

THE INITIAL MEDICAL ASSESSMENT OF DETAINEES UPON ADMISSION

An initial medical assessment is an evaluation by a doctor or other qualified health-care professional of all detainees¹ as soon as possible after their arrival in a place of detention. International standards and literature refer to this procedure in different ways, including 'initial medical screening', 'initial medical evaluation', 'receiving screening', 'initial reception health screening', 'initial health screening' or 'initial health check'. This tool will use the term 'initial medical assessment' (IMA).

The IMA is an important means for the early identification of cases of torture and other cruel, inhuman or degrading treatment or punishment (ill-treatment). It helps to ensure the protection and appropriate medical and psychological treatment of victims of torture or other ill-treatment and provides an opportunity for the referral of any such potential cases to the relevant authorities for investigation and, if grounds exist, for prosecution. Furthermore, the IMA may prevent ill-treatment by identifying and attending to health conditions of an arriving detainee requiring urgent attention and serve as a deterrent against acts of torture or ill-treatment that may take place before a detainee is transferred to a pre-trial facility or a prison.

While the IMA is not specifically mentioned in the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), it is an important means to prevent acts of torture and ill-treatment and has a solid basis in several international and regional standards. National and international monitoring bodies, however, have reported shortcomings in the quality and consistency of the conduct of IMAs in many countries worldwide.

The IMA should be implemented in a way that considers the local circumstances in a particular country, including the available resources and staffing situation in pre-trial facilities and prisons. This tool provides country examples on good IMA practices already in place in different regions of the world, in order to assist States in recognising and addressing issues that can be improved in their national laws, policies, practices and procedures, so as to improve the effectiveness of IMAs and strengthen the prevention of torture and ill-treatment in their local context.

¹ In this tool, a detainee refers to a person deprived of their liberty in a pre-trial detention facility or prison.



THIS TOOL IS INTENDED TO:

Assist government policymakers, legislators, prison authorities and staff,² and other public officials

→ to effectively implement UNCAT and other key human rights laws and standards, through sharing expertise, knowledge and existing good State practices showcasing laws, policies, procedures and practices regarding effective IMAs in different parts of the world.

Illustrate good practice examples

→ of legislative, policy and practical measures and procedures adopted by States to ensure effective IMAs that contribute to the fulfilment of their obligations regarding the prevention, identification and documentation of cases of torture and other ill-treatment.

This document focuses specifically on IMAs in prisons and pre-trial detention facilities, and does not cover police stations,³ psychiatric or other specialised institutions, given the specificities of such institutions. During their time in detention, a detainee is also entitled to a medical examination at any time upon their request. The right to request and receive a medical examination is one of the safeguards during detention and, while such medical examinations are equally important in detecting and preventing torture and other ill-treatment, they are not the focus of this tool.

THE PURPOSES OF THE IMA



The IMA serves several important purposes, not only for detainees, but also for prison staff, other personnel working in detention facilities, prison management and administration, and society at large.

Purposes in relation to torture and other ill-treatment



① **The IMA has an important role in identifying torture and other ill-treatment and, ultimately, ensuring torture victims' rights to redress and full rehabilitation.** An IMA should include a systematic procedure to detect signs or allegations of torture or other ill-treatment upon admission. A properly implemented IMA will, therefore, help ensure that detainees who have been tortured or ill-treated upon arrest, in police custody or in prior detention facilities are identified, and that they are subjected to a thorough medical examination in accordance with the [Istanbul Protocol](#)⁴ to preserve evidence of such acts. This will allow for follow-up and referral to law enforcement and judicial authorities for further investigation, in accordance with international obligations to ensure perpetrators are held to account and victims obtain redress, thereby fighting impunity for acts of torture.

² This also includes staff working in pre-trial detention facilities and other specialised staff, such as social workers, medical staff and psychologists.

³ In settings where persons are held in police custody for more than 24 hours, however, an obligatory IMA should also be considered for police detention facilities.

⁴ This UN document outlines international legal standards and sets out specific guidelines on how to conduct effective legal and medical investigations into allegations of torture and other ill-treatment.



2 **The IMA has an important role in the prevention of torture and other ill-treatment.** Identifying signs that torture and ill-treatment has taken place is an important part of the IMA. Knowing that victims of torture are properly identified and, thus, that torture does not go unnoticed and that perpetrators are held to account may serve as a strong deterrent for perpetrators, so the IMA has a key role to play in the prevention of further acts of torture.



3 **The IMA prevents ill-treatment caused by neglect of a detainees' health-care needs.** An IMA should include the identification of any disease or condition that a detainee might have upon admission. This will help ensure the continuation of treatment already prescribed and the discovery of undiagnosed diseases or conditions that require treatment and/or other measures. This will help prevent ill-treatment caused by neglect of health-care needs.



4 **The IMA can protect staff and management of an institution against false allegations of torture or other ill-treatment.** The identification of torture upon arrival attests to the fact that the injuries were inflicted prior to arrival at the institution. This is not so when injuries occur later during the stay. The IMA is important, therefore, in the context of addressing false allegations and the burden of proof of the State once an alleged case of torture reaches court.

Other purposes

The IMA also has other important purposes not necessarily directly linked with torture or other ill-treatment. These include:

- **identifying detainees with special needs**, e.g. physical disabilities or chronic medical conditions that would increase their vulnerability in the institution, possibly resulting in ill-treatment;
- **identifying communicable diseases**, such as COVID-19, scabies, hepatitis and active tuberculosis upon admission, which will help prevent these from spreading to other detainees, staff and visitors inside an institution and to the outside community; and
- **providing an opportunity to introduce detainees to the health-care services** in the institution, which may contribute to fostering trust in health staff among detainees and increase the chances that health staff are informed about future incidents of violence or ill-treatment, or even torture.



United States of America: screening for COVID-19 upon admission

In the United States, the Centers for Disease Control and Prevention (CDC) has issued guidance on movement-based screening testing for COVID-19 for all incoming detained persons and those returning after more than 24 hours away from a facility. Individual housing (when feasible) while waiting for test results is recommended. For persons who are not fully vaccinated, testing can be combined with a 14-day observation period (sometimes referred to as “routine intake quarantine”) before persons are assigned housing with the rest of the facility’s population. In this case, individuals should be quarantined in individual cells or as a cohort, and separate from those with confirmed or suspected COVID-19. Individuals who test positive for COVID-19 should be placed in medical isolation. The CDC stresses that it should be ensured that medical isolation for COVID-19 is distinct from punitive solitary confinement, both in name and practice.



Mongolia: screening for tuberculosis upon admission

A tuberculosis policy with systematic admission screening on detention was developed in Mongolia and implemented in 2002. Upon being admitted to a detention centre or prison, each individual is screened for tuberculosis by symptom screening and X-ray. Microscopy is used where cases are suspected based on the results of the screening. Tuberculosis treatment can then be started at the detention centre. Men with tuberculosis are transferred to the prison tuberculosis hospital for treatment, and women with tuberculosis are sent to a female prison unit where treatment is also available.

Due to the tuberculosis policy in prisons and improved living conditions, the tuberculosis infection rate among people in prison, which in 2001 was 18 times higher than among the general population, was reduced to 5 times higher by 2009.⁵

The IMA as a window of opportunity

International standards unanimously – albeit with slightly different wordings – state that the IMA should take place as soon as possible after admission, and some specify that this means at the point of admission or within the first 24 hours. Physical signs of torture and ill-treatment may disappear over time, so the IMA needs to be compliant with this standard for an IMA to fulfil its role in providing medical evidence and identifying victims.

Ensuring a detainee's right to health upon admission to an institution entails, among other things, the continuation of life-saving medications (continuity of care), the treatment of potentially life-threatening substance or alcohol withdrawal symptoms developing within the first hours or days after admission, and the identification and handling of detainees at acute risk of suicide or self-harm. It also requires the identification of contagious diseases, so that the necessary steps can be taken to prevent these from spreading to other detainees, staff and visitors.

Although not explicitly stated in all standards, an IMA is also recommended as soon as possible after transfer to another institution or after transport (e.g., to a court), in addition to that performed upon a detainee's first entry. This will help identify cases of torture or other ill-treatment happening in other institutions and during transportation and will help prevent false accusations being made in the receiving institution.

In conclusion, not scheduling an IMA within time limits that are compliant with international standards defeats many of the purposes of the IMA, including those related to torture and other ill-treatment.



Georgia: IMA procedure and content

In Georgia, an initial medical examination of accused/convicted persons is to be conducted by a doctor of relevant qualification within 24 hours of their admission to a correctional institution. In the course of the initial medical examination, the health condition of the accused/convicted person is to be described and documented objectively. The following information shall be noted:

- Description and documentation of physical injuries and their traces (signs of violence and/or facts of violence, described by the person, tattoos, piercings etc.);
- Determination whether the accused/convicted person is a carrier of such communicable diseases, that pose risk to the health of the person themselves, as well as persons exposed to such risks;
- Determination of the need of mental care and an initial assessment of suicide-related risks;
- Determination of the need for urgent medical intervention (including problems related to drug or alcohol intoxication or withdrawal), detoxication and treatment; and
- For the purpose of avoiding the interruption of ongoing medical treatment, information to ensure the provision of urgent medical care and an uninterrupted supply of medication.

In the course of initial medical examination, relevant laboratory tests and instrumental examinations are to be planned for each accused/convicted person and preventive measures are to be conducted, including:

- Screening for TB symptoms and, in the case of the presence of symptoms, conducting further diagnostic examinations;
- Voluntary consultation and testing for HIV/AIDS;
- Voluntary consultation and testing for hepatitis B and C, as well as vaccination for hepatitis B; and
- The offer of laboratory testing and treatment for syphilis.

⁵ The Global Fund, [Technical Brief: Addressing HIV and TB in Prisons, Pre-Trial Detention and Other Closed Settings](#), June 2020.

THE IMA IN PRACTICE



Who should carry out the IMA?

According to Rule 30 of the revised United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), the IMA should be carried out by a physician or other qualified health-care professional. Also, other international standards and guidelines stress the need to conduct an initial medical assessment of detainees by a member of the prison health services as soon as possible after their admission to the institution.

Although an IMA performed by a health-care professional should be considered the “gold standard”, practice shows that, in many countries around the world, all or parts of the assessment are often carried out by prison guards, social workers or other non-health-care professionals employed in the facility. This may be considered in line with the requirement for an effective IMA if certain safeguards are in place, such as sufficient training and the possibility of referral to and follow-up by a health-care professional. For instance, an initial health check could be performed by a non-health-care professional following a standard form/checklist, after which the detainee is referred to a health-care professional for further examination only if necessary. In some contexts, screening for the risk of suicide or self-harm is undertaken by a social worker with specific expertise in this area (for instance, a suicide prevention officer).

It is good practice to have a psychologist involved in the IMA, particularly because signs of torture and other ill-treatment and suicidal/self-harm tendencies are not always visible.

In case that health-care professionals are not available for the IMA, certain safeguards must be implemented to avoid serious harm to the health of prisoners:

- 1 Staff performing the IMA must be trained and have clear written instructions
- 2 There must be the possibility for them to refer cases to health-care professionals, urgently if needed
- 3 They must be bound by confidentiality in relation to the medical information obtained
- 4 They must not perform functions exceeding their competences, such as physical examinations
- 5 They must not be involved in disciplinary sanctions or the use of force



Australia (Tasmania): IMA by a nurse

In Tasmanian prisons, the IMA is conducted by a nurse. The detainee will be met by a nurse upon admission, where the nurse will discuss with the detainee their health and how they are feeling, and will perform a general health assessment. The nurse will also ask for the detainee’s consent to obtain information about medication from their general practitioner or pharmacy, take blood and urine samples for testing and ask for permission to provide the prison with some of the detainee’s information. The nurse will ask questions about:

- Medical history and physical health, including any chronic health conditions;
- Mental health (including previous history);
- Medications (prescribed and/or others);
- Whether the detainee is Aboriginal and/or a Torres Strait Islander;
- Allergies and dietary issues;
- Alcohol or drug use; and
- Disabilities



United Kingdom: IMA by a health-care professional

The National Offender Management Service in the United Kingdom has published an instruction for prisons and community rehabilitation companies on the early days in custody. The instruction states that all incoming detainees must be medically examined, in private if possible, by a qualified member of the health-care team, or a competent and trained Health Care Assistant who has been trained in Assessment Care in Custody and Teamwork (ACCT) procedures, to determine whether they have any short- or long-term physical or mental health needs.

Presence of others

There are situations in which it is necessary for an additional person to be present during the IMA. These include the following situations:

- Where detainees do not speak the national language or another language enabling communication with the person conducting the IMA. The presence of an interpreter during the IMA is essential in these situations, to prevent misunderstandings and possible health complications;
- Where detainees exhibit aggressive behaviour, so that the health professional requires the presence of a security/prison guard;
- Where women detainees request the presence of another woman in cases where the IMA is conducted by a man. According to the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), the presence of a woman physician or nurse or, if it is necessary for non-medical staff to be present during the IMA, the presence of women staff should always be made possible.

The presence of others requires careful consideration, as it may breach medical confidentiality.

What are the elements of an IMA?

For the IMA to serve its many purposes and be in compliance with international standards, it needs to consist of a range of different elements, such as an interview, physical examination and others. In practice, the context will influence the specific contents of an IMA, including disease patterns, the availability of qualified staff, and the time and resources allocated to the assessment.

✔ Interview

The core element of the IMA in any context is the interview. This serves to obtain information that the detainee is able and willing to provide, and guides all subsequent actions. It is of utmost importance that the interview is carried out professionally, using carefully phrased and targeted questions, and in a way that ensures trust and confidentiality. Formats with model questions may guide the interview and, in some situations, it may be relevant to include actual screening tools in the interview, e.g., when assessing the risk of suicide or of a specific disease.

✔ Clinical physical examination

The clinical physical examination may bring to light health conditions that a newly arrived detainee has not been aware of or has not mentioned during the interview. It is also during the physical examination that medical evidence of torture or other ill-treatment might be discovered. A clinical physical examination should only be performed by a trained health-care professional, and the extent of the examination will depend on their professional skills and profile. Some physical examinations, including specialist forensic examinations when torture or other ill-treatment is suspected, cannot be performed by prison health staff but, instead, will require referral to a specialist.

✔ Clinical psychological examination

A clinical psychological examination may also be relevant, especially if the initial IMA reveals signs of mental health problems. Such examinations also require specialist skills and should only be performed by professionals (doctors, psychiatrists, psychologists) who possess such skills.

✔ Information from previous treatment

If the IMA points to pre-existing health problems for which the newly arrived detainee has received treatment prior to admission, it may be relevant to request a copy of medical records from other health providers, both within and outside of the criminal justice system. This information will help ensure compliance with the principle of continuity of care. Requesting the information needs to be considered carefully, however, and should only be done with the informed consent of the involved detainee.

✔ Tests

It may be part of the IMA to further investigate where there is the suspicion or identification of an illness through laboratory tests (e.g., blood tests, urine tests, pharyngeal swabs, etc.), as well as other tests, such as pulmonary X-rays (if tuberculosis is suspected or highly prevalent, so that screening is warranted).

✔ Referral to specialists

Detainees should enjoy the same standards of health care that are available in the outside community (also called 'equivalence of care'), and referral to specialists inside or outside the criminal justice system may be needed if a detainee presents a health condition that cannot be treated at a sufficient specialist level in the institution where the IMA takes place.

MANDELA RULE 30:

A physician or other qualified health-care professional, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following their admission and thereafter as necessary. Particular attention shall be paid to:

- A Identifying health-care needs and taking all necessary measures for treatment.
- B Identifying any ill-treatment that arriving detainees may have been subjected to prior to admission.
- C Identifying any signs of psychological or other stress brought on by the fact of imprisonment, including, but not limited to, the risk of suicide or self-harm and withdrawal symptoms resulting from the use of drugs, medication or alcohol, and undertaking all appropriate individualized measures or treatment.
- D In cases where detainees are suspected of having contagious diseases, providing for the clinical isolation and adequate treatment of those detainees during the infectious period.
- E Determining the fitness of detainees to work, to exercise and to participate in other activities, as appropriate.



Benin: IMA procedure and content

The screening of people arriving in prison from police and gendarmerie custody is of key importance for the prevention of ill-treatment by the police or gendarmerie. In Benin, as per regulation, all detainees shall be examined by the prison health-care provider upon admission. A delegation from the Subcommittee on the Prevention of Torture examined the recording of the medical screening at Cotonou Prison in 2011, which included all of the basic required information, although very summarily.



Morocco: Screening for risk of suicide and self-harm

Following an analysis of the handling of cases of suicide and self-harm in prisons, prison health authorities in Morocco updated the format of their pre-existing IMA. It now includes a few initial screening questions related to the detainee's history of suicide attempts or self-harm, as well as to their current mental well-being. If risk factors are identified during the initial screening done by nurses, they are directed to fill in a supplementary questionnaire that will eventually guide them in deciding whether the newly arrived detainee needs to be seen by a doctor or a psychologist, and whether an urgent referral is needed.⁶



Philippines: IMA procedure and content

In the Philippines, the Bureau for Jail Management and Penology's Comprehensive Operations Manual of 2015 states that all incoming detainees shall undergo a thorough physical examination by the jail medical office or a designated nurse, as well as a dental examination by the jail dentist and a psychological examination by the jail psychologist-in-charge. The manual further states that findings shall be recorded, and that medical and dental issues shall be attended to. A separate handbook specifies how cases of suspected torture shall be dealt with, including documentation, reporting and rehabilitation, and includes a torture assessment form to be filled out by the medical staff. The form includes an overview of the torture history as well as forensic drawings to illustrate the findings and an overview of contact with other health-care professionals.

✓ Additional considerations when performing an IMA

Health care in places of detention is guided by the same ethical principles as health care in the community. These principles are often summarized in the four basic principles of medical ethics: autonomy, justice, beneficence and non-maleficence (do no harm). Key elements of those principles are:

- 1 **Instructions:** It is of key importance that non-health-care professionals carrying out parts of an IMA get clear instructions from health-care professionals on how to ensure medical confidentiality and on how to carry out an assessment without doing harm to the detainee.
- 2 **Documentation:** Since the IMA is where initial and prospectively temporary medical evidence of torture and other ill-treatment may be secured, it is of utmost importance that the results of the assessment are properly documented in the detainee's medical files. Such files should be kept confidential and stored in a secure place, to avoid misuse.
- 3 **Informed/refusal to consent:** Most detainees consent to undergo an IMA after their admission to a place of detention, but some might not agree to the process. This poses a dilemma for staff charged with performing the IMA, as the IMA is not only in the interest of the detainee who undergoes the assessment, but also of others residing in the institution, for instance, in the case of communicable diseases, or to those in other institutions in the case of torture being reported. There is a difficult trade-off between ethical considerations towards the patient, in terms of accepting their refusal to undergo the assessment, and the public health interest of performing the IMA without the detainee's informed consent. As a principle, voluntary cooperation and the informed consent of a detainee to the IMA, as well as to the follow up on its results, should always be sought by providing proper information about the assessment and its importance to the detainee themselves and to others in the institution.

⁶ Experience from the project "Prevention of suicide, Suicide Attempts & Self-Harm in Moroccan Prisons", DIGNITY-DGAPR 2017-2019.

FOLLOW-UP ON SIGNS AND ALLEGATIONS OF TORTURE OR OTHER ILL-TREATMENT DURING THE IMA



Documenting signs and allegations of torture and ill-treatment

Any visible injuries and complaints about prior ill-treatment shall be entered in the detainee file management system upon admission of every detainee (UN Nelson Mandela Rule 7). This implies meticulously recording all available information in the format dedicated to the IMA and/or in the detainee's medical file, together with any additional information or data, such as body drawings, photos and the results of additional medical exams and tests. This information may later serve as important initial evidence if the case is being prosecuted by the relevant authorities. To ensure the best available evidence, it is important that the documentation is done by the best qualified staff in the institution, typically a doctor if available.

Treating the injuries

The detainee should be offered the necessary treatment of their injuries. To the extent possible, a full physical examination should be carried out before offering treatment or referring for further examinations such as X-rays, etc., so as not to lose physical evidence that might fade over time, but this should obviously not stand in the way of the treatment of acute conditions that are life-threatening or could bring long-term damage, or those causing extreme pain.

Protecting the victim

If there is a risk that the victim could face reprisals from staff or other detainees, steps should be taken to mitigate such risks and protect the victim. This may include having the victim moved to another institution or released, ensuring daily visits to check on their well-being, and/or communicating authoritatively that the victim must be protected and that any reprisals will have severe consequences. The means of protection against reprisals available will vary from place to place.

Referring the case to relevant authorities

Identified cases should be documented and referred to further medico-legal documentation, criminal investigation and possible prosecution.⁷ Similarly to the refusal to consent to an IMA, there is an ethical dilemma in cases where health-care staff find themselves balancing the principle of informed consent with the obligation to report torture detected during an IMA. Medical ethics require health-care staff to receive informed consent from patients before passing on any health-related information, including about injuries inflicted through torture or ill-treatment. The Bangkok Rules (Rule 7), which deal explicitly with the treatment of women prisoners, suggest that legal action should only be pursued if a woman prisoner agrees to it. In this context, the European Committee for the Prevention of Torture (CPT) has suggested that, in the interest of preventing human rights violations as egregious as torture, mandatory reporting should be an overruling principle to prevent torture from remaining undetected and possibly becoming systemic.⁸ In principle, before referring a case – and in compliance with medical ethics – the consent of the victim should be sought after they have been provided with information about the procedures and what to expect. Where consent is not given, health-care staff might consider reporting the incident with anonymized information, providing it is possible to provide sufficient details without identifying the victim. In any event, the victim should always be informed about the reporting procedures and which types of information are included in

⁷ UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), Articles 12-13, and Istanbul Protocol.

⁸ 3rd General Report, CPT/Inf (2013) 29, note 342, paras. 77-80.

the report. A decision to not report a case does not interfere with the obligation of the health-care professional to make an adequate recording of the findings and ensure their safe and proper storage, preferably offering a copy to the victim.⁹

IMPLEMENTATION STRATEGIES



In order to provide for effective IMAs, it is recommended that States consider the following:

AT THE POLICY LEVEL:

1. Make IMAs a standard procedure in the national legal framework; and
2. Define the required professional background and training for staff performing the IMA.

AT THE ADMINISTRATIVE LEVEL:

3. Develop a standardized format for IMAs, taking into account:
 - The national context, including the capacities and resources of the health-care system in places of detention, the management and organizational structure of the criminal justice system, and the prevalent disease patterns in the country;
 - The purposes of the IMA; and
 - Ethical and professional standards for staff performing IMAs.
4. Ensure that the IMA format provides practical guidance on:
 - Reporting of signs or allegations of torture or other ill-treatment;
 - Procedures for the support and protection of victims of torture against reprisals;
 - The use of relevant and effective assessment tools; and
 - The referral of detainees to specialised health staff in and outside the institution.

IN PRACTICE:

5. Ensure that staff carrying out the IMA are well-qualified, by means of adequate training and supervision;
6. Ensure adequate support to victims of torture and other ill-treatment identified through the IMA;
7. Ensure adequate support to prison (health) staff who report cases of torture or other ill-treatment identified during the IMA, to avoid reprisals; and
8. Analyze how data compiled from the IMA can be used for strategic planning and action.

⁹ ODIHR/PRI Guidance Document on the Nelson Mandela Rules (2018), Chapter 6.4, paras. 76 -101.

Additional resources

International standards/recommendations

- United Nations, [Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment](#) (1984)
- [UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment](#) (1988), Principle 24
- Office of the United Nations UN Office of the High Commissioner for Human Rights (OHCHR), [Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#) ("Istanbul Protocol"), 2004, Professional Training Series No. 8, HR/P/PT/8/Rev. 1
- [United Nations Rules for the Treatment of Women Detainees and Non-custodial Measures for Women Offenders](#) (the Bangkok Rules), Rule 6
- [United Nations Standard Minimum Rules for the Treatment of Prisoners](#) (the Nelson Mandela Rules) (2015), Rules 30, 34
- Subcommittee for the Prevention of Torture (SPT), [Second annual report of the SPT](#) (2009), CAT/C/42/2, Annex VII – Analysis of the Istanbul Protocol
- SPT, [Report on the visit of the SPT to Mexico](#), CAT/OP/Mex/1, paras. 130-139
- WHO/Europe (2021), [Preparedness, prevention and control of COVID-19 in prisons and other places of detention](#), Interim guidance 8 February 2021
- World Medical Association (WMA), [Declaration of Edinburgh on prison conditions and the spread of tuberculosis and other communicable diseases](#) (2011), Action 7

Regional standards/recommendations

- Inter-American Commission for Human Rights, [Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas](#), Principle IX.3 (Medical examination)
- Council of Europe, [Recommendation Rec \(2006\)2-rev of the Committee of Ministers to Member States on the European Prison Rules](#), (July 2020), Part III – Health, paras. 42.1 and 42.3
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), [CPT standards, CPT/Inf/E \(2002\) – Rev.2010](#), Health care services in prisons (para. 33)
- CPT, [23rd General Report of the CPT](#) (2013), CPT/Inf (2013) 29, Documenting and reporting medical evidence of ill-treatment (paras. 73-75)
- CPT, [26th General Report of the CPT](#) (2017), Remand detention and health care (paras. 72-73)

Publications

- OSCE/ODIHR and PRI, [Guidance document on the Nelson Mandela Rules](#). Implementing the United Nations revised standards minimum rules for the treatment of detainees (2018)
- Physicians for Human Rights, Dual Loyalty and Human Rights, [In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms, IV. Proposed Guidelines for Practice in Difficult Settings - Prison Detention and Other Custodial Settings](#). (2002)



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