The Impact of Prison Amnesties on Tuberculosis Control in Russia

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Despite advances in methods of detection and pharmacological therapies, the global burden of tuberculosis (TB) remains staggering high, with approximately one third of the world’s population estimated to be infected with the mycobacterium that causes TB. The explosive epidemic of TB has been particularly acute in the correctional institutions of the Russian Federation, where extraordinary levels of penal overcrowding have facilitated the rapid transmission of TB infection. In an attempt to alleviate the negative health consequences arising from massive prisoner overcrowding, particularly in pre-trial detention centers, the Russian government has authorized a series of sweeping prisoner amnesties that have released several thousand convicts into civil society. Due to poor surveillance and treatment, however, many of these amnestied individuals are infected with latent and active TB, including multi-drug resistant strains of TB (MDR-TB). Although the impact of these amnesties on TB incidence in the general population remains unclear, it appears likely that TB exposure in the general population has increased considerably since these amnesties have been enacted. This paper focuses on the relationship between penal overcrowding and increased TB transmission, and evaluates the utility of large-scale amnesties in reducing the prisoner population against the public health consequences of releasing potentially infectious TB-positive prisoners into the general public.

Rates of TB Infection

Global Dimensions of TB Infection

While TB has, until the last decade, been considered largely an obsolete disease in many industrialized nations, the global

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rates of TB infection are staggering. Approximately 7-8 million people develop TB each year, with one third of the world’s population, or roughly 2 billion people, estimated to be infected with TB.2 TB causes more deaths (an estimated 2 million preventable deaths each year) than all other infectious diseases except HIV.3 Fully 95% of all TB cases occur in developing countries, with the World Health Organization (WHO) estimating that by 2020, 1 billion people will become newly TB infected, 200 million will develop active TB disease, and 70 million people will die from TB.4,5 The global increase in TB disease may also be explained by the precipitous rise in HIV cases worldwide. Because HIV infection weakens an individual’s immune system and may lead to reactivation of latent TB disease and/or rapid disease progression, HIV status is the single most important risk factor for TB. HIV-positive individuals have a 10 times increased risk of developing TB than do HIV-negative individuals, and TB continues to be the leading cause of death among HIV-positive individuals worldwide.6,7 Evidence also suggests that TB infection may increase HIV replication, causing faster progression to AIDS.8

TB Infection in the Russian Federation

While Russia has historically enjoyed tremendous success in controlling and managing epidemic rates of tuberculosis infection in the general public, recent figures indicate that Russia has experienced a massive increase in TB disease since 1991.9-14 Case reporting increased from 34 per 100,000 in 1991 to 82 per 100,000 in 1997 and 92 per 100,000 in 2001.15,16 It has been estimated that up to 40% of TB patients receive irregular treatment, compounding poor treatment outcomes with emergent strains of MDR-TB.17 Since 1999, MDR-TB has been detected in 2.9% of all new TB cases as well as 7.1% of sputum smear positive individuals.18 Additionally, the published data on TB incidence may actually be much lower than the true incidence.19-20 Unless effective TB management programs are instituted immediately, Russian TB rates will likely rise even more in the coming years due to potentially soaring rates of HIV infection.

It should be noted that the Russian HIV situation is unique in that the majority of HIV infection and transmission appear linked to injection drug use (IDU). More than 90% of all individuals infected with HIV are IDUs; approximately 2 of every 5 IDUs are believed to be HIV-positive; and approximately 3 of 4 individuals with HIV/AIDS are narcotic addicts between the ages of 17-30.21-23 Moreover, recent studies indicate that the paradigm of HIV infection is shifting to include other modes of transmission, especially heterosexual sex.24 Thus, the rise in HIV infection could be even greater than expected, and will almost certainly affect a larger, more varied demographic.

Significant Social, Economic, and Political Events and Its Relevance to the Current TB Situation in the Russian Federation

Several key political, social, and economic factors have led to the recent resurgence of TB in Russia. The introduction of capi-
talistic and democratic policy reforms, including “openness” (Glastnost) and re-construction of the Communist state (Perestroika) in the 1980s resulted in massive destabilization of the county and serious economic crisis.\textsuperscript{25} At the end of 1991, the Soviet Union was dismantled into 15 independent republics (the Commonwealth of Independent States) with the aggregation of the remaining Russian republics into what is now the Russian Federation.\textsuperscript{26} As a result of the political and geographical fragmentation, increased migration, and the ensuing increased hostilities in several territories of Russia and the Commonwealth of Independent States, public health initiatives, especially TB control, have been severely compromised.\textsuperscript{27}

More importantly, the dissolution of the Soviet Union resulted in the rapid deterioration of social and economic order, with resulting impacts for access to social services and disruption/destruction of the public health infrastructure for TB management. The adoption of new economic policies, most notably the privatization of state-run enterprises and liberalization of prices, had a tremendous effect on increasing poverty, homelessness, alcoholism, illegal drug use, and prostitution, further exacerbating difficulties with health care access and contributing to poor health outcomes.\textsuperscript{28} For example, in 1995, 35% of the population was living below the poverty line, with 10.9% of the population living below one-half of the poverty line.\textsuperscript{29} By 1998, the number of people living below the poverty line was estimated at 50% of the population with a 15% national unemployment rate.\textsuperscript{30} Widespread drug use and participation in the regional drug trade, in particular, has been fueled by the decrease in legitimate employment opportunities combined with the emergence of significant economic incentives tied to the drug industry. Increased drug use, in turn, has resulted in greater rates of incarceration and police detention based on drug convictions, further exacerbating problems associated with depressed socio-economic conditions and accelerating increased TB transmission.

**TB Infection in Prisons**

In many areas of the world, rates of TB infection are much higher among prisoners (defined as those confined in any place of detention) than civilians.\textsuperscript{31} Several factors have been identified by the WHO as responsible for the disparity between TB rates among prisoners and civilians, including poor access to health treatment, infrastructural limitations associated with the penal system, and the high incidence of co-existing pathologies.\textsuperscript{32-33} Just as TB infection is greater among prisoners than civilians, prisoners are also at higher risk of infection and transmission of HIV due, for example, to lack of access to treatment and increased exposure to HIV infection through risk behaviors such as IDU and unsafe sexual practices.\textsuperscript{34}

While additional studies will provide greater epidemiological insight into the mechanism of increased TB risk in prisons, imprisonment appears positively associated with TB and HIV infection and transmission. Given Russia's rising rates of TB and HIV infection as well as the enormous prison population, effective TB control in Russia must include the prison population.
TB Infection in Russian Prisons

Although the term “prison” refers to a jail facility for convicted criminals, “prison” is also commonly used to refer to any place of detention. In Russia, there are five basic forms of custodial detention in the criminal justice system: police detention centers, pre-trial detention centers (SIZOs), correctional labor colonies (ITKs), prisons for those who violate ITK rules, and educational labor colonies (VTKs).35

The majority of Russia’s convicts are funneled into ITKs, where living conditions are generally much better than in SIZOs and rules are substantially less rigid.36 VTK living conditions are substantially better than SIZOs and also significantly better than in ITKs, though this is not the case for juvenile ITKs in which the conditions are more closely commensurate with the deplorable conditions in SIZOs.37 The Ministry of Justice’s Main Directorate for Execution of Sentences (GUIN) is charged with the responsibility of overseeing and operating all 996 correctional facilities.38 It should be noted that the data on prisoner health in Russia does not always explicitly carve out distinctions between the different forms of custodial detention.

Nonetheless, the following general description of Russian prisoners serves to illustrate the magnitude of Russia’s current prison population. Russia ranks second only to the US in the number of citizens incarcerated every year at a rate of 666 people per every 100,000 citizens, representing a total of 960,000 inmates in 2002.39 As of 2001, at least 8.7 million people are confined in penal institutions worldwide, either as pre-trial detainees or as convicted prisoners.40 In comparison, approximately 5 million individuals cycle through the Russian prison system each year.41 It is estimated that one of every four Russian men is a former prisoner.42 As of 1999, 50% of sentenced adult prisoners had previous convictions.33 While the majority of crimes continue to be committed by men, the crime rate for women is steadily increasing.44 Finally, because many released prisoners experience difficulties with the transition back into civilian life, rates of joblessness, homelessness, and alcoholism among released prisoners remain quite high. For example, in a TB hospital in Kemerovo, approximately half of the patients are former prisoners, 61% are disabled (though only 29% receive a disability allowance), about 25% have no permanent registration, less than 10% are employed, and the majority suffer from alcohol addiction.45 It should be noted that only one in ten individuals who are homeless and addicted to alcohol have been able to complete TB treatment successfully.46

While precise data on prisoners and TB may be lacking, there is no doubt that the TB epidemic in Russia has ravaged the prisoner population. As stated by I. Simonov, former Chief Inspector of Prisons, “simply being in prison is one of Russia’s biggest risk factors for TB.”47 Of the 133,000 newly diagnosed cases of TB in Russia in 2002, 100,000 cases occurred in prisons (representing just under 10% of all individuals serving custodial sentences).48 Of the new TB cases in prisons, nearly 30% of TB patients were infected with MDR-TB, reflecting a 10% increase in just two years.49 Approximately 42% of all Russian TB patients and at least 60% of Russian MDR-TB patients are in prison at
any time. Although a modest network of “TB penal colonies” (consisting of 33 TB hospitals and 55 TB referral centers) exists to treat TB among prisoners, only convicted prisoners (not SIZO detainees) are permitted to transfer there. With long delays before cases can be finally adjudicated, even prisoners with active TB disease may be unable to receive TB treatment for months at a time. Furthermore, given the ease of modern travel, the rising rate of MDR-TB among Russian prisoners represents serious health risks not only to the general Russian population, but also to other parts of the world. For example, a strain of MDR-TB identified as originating from a prison in Tomsk, Siberia appeared in Brighton Beach in Brooklyn, New York.

**Factors Relevant to the Promotion of TB Infection/Transmission in Russian Prisons**

Several factors account for the epidemic of TB in Russian prisons, including lack of funding and infrastructural support, poor medical care, poor nutrition, poor hygiene, lack of sunlight and adequate ventilation, and most importantly, dangerously high levels of overcrowding.

Many of the problems associated with poor prison conditions can be directly attributed to chronically severe shortages in funding and lack of needed structural support for the prison system in Russia. Allocations for prison system maintenance not only fail to meet the requirements, but the amount of funds eventually received is often significantly less than the original allocation. Underfunding of the prison system also extends to inadequate compensation provided to prison staff as well as to judges and other officers of the court. Prison staff are nearly as poor as the inmates, making them more susceptible to bribery. And, although the law provides for parole supervision, the government simply cannot afford to hire parole supervisors to assist released prisoners reintegrate into civil society, thereby potentially contributing to increased rates of recidivism.

Underfunding of the judicial system also creates organizational difficulties that lead directly to postponement of criminal and civil cases, leading to longer periods of detention during investigation and more numerous violations of procedural and substantive legal rights. For example, Russia’s official rate of solved crimes in 1998 was 74.4%, a figure far in excess of the 30-40% considered by experts to be consistent with democratic practices and international standards for procedural due process. Sergei Pashin, a Moscow City Court Judge, stated that in 1998, less than 1% of all defendants in Russia were acquitted. As Yuri Kalinin, Deputy Minister of Justice of the Russian Federation, noted in an interview on Russian TV, “[w]e also have to change the mentality of our staff, who can simply detain suspects for security reasons…” In addition, numerous credible reports have documented the widespread use of torture and battery by law enforcement and prison personnel to coerce confessions and gather evidence, usually within the first few hours or days of arrest.

Second, inadequate medical services available to Russian prisoners, coupled with poor nutrition, hygiene, and lack of appropriate ventilation, have increased
prisoners’ susceptibility to TB infection and transmission and significantly decreased chances for positive health outcomes. Prison dispensaries lack adequate numbers of trained medical professionals, and essential medical equipment and medications, including first line drugs to combat TB. Many penal institutions can no longer afford to perform routine HIV testing of new arrivals. Approximately 95% of medical institutions are located in unsuitable buildings with little or no space available for basic laboratories and other medical departments. Furthermore, difficulties in securing proper medical attention, including treatment for TB, are often exacerbated by a lack of communication and cooperation between prison officials and Ministry of Health officials, frequent movement of prisoners between places of detention and civil residence and other penal institutions during the investigation phase, as well as numerous transfers between and within prisons.

Likewise, prisons provide inmates with low quality foods that offer little nutritional value, which further increases the probability of poorer health outcomes among TB patients who require additional food supplementation. Such chronic malnutrition not only increases susceptibility to TB, it also results in other health problems such as skin diseases, scabies, head lice, parasitic infections, festering wounds, etc. Prisoners are forced to rely on food supplementation by visiting families and friends.

Places of detention rarely provide adequate ventilation and access to fresh air. Prison officials often order windows sealed or shut in wintertime to reduce heating costs. Citing security concerns, windows in pre-trial detention centers are often equipped with metal shutters that prevent the movement of air flow and sunlight into the cells, while the concrete floors help create and maintain a damp environment that facilitates increased TB transmission.

In addition, without the implementation of TB control/eradication programs, rates of TB infection in Russian prisons will likely climb even higher given the recent explosion of HIV infection in Russia generally, and in prisons especially.

Not only is IDU rampant within prisons, reports indicate that some penal institutions do not separately house HIV-negative and HIV-positive inmates, both as a matter of established prison protocol as well as practical compliance failure. As a consequence, HIV infection often spreads easily among inmates through heightened IDU and needle sharing, and also likely through voluntary and involuntary unprotected sex, widespread tattooing and piercing, injuries to skin and mucosa resulting from fighting among inmates, self-mutilation, poor personal hygiene and medical care.

Among all risk factors, the grossly high level of prison overcrowding remains principally responsible for the rapid transmission of TB among Russian prisoners. While estimates of prison overcrowding vary in the literature, a review of the available data strongly supports the existence of overwhelming levels of prison overcrowding. In 1999, the rates of overcrowding included: 105% of capacity in corrective colonies for life prisoners, 110% of capacity in general corrective colonies, and 145% in colonies for the maintenance of TB prisoners. Even among highly overcrowded correctional institutions, SIZOs
present the densest, most severe rates of prison overcrowding. It has been estimated that one third of all Russian prisoners are simply awaiting trial, most of whom are interned in SIZOs during the pendency of preliminary and judicial investigations. Individual prisoners are allotted an average of between 0.5 and 1.73 square meters of cell floor space, a significant reduction from the minimum 4 square meters per person required under federal law as of Jan. 1, 1998. In some prisons, cells meant to hold only 28 people, now hold up to 110 people, with inmates often forced to sleep in shifts. Few individuals are released before trial, and although the law provides for release upon bail, few Russians can afford to post the surety. Furthermore, because Russian law does not permit a system for guilty pleas and plea bargaining, every case must be heard. Defendants who have confessed to crimes must still wait months before they can be tried in court. Overcrowding in SIZOs, therefore, is much worse than in other penal facilities. It should be noted, however, that legal advocacy designed to encourage the adoption of plea bargaining should consider carefully the balance between the potential benefits of reduced SIZO overcrowding and potential rights abuses, particularly given the pernicious history of police brutality and use of torture in coerced confessions.

Given the high rates of TB incidence in SIZOs, every cell likely contains at least one prisoner with active pulmonary TB. Combined with the lack of fresh air, poor nutrition, and cold damp concrete floors, confinement in Russian penal institutions, especially SIZOs, is likely to be tremendously conducive to TB transmission. In a survey conducted in three SIZOs in the Kemerovo region, MSF researchers found that from April 2000-April 2001 more than half (56.6%) of the prisoners who had TB were also infectious during the time of their confinement. Additionally, in some facilities, the lack of space has forced prison staff to house infectious TB and HIV-positive individuals together with uninfected prisoners, substantially increasing the risk of TB and HIV transmission. Crowded conditions also create difficulties for guards to monitor the movement of drugs and syringes among prisoners. TB and HIV transmission among prisoners is further accelerated because of unsophisticated prison policies that prohibit the distribution of condoms (since sex in prison is officially prohibited), bleach and methadone, which, though proven successful in easing heroin withdrawal, continues to be illegal in Russia.

Although prison overcrowding can be explained by the confluence of a number of factors, as discussed previously, the primary impetus for prison overcrowding in Russia stems from “overeager drug policies that mimic the US ‘zero tolerance’ approach to drug control.”

The Economic, Social, and Political Upheaval of the early 1990s affected not only rising rates of poverty and unemployment, but also spurred the development of a thriving drug industry in Russia. Russian citizens turned to drug cultivation and sales as a means of financial survival as well as emotional escape from hardship and disillusionment. The opening of borders...
and the resulting migration of refugees and individuals from neighboring republics facilitated the easy entry and movement of drugs within Russia. For example, Afghanistan produces 75% of the world's supply of opium. From Afghanistan, illicit drugs are commerced throughout the neighboring Central Asian countries (Tajikistan, Turkmenistan, and Uzbekistan) and on through Armenia, Azerbaijan, Georgia, Kazakhstan, and Kyrgyzstan into Western Europe. Because of Russia's central geographic position, Russia has become a transshipment nexus for Asian opiates and cannabis, as well as the major source for heroin precursor chemicals. In 1998, the illegal narcotics trade accounted for an estimated monthly revenue of $90 million dollars in Moscow and St. Petersburg, and an estimated $2.5 billion dollars in revenue for all of Russia. In addition, narcotics-related money laundering in Russia has been estimated to amount to between $2.5 and $7 billion dollars.

Given the massive increase in illegal drug activity in the early 1990s, it should not be surprising that the number of drug-related convictions in Russia has also skyrocketed. It is precisely this increase in drug-related convictions that has most contributed to tremendous growth in the prison population, which in turn has fueled the TB epidemic among Russian prisoners. From 1993-2001, the number of registered crimes related to illicit drugs has increased approximately 500%. While narcotics-related convictions have risen markedly over the last several years, Russian drug laws have remained relatively static, rooted in the "threshold amounts" sentencing guidelines first developed in the Soviet era. For example, any amount of heroin up to 0.005 of a gram falls within the "large scale" amount, and individuals convicted of possessing "large scale" amounts of heroin will receive a sentence of between 1-3 years of deprivation of freedom. Possession of an "especially large" amount of heroin (anything greater than 0.005 grams) usually results in incarceration of between 7-15 years. In comparison, in the US, where federal drug sentencing guidelines have been much criticized for being overly rigid and punitive, it is unlikely that federal prosecutors would even take a case involving 0.005 grams of heroin.

Compounding problems related to the use of "threshold amounts" in detaining and convicting individuals for drug crimes, such drug convictions often mandate incarceration. Sentences involving deprivations of freedom average about 3.7 years, although in 1999, the Ministry of Justice estimated the average sentence of all convicts held at correctional institutions to be 5.2 years. Increasing detention time not only contributes to prison overcrowding, but also corresponds to increased difficulty in adapting to post-release civilian life. Thus, the current scheme of drug laws, especially the use of "threshold amounts," admits increasingly enormous numbers of individuals into the penal system, contributing to increased TB disease among prisoners as a result of overcrowding as well as increasing the risks of disease transmission by repeatedly cycling TB and HIV infectious individuals through the prison system.

Because the rate of pre-trial detention and incarceration are closely linked with the heightened criminalization of drugs in Russia, policy decisions aimed at achieving a substantial decrease in prison overcrowd-
ing must target the repeal and amendment of current drug laws, especially as the data fail to show that punitive drug sentences actually reduce criminal behavior. Moreover, any revision of the drug laws will require some amount of transition time for its implementation and effect. Until such laws can produce tangible results in declining numbers of incarcerated individuals, an interim measure to control and reduce prison overcrowding must be instituted. One suggestion has been the use of periodic mass amnesties. As a result of the sweeping use of pardons and similarities in declarative language used, accurate information on the number and identity of those amnestied remains unclear. While the number of amnesties remains somewhat elusive, the public health objectives underlying the use of amnesties is clear: improvement of prisoner health, particularly TB, through reduced prison overcrowding. President Yeltsin affirmed that “[d]eclaring the amnesty will not only be a humanitarian gesture on the part of the state,… it will also let us ease the extremely tense situation in penal establishments and make it possible to bring the conditions of confinement for convicts and those in custody into line with generally recognised standards.”

The Use of Amnesties to Reduce the Prison Population

Amnesty – General Information
While the use of amnesties has likely contributed to a discernible reduction in prison overcrowding in Russia, accurate information about the use and effect of amnesties in Russia has been confounded by the inadvertent inclusion of data on pardons, producing an often varied and misleading medley of prisoner-release data. Pursuant to the creation of the Presidential Commission on Pardon in 1993, the use of pardons has increased dramatically in the 1990s, appearing to take on the character of amnesties in approving the release of groups rather than selected individuals. Although the expansive use of the presidential pardon power poses intriguing political, social, and legal questions, it is beyond the scope of this paper to address these issues.

Intended Amnesty Beneficiaries and How Many are Actually Released
Announcements of past amnesties usually target specific groups for release, typically focusing on women, juveniles, men over the age of 60, and first time offenders convicted of relatively minor crimes. For example, under the June 1999 amnesty, 271,000 individuals could have been eligible for release. In practice however, 201,562 individuals were actually amnestied, including 21,780 from prisons (approximately 1/5th the figure originally quoted). Under the May 2000 amnesty, nearly 50,000 individuals were released from pre-trial detention centers and 200,000 prisoners were released, decreasing the prison population from 1.1 million to 900,000. This amnesty represented the largest amnesty in Russian history, accounting for an almost 20% reduction in prison overcrowding.
in the pre-trial detention center population, which itself represented the entirety of the reduction in pre-trial detention for all of 2000-2001. By April 2001, however, the prison population increased to 930,000 and was still rising.

While official estimates of the potential number of released convicts appear to indicate the effectiveness of amnesties in reducing high levels of prison overcrowding, the official estimates may be misleading. First, most amnesties fail to reach anticipated levels of release because the Procuracy often “finds reasons not to release prisoners.” Second, being granted amnesty does not automatically translate to release from detainment or incarceration since amnesties apply to all forms of sentenced punishment, which includes incarceration, fines, and probation. For example, between December 1, 2001 and February 1, 2002, a total of 911 prisoners were amnestied in Stavropol, but only 171 (representing 19%) were actually released from custody. The remaining 740 simply received a reduction in the remaining period of their probation. Third, amnesties do not apply to repeat offenders, and many Russian prisoners are recidivists. Fourth, prisoners can easily be exempted from amnesty based on “assessments of their comportment while in custody.” Fifth, as a related matter, government and prison officials exercise significant control over which prisoners they allow to be amnestied. Sixth, although amnesties often explicitly target juveniles for release, juveniles are actually less likely to be successfully amnestied because of the nature of the crimes for which they are most often convicted. Finally, if drug law reforms are instituted to encourage drug treatment rather than punishment, amnesties may exacerbate gender inequalities in incarceration since women are more likely to be recidivists if their crimes continue to be linked primarily to prostitution. Accordingly, although targeted for release under amnesty, women may actually least benefit from amnesty in the long term.

As Oleg Filimonov, Deputy Director of GUIN, stated, “The numbers speak for themselves. We cannot count on amnesties [alone to reduce prison overcrowding].” However, it does appear likely that the combination of amnesties, legal reform (including reclassification of offenses), and changes in police practice has effected a reduction in Russian penal overcrowding, although how the amnesties have impacted TB transmission and control remain undocumented.

Role of Amnesties in Promoting the Transmission of TB

The description and analysis of prisoner overcrowding thus far suggest a strong correlation between penal overcrowding and increased risk of TB infection and transmission among prisoners and the general population. First, amnesties release potentially infectious TB-positive individuals with little to no advance preparation to ensure appropriate post-release treatment and care, increasing the risk of TB transmission to the general population. In fact, more than 300 prisoners with chronic, infectious TB were released from one single prison in Western Siberia. These amnestied convicts had all failed directly observed therapy with first line drugs, and most had MDR-TB.
Although potential amnesty grantees are screened for TB, with infectious individuals allowed an amnesty extension of six months to complete treatment before release, the penal infrastructure is poorly equipped to conduct accurate screenings for all patients who might apply for amnesty, or to provide comprehensive treatment for those who have active TB disease. Even where prisons officials have confirmed the identity of infectious individuals who are potential amnesty grantees, it is unknown whether such individuals are actually detained for treatment.

Among Russian prisoners, poor treatment adherence and increased resistance to TB arises from difficulties associated with multiple transfers within and between prisons, movement of prisoners during investigation, and lack of access and failure to continue treatment post-release. These long periods of treatment interruption have resulted not only in low rates of TB treatment within prisons, but also contributed to increased opportunities for the spread of TB and MDR-TB within the prison community as well as the general population. MSF has estimated that an average of 17% of individuals housed in pre-trial detention centers fail to complete TB treatment, and 10% of prisoners enrolled in MSF’s TB treatment program were released before treatment completion. Furthermore, in some areas of Russia, 75% of released prisoners were non-adherent to post-release TB treatment. Other sources report that 80% of released prisoners fail to register for TB treatment and 73.75% fail to present at outpatient clinics post-release. A study conducted in St. Petersburg by the Pasteur Institute in 2000-2001 found that 70% of IDUs did not seek medical care, and given that IDUs comprise a large subset of the prisoner population, the high rates of post-release treatment non-adherence seem reasonable. Farmer et. al. estimate that the Russian penal system releases 300,000 prisoners each year, of whom, 80% are infected with M. tuberculosis and 10% with active TB disease. Given that Russia releases approximately 300,000 prisoners every year, and that an individual with active TB can infect on average between 10-15 individuals each year, the low rate of TB treatment completion represents a significant public health challenge for the Russian government.

In addition, amnestied convicts in Russia face numerous challenges that may encourage reversion to a criminal lifestyle and eventual re-internment in penal institutions: difficulty finding jobs, difficulty obtaining passports (in which the inability to produce one upon request may often lead to arrest), homelessness, alcoholism, drug addiction, dislocation from familiar surroundings and a generalized inability to socialize in civilian environments. Furthermore, releasing the sickest individuals without providing for treatment post-release, will also more greatly stress the already heavily burdened health and social services sectors. In the Magadan region, for example, the chief of the penal department explained that the local government was obligated to provide all amnestied convicts, estimated at 400 in Magadan in 2000, with the means to travel homes, and financial assistance equivalent to one minimum wage if they had no work or work papers. The Magadan budget, however, had been unable to provide for such expenditures for the last six months.
Public health advocates are concerned that the worldwide use of coercive public health practices to constrain those thought to pose serious public health risks may be increasing. Russia must remain particularly vigilant in guarding against the use of overly restrictive, coercive methods of TB control, especially since the individuals most likely to be risk of receiving such treatment tend to be the impoverished and powerless.144

On the other hand, if amnesties grant release only to the most healthy applicants, it may result in the discriminatory selection of the wealthiest or most politically well-connected individuals. For example, the healthiest prisoners typically have strong networks of social and financial support through which they receive supplementation of food, clothing, and other goods used in the prison barter system. The poorest, most marginalized members of the community, such as drug addicts, the homeless, and the mentally ill, will occupy the lowest priority for release through amnesty. Amnesties, therefore, also reinforce the current social and political trend toward punitive, rather than palliative/rehabilitative, treatment of IDUs and TB infected individuals. It should be noted that petty offenders continue to comprise the majority of the prison population, while the more notorious criminals responsible for large-scale corruption, organized crime, and contract murders are rarely apprehended or evade capture through bribery of officials.145 And finally, in addition to the potential discriminatory effects, amnesties might also perversely select for the most criminally successful individuals. In the rigid hierarchy of the Russian prison caste system, higher ranking prisoners routinely beat and torture lower ranking prisoners into forfeiting food, medicines, work services, and even healthy blood or urine samples to higher ranking prisoners.146 Lower ranking prisoners are often forced to hoard TB medications for use by higher ranking prisoners. In addition, TB medications are also used in the barter system for goods and payment of gambling debts as well as to bribe against rapes, beatings, and other violent acts.147 Higher ranking prisoners also often enter into collusive arrangements with prison staff to coerce confessions from fellow inmates, beat fellow inmates into submission to maintain prison order, and engender suspicion among inmates to block the development of strong ties among inmates.148 Not only do these high ranking prisoners engage in corrupt prison activities, prison staff and administrators are more likely to assign positive “assessments of comportment while in custody” to prisoners with whom they enjoy a mutually profitable relationship, rather than with poor, low-ranking prisoners who do not have the resources to enter into such relationships. Thus, high ranking prisoners may not actually constitute the healthiest applicants (if, for example, test samples are not their own), and may also actually embody the more “successful” criminal.

Conclusion

In response to record levels of prisoner overcrowding, the Russian government has focused on the use of amnesties in recent years to reduce prisoner overcrowding. However, the public health consequences of granting large scale amnesties, particu-
larly as it relates to the growing problem of TB in Russia, have not been addressed.

Although grants of amnesty represent one of the very few ways in which detained or imprisoned individuals in Russia can effect release from custody, implementation of the reforms necessary to ensure that amnesties do not result in the release of TB infectious prisoners requires tremendous financial and political support by the federal government, which simply may not be possible given the economic situation in Russia. Although a careful analysis and restructuring of resource allocation might reveal the feasibility of such reforms, it appears highly unlikely that the Russian government can afford to implement a multi-factorial approach to amnesties and TB control. Therefore, when balanced against the health benefits associated with decreased penal overcrowding, the enormous risk of TB transmission and the potentially devastating health consequences, especially of MDR-TB transmission, to the general public suggest strongly that the use of amnesties as currently devised cannot be encouraged. Additional research focusing specifically on how amnesty affects TB transmission post-release will provide greater insight into the utility of amnesties and TB control. Therefore, when balanced against the health benefits associated with decreased penal overcrowding, the enormous risk of TB transmission and the potentially devastating health consequences, especially of MDR-TB transmission, to the general public suggest strongly that the use of amnesties as currently devised cannot be encouraged.

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66. Schoofs, Mark, “Infected Cells: As HIV Epidemic Hits Russia, Crux of Problem is Jail – Surge in Illicit Drugs on Street Bring the Virus to Prisons, Where Needles are Shared – Getting into General Populace”, 2002.


74. Schoofs, Mark, “Infected Cells: As HIV Epidemic Hits Russia, Crux of Problem is Jail – Surge in Illicit Drugs on Street Bring the Virus to Prisons, Where Needles are Shared – Getting into General Populace”, 2002.
76. “A Brief Description of the System at the Present Stage”, Moscow Center for Prison Reform.
77. “A Brief Description of the System at the Present Stage”, Moscow Center for Prison Reform.
80. Kalinin, p. 11.
81. Farmer et al., p. 55.
83. Schoofs, Mark, “Infected Cells: As HIV Epidemic Hits Russia, Crux of Problem is Jail – Surge in Illicit Drugs on Street Bring the Virus to Prisons, Where Needles are Shared – Getting into General Populace”, 2002.
84. Ibid.
85. Ibid.
87. Drugs, AIDS, and Harm Reduction: How to Slow the HIV Epidemic in Eastern Europe and the Former Soviet Union, p. 14; and see also Skolnick, Andrew, “Some Experts Suggest the Nation’s War on Drugs is Helping Tuberculosis Stage a Deadly Comeback”, JAMA, Dec. 9, 1992, Vol. 268, No. 22, p. 3177-3178.
89. Ibid.
91. Butler, p. 49.
92. Ibid.
93. See Skolnick, p. 3177-3178 for an excellent study on the relationship between restrictive US drug laws and the re-emergence of TB in the US in the 1990s, including a discussion of the factors most relevant to the surge in TB – harshly punitive mandatory drug laws and prison overcrowding.
94. Ibid.
95. Please see Table 1 for a comprehensive listing of “threshold amounts” for many of the illegal drugs currently trafficked in Russia in Butler, p. 159; and Grist and Wallander, p. 14.
97. Schoofs, Mark, “Infected Cells: As HIV Epidemic Hits Russia, Crux of Problem is Jail – Surge in Illicit Drugs on Street Bring the Virus to Prisons, Where Needles are Shared – Getting into General Populace”, 2002.
98. “Characterization of Convicts Kept at Correctional Institutions (UI of GUIN of the RF MoJ by Their Crimes, and Terms of Imprisonment)”, Moscow Center for Prison Reform.
100. Foglesong, p. 113; and Constitution of the Russian Federation, as approved by Russian Federation President Boris Yeltsin and adopted by National Referendum on December 12, 1993, Section I, Chapter 4: President of the Russian Federation, Article 89: “The President of the Russian Federation shall: a) resolve issues of citizenship of the Russian Federation and of granting political asylum; b) award state decorations of the Russian Federation, confer honorary titles of the Russian Federation and top military ranks and top specialized titles; c) grant pardon.”
102. “Russian Parliament Declares Amnesty Bill”, People’s Daily Online, Saturday May 27, 2000, noting that in May 2000, the Duma approved an amnesty for up to 300,000 prisoners in commemoration of the 55th anniversary of the victory over the Nazis.
105. Foglesong, p. 113.
106. Ibid.
108. Personal communication with T. Foglesong.
109. Personal communication with T. Foglesong.
110. Ibid.
112. Personal communication with T. Foglesong.
114. Foglesong, p. 113.
115. Ibid.
116. Ibid.
117. Ibid.
120. Ibid.
123. Ibid.
128. Farmer et al., p. 59.
131. Ibid.
132. Ibid.
133. Stern, Vivien, “Where Are We Now? – Two Years after the Sigtuna Meeting”, in Tuberculosis Among Prisoners: Second Interdisciplinary Expert Meeting on Prevention and Control in
the Baltic Sea Region, report from meeting in St. Petersburg, Russia, November 25-27, 2002, p. 16.


135. Unpublished thesis, Rebecca Fry, 2003, finding that of the 80 active TB patients who were released from the Leningrad Oblast prison system, only 21 presented to the St. Petersburg outpatient dispensary system with single visits recorded for 2 of the 21.


137. Farmer et al., p. 59.

138. Stern, p. 16.

139. “Tuberculosis in Russian Prisons: Dying for Reform”, Moscow Helsinki Group; and “Tracing Defaulters”, MSF-USA: Field News March 23, 2002 which notes that the average number of infections can range between 10-20 individuals per year.

140. “Russia: Amnesty Law Approved”, 1999, Issue 6. Although it should be noted that recidivism among those amnestied in 1997 was only 1.02%, in contrast to the 36% rate of recidivism among the general prison population. Given the high rates of recidivism among Russian prisoners, more information about rates of recidivism among amnestied convicts must be obtained before conclusions can responsibly be drawn.


142. Krajick, Kevin, “Russia’s Prison Meltdown”, 2001, noting that 40% of ex-prisoners not convicted of political crimes are homeless upon release from prison.


148. “Prison Words”, Moscow Center for Prison Reform; “Situation of Prisoners in Contemporary Russia”, Moscow Helsinki Group; and “A Persistent Pattern of Torture and Ill-Treatment”, Confessions at Any Cost: Police Torture in Russia, 1999.