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PRISON STAFF EXPOSURE TO PATHOGENIC DISEASE AND OCCUPATIONAL HEALTH RESEARCH IN AFRICAN PRISONS: A NEGLECTED AREA

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Like all persons, prisoners are entitled to enjoy the highest attainable standard of health and humane treatment. Specifically, Rule 2 of the Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) states that in applying the principle of non-discrimination, prison authorities shall consider the individual needs of prisoners, particularly the most vulnerable. Rule 24 of the Nelson Mandela Rules further mandates that provision of health care for prisoners is a state responsibility, ensuring that prisoners should enjoy the same standards of health care as those available in the community. The Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules) specifically stipulate required standards for equivalence of healthcare programming and recognition of women's (and their children's) specific health care needs during incarceration. Despite these international mandates (and the presence of various African charters), there is severe health disparity of men, women and children deprived of their liberty in African prisons (Telisinghe, Charalambous, Topp, Herce, Hoffmann, Barron, Schouten, Jahn, Zacheriah, Harries, Beyrer and Amon, 2016). Human rights violations, systemic abuse and deplorable environmental determinants of health in these prisons (overcrowding, lack of space, malnutrition, inadequate sanitation, ventilation and hygiene) continue. African prison authorities are hindered by their weak prison health and public health systems, dated physical infrastructure, and severe congestion caused by high pre-trial detention rates (for example as high as 90% in Libya) (World Prison Brief, 2020). Many State facilities continue to breach the minimum conditions and standards of care. Some are deemed life threatening when investigated by international human rights monitors.

Prison settings in Africa are particularly conducive to spread of disease (for example HIV, TB, viral hepatitis, influenza, COVID-19) (Todrys and Amon, 2012; Telisinghe et al., 2016). For example, HIV prevalence among prisoners in the sub-Saharan African region has been estimated at two to 50 times the prevalence in general populations, and with TB prevalence estimated to be six to 30 times that of national rates (United Nations Office on Drugs and Crime, UNODC, 2008; Telisinghe et al., 2016). This is due in part due to the State prioritisation of prison security rather than to basic health rights (for example adequate ventilation, space, sanitation, safe drinking water, hygiene, nutrition), the lack of prison based medical care and sufficient measures to prevent disease, high rates of HIV and TB co-infection amongst prisoners, and the presence of multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB (Habeenzu, Mitarai, Lubasi, Mudenda, Kantenga, Mwansa and Maslow, 2007; Telisinghe et al., 2016). Particularly vulnerable prisoners include those who are immuno-compromised, malnourished, juveniles, and women and their circumstantial children, whose basic medical, gender and age sensitive health needs are often ill-resourced by African correctional authorities (Van Hout and Mhlanga-Gunda, 2018; 2019a:b).

Research into prison health in Africa continues to be of low priority and is underdeveloped (Mhlanga-Gunda et al., 2020). The complexities and bureaucracies around researcher access into prisons, and the requirements for robust ethical

governance and academic transparency in reporting compound this issue. A series of three extensive scoping reviews on prison health standards and situation in the sub-Saharan African region have compiled extant literature from all 49 Member States since 2000 (Van Hout and Mhlanga-Gunda, 2018; 2019a:b). These reviews illustrate an evident lack of academic interest, attention and monitoring of prison health situation in many sub-Saharan African countries, where in some, no academic literature has been published, and where government health and infections related data, and inspectorate reports are embargoed (Van Hout and Mhlanga-Gunda, 2018; 2019a:b). There is a concerning lack of visibility of strategic health information and academic activity in the field of prison health. Information where available is largely confined to rapid assessment of infectious diseases (HIV, TB), post graduate theses, prison case studies and international human rights monitors. For example, there are various African Commission on Human and Peoples' Rights reports on conditions of detention in the sub-Saharan African region in the past twenty years (for example Côte d'Ivoire , Gambia, Malawi, Namibia, Uganda, Mozambique, Ethiopia, Cameroon, South Africa), Human Rights Watch (Zambia), Penal Reform International (Uganda); and Amnesty international (Chad). There are also some very encouraging empirical multi-stakeholder research studies conducted by Stephanie Topp and colleagues since 2016. These are a flagship for positive research activity used to inform the Zambian prison health system reform, the use of Prison Health Committees (PrHCs) to improve social accountability, and the upscaling of prison health provision in the country.

Of note for this *Commentary* is that whilst these three reviews which showcase extant published literature in the past 20 years on prison health in sub-Saharan Africa (Van Hout and Mhlanga-Gunda, 2018; 2019a:b) and indicate low level interest in the field of prison health; multi-stakeholder studies (for example in Zambia, Cameroon, Zimbabwe, Malawi; Kenya and Uganda) who do consult with prison staff, focus their attention on staff perspectives on conditions for prisoners (adult men, women, children born in prison, juveniles). The reviews further highlight a startling lack of focused empirical research activity on the occupational health experience of prison staff. This aspect of prison health or correctional services research is notably absent. There is no information on their health needs, perceptions of risk, or their well-being. Prison staff from ground level up to management operate in extremely challenging environments in sub-Saharan prisons, and appear neglected and ignored by researchers, human rights monitors and sub-Saharan African governments. It is notable that in the wider justice literature, prison and custodial staff are generally represented as targets of reform or objects/subjects of critique (Jefferson, 2007; Trounson and Pfeifer, 2017). They do not appear to warrant attention in terms of their human or indeed occupational health rights within the confines of the prison working environment.

Understanding the social determinants of health and cultures which shape prison and custodial staff responsiveness to contagion, impact of environmental conditions, risk navigation, health protection awareness, and work-related stress is vital to improve their health and well-being, and their working conditions in sub-Saharan Africa (Gadama, Thakwalakwa, Mula, Mhango, Banda, Kewley, Hillis and Van Hout, 2020; Mhlanga- Gunda, Kewley, Chivandikwa and Van Hout, 2020). These studies have illustrated an increased staff awareness of prisoner right to health in line with international norms, and staff concern for the lack of basic necessities (safe drinking water, soap, food, clothes, medicines) for those deprived of their liberty. This is a positive outcome in terms of slowly stimulating a shift toward improved environmental health conditions for prisoners, alongside a greater appreciation of their human and health rights. However, it is tempered by the documentation of the deep concerns by prison staff for their personal health and that of their families, and their anxiety around bio-hazard risks (particularly airborne disease) linked to the working conditions of the prison environment itself (congestion and lack of ventilation in cells, lack of soap, clean water, unsanitary toilets), and the physical and psychological stressors related to their job.

It is vital that greater academic and policy level attention is now devoted to addressing the risks encountered by prison staff with regard to the prison environment, and particularly in terms of prevention of infectious and contagious disease. The *"bridge"* between prison and community cannot be under estimated in Africa, with risks of disease transmission not limited to those deprived of their liberty but extending to visitors to the prisons, prison staff and clinicians who work there, and their families living in surrounding communities (Kachisi, Harries, and Salaniponi, 2002; Mhlanga-Gunda, Motsomi-Moshoeshoe, Plugge and Van Hout, 2020). Disease is spread via the prison eco-system of *structural deficits* causing congestion, poor sanitation and ventilation, and the *resource deficits* compounding efforts to control disease and outbreaks. There is great risk of outbreaks and disease amplification (HIV, TB, hepatitis, influenza, and now COVID-19) (Telisinghe et al., 2016; Van Hout and Aaraj, 2020; Van Hout, 2020). As mentioned earlier, HIV and TB rates are higher than in the general population, there is a concerning presence of drug resistant TB, co-infection rates, and most recently, a steep increase in COVID-19 cases in African prisons (prisoners and staff) (for example in South Africa, Kenya, Ivory Coast, Ethiopia, Algeria, Morocco, and Cameroon) (Prison Insider, 2020). Prison staff cannot be "*left behind"* in the government focus in tackling disease. They are exposed to the same environmental pathogens, they generally share the same congested space; air for breathing; toilets and water for washing, drinking and cooking. They are also further marginalised by low wages, significant stressors associated with their role, and experience significant risk to their health (and their families). The often poor continuum of health care of prisoners into the community, and scarce human and civic resources for health of both prisoners and staff in the prison compounds the issue.

In 2000, the Human Rights Committee of the Economic and Social Council published the Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14 (Article 12) on the "*Right to the Highest Attainable Standard of Health"* underscored that the right to health transcends provision of /access to services and is grounded in health determinants such as access to adequate food, nutrition, housing and water. These health determinants directly relate to poverty levels, and are closely tied to state responsibility to tackle poverty. This also applies to the prison situation. Prison authorities and management have an important role to play in ensuring that both prison staff and prisoners feel safe and have the opportunity to maintain and improve their heath (World Health Organization: WHO, 2007; 2014). It is a human rights breach to continue to ignore prison staff in research and human rights monitoring on the state of African prisons, and it is now urgent that authorities uphold and respect their rights to a supportive and safe working environment. Much more needs to be done to recognise their unique occupational health risks in African prisons. Sadly they represent a neglected and unique prison population.

Ultimately the prioritisation of security in African prisons must not eliminate the public health issues at hand (Keehn and Nevin, 2018). Tackling disease in prisons is a human rights and public health issue, and requires a strategic approach to prevent transmission and improve health for all, including as an occupational and community health issue. The basis of safer working conditions for custodial staff pertaining to disease in African prisons is underpinned by packages of HIV, TB and now COVID-19 health interventions (UNODC, 2010; 2013; 2020; WHO, 2016). These are generally not sufficiently implemented in Africa due to a host of resource, policy and systems related barriers (for example, fragile health systems, low health system preparedness, lack of political will, laws criminalising sexual acts between men, prison congestion and high pre-trial detention caused by weak justice systems, low resource allocation to prison health, and lack of routine disease surveillance and prevention protocols) (Van Hout, 2020; Van Hout and Aaraj, 2020). Protection of prison staff from biohazards is mandated by the United Nations (UN) comprehensive packages (UNODC, 2013;2020). Principles of equality and non-discrimination, right to safe working conditions for custodial staff, and training requirements and assurances are additionally mandated in international and regional human rights law, standards and safeguards (UNODC,

2010). Gaps in implementation will have severe consequences for prison populations of prisoners and staff, local communities, and domestic public health.

The UN Declaration on the Right to Development (*Articles, 2,3 and 4*) underscores the need for equitable development polices which improve health and well-being, the realisation of the right to development, promotion of participation of vulnerable societal groups and state cooperation. Hence, a focused attention on the health and well-being of prison staff in Africa could contribute to strengthened collaboration and their right to be heard, alongside enhanced transparency, greater social accountability in tackling prison and occupational health, buy-in from government and prison officials, and the future upscaling of holistic prison health initiatives. Despite recognising that prisons exert significant influence on the social determinants of health, there are yet to be sustainable health promoting and protecting interventions which address health impact on prison staff in Africa. Such a concerted and strategic effort must be underpinned by collaborative policy-academic research and the support and encouragement of interested researchers wishing to study prison health and well-being of both prisoners and staff. Such an informed policy can support a positive shift to reforming African prison health and occupation health operations and systems in a sustainable manner. Important components include identifying occupational health deficits; including rights assurances of prison staff, occupational health rights training, and health protection support initiatives (routine health checks, active case finding of disease) to improve prison health standards and outbreak preparedness in African prisons, alongside efforts to alleviate congestion through prisoner release schemes, restorative justice for minors and alternatives to incarceration.

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