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Evaluations of the medical treatment in the penitentiary environment in the prisons of Nouakchott: Review of the literature

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Abstract

Introduction : *Health units have a heavy responsibility to ensure access to care for people in custody in an environment where the deprivation of individual freedoms makes their coordination sometimes complex. According to the current principles of the law of 18 January 1994, which aims to guarantee continuity of care for prisoners and makes it comparable to those provided in the general population, the experience of "patient-prisoner" remains largely under-represented. A prison population that seems to obey determinants of its own, which impact the assessment of medical care provided in a prison setting. Thus, the objective of our study is to evaluate the particularity of medical care in prisons in Nouakchott while trying to identify factors that may exert an influence on it.*

Méthods : *we conducted a prospective analytical and descriptive study with distribution of anonymous questionnaires to all the prisoners incarcerated in the different prisons of Nouakchott.*

Results : *Responses were collected from 316 inmates. Overall, participants seemed dissatisfied with the care provided by the health unit earlier, 38.9% of inmates considering their medical treatment in detention equivalent to that known before and 16.2% even considered it better. Contrary to what might have been expected, the age of inmates and gender did not appear to be determinants in the perception of medical care. Extended time to care in an emergency. The general perception of a state of health in detention, reported as degraded by 44.62% of detainees.*

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Conclusion : *our study shows that medical care does not tend to meet the expectations of the prison population, which is dissatisfied with the care provided by the health unit. Improving this management remains a challenge for the prison medicine of tomorrow.*

Keywords: *prison, prison medicine, inmates, health, medical care.*

INTRODUCTION

The prison environment is a violent, closed and oppressive environment where the individual deprived of liberty is subject to potentially totalitarian authority, binding disciplinary measures and codes of operation between inmates. Thus, the prisoner finds himself isolated in a threatening universe where he is confronted with repression, the dangerousness of the environment as well as his own anxieties and solitude (1). Prison became the most widely used form of punishment in criminal law from the 19th century, while torture and other punishments were abandoned. Thus, the prison structures do not take care of prisoners in the same way, whether they are «prejudged» or «sentenced», the inmates are likely to complete all or part of their sentence in different places (2). In this perspective of medical treatment at the prison level, our study aims to assess the health of this population during incarceration at the prisons of Nouakchott.

MATERIALS AND METHODS

We conducted a prospective analytical and descriptive study with distribution of anonymous questionnaires to all the prisoners incarcerated in the different prisons of Nouakchott. The survey included all prisoners in prisons at the time of distribution of the questionnaire.

We did not use an exclusion criterion when distributing the questionnaires, which is also intrinsically linked to the anonymous nature of the responses. All 765 questionnaires were distributed to the inmates in the various prison centres by the guards and a delay of one week was waited before the already filled-in questionnaires were retrieved. Thus, questionnaire data was entered in a handwritten and anonymized form. They were then transcribed on a SPSS computer file and analyzed on SPSS version 25 and Excel 2016, then this resulted in a bivariate analysis or the Pearson Chi two test at the threshold of significance less than or equal to 5% was used.

RESULTS

Out of the 765 questionnaires distributed, we received 316 valid questionnaires, a response rate of 41.3%. We can see that the majority of inmates who answered the questionnaire are men; precisely more than 93% (n=294) against only 7% women (n=22). The age group between 25 and 50 seems to be the most represented category of people interviewed, 59.5% (n=188), followed by the group of prisoners who report an age below 25 with 21.8% (n=69). Only 18.7% of inmates report age over 50 (n=59) (Figure 1).

The length of incarceration is largely represented by sentences served ranging from 1 year to less than 5 years with respectively 39.4% (n=125), incarcerations between one month and one year 32% (n= 101), 16.5% for the duration longer than 5 years (n=52). Shorter sentences, here characterized by a period of less than one month, accounted for 12% of the responses (n=38) (Figure 2). The medical examination was carried out on 53.5% (n=169) of the detainees, whereas 46.5% (n=147) did not receive a medical consultation upon arrival; The majority of detainees who received a medical examination on arrival did so after one week for 53.8% (n=170), 24.7% did so after 48 hours and only 6.3% were consulted within 24 hours of their incarceration. On the other hand, of the 169 consultations made at arrival, 0.6% of the cases (n = 1) were spontaneous and the 99.4% (n = 168) remaining were on demand. It should be noted that the arrival medical consultation was deemed necessary for 34.1% (n=108) of cases; was not done quickly enough for 33.9% (n=107) of cases and a loss of time in 32% (n= 101) of cases. Almost half of the inmates who consulted were dissatisfied with the arrival consultation, 46.47% (n=79), while 35.29% (n=60) were satisfied and 18.24% (n=31) were not at all satisfied with the consultation (Figure 3). Among the prisoners interviewed, 60.76% (n=192) reported having a chronic disease and 39.24% (n=124) believe they are free of pathology. Thus, participants with chronic disease do not regularly receive their medication in 59.68% (n=74) of cases compared to 40.32% (n=50) of cases reporting regular drug use. Among the 74 inmates with chronic diseases who do not regularly receive their medication, 63.5% (n=47) say that the stock was insufficient while 36.5% (n=27) of the cases note that the cause was a lack of organization. Among the inmates with chronic disease, only 13.7% (n=17) of the cases report being unfollowed, compared to 86.3% (n=107) regularly followed. Regarding the type of follow-up for sick prisoners, we found that 71.3% (n=76) of cases were followed by a specialist doctor compared to 28.7% (n=31) of cases by a general practitioner. Thus, the majority of specialized consultations are held in hospital in 80.4% (n=86) of cases and 19.6% (n=21) of the remaining cases are held in prison. At the time of consultation, prison staff were present during the majority of consultations, 82.2% (n=88) of cases, and not in 17.8% (n=19). In addition, prison staff requested to stay during the consultation for 79.5% (n=70) of cases, compared with 20.5% (n=18) of cases where it was at the request of medical personnel. Regarding the need for emergency care, a little less than half of the inmates or 50.3% (n=159) of the cases did not report a lived experience of a medical emergency situation; by contrast, 49.7% (n=157) of the answers reported having needed an emergency medical consultation. The question concerning the time limits for an emergency consultation reveals that a time limit considered to be long for half of the returns 52.9% (n=83) of cases and adapted for 47.1% (n=74) of cases.

Regarding ththeme addressed, namely the overall perception of the evolution of health status since incarceration, most respondents 44.8% (n=141) of cases seem to perceive a deterioration in their state of health. Thus, the statements of inmates who have benefited from prevention awareness are fairly unevenly distributed among the different providers. They mention that 69.3% of them (or n=216) were sensitized by a doctor, 19.3% (n=61) were sensitized by the nursing team. In 11.4% (n=36) of the responses, there was a total lack of prevention education. Furthermore, this awareness-raising on the prevention of persons in detention resulted in a

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screening for infectious diseases in 50.63% (n=160) of cases while 49.37% (n=156) of prisoners refused to be screened (Figure 4).

On the therapeutic side, respondents found that the quality of care was less good in 56.9% (n=178) of cases.

DISCUSSION

The people we interviewed had an overall negative opinion on the quality of care. This finding is consistent with those of other foreign studies that have focused on the perspective of incarcerated individuals. In Canada, access to health services during women's incarceration was analyzed in 2016 by Ahmed R. et al., and it was found that women were often dissatisfied with the quality of care due to multiple barriers in the prison system, Causing adverse health consequences. This is due to a lack of understanding of the care provided during their incarceration, as well as the absence of systematic visits at the time they enter and leave prison (3). The majority of women interviewed were not satisfied with the quality of care. A satisfaction study conducted in 2009 by Johan Hakon Bjorngaard (4) among people detained in Norwegian prisons found a high level of dissatisfaction with the care provided after release from detention.

In 2006, Louise Condon and Al. (5) interviewed 111 people in English prisons about their views on care. The quality of care felt varied greatly depending on the place of detention.

Other studies have shown high levels of satisfaction. Reference can be made to the research work conducted by Labrouhe et al. (6). In this study, the satisfaction of about 100 patients-inmates hospitalized in two specially equipped hospital units (UHSA) was examined. The results of this study showed an overall satisfaction rate of about 70%. In 2014, a thesis work on a qualitative study concerning the perception of care by people incarcerated at the prison of Grenoble-Varces, carried out by Dr Keller Marie and Dr Ploton Noémie (7), found that the majority of opinions expressed were favourable to the care received.

As for Farhat A. (8) in 2023 in his comparative study of medical treatment before and during incarceration of patients detained at the Riom Prison, the inmates interviewed expressed an overall positive opinion on the quality of care.

This discrepancy could be partly explained by the specificity of the functioning of prison care in each country, which is not subject to a universal line of conduct, or by possible differences in the characteristics of the prison populations that would justify this difference in perception. We have not found any studies that systematically relate the different modes of organization of prison care and that could explain this gap in satisfaction.

One of the main characteristics of prison demographics is the overwhelming majority of men. In our study, women made up 7% of the prison population studied. This finding corroborates the results of several studies, including the study by Farhat A. (8) with a rate of 10% of women who represent two thirds of the prison population in his study. A study proposed by Ashdown J. et al. (9), on the demographics and judicial status of women in prison, found that the reasons for incarceration were mainly secondary to offences, most often minor and non-violent, which were very often closely linked to a situation of poverty, in a population largely coming from a disadvantaged social environment.

An observation that appears in line with the finding that women are significantly less found associated with sentences of more than five years in our study (n = 2) 0.4%. In some studies there were no women at the penitentiary centre, as was the case at the Aix-Luynes detention centre during the thesis study of Dr Laugier S. (10) in 2020. In our study, the sex of participants did not appear to have an influence on their health status. This finding is corroborated by the results of the study by Farhat A (8) and Laugier S. (10).

In our study, the predominant age group is between 25 and 50 years (n=188), or 59.5%. Other studies highlight an ageing of the prison population such as the prison population of the Riom penitentiary centre who are aged 50 or older, represent more than a quarter of the responses their study (26%) (11). There are relatively few studies of the impact of length of incarceration on health, but we cannot reach consensus.

The experience of care in a medical emergency was reported by 49.7% of the inmates interviewed in our study, which does not make it an exceptional situation. The urgency of the medical situation, left to the discretion of the participants, can be difficult to grasp, because it may concern both a vital emergency requiring the intervention of the SMUR in the prison compound and a relative emergency, as a simple pain. We did not study the reasons for consultations in our questionnaire, which does not allow us to distinguish between different degrees of urgency.

In our study, the majority of participants (n=83) found that management was considered long. This impression contrasts with what can be found in the literature and, in particular, in the 2014 Marie K. study (7), which collected the testimony of many experiences of delays in accessing emergency care, especially at night and on weekends (7). A report of the Assembly on the organization and permanence of care admitted that, in the context of incarceration, "the persons held in custody are truly penalized and lose their chances of receiving adequate care within a reasonable time, especially during night periods" (7).

In a context of deprivation of liberty, the issue of access to medical care and therefore to the rights to health extended to public hospitals is a central element to be taken into account in defining the health care offered by the health unit. In our study, the use of medical extraction as part of a specialized consultation was reported in just over one quarter of the questionnaires; Thus, in its last survey on access to specialized care in prison from 2022, the International Observatory of Prisons (OIP) notes that medical extractions are still the main factor limiting access to specialized care and that require health professionals to prioritize patients, which is incompatible with an objective of equity in the right to health (12).

Added to this escorts which, according to the 2017 report of the Comptroller General of Places of Deprivation of Liberty (CGLPL) which do not take into account the dangerousness or personality of the detained person and sometimes even require the presence of prison staff in medical consultation, in our study their presence is reported in 82.24% of cases (11). The way in which participants in our study describe the stigma they face when mining agents put restraints on them (48.6%) is eloquent and draws attention to this problem.

However, even at the lowest level of surveillance, handcuffing is one possibility. Thus, the means of coercion are applied systematically, regardless of the personality and dangerousness of the detained persons (13).

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According to the CNCE, in its opinion on health and medicine in prison, these practices undoubtedly constitute humiliation and inhuman and degrading treatment (14). The CPT also notes that this practice is highly questionable from an ethical and clinical point of view (15). However, medical extractions still remain in 2024 often the only means of access to consultations for many specialties in a majority of prison centers. They impose, because of the many limitations of their organization, time limits that may seem disproportionate or at least felt as such by many inmates.

Medical confidentiality is a right for the patient. It is even an absolute duty for the doctor, to whom it is imposed.

For a large part of them, the detained persons are handcuffed and restrained during transfer to the health facility but also during medical consultations and/ or examinations and sometimes even during surgical procedures. In addition, the escorts remain present, in disregard of medical confidentiality and privacy of the detained person.

It goes without saying that the presence of the escorts' personnel does not allow to ensure the necessary preservation of medical confidentiality, which corroborates our study or 42.81% of detainees were not satisfied with the relative respect of medical secrecy during consultations.

The proposal for screening for sexually transmitted diseases in different detention centres and its availability throughout the period of detention was in effect during our research.

CONCLUSION

As evidenced by the numerous reports published on this subject, care given to incarcerated persons is of concern to many institutions and associations. Despite this interest, serious inadequacies still exist in prison health and care. Thus, in view of the elements highlighted and the observations made by this first survey on the health of patients incarcerated in prisons in Nouakchott, its renewal could support certain results and clarify certain trends.

Moreover, this work could be extended to all patients incarcerated throughout the country, not only to patients incarcerated in prisons in Nouakchott.

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