Week 4

Frédéric Le Marcis

How should we consider health in prison?
Should inmates be seen as precarious populations
or illegitimate populations?
Should prison be analysed as a space of therapeutic digression
or as a place of risk?

Indeed, analysing health-related issues in prison equates
to understanding the inequalities and power issues
that structure the experience of actors in detention.

Examining health in prisons also requires a recognition
of society's responsibility towards inmates.

While they have been convicted,
an absence of care is not part of their sentence.
It is important that we untangle the web
of health-related issues in detention.
We must understand the power issues, the political issues,
and the values that structure health care in prisons,
in particular through the accounts of a number of implicated actors:
inmates, healthcare professionals, national political figures,
and agents who work with international organisations.

Week 4.1

Health in prison: A public health target and an object of the social sciences

Health in prison: A public health target and an object of the social sciences

Marie Morelle
HDR lecturer in geography, University of Paris 1 Pantheon-Sorbonne, Prodig, Ecoppaf programme

Frédéric Le Marcis
Professor of social anthropology, ENS de Lyon, Triangle, Ecoppaf programme

Dr Karim Traoré
Doctor, Director of Health and Social Welfare at the Ministry of Justice, Burkina Faso

Dr Marcel Bléhoué Angora
Head Doctor, Medical Service of the Abidjan Detention and Correctional Centre, Côte d'Ivoire

Prison and health risks

Marie: In an article published in The Lancet in 2016, the authors discuss HIV, hepatitis B, and tuberculosis in prison, and they talk about a 'perfect storm in the making'. What do they mean by this?

Frédéric: This expression reflects both an epidemiological reality and a focus on health in prison. From an epidemiological point of view, prison brings together a particularly vulnerable population. Generally speaking, this prison population comes mainly from disadvantaged environments, from neighbourhoods where individuals benefit little from preventive actions or do not have much access to care. This is the case, for instance, of the Koumassi-Campement neighbourhood in Abidjan. All too often, for populations coming from these neighbourhoods, the prison experience amounts to an experience of insecurity and exclusion that repeats an experience of insecurity and exclusion that they have already experienced outside of prison. Moreover, this translates into epidemiological data that speak for themselves.

This table offers a comparison of HIV prevalence rates inside and outside prisons in the same country. Three examples: in Tanzania in 2012, the HIV prevalence rate in prison was 6.7%, while it was 4.7% on the outside in 2016, according to the WHO. In Burkina Faso in 2009, the prevalence rate in prison was 5%, while it was 0.8% on the outside, according to the WHO. Finally, in Togo, the prevalence rates in 2013 were 4.6% in prison, compared to 2.4% on the outside. In addition to this distinction between prison and the outside, there are other inequalities, especially gender inequalities. For example, we know that although women are incarcerated to a lesser extent than men, they nevertheless suffer from far higher rates of infection than men. As an example, at the continent-wide level, there are estimates that HIV prevalence among incarcerated women is about twice that of incarcerated men, according to the WHO: 13.1% for women, compared to an HIV prevalence rate of 7.1% for men.

Country	HIV prevalence rate in prison	HIV prevalence rate for those aged 15–49, WHO 2016	References
Tanzania	**6.7***	**4.7**	*TACAIDS/Ministry of Home Affairs (2012). *HIV Prevalence and Related Risk Factors in Prison Settings in Mainland Tanzania. Findings from a Rapid Situational Assessment*.
Burkina Faso	**5****	**0.8**	**Diendéré E.A., Tiéno H., Bognounou R. et al. (2011). 'Prevalence and Risk Factors Associated with Infection by Human Immunodeficiency Virus, Hepatitis B Virus, Syphilis and Bacillary Pulmonary Tuberculosis in Prisons in Burkina Faso'. *Med Trop* (Mars) 71, 5: 464–7.
Togo	**4.6*****	**2.4**	***Ekouevi D.K.; D'almeida S.; Salou M.; Kariyiare B.G.; Coffie P.A.; Dagnra A.C.; Tchounga B.; Becquet R.; Prince-David M.; Pitche V.P. (2013). 'HIV seroprevalence among inmates in Togo'. *Médecine et maladies infectieuses* 43, 7: 279–85.

This vulnerability and exposure to risk among inmates of course varies depending on country and gender, but a recent global review on health in prison published by the WHO reminds us that worldwide HIV prevalence rates remain higher among prison populations than among the general population. In addition, the same literature review highlights the fact that even if inmates were not infected when entering prison, the practices that take place inside expose them to infections.

High-risk practices in prison

Marie: What are these practices?

Frédéric: These practices include the injection of drugs, the use of syringes in the context of drug use. Although this practice is not yet all that widespread in African prisons, it is becoming increasingly prevalent, and therefore it is a trend that should be monitored. Sexual relations are also a source of contamination. These are all the more significant in contexts where resources are limited, as sex becomes a means to access resources and support, and sex in prison is not subject to preventive practices—specifically the distribution of condoms—because homosexuality is not acknowledged in African prisons. Finally, there are other practices, such as tattooing, where the shared use of needles can also help spread both HIV and hepatitis C.

Prison: A public health opportunity

Marie: So, from a public health point of view, prison is a very strategic place?

Frédéric: OYes, and for at least two reasons! First, it is a place of opportunity for care, for populations who, as we have seen, are often in an insecure position and on the margins of the healthcare system. We therefore speak of prison as a therapeutic digression. Moreover, this issue also applies to prisons in Europe, and I refer you for example to the book by Gilles Chantraine, Par-delà les murs, which gives a very good account of how an inmate has his teeth treated by going into prison, leaves, and then returns a little while later to get treated again. Finally, it is also a place of risk of infection among inmates, where epidemics can be produced and then spread among the general population.

Marie: How is that?

Frédéric: Let's take an example from a non-African country. In his book *Pathologies of Power*, Paul Farmer tells of how in Russia, the prison system fosters the spread of a multidrug-resistant tuberculosis epidemic for two reasons: first, the justice system works poorly, which means that inmates are in pre-trial detention for a very long time, and when they are in pre-trial detention for a very long time, they have to endure very poor detention conditions, and they are particularly exposed to tuberculosis due to overcrowding. Then they're given treatment, but the treatment is not regular and they develop resistance. They end up leaving prison, and when they're out, they carry a TB virus that is resistant to the first line of antibiotics. This virus will spread to the general population, but antibiotics for multidrug-resistant TB are not available in the general health system.

Health in prison as an international issue

Marie: So, prison is an important health issue at the national and international level?

Frédéric: Absolutely! Improving health care responds to multiple issues. But thinking about the quality of care does not just mean providing health care, it also implies taking on board the Ouagadougou Declaration, which was published following the conference of the same name that took place in 2002 in Ouagadougou, Burkina Faso. In the Ouagadougou Declaration, the African countries that took part in this conference (over thirty-three) committed to promote respect for the rights of inmates in the prison system and to improve their detention conditions. Therefore, respecting the rights of inmates is not just about the right to health care, it is about combining the right to health care with the right to justice. Rights to health care, as with the right to justice, were among the rights promoted by the Ouagadougou Declaration.

Marie: There was the Ouagadougou Declaration, and there were also the Mandela Rules. Ultimately, has this changed anything?

The constraints on the development of a health policy in prisons

Frédéric: Yes, of course. There has been a plethora of declarations, political commitments, yet, in spite of everything, making good on the rights to health care is hampered by at least six points. I will list them:

- The first is inmates' lack of legitimacy in general society. Taking care of inmates in prison is really not a priority, neither for the general population nor for politicians. It is often considered that there are issues to be addressed among the outside population before taking care of those who are punished in prison.
- The second is the constraint posed by the prison context, which complicates access to care and the delivery of care, and in particular the use of health resources outside the prison.
- Thirdly, there is the issue of prison overpopulation. Clearly, this presents a challenge. Let's take the example of the MACA: in June 2018 it had 7,000 inmates, while the prison was built to accommodate 1,500. We can clearly see how this makes matters difficult.
- Fourthly, poor hygiene conditions: lack of access to water in prisons, no toilets in cells.
- The fifth point is that of the power dynamics and violence, including sexual violence, that take place within prison, both between inmates themselves and between guards and inmates, and which necessarily complicate the equitable and consistent delivery of care in prison.
- Finally, the sixth point is the fact that establishing a healthcare programme in prison always requires taking into account not just the inmates but also the guards, who come from the same neighbourhoods, who have the same socio-economic characteristics, and who also suffer from the stigma of prison. We can't do something for one group without doing the same for the other.

Considering health in prison from the perspective of prison government

Marie: Okay, so we should understand how prison works in order to gain a better grasp of the health issues associated with it?

Frédéric: Yes, absolutely. It is important to think about health not just based on epidemiological data, as we have just pointed out, but also to think about health as a legitimate subject of study for the social sciences, and which we must also consider within the framework of issues of power and the politics of prison, if you will.

So, from this perspective, we can clearly see how health is the subject of definitions and practices that are in fact dependent on the internal power relations of prison: power relations that are characteristic of prison life. There is the issue of access to the infirmary, which is not merely a health issue for inmates but also a means of accessing resources, as they go there to engage in trafficking, or to the courtyard to get some fresh air and to buy goods and services. The infirmary no longer represents a place of care but a place of exchange, circulation, and trafficking. Regarding the recognition of health issues, one must also observe a form of hierarchisation in terms of what is legitimate as a health issue and what is less so.

Defining health priorities in prison: Epidemiological issues and local priorities

Marie: What do you mean by this?

Frédéric: For example, everyone agrees that infectious diseases are a serious problem that threatens inmates, the societies where prisons are located, and the wider world. But when we speak with inmates or healthcare professionals working in prisons, we quickly discover that they highlight other problems regarding detention that are not the priority for international health programmes. I suggest that we listen to Dr Traoré in this regard. He is Director of Health and Social Welfare at the Ministry of Justice of Burkina Faso.

Dr Traoré: On the epidemiological front, in terms of the most common conditions encountered in prisons, I would like to talk about the top five: first, there is malaria, common malaria and

severe malaria, which are brutal; then there are respiratory diseases including tuberculosis and lower and upper respiratory tract infections—we recently had twenty-seven cases of tuberculosis in an epidemic in Bobo-Dioulasso. Then there are skin conditions. When I talk about skin conditions, this is most often the case during the hot season, in April [...].

Frédéric: So, beyond the issues highlighted by Dr Traoré, in terms of these somewhat ignored or orphaned pathologies, we must also add problems of addiction, which are rarely taken into account, even though drugs circulate around prisons. Psychiatric disorders are another forgotten child of health in prison. At best, inmates who have a psychiatric disorder, but who present a danger to their fellow inmates, will be put in solitary confinement, where they will be locked up for an indefinite period during their incarceration. Psychiatric consultations are extremely rare and hardly systematic in prison. For instance, to take the case of Côte d'Ivoire and the MACA once again, the MACA had 7,000 inmates in 2018, with a single psychiatric nurse for all inmates. These conditions, be they addictions or psychiatric disorders, therefore receive little funding from donors or states. And the fact that these conditions do not represent a problem in terms of epidemics is clearly not insignificant in this. One could imagine that if psychiatric disorders were transmissible through spitting, everyone would be dealing with them in order to fight against the risks of contagion.

Providing care in prison

Marie: Ultimately, what do caregivers do to address everything you describe?

Frédéric: You are right to talk about caregivers. One could speak of a form of solitude of caregivers in prison, as they are often the sole recourse for inmates—inmates who have no other means but to place themselves in the hands of the caregivers, and who often cannot afford to pay for medication from outside. Listen to what Dr Angora says about this. He is a doctor at the MACA, in Abidjan.

Dr Angora: As doctors in prison, we are obliged to be able to handle all possible conditions. We are the last resort. In prison, an inmate sees but us, as the last resort. The conditions they present are multifaceted.

The values of health

Marie: And these different ways of thinking of and practising healthcare in prison, do they coexist?

Frédéric: Yes, quite so! Indeed, it implies always thinking about health in prison, according to a context of interaction, depending on who you are and where you are speaking from. This is what we call the context of interaction or the context of utterance in social sciences, i.e., the place from which an individual produces speech, and which makes it possible to capture the intentionality of their speech. Well, the meaning given to health, the uses made of the notion, will vary depending on the context of utterance, and this is not to say that someone is speaking the truth and someone else is not, but it is simply an attempt to understand the logic of how things work, to grasp the deeper meaning of individuals' actions and ways of thinking and acting. We can thus think of health in the frame of an economy of value, which involves recognising the meaning and use of a notion such as health, and recognising that this notion is not a given; it is constantly negotiated, translated, and it is the subject of a transaction. To think about health in prison is to examine the legitimacy or illegitimacy of a particular inmate as a recipient of care, in a context of limited resources where the provision would not be satisfactory for the general population. I suggest that we listen again to Dr Angora in this regard.

Dr Angora: I was based in Adiaké, then I asked to come to Abidjan to specialise. Being a general practitioner, I wanted to specialise, I wanted to do dermatology. I kept asking, but I had no joy. I insisted, I insisted, and then one morning I was told that I had been assigned to the MACA. I informed my eldest son. What does he say to me? He tells me, but that can't be right? With so many health centres in Abidjan, they go and put you in the MACA? In a prison? I said, well, I'm going to try, because if people are there, I can do it, I'll have plenty to do. And so, I put myself to the test.

Key takeaways

We must understand the plurality of meanings and logics behind the involvement of health care actors in prisons, from epidemiological logics of controlling contagion to the resources of local health practices. The provision of health care in prison relies on a precarious balance between these different parameters.

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Week 4.2

The constraints on prison policies

The constraints on prison policies

Marie Morelle
HDR lecturer in geography, University of Paris 1 Pantheon-Sorbonne, Prodig, Ecoppaf programme
Frédéric Le Marcis
Professor of social anthropology, ENS de Lyon, Triangle, Ecoppaf programme
Dr Karim Traoré
Doctor, Director of Health and Social Welfare at the Ministry of Justice, Burkina Faso

The will and realism of prison health policies

Marie: Health policies are implemented under certain constraints in the prison context. This is what Dr Karim Traoré demonstrates. This doctor has long been involved in the care given to inmates at the MACO, the Ouagadougou Detention and Correctional Centre in Burkina Faso. He was recently appointed Director of Health and Social Welfare at the Ministry of Justice.

Frédéric: Yes, he speaks about the conditions and political significance of his appointment, but also about the practical conditions for the implementation of a progressive policy towards a socially illegitimate population.

Dr Traoré: My appointment as Director of Health and Social Welfare at the Ministry of Justice reflects the ministry's political will to really address the health issues that affect prison populations. The political project, as it was drafted, is very progressive. In 2017, we saw the enactment of Act 10 on the penitentiary system, which granted adequate health rights to prisoners, including free access to all medical care available at the infirmary, university hospitals, or district hospitals. This law also enshrines the exemption from all forms of paramedical assessments for these prisoners. This law also requires district doctors to visit prisons to perform medical consultations on a weekly basis. It also provides for the construction of secure hospital units at university hospitals and regional hospitals. So the political project is very progressive, but the problem is the lack of resources to be able to truly implement all the provisions of this law. Another problem is the issue of legitimacy: how can we defend all the money that will be spent on these inmates, on a population whose legitimacy is a problematic issue for the general population. Inmates are rejected and there really is a problem of recognition with regard to spending to cover free health care and free food for people deemed illegitimate.

The health consequences of the illegitimacy of inmates

Marie: Dr Traoré talks about the illegitimacy of inmates. What does this mean exactly?

Frédéric: For families, detention quite often amounts to a form of banishment. Many inmates are socially disaffiliated. They receive no visits, no financial support, no food parcels. But that has serious consequences for their health: an inmate in such conditions, if he needs to pay fees, pay for medicine, fund an external consultation, he will be unable to do so. He will need to rely on the involvement of NGOs and denominational actors, who are occasionally involved in prisons, or he could possibly approach the prison authorities. There are usually budgetary provisions to fund the care of this type of inmate, but the funds are either not requested by prison governors or they are simply insufficient. Moreover, the prison ration, the daily food ration given to inmates for their nourishment, is of really poor quality. As a result, inmates who rely wholly on this food for their nourishment become heavily exposed to dietary deficiencies and deficiency conditions. Dr Traoré explains what these deficiency conditions are.

Dr Traoré: In terms of deficiency conditions, these are primarily beriberi, which is a deficiency in thiamine or vitamin B, of course linked to inmates' diet, which is deficient in vitamin B1. There are also skin conditions. These conditions do not receive support from any specific programme, although they are quite numerous in our prisons. Unfortunately, they do not benefit from a support programme like those for HIV/AIDS and tuberculosis, for example.

Frédéric: In fact, from a political point of view, the illegitimacy of inmates translates into too high a political cost for investing in the health of inmates. For example, a health minister from a West African country explained to me that he could not justify investing in the health care of inmates as long as the entire general population did not have access to the same type of services. It's a problem.

The tension between population-based and individual-based approaches to health

Marie: In this context of limited resources, could we not expect the involvement of international partners?

Frédéric: Not really! In fact, the international aid agenda does not necessarily meet the needs felt by actors on the ground. From the epidemiological point of view, at the national or even international level, it is of course entirely legitimate and appropriate to want to deal with contagious diseases such as HIV, tuberculosis, or hepatitis, because the prison system is a site of production and reproduction of this type of epidemic. However, this thinking at a population level ignores individual needs as expressed in the words of inmates or caregivers at the local level. Dr Traoré comes back to this question and helps us to understand the tension between individual-based and population-based approaches.

Dr Traoré: We have international partners who support us in addressing our inmates' health concerns. Among the rationales behind international aid actions, there are considerations such as visibility, as well as predetermined themes that are not necessarily our priorities. Among our priorities are the issues of prison overpopulation and other health conditions that are quite significant in prisons and that do not benefit from a specific programme. I am referring to dermatosis, for example. So, such is the situation, meaning that we have partners who support us, but unfortunately they have predetermined themes and we make do with what the partner says. Meanwhile, we have priorities that are just as important. People will of course say that it is the government's responsibility to address issues of overpopulation; that it is the government's responsibility to address food issues; of course, but our priorities are still not necessarily the same as those of our international partners. These are some of the constraints we face in terms of collaboration.

Marie: Yes, it's very clear. So there is a population-based logic—the management of epidemics—and an individual-based logic—personal health. But what would be the watchword for health care in prison?

Key takeaways

To summarise, we could say that prison represents disruption. But biographical disruption and the disruption of social bonds and of family life that incarceration represents should not be compounded by disruption in the chain of care. In other words, the administration of punishment that incarceration involves must not result in a withdrawal of care. What does that mean? It means that healthcare workers in prison must absolutely ensure the continuity of care.
This continuity of care is expressed in two ways: First, for inmates entering prison, it is right that an inmate who arrives with a condition and who is undergoing treatment should not be prevented from continuing his treatment once incarcerated. Second, an inmate who develops a condition in prison, or whose condition is discovered in prison, should be able to continue his treatment once he leaves. Dr Traoré, recalling the constraints in the implementation of this continuity of care in the context of prison healthcare services in Burkina Faso, provides us with a very enlightening example.

Dr Traoré: Our constraints are many: constraints in terms of insufficient resources—material resources, logistical resources, human resources. There are also constraints when it comes to release from prison. How do we ensure continuity of care for some patients upon leaving prison? This presents us with enormous challenges. If I take the example of Bobo-Dioulasso last November-December, where we were able to detect twenty-seven tuberculosis patients, the real issue now is the continuity of care, because, out of these twenty-seven tuberculosis patients, there are five who have been released whose continuity of care we are uncertain of in an external environment. Our vision is to be able to turn the care of inmates into a central and overarching issue. Our vision is that, upon entry, care may be systematised through a number of care events, visits, physical examinations, a paramedical examination, and a full biological and radiological assessment, so that an inmate who arrives in prison cannot bring a disease with him to contaminate others. And also that, upon exit, this care be equally systematised, so that the host family, families, or the general population cannot be contaminated by conditions picked up in prison.

This very reasonable proposal remains dependent on two key factors: First, the will of the state and its ability to act in the field of prison health. Naturally, this requires a radical transformation of the way these populations are considered, and in particular a transformation of their depiction as illegitimate. Secondly, it implies a real transformation of the practical conditions for delivering care in the prison environment.

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Week 4.3

The delegation of health care

The delegation of health care

Frédéric Le Marcis
Professor of social anthropology, ENS de Lyon, Triangle, Ecoppaf programme
Marie Morelle
HDR lecturer in geography, University of Paris 1 Pantheon-Sorbonne, Prodig, Ecoppaf programme
Pacôme (pseudonyme)
Former inmate and head of the infirmary block at the Abidjan Detention and Correctional Centre, Côte d'Ivoire

The delegation of tasks: A widespread reality in the public sector

Frédéric: Here, we will address the issue of the delegation of health care in prison. Before delving into this subject, it is worth remembering that the question of delegation is inseparable from prisons on the continent. Ever since the colonial era, there has been a delegation of authority from guards to inmates in managing the day-to-day running of prisons. Clearly, the issue of delegation is something that varies depending on the country and even, within countries, depending on the prison. Nevertheless, the fact remains that this issue is characteristic of prisons in the African context.

Marie: Yes, quite so! This specific mode of governance was the subject of a special issue of the *British Prison Service Journal*, entitled 'Everyday Prison Governance in Africa'.

Frédéric: Yes! From this point of view, health care really is no exception. Alongside official care actors in prisons, you also find (much like health centres in the outside world) a set of actors who are not officially registered as professional healthcare workers, but who 'act as such' within organisations. In prison, these are 'corvéables', or unpaid labourers, who take care of dressings and perhaps give injections, as well as recording vital signs or watching over patients during the night when the professionals have gone home; even if they are on call, the professionals do not spend the night on site. Let's take an example from the MACA, the Abidjan Detention and Correctional Centre. This is the largest prison in Abidjan. In June 2018, there were 7,000 inmates, which is over half of the total prison population of Côte d'Ivoire. This map shows the guards-to-inmates ratio:

Frédéric: In a prison with a ratio like that of the MACA, it is clearly vital that inmates play a significant role in the day-to-day running of the prison. At the MACA, these inmates are called '*corvéables*'—those who intervene in health care, in the infirmary, are generally people who have some experience of health care in the outside world, but not exclusively so. We will also find people who play the role of care assistant, or perhaps a sort of nurse, and these will also be inmates. They may simply be there because they know one of the professionals in the infirmary who is from the same neighbourhood as them, who knows one of their relatives or a friend, and who will try and help that inmate by ensuring better conditions for their time in prison. Because, when working in the infirmary, you can move freely around the prison, you eat better, you can move around, you can have a point of entry to the outside, since you will naturally be in daily contact with professionals who are a kind of a 'go-between', a point of mediation between the inside and the outside.

Marie: Can you give a practical example?

Healthcare tasks in prison: Accession, distribution, benefits

Frédéric: Pacôme was head of the infirmary block at the MACA for several years. We met for an interview in Abidjan, where he described what the activity of the head of the infirmary block at the MACA looked like in practice.

Pacôme: I became a *corvéable* at the infirmary building because, in civilian life, I worked in health care. I was a care assistant before entering prison. I was a convict, which meant that I met the conditions in the eyes of the authorities, and I was from a healthcare background, which allowed me to be in the infirmary to organise things for my fellow inmates and for myself and to help the medical staff treat the sick.

Frédéric: Could you tell us what are the necessary conditions to become a *corvéable* in the infirmary, and what are the benefits of that role in prison?

Pacôme: The benefits of being at the infirmary? I could move between the main office and within the prison without threat, without fear. It was as though I were free in a way.

Frédéric: Somewhat untouchable? Respected by...

Pacôme: Respected by everyone, by the prison authorities, by my fellow inmates, and by the healthcare team. At the block, I had my head employee who had employees that he was responsible for. There were two people who were at the records office, there were workers responsible for the wards and for the patients who can't move, there were key masters responsible for security at the infirmary, there were morgue workers who were also inmates, who were in charge of the morgue, and there were inmates who were at the anti-tuberculosis centre, who also cared for TB patients and who helped the TB care staff.

Frédéric: As head of block, you lived at the infirmary, you had your own personal cell at the infirmary. The other *corvéables* lived in the incarceration blocks, but were '*décalés*' ['shifted'], as they say, to leave their cell early in the morning to come to the infirmary.

Pacôme: I slept at the infirmary and the others lived in blocks A or B. In the morning, they came to do their tasks and, in the evening, from 6 p.m. onwards, everyone returned to their block.

Unequal access to care as a result of inequalities in prison

Frédéric: Could you explain to us how the inmates in the blocks could access the infirmary, and in particular explain to us what the role of the sick book was?

Pacôme: In the other blocks, there are people who are responsible for taking note of all those who are sick, of entering them all in their sick book, in order to bring them to the hospital. This is what emerged from various consultations we had with the different heads of blocks. But things didn't work out the way we'd hoped, as those responsible for taking note of the names would ask the inmates for money in order to let them leave, to 'shift' them to the infirmary.

Marie: But in this system, the delivery of care is inevitably unequal, it depends on the finances or social networks of the inmates?

Frédéric: Yes, quite so! Pacôme also explained how inmates manage to access care outside the prison. Pacôme, in this context, who are those who manage, for instance, to go to the hospital or access specialist medicine, or have a consultation such as an x-ray, outside of the prison?

Pacôme: Well, that really depends on who the inmate is. Because most of those who are allowed out to go to a university hospital outside of the prison are inmates from the assimilés. The assimilés is a block where the bigwigs stay: ministers, company CEOs, civil servants, high-ranking officials who end up in prison; their kind have easy access to hospitals.

The internal and external logics of the absence of care in prison

Marie: But does prison entail the systematic death of the poorest inmates?

Frédéric: Not necessarily. In fact, social representations of the illness, the way the illness is perceived and its gravity on the outside, in general society, also play a role in how people think about the illness in prison. Sometimes prison can be a place of care, but at the same time it can also be a place of death, where security issues may be put forward to justify the fact that a patient will not be cared for and may potentially be left to perish. Pacôme told me about something he himself witnessed in relation to this. Pacôme, could you tell us, regarding your prison experience, what was perhaps the moment when you were most satisfied with your work in the prison healthcare sector, and possibly the moment when you were most disappointed about your inability to do something?

Pacôme: I witnessed something one day. A new inmate arrived in prison, who had a bit of bad luck in his cell, and he came to the infirmary. He was hospitalised and, given that his condition was very critical, the doctor issued an evacuation ticket. The prison authorities found out that he was a newcomer who had no status. They held things up and held things up, until two days later, three days later, as he was being evacuated, the man sadly passed away. But even so, they pretended not to be aware of his death when they placed him in the ambulance; they left, and the university hospital reported his death.

Frédéric: Do you have a memory of a somewhat positive action?

Pacôme: On the other hand, there was a case of attempted suicide. An inmate climbed up to the esplanade on the fifth floor. He let himself fall, he had multiple fractures. I was the only healthcare worker because it was a Saturday, so everyone was away. So I immediately got out my phone, which was banned in prison. In front of my supervisors, I called the nurse on duty who immediately came to have a look, and then a chain of solidarity ensued in the hours that followed. They came and evacuated the man. Some three to four months later, he returned in good health. I was truly relieved, and I was really happy for this man.

Frédéric: And, in your view, what made the difference between the man who was evacuated and the man you told us about who could not be evacuated in time? Why did one manage to go and not the other?

Pacôme: He was evacuated because it was something visible. Everyone saw his dislocated foot. He had fractures, all the inmates, all the prison guards were there. It was a real spectacle. He had broken his jaw, his hands, there was blood everywhere, so this worked in his favour and he was evacuated even without the need to prepare an x-ray file, an evacuation file. Whereas the other one, he was very big. The one who passed away, he was quite fit, very big, but his body was suffering, and upon seeing his medical chart, the doctor called for his evacuation; unfortunately, the prison authorities did not recognise it.

Key takeaways

We must not conclude based on these accounts that health care in prison is limited to what happens within prison. When inmates begin a treatment in prison, they quite often become lost to the care services upon their release. This happens for two main reasons: First, when they return to their neighbourhoods, they cannot access healthcare services because these poor neighbourhoods lack services. Second, the stigma of prison follows them, and they do not dare present themselves at health centres admitting their prison origins, and, as a result, they abandon treatment.

Pacôme reminded us during our interview in Abidjan that, upon his release from prison, he would have liked to have played a more important role in delivering care for these inmates who went off the radar, by seeking them out in their neighbourhoods, on account of the trust they had forged during their time in prison. It wasn't possible and he regrets it.

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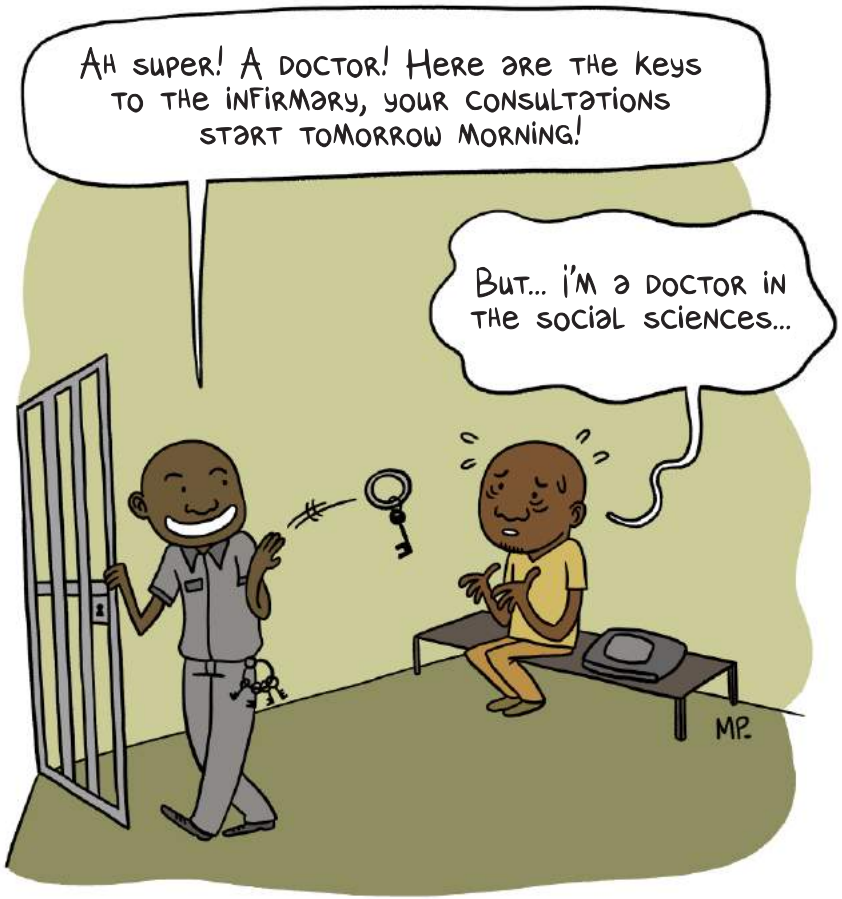

Week 4.4

The treatment of HIV at the MACA: A case study

The treatment of HIV at the MACA: A case study

Frédéric Le Marcis
Professor of social anthropology, ENS de Lyon, Triangle, Ecoppaf programme

Dr. Jeanne D'Arc Assemien-Ouattara
Doctor, Health Coordinator at Expertise France, Côte d'Ivoire

The epidemiological observations that inspired the programme

Frédéric: Today, we would like to come back to the implementation of the HIV and tuberculosis programme launched in 2008 in Côte d'Ivoire by Expertise France, with funding from the Global Fund. To talk to us about it, we have Dr Jeanne d'Arc Assemien. Jeanne D'Arc, you are the head of the health side of Expertise France in Côte d'Ivoire. Before going into the details of the programme, perhaps we could recall a fact, which is that Côte d'Ivoire is a country strongly affected by HIV, with a prevalence rate of 3.7% among the general population. By way of comparison, there is an estimated prevalence rate of 7% among women in prison. The treatment of HIV in prisons was not systematically present in Côte d'Ivoire prior to your intervention in 2008. In this context, Jeanne d'Arc, what was the driving force behind the intervention by Expertise France at the MACA?

Dr Assemien: The intervention of Expertise France was based on the principle of equal rights of access to health care for prison populations and populations on the outside.

Frédéric: What was the aim of your programme?

Dr Assemien: The aim was to provide preventive measures, treatment, and psychosocial follow-up to these patients.

Frédéric: How did you operate and how did you manage to find local representatives for your project?

Bringing together and coordinating the different actors in prison health care

Dr Assemien: The representatives are politicians interested in our project, but also actors on the ground. We relied on the partnership that had been established between the infirmary of the Bordeaux-Gradignan prison and the infirmary of the Abidjan Detention and Correctional Centre. We organised placements, or at least study missions, for the main officials of the Ministries of Health and Justice, which therefore included the DGS (the Director-General of Health), the Director of Penitentiary Affairs, the governor of the Abidjan prison, and the prison's head doctor. These people made on-site visits, and they came to realise that the level there was so low that they were not even familiar with the realities in Abidjan within the context of Côte d'Ivoire. Upon their return, they undertook a situational analysis of nine operating prisons, and in May 2009 there was a feedback workshop on these two missions, which brought together all the leaders at the Ministry of Health, who wanted to consider medical conditions in the prison environment, as well as those at the Ministry of Justice and the DAP [Department for Prison Affairs] and the Ministry of Economy and Finance.

Frédéric: So you set up a network with national and international partners?

Dr Assemien: Absolutely. The ICRC, of course, and the UNOCI were also involved.

Frédéric: What were some of the stumbling blocks you came across in the programme?

The constraints on health promotion in prison

Dr Assemien: The first stumbling block was food. Food, because it cost 150 francs per day per inmate. There was also the issue of referrals, i.e., treatment at the referral hospital. There were no essential medicines in the prisons. There was also the issue of care staff, who were not available across the board in prison infirmaries. Those were the big difficulties we faced.

Frédéric: You trained peer educators in the field. Did you encounter difficulties with these peer educators? And of what kind?

Dr Assemien: We trained not only peer educators but also community counsellors for the psychosocial care of patients. We trained nurses to the point of obtaining inter-university degrees, in particular in Ouagadougou; we financed placements abroad, especially in Bordeaux, so that all knowledge could be exchanged. But of course, with peer educators, the main difficulty was the turnover, that is to say, they came in and out. So, we trained people who were then released after two or three months or a year, meaning we were understaffed.

Frédéric: They were released in the context of presidential pardons, which are one of the ways of managing overpopulation in our prisons.

Dr Assemien: Exactly, that was one of the ways of dealing with this crisis.

Frédéric: You were losing the training capital that you had invested in these peer educators because they were being released.

From the programme to prison policies

Dr Assemien: Absolutely. So this workshop allowed us to establish a joint committee on health in prison, which brought together all the departments of the Ministry of Health: the national AIDS programme, the national tuberculosis and malaria programmes, the programme for nutrition, as well as the directors of health facilities and professions in order to monitor all of this. This enabled the creation of the joint committee and the drafting of the prison health policy document, followed by the health standards and guidelines. This is a document that did not exist at all beforehand, so it was truly one of the results of the project.

Frédéric: This national policy document was presented to the Council of Ministers. However, it was not followed up by the publication of implementing decrees. How do you explain this situation?

Dr Assemien: I think it's due to the budget trade-offs that the state is faced with. And also the fact that the size of the prison population is by no means easy to gauge, since there are many entries and exits happening simultaneously, making budgeting a little risky. Finally, there is the fact that, due to a lack of funding, you sometimes have to set priorities, and so, faced with a population that is not exactly legitimate, you have other priorities. The minister tends to want to treat the entire population of Côte d'Ivoire, but with certain priorities.

Frédéric: Before we finish, could you give us some figures on the practical results of your programme in terms of the screening of patients?

Key takeaways

Dr Assemien: Yes! We screened approximately 66,000 inmates between 2008 and 2017. We also diagnosed about 1,900 HIV-positive inmates using rapid tests. We gave treatment to around 680 people living with HIV, in accordance with the national guidelines. I must also mention that we were able to improve the working environment of the care staff through the refurbishment of hospitals. We gave them equipment; we were also able to make sure that these healthcare workers could truly benefit from training, conferences, and so on. Nurses have, for instance, been trained in the delegation of tasks, because doctors were the ones responsible for this previously, but we did this because they were resident nurses.

Frédéric: So, nurses have learned, for instance, to administer antiretrovirals?

Dr Assemien: Absolutely! But for first-line staff who work with a doctor who is not necessarily at the prison. Nowadays, we have doctors and nurses in the majority of prisons in Côte d'Ivoire.

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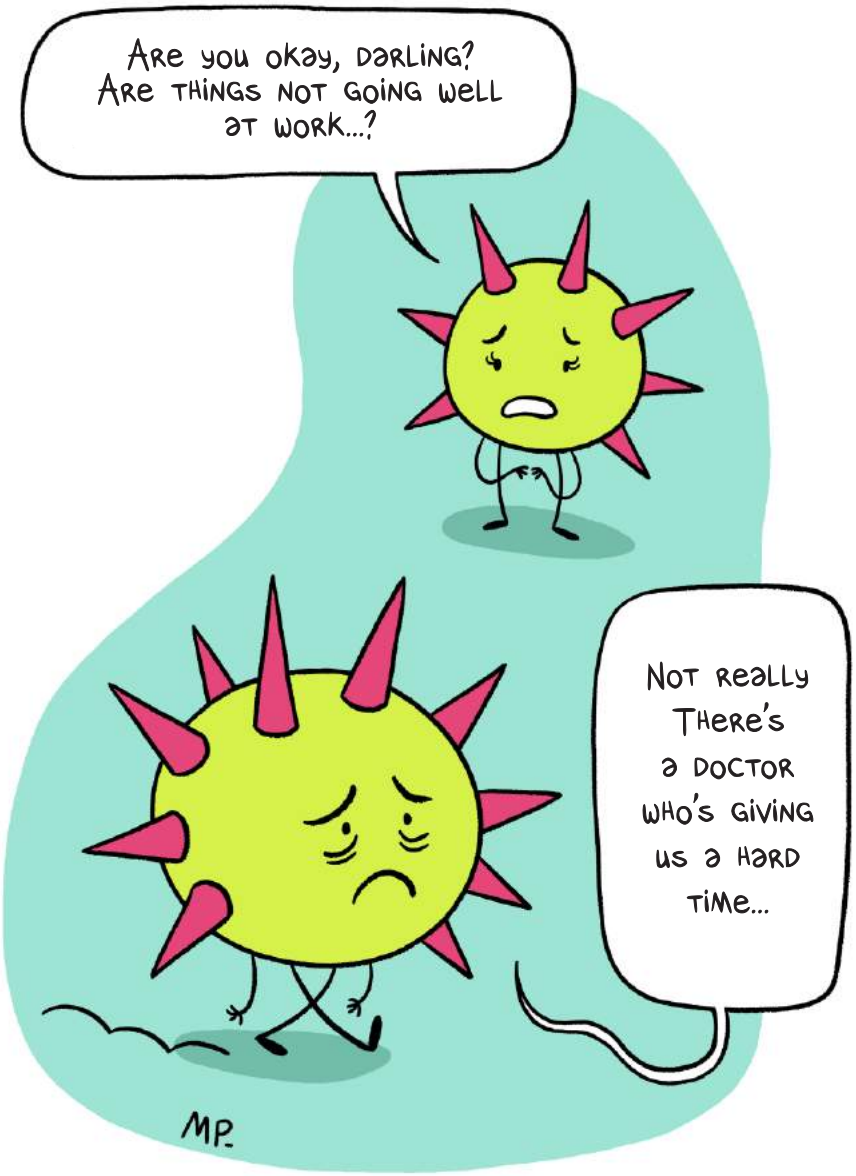


Week 4.5

Supporting, influencing, mobilising. The ICRC and health in prison

Supporting, influencing, mobilising. The ICRC and health in prison

Frédéric Le Marcis
Professor of social anthropology, ENS de Lyon, Triangle, Ecoppaf programme

Dr. Carole Dromer
Doctor, Coordinator of the Health Care in Detention programme of the International Committee of the Red Cross (ICRC)

The ICRC's work in the field of health in prison

Frédéric: Carole Dromer, you are a doctor and the coordinator of the ICRC's Health Care in Detention programme. Could you tell us what is the nature of the ICRC's work in prisons?

Dr Dromer: The nature of the ICRC's work in prisons, or elsewhere for that matter, is humanitarian. I would even add that it is sustainably humanitarian, wherever possible and appropriate. We work on armed conflicts and other situations of violence; and we have major operating principles that have been followed for years, ever since the ICRC came into being. These are neutrality, independence, and impartiality. Neutrality means that the ICRC does not take a side. Independence means that the ICRC itself decides on its actions. And impartiality means that the ICRC does not discriminate between populations or individuals. New concepts are increasingly being added to how it operates, which include partnership, taking into account the desires of the people for whom and with whom the action is being led, and accountability to those people. Ultimately, the foremost value remains the dignity of every man and woman.

Frédéric: From a healthcare point of view, how do these principles apply in practice?

Dr Dromer: From a healthcare point of view, that's where we think from the outset about sustainable humanitarian action in prisons. This means that, from the beginning of the emergency itself, we will be thinking about the sustainability of the action, and, as part of a sustainable action, we will be thinking about what happens if there is an emergency. So our goal, when it comes to detention, becomes one of sustainably improving the living conditions of inmates. And in order to achieve this, the ICRC has the opportunity not only to work with the authorities, but also to have multidisciplinary teams. This allows us to work on the determinants of health, and not just on access to care. So we will be working on water, on housing, on food, on education, on family ties, on leisure activities, on legal guarantees. All of this is important because every aspect of health, every aspect of detention, has an impact on people's health or even the health of societies, since these people will sooner or later be released into society.

Frédéric: You only intervene in crisis situations or post-conflict situations. Across the continent, how many countries do your interventions cover?

The scope and duration of the ICRC's interventions in prisons in Africa

Dr Dromer: In terms of health care in detention, it's twenty countries, a figure that is slightly higher if we are talking about the ICRC's general presence. But as far as health care in detention is concerned, it's twenty countries. And that covers around 200,000 inmates and 250 detention sites.

Frédéric: What is the average duration of your interventions?

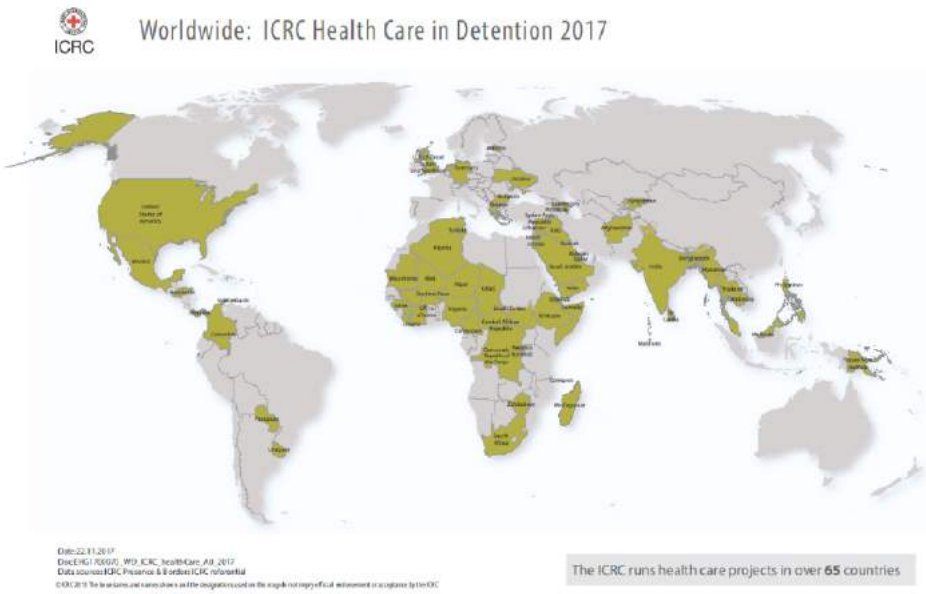
Dr Dromer: There really is no average duration, but anyway, the ICRC is in it for the long term. We stay for years and years. There are some exceptions, but we stay for years. Just as armed conflicts and situations of violence tend to last a long time, so does the work of the ICRC.

Frédéric: You operate all around the world. Does your intervention in African have any specificities, is there a healthcare issue specific to the continent?

Malnutrition: The first characteristic of Sub-Saharan African prisons

Dr Dromer: There are specificities, as well as similarities, but they take on an entirely different dimension. One of the major specificities is the presence of malnutrition. This is not the case for all the countries where we operate. We operate in twenty countries in relation to health care in detention, and in sixteen of these we are working on malnutrition, that is, preventing or treating malnutrition. And last year, for instance, we treated just over 35,000 people who were suffering from malnutrition. So it's a major problem.

Frédéric: Does this concern the entire continent equally, or are there are disparities both between the continent's major regions and perhaps between regions within the same country?



Dr Dromer: There are mainly disparities from one country to another. North Africa is quite unaffected by all of this, as one of the primary causes of malnutrition in detention is a food ration that is inadequate in terms of quantity and quality. This is among the primary reasons. And we don't face such problems in North Africa.

Frédéric: You showed us a photo of a kitchen in a rural prison in Africa. This picture clearly demonstrates that the problems are not just about providing food, but also about being able to cook it. In what kind of prisons are these situations observed?

Dr Dromer: Well, this type of situation may appear extreme, but it is quite common, especially in rural prisons in Africa. It is quite clear that this person who has to cook for a thousand people is unlikely to manage to do so. With this lack of resources in the kitchen, even if there were food in the prison, it would be impossible to feed so many inmates. So, there are disparities within the same country. In general, the prisons that hold the most inmates and that are in capital cities are a bit better off than prisons in remote areas.

Little use of solitary confinement: A second characteristic of Sub-Saharan African prisons

Frédéric: Could you give us another example of a shared feature of African prisons?

Dr Dromer: There is another shared feature that happens to be rather more positive, and it is the fact that there is little use of solitary confinement. While this is not the case in North Africa, it is true in other parts of Africa. And I would say that this is positive, because solitary confinement is very harmful to people's health; very detrimental to both their family and their society, because it causes serious damage to health.

Lack of treatment for mental health problems: A third characteristic of Sub-Saharan African prisons

Frédéric: One final shared feature, I believe, is the treatment of mental health problems?

Dr Dromer: Yes! This is a similarity found in all countries across the world. But in Africa it takes on significant proportions, because even the free population has very little access to mental health treatment. And prison populations have even less. What occurs in some countries is that because society is unable to come to grips with this problem, there is little understanding as to what to do with these people suffering from serious mental disorders, and so they end up being incarcerated. As a consequence, these people suffering from mental disorders find themselves incarcerated, locked up without treatment.

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Key takeaways

Frédéric: So, we are also faced with a problem of a lack of resources?

Dr Dromer: Yes, that's another similarity that takes on huge proportions. It is indeed a question of a lack of resources. Many countries in Africa lack the means to provide inmates with even the bare minimum. I am not even talking about access to care in this case; I'm talking about sufficient drinking water, a balanced and healthy diet, clean living conditions—even that is a problem.

Frédéric: It is a political issue that is also related to the question of the legitimacy of inmates in the eyes of general populations.

Dr Dromer: Indeed, because states are largely just a reflection of their own societies. So, if their societies see inmates as people who can be abandoned or neglected, states will do the same.

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