

THE WORLD MEDICAL ASSOCIATION, INC.

**WMA DECLARATION OF EDINBURGH  
ON  
PRISON CONDITIONS AND THE SPREAD OF TUBERCULOSIS  
AND OTHER COMMUNICABLE DISEASES**

Adopted by the 52<sup>nd</sup> WMA General Assembly, Edinburgh, Scotland, October 2000  
and revised by the 62<sup>nd</sup> WMA General Assembly, Montevideo, Uruguay, October 2011

**PREAMBLE**

Prisoners enjoy the same health care rights as all other people. This includes the right to humane treatment and appropriate medical care. The standards for the treatment of prisoners have been set down in a number of Declarations and Guidelines adopted by various bodies of the United Nations.

The relationship between physician and prisoner is governed by the same ethical principles as that between the physician and any other patient. There are specific tensions within the patient/physician relationship, which do not exist in other settings, in particular the relationship of the physician with his/her employer, the prison service, and the general attitude of society to prisoners.

There are also strong public health reasons for reinforcing the importance of these rules. The high incidence of tuberculosis amongst prisoners in a number of countries reinforces the need for considering public health as an important element when designing new prison regimens, and for reforming existing penal and prison systems.

Individuals facing imprisonment are often from the most marginalised sections of society, may have had limited access to health care before imprisonment, may suffer worse health than many other citizens and may enter prison with undiagnosed, undetected and untreated health problems.

Prisons can be breeding grounds for infection. Overcrowding, lengthy confinement within tightly enclosed, poorly lit, badly heated and consequently poorly ventilated and often humid spaces are all conditions frequently associated with imprisonment and all of which contribute to the spread of disease and ill-health. Where these factors are combined with poor hygiene, inadequate nutrition and limited access to adequate health care, prisons can represent a major public health challenge.

Keeping prisoners in conditions, which expose them to substantial medical risk, poses a humanitarian challenge. An infectious prisoner is a risk to other prisoners, prison personnel, relatives and other prison visitors and the wider community - not only when the prisoner is released, but also because prison bars do not keep Tuberculosis bacilli from spreading into the outside world. The most effective and efficient way of reducing disease transmission is to improve the prison environment, by putting together an efficient medical service that is capable of detecting and treating the disease, and by targeting prison overcrowding as the most urgent action.

The increase in active Tuberculosis in prison populations and the development within some of these populations of resistant and especially "multi-drug" and "extremely-drug" resistant forms of TB, as recognised by the World Medical Association in its Statement on Drug Treatment of Tuberculosis, is reaching very high prevalence and incidence rates in prisons in some parts of the world.

Other conditions, such as Hepatitis C and HIV Disease, do not have as high a risk of person-to-person communicability as TB but pose transmission risks from blood to blood borne spread, or sharing and exchange of body fluids. Overcrowded prison conditions also promote the spread of sexually transmitted diseases. Intravenous drug use will also contribute to the spread of HIV as well as the more contagious Hepatitis B and C. These need specific solutions that are not dealt with in this statement. However the principles set out below will also be helpful in reducing the risk from such infective agents.

### **Actions Required**

The World Medical Association considers it essential both for public health and humanitarian reasons that careful attention is paid to:

1. Protecting the rights of prisoners according to the various UN instruments relating to conditions of imprisonment. Prisoners should enjoy the same rights as other patients, as outlined in the WMA Declaration of Lisbon;
2. Not allowing the rights of prisoners to be ignored or invalidated because they have an infectious illness;
3. Ensuring that the conditions in which detainees and prisoners are kept, whether they are held during the investigation of a crime, whilst waiting for trial, or as punishment once sentenced, do not contribute to the development, worsening or transmission of disease;
4. Ensuring that persons being held while going through immigration procedures, are kept in conditions which do not encourage the spread of disease, although prisons should not normally be used to house such persons;
5. Ensuring the coordination of health services within and outside prisons to facilitate continuity of care and epidemiological monitoring of inmate patients when they are released;
6. Ensuring that prisoners are not isolated, or placed in solitary confinement, as a response to their infected status without adequate access to health care and the appropriate medical treatment of their infected status;
7. Ensuring that, upon admission to or transfer to a different prison, inmates' health status is reviewed within 24 hours of arrival to assure continuity of care;
8. Ensuring the provision of follow-up treatment for prisoners who, on their release, are still ill, particularly with TB or any other infectious disease. Because erratic treatments or interruptions of treatment may be particularly hazardous epidemiologically and to the individual, planning for and providing continuing care are essential elements of prison health care provision;
9. Recognising that the public health mechanisms, which may in the rarest and most exceptional cases involve the compulsory detention of individuals who pose a serious risk of infection to the wider community must be efficacious, necessary and justified, and proportional to the risks posed. Such steps should be exceptional and must follow careful and critical questioning of the need for such constraints and the absence of any effective alternative. In such circumstances detention should be for as short a time as possible and be as limited in restrictions as feasible.

There must also be a system of independent appraisal and periodic review of any such measures, including a mechanism for appeal by the patients themselves. Wherever possible alternatives to such detention should be used;

10. This model should be used in considering all steps to prevent cross infection and to treat existing infected persons within the prison environment;
11. Physicians working in prisons have a duty to report to the health authorities and professional organisations of their country any deficiency in health care provided to the inmates and any situation involving high epidemiological risk. NMAs are obliged to attempt to protect those physicians against any possible reprisals;
12. Physicians working in prisons have a duty to follow national public health guidelines, where these are ethically appropriate, particularly concerning the mandatory reporting of infectious and communicable diseases;
13. The WMA calls upon member associations to work with national and local governments and prison authorities to address health promotion and health care in their institutions, and to adopt programmes that ensure a safe and healthy prison environment.

## **Annex**

International texts relating to medical care in prisons:

Universal Declaration of Human Rights (Articles 4, 9, 10 and 11). Adopted by the United Nations General Assembly on 16 December 1948.

Standard Minimum Rules for the Treatment of Prisoners (Rules 22-26). Approved by the United Nations Economic and Social Council on 31 July 1957.

International Covenant on Economic, Social and Cultural Rights (Article 12). Adopted by the United Nations General Assembly on 16 December 1966. Entry into force: 3 January 1976.

International Covenant on Civil and Political Rights (Articles 6, 7 and 10). Adopted by the United Nations General Assembly on 16 December 1966. Entry into force: 23 March 1976.

Principles of Medical Ethics Relevant to the Protection of Prisoners Against Torture (Principle 1). Adopted by the United Nations General Assembly on 18 December 1982.

Body of Principles for the Protection of All Persons Under Any Forms of Detention or Imprisonment (Principle 24). Adopted by the United Nations General Assembly on 9 December 1988.

Basic Principles for the Treatment of Prisoners (Article 9). Adopted by the United Nations General Assembly on 14 December 1990.

United Nations Rules for the Protection of Juveniles Deprived of Their Liberty (Principles 50-54). Adopted by the United Nations General Assembly on 14 December 1990.

WHO Guidelines on HIV Infection and AIDS in Prison. Issued in March 1993, Geneva (Document WHO/GPA/DIR/93.3).