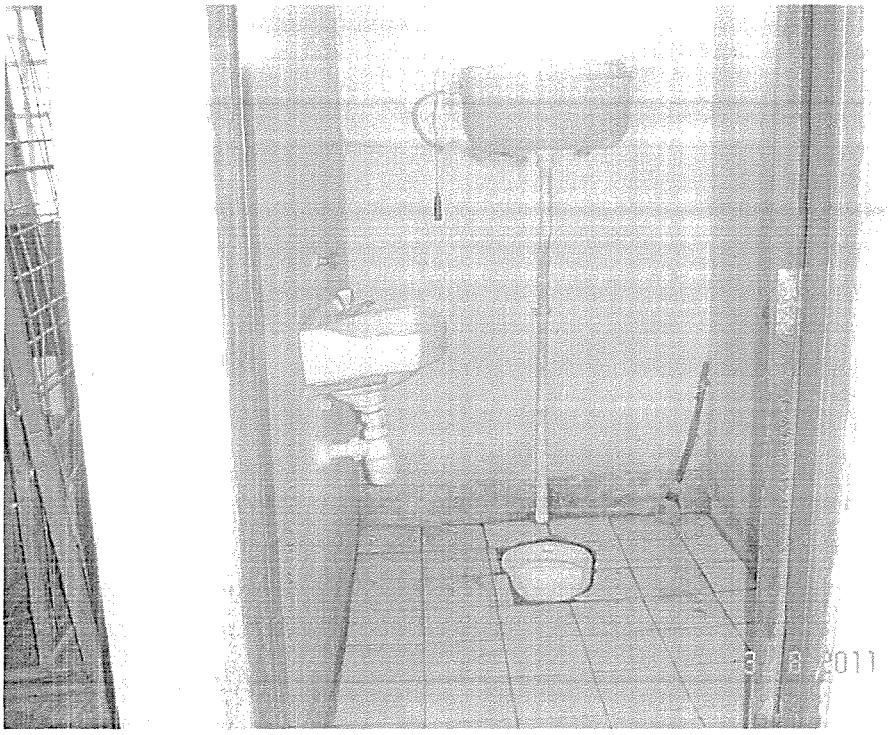
85 % of both the female and male inmates that Remand inmates had 1 Uniform each while Convicts had 2- 3 uniforms. The Remands stated having only one uniform had compromised their personal hygiene especially when one lack soap for washing daily.

The female participants chorused this during a Focus Group Discussion:

The basic necessities in here are a small piece of bar soap given twice a month and a packet of 10 Sanitary towels that must be used for two months (5pads each month), yet most of us menstruate for at least 5 days. When yours is done and you can afford, then you have to buy for your self to feel comfortable for your own self-confidence....Those of us who are not visited by either friends or relatives improvise with worn out pieces of our polyester prison uniform...Sometimes, you just sit and leave it to floor because even those old pieces of uniform that we use have caused us Candida....Those of us who have never been visited and do not have any money depend on the mercy of kind madam's and our colleagues who are regularly visited...We tend to share a lot here as you cannot watch your friends suffering when you can help.

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 and degrading. The UPS 2000 Policy Document Value 10 Principles have guaranteed the provision of sanitary napkins or substitutes for female inmates and daily access to showers or their

PHOTO OF FEMALE TOIETS



Leo (fictive name) Head Prefect/ Atikiro, a male inmate who had been in custody for the last 9 years remarked:

All I can say regarding prison hygiene and sanitation is that it has greatly improved; we now have all the required cleaning detergents and the inmates themselves are committed to personal and general cleanliness.

The female inmates had this to say regarding the general state of hygiene and sanitation:

This place is even more clean than some of our homes; our wards are mopped daily, the bathrooms and toilets are cleaned with at least some detergent and our compound as you can see by your self is swept daily and slashed whenever it tries to become bushy.

ventilators and Doors were opened at 6 P.M and closed either at 3 P.M or 4 P.M; last lock up was either 3 or 4 P.M; they kept opening for those returning late from the garden or court or hospital.

The male participants remarked:

It is only the women who have better accommodation in prison; they sleep like students at High School and all of them have Mosquito Nets...We the men generally sleep like animals...That is why our weaker colleagues are easily sodomised by those of us who cannot do without sex. Some of our wards are of a Colonial System; they are poorly ventilated yet we are also over crowded. Administration believes that a prisoner is not a free person; they do not want wise prisoners. We do not have mosquito nets; they have them at the Reception kept; the debate is that nets and bed sheets can be used by us for committing suicide. We have lice here in plenty and the administration has just over looked at it.

The findings of this study indicate that the male inmates had poor bedding facilities compared to their female counterparts and the males were quite vulnerable to disease infections than the female inmates who were only 25 in number but occupying 3 wards.

rights and well-being of both female and male inmates. The female and male inmates both stated that imprisonment had generally affected them physically and psychologically. The respondents reported contraction of new diseases, psychological distress which arose out of the exposure to risks and worries about the state of biological children left home.

The second question was on the effect of Health Care Service Provision on the health rights and well-being of inmates. The findings here suggest that both female and male inmates received improper and inadequate medical care, poor medication, poor routine check-ups and follow-ups, unavailability of a medical doctor among the prison medical staff, good relationship between inmates and medical team and a poor relationship between inmates and prison guards.

The third question looked at the effect of nutrition on the health rights and well-being of inmates. The findings here revealed that male inmates had poor nutrition compared to their female counterparts. The female inmates on the other hand lacked games and educational activities compared to their male counterparts who had some games and dram as recreational activities.

Finally, the last Research Question related to the impact of hygiene and sanitation on the health rights and well-being of inmates. The findings showed that personal hygiene of the inmates (female and male) had been compromised with. For example both the female and male inmates were given a piece of bar soap twice a month. The female inmates were given a packet of 10 pads for two months and 85 % of both the male and female inmates used a stick for brushing without toothpaste. However, the general cleanliness or hygiene and sanitation of the prison had remarkably improved compared to before where detergents were not a priority according to the inmates.

Avail gloves for cleaning

Repair flashing toilet system

Provide for recreational activities like games to keep people busy

Balanced diet; changing food that contain all food values because our kidneys are getting sick and proper cooking and serving of food.

People on special diet like those who do not eat either beans or posho should be given an alternative meal.

HIV/AIDS patients should be given the food that their colleagues out side there are getting so that their CD4 rises and so that they do not die in prison; 36/313 male inmates are confirmed HIV/AIDS patients and all on ART.

Spacing of the sleeping arrangement

Train prison staff on human rights so that they do not torture us; they are very hostile; they can lock us for a whole day when they are angry; they order our prefects to push and beat us; at least each day there is someone being beaten most especially in the morning; they push us like cattle being chased out of the kraal.

5.3. RECOMMENDATIONS BY THE RESEARCHER

Various forms of actions are being taken by the International Community to address Health Care in prisons. Whatever diverse prisons may be worldwide, health professionals involved in prisons share a direct responsibility to make sure that the right to health is properly enjoyed. Adhering to

The research findings unveiled the need to improve on the quality of Health Care Service Provision, Nutrition and Activity in prison, the urgent need to have at least one qualified medical doctor and permanent skilled medical personnel in the prison health centre to handle the emergency health needs of inmates. A fully pledged or equipped clinic needs to be created in the Women's Prison as opposed to depending on the 4 nurses meant for the male prison.

The Statement of Purpose for the Prison Service requires Prison Authorities to abide by a humane duty to care for prisoners, where prisoners must be supported in preparing for useful, productive and law-abiding lives following release.

The Prison Administration need to implement guidelines regarding women prisoners requiring assistance in pregnancy, ante-natal, natal and post-natal care. Children of the women prisoner must be provided care as per the guidelines. Any intervention must start with the prisoner, the moment she enters the prisoner.

Women prisoners' privacy and dignity must receive the top most priority.

Women prisoners must be routinely screened for physical and mental health problems and provided treatment at the earliest.

Self-help groups among women prisoners can be of great help during stressful situations-entry into prison, during bail, preparation for court, unpleasant events at home like death of a family member, before, during and after judgment.

Epidemiological Research is undeniably important in terms of tracking and monitoring the state of prison health care service.

It may be more appropriate, in seeking to explain why prisoners experience poorer health than the general population, to explore whether there are health-limiting factors, conditions or determinants beyond the individual that prevail within prisons and characterise imprisonment.

The government should incorporate prison health into public health policy; and to recognise the right to health in prison.

APPENDIX II

RESEARCH QUESTIONNAIRE

RESEARCH TOPIC: IMPACT OF IMPRISONMENT ON THE HEALTH RIGHTS OF FEMALE INMATES. A COMPARATIVE STUDY. A CASE STUDY OF SOROTI PRISON

PART A: GENERAL IMPACT OF IMPRISONMENT ON INMATES HEALTH

1. How can you describe your general health condition and well-being before imprisonment or what was your general health state before imprisonment?
2. How has being in prison affected your general health and well-being?
3. How many times have you fallen sick since you were imprisoned?
4. How often do you now fall sick in prison?
5. What are some of the diseases you have contracted since your imprisonment?
6. What do you think causes you ill or poor health?
7. How do you cope with your health related challenges?

PART B: HEALTH CARE SERVICE PROVISION OR DELIVERY

1. Do you have a Medical care Unit within the prison?

2. How does the clinic within the prison operate?

3. How do you access the Health Care service?

4. How long approximately do you take waiting to receive the service?

5. What kind of health care do you receive in prison when you are sick?

6. How often is routine medical check ups carried out?

7. Who carries out these medical check ups (Medical doctor / Clinical Officers / Nurses / Prison Staff)?

8. How many medical care staff do you have?

9. Do you have a permanent qualified medical doctor in the medical team within the prison medical care unit?

10. How often do you when sick get reviewed by a qualified medical doctor?

ACTIVITY

1. What kind of manual work do you do?
2. How often do you carry out this work?
3. How many hours approximately do work in a day?
4. What Gaming and Sporting activities are available?
5. What is your general response towards recreational activities?
6. Would you be willing to participate in any other gaming, sporting and educational activities if they were available? If yes, why and if no, why?
7. What would you like to see different with the sporting, gaming and educational activities being carried out?

PART D. HYGIENE AND SANITATION

PERSONAL

1. What do you use for brushing your teeth?

2. Do you use tooth paste? If yes, who provides for it? If no, why?

3. How often do you bath?

4. What kind of bathing detergents do you use? Who provides for these?

5. What do you use for bathing (Basin, Bucket / Jerry can)?

6. How are the bathing equipments provided?

7. Are bathing equipments like basins or buckets shared?

8. If yes, how do you think sharing them has affected you personally?

HYGIENE AND SANITATION

9. How many uniforms do you have?

10. How often do you wash them?

11. What do you use for washing them?

FEMALES

1. What do you use during your menstrual period?

2. Who provides for them?

APPENDIX 111

PERMISSION LETTER TO INTERVIEW FEMALE INMATES

WEBSITE: www.prisons.go.ug
TELEPHONE: 256 - 414 - 258761
FAX: 256 - 414 - 344104
E-MAIL: comprisons@utlonline.co.ug
info@prisons.go.ug

PRISONS HEADQUATERS
P. O. Box 7182,
KAMPALA, UGANDA

ALL MAIL TO THIS LETTER SHOULD BE ADDRESSED TO THE COMMISSIONER GENERAL OF PRISONS AND THE FOLLOWING REFERENCE NO. QUOTED: PRC

ADM/143/219/01

19th January 2011

Ms Akiror Mariam
Kampala International University
P.O. Box 25338
KAMPALA

RE: APPLICATION FOR PERMISSION TO CARRY OUT AN ACADEMIC RESEARCH AT LUZIRA OR SOROTI PRISON

Yours dated 10th January 2011 on the above subject matter refers.

I am pleased for inform you that permission is hereby granted to you to conduct the said research. You are to report to the Officer-in-Charge Soroti (W), who will help you with your work

NB: Please note that the information gathered must be strictly for academic purposes and not for public consumption.

D.A. Ahimbisibwe
FOR: COMMISSIONER GENERAL OF PRISONS

Copied to: The Regional Prisons Commander
EASTERN REGION

The Officer-in-Charge
U.G. Soroti (W) Prison

The Deputy Dean Faculty of Law
Kampala International University
KAMPALA

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