Beyond Cells and Walls:

Exploring Human Rights and Social Justice through Health and Nutrition in Lebanese Prisons

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ABSTRACT

In light of the complex intersection of human rights, imprisonment with health and nutrition, the right to health lays as a basic and fundamental human right that often clashes with vulnerabilities and social injustice behind the prison's walls and cells.

This study investigates how effectively the Lebanese prison healthcare system aligns with international human rights standards, particularly concerning food and healthcare access. It addresses a gap in research by focusing on the Middle East and North Africa (MENA) region. The central question in this thesis asks how effectively does the prison healthcare system in Lebanon meets international human rights standards, addresses the diverse needs of its prisoner population (including considerations of human dignity, physical, mental, and social health), and ensures equitable access for vulnerable groups, while considering potential shortcomings and opportunities for improvement. Data collection included documents review, interviews and self-administered questionnaires. The research explores both areas of strengths, like emergency referral systems, and shortcomings in outdated legislation, overcrowding, dietary quality, health screenings, and mental health resources. Financial and human resource limitations pose significant challenges. This study emphasizes the urgent need for legal reforms, improved policies, and systemic changes to achieve compliance. Multisectoral collaboration involving the Lebanese government through ministries, local and international NGOs (Non-Governmental Organizations), and academic institutions is crucial for ensuring equitable healthcare access, upholding human rights and social justice, and ultimately promoting the well-being of all prisoners in Lebanon, and thereby promote for a sustainable society.

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AIDS: Acquired Immunodeficiency Syndrome

BWP: Baabda Women Prison

COPD: Chronic Obstructive Pulmonary Disease

CSO: Civil Society Organizations

DMP: Data Management Plan

ENT: Ear, Nose, and Throat Doctor

EEF: Extended Fund Arrangement

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

ICRC: International Committee of Red Cross

IRB: Institutional Review Board

ISF: Internal Security Forces

LCRP: Lebanon Crisis Response Plan

LBP: Lebanese Pound

MENA: Middle East and North Africa

MHP: Mental Health Professionals

MOIM: Ministry of Interior and Municipalities

MoJ: Ministry of Justice

MoPH: Ministry of Public Health

MoSA: Ministry of Social Affairs

NCD: Non-Communicable Diseases

NGOs: Non-Governmental Organizations

NMHP: National Mental Health Program

NMR: Nelson Mandela Rules

OCHCR: Office of High Commissioner for Human Rights

PHC: Primary Healthcare Centers

RCP: Roumieh Central Prison

REC: Research Ethics Committee

SDGs: Sustainable Development Goals

TB: Tuberculosis

TMH: Technology-based mental health

UDHR: Universal Declaration of Human Rights

UK: United Kingdom

UN: United Nations

USA: United States of America

USD: United States Dollar

WHO: World Health Organization

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CHAPTER 1: INTRODUCTION

> Where, after all, do universal human rights begin? In small places, close to home – so close and so small that they cannot be seen on any map of the world. Yet they are the world of the individual person; the neighborhood he lives in; the town or village he loves; the country he knows. Wherever men and women strive for a better future for themselves and their children, that is where the universal struggle for human rights begins. (Eleanor Roosevelt, 1958)

Behind the fortified walls of prisons, where bars clink and shadows lengthen, lies a hidden corner where the right to health often clashes with the stark realities of confinement. In this world, the echoes of suffering resonate not from violence alone, but from the systemic neglect of basic needs – food and healthcare among them. This thesis explores the complex realities of Lebanese prisons and the intersection of human rights, prisons, health and nutrition, shedding light on the pervasive vulnerabilities and injustices faced by those deemed unworthy of a fundamental human right: the right to health. It aims to investigate and develop an understanding of fulfillment of determinants of human rights and social justice as related to health and food.

This chapter provides a context for the study, the main concepts, rational for research, research questions, contribution to literature and an outline of the thesis.

Chapter 1.1 Main concepts

Chapter 1.1.1 Human rights

The fulfillment of human rights stands as a cornerstone for societies aspiring to cultivate a culture of development and prosperity within their communities (Sen, 2004). However, in the fabric of everyday life, narratives echoing tales of cruelty and injustice serve as stark reminders of the challenges in upholding these fundamental rights. The global discourse on human rights, considered both essential and universal, transcends boundaries such as nationality, ethnicity, religion, gender, and other defining characteristics (Donnelly, 2013). As a result, human rights serve as a potent force, empowering individuals by acknowledging and safeguarding their inherent

dignity (Sen, 2004). By establishing a framework for individuals to assert their rights, human rights cultivate a sense of agency and autonomy. Furthermore, beyond the individual, these rights advocate for social justice and equality, challenging discriminatory practices and fostering inclusivity. They lay the foundation for legal systems, informing constitutions, statutes, and international agreements (Donnelly, 2013). Moreover, human rights principles instill a sense of social responsibility, encouraging respect for the rights of others and active participation in societal improvement.

Amidst societal conflicts, human rights provide a constructive framework for resolution. By prioritizing dialogue, understanding, and the protection of individual rights, societies can navigate toward peaceful resolutions. The global perspective on human rights underscores interconnectedness, emphasizing a shared commitment to a more just and humane world. At its core, the principle of human dignity stands paramount in the realm of human rights, shaping societies that recognize and protect the intrinsic worth and value of every individual.

Human rights fulfillment is seen a prerequisite to observe a society that believes in a culture of development and prosperity for its community. Throughout my daily life in Lebanon, I hear stories from here and there about cruelties and injustice. Real stories are all over tackling violation of human rights in different settings knowing that the country has been going through harsh times throughout its history with a multidimensional crisis since late 2019.

Human rights play the crucial role in shaping and defining the dynamics of societies worldwide. These rights, often considered fundamental and universal, are inherent to all individuals regardless of their nationality, ethnicity, religion, gender, or any other characteristic. The relationship between human rights and society is multifaceted and encompasses several key aspects. Human rights empower individuals by recognizing and safeguarding their inherent dignity. They provide a framework for individuals to claim and assert their rights, fostering a sense of agency and autonomy. Additionally, human rights advocate for social justice and equality, challenging discriminatory practices and promoting inclusivity. They serve as a foundation for laws and policies that strive to eliminate discrimination and ensure equal opportunities for all members of society. Furthermore, human rights are also often enshrined in national and international legal frameworks. They form the basis for constitutions, statutes, and international agreements that

guide the legal systems within societies. Moreover, human rights principles encourage a sense of social responsibility among individuals, communities, and institutions. This responsibility includes respecting the rights of others and actively working towards the betterment of society as a whole. In addition, human rights also provide a framework for addressing and resolving conflicts within society. By promoting dialogue, understanding, and the protection of individuals' rights, societies can work towards peaceful resolutions. Human rights promote a sense of global solidarity, emphasizing the interconnectedness of individuals and societies worldwide. International efforts to protect human rights contribute to a shared commitment to a more just and humane world.

Indeed, at the core of human rights is the principle of human dignity. Steinmann (2016) defines human dignity as the inherent worth possessed by all human beings solely by virtue of their humanity. This inherent worth is independent of external factors like social status, race, or ability.

As a result, societies that uphold human rights acknowledge the intrinsic worth and value of every individual, fostering environments that respect and protect this dignity.

Frameworks of human rights recognize the importance of cultural diversity. Efforts are made to ensure that human rights are respected while taking into account the cultural context of different societies. Moreover, human rights also contribute to the establishment of accountability mechanisms and the rule of law. They provide a basis for holding individuals, institutions, and governments.

Chapter 1.1.2 Prisoners

Prisoners are individuals who have been deprived of their liberty and are confined within a prison or correctional facility. Understanding the context of imprisonment requires an exploration of the various factors that influence how prisoners are categorized. Diverse factors, including the nature of the crime, legal frameworks, and facility types, contribute to the categorization of prisoners. Across legal systems and jurisdictions, the conditions, rights, and treatment of prisoners exhibit significant variations. Striking a balance between punitive measures and rehabilitative efforts is a common societal goal, aiming to address the root causes of criminal behavior (Zehr, 2002).

Examining human rights within the prison context is crucial to ensuring that individuals in custody receive treatment characterized by dignity and respect, irrespective of their legal standing. This

examination emphasizes the necessity of upholding fundamental rights, which are essential for the humane treatment of prisoners. This encompasses fundamental rights such as access to healthcare, proper nutrition, and humane living conditions. The interconnectedness of prisoners with human rights is undeniable, rooted in the universal, inalienable, and indivisible nature of these rights, applicable to every individual regardless of legal or societal status. The foundational concept of human rights rests upon recognizing the inherent dignity of every person, unaltered by their actions or legal standing (United Nations, 2006).

Researching human rights in the context of prisons ensures that individuals in custody are treated with dignity and respect, regardless of their legal status. This reinforces the notion that the principles of human rights should extend into the prison system. This includes access to healthcare, proper nutrition, and other necessities. Like all individuals, prisoners are entitled to fundamental human rights and dignity. Human rights are universal, inalienable, and indivisible, applying to every person regardless of their legal or societal status. Regardless of a person's actions or legal status, they retain a basic level of dignity that should be respected. Imprisonment does not strip individuals of their intrinsic humanity. Prisoners should always be protected from inhumane treatment. This protection is grounded in international human rights standards that outline the expectations for treatment within correctional facilities. International human rights standards prohibit torture, cruel, inhuman, or degrading treatment or punishment.

Prisoners should be treated with respect and dignity. In its universal document in 1990, UN General Assembly forbids discrimination and emphasizes respecting cultural and religious needs. This highlights the importance of addressing the diverse backgrounds of prisoners while maintaining security within prisons. Prisons must balance security while promoting prisoner well-being and societal benefit. Prisoners retain most human rights and should be offered opportunities for education, work, and healthcare to help them reintegrate into society upon release. Solitary confinement is discouraged, and overall, these principles aim for fair and humane treatment of all prisoners (OHCHR, 1990). Likewise, Fair & Coyle (2018) argue that all people deprived of liberty deserve humane treatment that respects their inherent dignity in accordance with international instruments like the International Covenant on Civil and Political Rights, Nelson Mandela Rules(NMR), and various regional human rights conventions. This alignment with international standards underscores the global consensus on the rights of prisoners. This core principle prohibits

torture and cruel treatment, emphasizing the importance of safeguarding the fundamental worth of every individual, regardless of their incarceration.

In fact, the right to life is a fundamental human right, and prisoners retain this right. This fundamental right compels authorities to prioritize the safety and security of individuals within their custody. Authorities must take measures to ensure the safety and security of individuals in jail.

In summary, prisoners are connected to human rights because these rights are inherent, applying to all individuals irrespective of their legal status. Recognizing this connection is essential for fostering a more just and humane approach to incarceration. Respecting human rights in the context of imprisonment ensures that individuals are treated with dignity, fairness, and humanity, even as they serve their sentences or await trial.

Chapter 1.1.3 Health and nutrition

As aptly illustrated by Popkin et al. (2012), health and nutrition are not mere academic pursuits, but cornerstones of human well-being, impacting individuals, communities, and the world at large. This foundational understanding emphasizes the urgent need for research, particularly in contexts where access to resources is limited. Their importance is especially pronounced for at-risk communities, who often face greater challenges in accessing healthy food and healthcare, further amplifying the need for robust research and targeted interventions.

The reasons for prioritizing research in health and nutrition are numerous and far-reaching. Understanding these reasons allows us to appreciate the holistic benefits that stem from a focus on health and nutrition. For individuals, a healthy diet and good health are the very foundation for a fulfilling life, enabling physical and mental well-being, increased productivity, and a sense of self-sufficiency. As illustrated by a study by World Food Program USA (2023) proper nutrition has been linked to improved cognitive function and academic performance, particularly among children from disadvantaged backgrounds.

On a broader scale, research in health and nutrition provides the foundation for effective public health initiatives. By addressing health concerns at the community level, we can translate individual benefits into societal improvements. By identifying and addressing health issues at the

population level, we can prevent the spread of diseases, promote healthier lifestyles, and ultimately decrease the strain on healthcare systems (World Health Organization, 2022). This is particularly crucial for at-risk communities, who often bear a disproportionate burden of preventable diseases.

The benefits of health and nutrition research extend far beyond public health measures. This broader perspective reinforces the critical role that nutrition plays in managing health outcomes. Studies have shown a clear link between good nutrition and disease prevention/management, especially for prevalent conditions like obesity, diabetes, and cardiovascular diseases (Kearney et al., 2005). For at-risk communities, where access to proper healthcare and nutritious food can be limited, this research is critical in developing affordable and sustainable interventions to manage these chronic conditions.

The significance of health and nutrition research transcends individual and societal well-being. This wide-reaching impact highlights the importance of a comprehensive approach to health and nutrition. It is a key driver for improving the quality of life for everyone, especially those facing social and economic disadvantages. By understanding how various factors like medical history, health encounters, diet, exercise, and lifestyle choices impact quality of life, we can develop targeted strategies to ensure that everyone, regardless of background, has the opportunity to live a healthy and fulfilling life.

Certainly, health and nutrition are crucial concepts to research for several reasons. Exploring these reasons further elucidates the multifaceted nature of health and nutrition's impact on society. First, understanding health and nutrition is fundamental for promoting individual well-being. Proper nutrition and good health contribute to overall physical and mental wellness, ensuring that individuals can lead productive and fulfilling lives (Zavitsanou & Drigas, 2021).

Second, research in health and nutrition is essential for public health initiatives. It helps in identifying and addressing health issues at the population level, preventing diseases, and promoting healthier lifestyles. This research is vital for creating effective public health policies and interventions (Masood et al., 2018). Third, studying health and nutrition is integral to preventing and managing various diseases. Research helps in identifying risk factors, developing preventive measures, and advancing treatments for conditions related to nutrition and health, such as obesity, diabetes, and cardiovascular diseases (Mahan, 2016). Fourth, good health and nutrition

significantly contribute to an improved quality of life. Research in these areas helps in understanding how different factors, including diet, exercise, and lifestyle choices, impact the overall quality of life for individuals and communities (Mahan, 2016).

Fifth, health-related issues can have a substantial economic impact on individuals, communities, and nations. Research in health and nutrition can provide insights into the economic burden of diseases, healthcare costs, and the potential cost-effectiveness of preventive measures (Dötsch-Klerk et al., 2022). Sixth, health and nutrition are central to addressing global challenges such as malnutrition, infectious diseases, and emerging health threats. This global perspective underscores the urgency for collective action and research efforts. Research helps in developing strategies to combat these challenges, improve healthcare systems, and enhance global health security (Neufeld et al., 2023). Seventh, understanding the role of nutrition and health in the aging process is crucial for promoting healthy aging and addressing age-related health issues. Research in this area contributes to strategies for enhancing the lifespan and well-being of the aging population (Mathers, 2013). Eighth, proper nutrition is essential for the growth and development of children (UNICEF, 2019). Focusing on children's nutrition highlights the importance of early intervention and long-term health outcomes. Research in health and nutrition focuses on early childhood nutrition, identifying critical periods for development, and ensuring that children have the best possible start in life. Nineth, the food system and dietary choices have environmental implications (Mahan, 2016). This connection between health, nutrition, and the environment is increasingly important in our globalized world. Research in health and nutrition helps in identifying sustainable and environmentally friendly practices in food production and consumption.

In summary, research in health and nutrition is multifaceted and plays a vital role in improving individual and public health, preventing diseases, enhancing the quality of life, addressing global challenges, and promoting overall well-being. Given the multifaceted nature of these issues, it is clear that urgent and dedicated efforts are required. The well-being of high-risk communities demands immediate attention and dedicated efforts to improve their situation.

Chapter 1.1.4 Intersectionality of human rights, health and nutrition with prisoners

The intricate entanglement of human rights, health, and nutrition within prison walls necessitates a critical and holistic examination. This complexity underscores the importance of understanding how these elements interact within the confines of incarceration. The concept of human rights itself can sometimes be plagued by "compossibility" issues, where fulfilling one right potentially hinders another (Freeman, 2017). Incarceration itself takes away the right to freedom and family life for example.

Accordingly, I see fulfillment of health and nutrition related right an absolute pre-requisite to survive life and ultimately take advantage of other human rights. This perspective highlights the foundational role that health and nutrition play in ensuring the viability of other rights. Certain rights like those related to health and nutrition transcend this dilemma. Adequate nourishment and healthcare are, quite simply, prerequisites for life itself, forming the bedrock upon which the enjoyment of other fundamental rights—freedom, education, voting—rests (UN Economic and Social Council., 1999). Thus, bonding and blending between these three concepts in prisons is not merely academic; it is a moral imperative.

By examining this relationship, we can illuminate the legal and ethical implications of correctional practices, unveiling and rectifying potential violations of human dignity. This investigation serves as a critical step in advocating for reforms within the correctional system. Deeply examining these intertwined threads enables a holistic understanding, informing the development of evidence-based policies that humanize prisons, ensuring rights are upheld, and fostering health and well-being (Enggist et al., 2014).

Furthermore, exploring this intersection sheds light on the unique health vulnerabilities of incarcerated individuals. Recognizing these vulnerabilities is essential for addressing the specific challenges faced by this population. Compared to the general population, they often struggle with higher rates of chronic diseases, mental health issues, and substance abuse (Presley & Cuthrell, 2022). Studying their health not only helps rectify these disparities but also strengthens public health overall, considering the potential for disease transmission within prisons and its subsequent impact on staff and the broader community upon release (NCD Risk Factor Collaboration, 2016).

Similarly, neglecting nutrition within prison walls has profound consequences. This neglect further exacerbates the health issues already present in correctional facilities. It can not only compromise

inmate well-being and impede rehabilitation efforts but also contribute to a volatile and challenging prison environment due to increased health problems (Philips, 2023). Conversely, ensuring adequate nutrition can not only prevent illness but also empower inmates to actively engage in rehabilitation programs and prepare for successful reintegration into society (Walker et al., 2023).

Ultimately, disentangling the interwoven threads of prisons, health, and nutrition offers invaluable insights into their interconnectedness and profound impact on both the individual and society at large. This interconnectedness highlights the need for a comprehensive approach to policy development. This collective lens not only facilitates the development of informed policies and promotes social justice but also paves the way for creating humane and healthy correctional systems, ensuring the fundamental rights of those behind bars are not merely enshrined in law but translated into lived realities.

Examining the intersection of human rights, health, and nutrition in prisons is essential for evaluating the legal and ethical dimensions of correctional practices, helping to identify and rectify any violations. This examination is critical for fostering accountability and improving conditions within the prison system. Indeed, researching these three concepts together provides a holistic understanding that can inform the development of evidence-based policies aimed at improving conditions in prisons, ensuring human rights, and promoting health and nutrition.

Researching prisons, health, and nutrition together is imperative because these three concepts are interconnected and can significantly impact each other. Understanding these interconnections is crucial for developing effective interventions and policies. Understanding the relationships between these areas can provide valuable insights into broader social, ethical, and policy considerations.

Certainly, it is important to discuss incarcerated population's health. Focusing on health within this demographic reveals systemic issues that require urgent attention. Prison populations often experience higher rates of health issues than the general population. Studying the health of incarcerated individuals helps identify and address disparities, contributing to a more equitable healthcare system. In fact, the health of incarcerated individuals can have implications for public health, as diseases can spread within correctional facilities, affect personnel that work within

prisons and accordingly the broader community can be impacted through staff and inmates upon their release.

Likewise, nutrition and well-being in prisons are crucial factors. Recognizing the role of nutrition is essential for fostering overall inmate well-being. These factors can have a devastating effect on rehabilitation of prisoners. Nutrition plays a crucial role in the overall well-being of individuals. Researching nutrition in prisons can help determine how diet influences rehabilitation efforts, mental health, and the likelihood of successful reintegration into society.

Also, adequate nutrition can contribute to preventing health problems among inmates, leading to a healthier and a more manageable prison environment. This preventative aspect is vital for reducing the strain on prison healthcare resources. Health and nutrition during incarceration can also impact an individual's ability to reintegrate into society successfully. Poor health and nutrition may hinder the chances of obtaining employment, education, and overall well-being after release.

In summary, investigating prisons, health, and nutrition together is essential for a comprehensive understanding of the complex interplay between these factors. This comprehensive approach is necessary for crafting effective and humane correctional policies. It facilitates the development of informed policies, promotes social justice, and contributes to creating healthier and more humane correctional systems.

Chapter 1.2 Rationale and context of Research

In screening and assessment of such a critical issue tackling human rights fulfillment in general and health and nutrition specifically in prisons, attention goes to countries and communities that are under-researched in such context and/or are suffering from crisis on the financial, economic, political, humanitarian, health or civil level. This focus on under-researched areas is vital for understanding the broader implications of human rights violations. Lebanon, my country of origin, satisfies both criteria by being located in the under-researched MENA region and experiencing a crisis over the last five years.

Lebanon, a nation nestled between the azure waters of the Mediterranean and the snow-capped peaks of Mount Lebanon, presents a compelling case for in-depth research at the intersection of human rights, health, nutrition, and prisons. The unique challenges facing Lebanon create a

pressing need for targeted inquiry. This blend of factors - Lebanon's unique socio-political fabric, its ongoing economic crisis, and its vulnerable prison population - creates a package where the complex interplay of these crucial elements demands urgent attention. Firstly, Lebanon's socio-political landscape presents a unique backdrop for studying the intersection of human rights, health, and prisons. The country's rich cultural and religious diversity, coupled with its long history of conflict and political instability, has resulted in a complex web of social and legal frameworks governing the treatment of prisoners. This complexity calls for nuanced research that is sensitive to the local context. This intricate context necessitates nuanced research that delves beyond simplistic generalizations, taking into account the specific challenges and opportunities presented by the Lebanese context (Human Rights Watch, 2023).

Secondly, Lebanon's ongoing economic crisis has exacerbated existing vulnerabilities within the prison system, directly impacting the health and nutritional well-being of incarcerated individuals. Understanding the economic dimension is crucial for grasping the full scope of the challenges faced by prisoners. With inflation skyrocketing and essential resources falling, prisons often struggle to provide inmates with adequate food, healthcare, and sanitation facilities (Lebanese Center for Human Rights, 2021). This dire situation underscores the urgent need for research that sheds light on the specific health and nutritional challenges faced by Lebanese prisoners and proposes evidence-based solutions to address them (World Health Organization, 2023).

Investigating these realities through a human rights lens can inform policy changes and interventions aimed at improving prison conditions and upholding the fundamental rights of inmates. This approach not only addresses immediate concerns but also contributes to systemic reform.Lebanon's unique confluence of socio-political complexities, economic hardship, and a large prison population makes it a fertile ground for research at the nexus of human rights, health, nutrition, and prisons. By going deep into this intricate web of factors, researchers can contribute to improving the lives of incarcerated individuals, upholding human dignity within the prison system, and ultimately promoting a more just, equitable and sustainable society for all.

In fact, examining prisons in Lebanon during times of crisis is essential for addressing immediate humanitarian concerns, protecting vulnerable populations, ensuring emergency preparedness, preventing human rights violations, and guiding effective crisis management strategies within correctional facilities (Boivin & Moro, 2023). This examination highlights the urgent need for

responsive policies that safeguard human rights even in the most challenging circumstances. It contributes to a more comprehensive understanding of the complexities involved and facilitates targeted interventions to improve the overall well-being of inmates.

Crisis situations, such as political unrest, armed conflict, or natural disasters, can exacerbate the already challenging conditions in prisons. Recognizing these conditions is critical for effective policy-making and resource allocation. Studying prisons during crises helps identify and address immediate humanitarian concerns, ensuring the safety and well-being of incarcerated individuals.

In times of crisis, certain groups within prison populations, such as women, children, elderly inmates, or those with pre-existing health conditions, may be particularly vulnerable. Identifying these vulnerable groups allows for more tailored interventions that address their specific needs. Researching prisons during crises allows for targeted interventions to protect such vulnerable populations (Haney, 2008; Reiter, 2021).

The health of individuals within prisons is interconnected with the health of the broader community (Dumont et al., 2013). Understanding this interconnectedness is vital for developing holistic public health strategies. Studying prisons during crises helps assess the potential impact of prison conditions on community health, especially in terms of disease transmission and public safety.

Thus, such a study would reveal weaknesses or gaps in existing prison policies and procedures, highlighting areas for reform and improvement. which would inform adaptive policies and reforms, ensuring that the correctional system is resilient and responsive to emerging challenges.

Chapter 1.3 Research questions

The central question in this thesis asks How effectively does the prison healthcare system in Lebanon meet international human rights standards, address the diverse needs of its prisoner population (including considerations of human dignity, physical, mental, and social health), and ensure equitable access for vulnerable groups, while considering potential shortcomings and opportunities for improvement?

Accordingly, this research seeks to address the following research questions (RQ):

RQ 1: How do current prison policies and practices in Lebanon regarding food and healthcare access align with international human rights conventions and other relevant standards?

RQ 2: To what extent do international standards for prison healthcare reflect the lived experiences and diverse needs of prisoner populations, including considerations of human dignity?

RQ 3: How effectively does the prison health system in Lebanon address the specific physical, mental, and social health needs of its prisoner population, beyond just meeting minimum international standards?

RQ 4: In what ways does the prison nutrition and healthcare system in Lebanon address the specific needs and potential vulnerabilities of diverse prisoner populations, including women, migrants, and refugees?

RQ 5: What are the key strengths and weaknesses of the current prison health system in Lebanon, and what interventions could be implemented to address identified shortcomings?

Chapter 1.4 Research Aim and Objectives

The aim of this study is to evaluate the alignment of current prison policies and practices regarding food and healthcare access with international human rights conventions and relevant standards, while also examining the extent to which these standards cater to the diverse needs and experiences of incarcerated individuals.

Research objectives are the following:

1. To assess the degree of conformity between current prison policies and practices in Lebanon regarding food and healthcare access and international human rights conventions and other pertinent standards.
2. To analyze the extent to which international standards for prison healthcare consider the lived experiences and diverse needs of prisoner populations, with particular emphasis on aspects related to human dignity.

3. To evaluate the effectiveness of the Lebanese prison health system in addressing the comprehensive physical, mental, and social health needs of incarcerated individuals, going beyond minimum international standards.

4. To identify the specific measures undertaken by the prison nutrition and healthcare system in Lebanon to cater to the needs and vulnerabilities of diverse prisoner populations, including women, migrants, and refugees.

5. To identify the key strengths and weaknesses inherent in the current prison health system in Lebanon and propose feasible interventions aimed at addressing the identified shortcomings to enhance the overall quality of healthcare provision within prison settings.

Chapter 1.5 Research Contribution

Knowing the necessity of fulfilling international standards regarding confinement, health and nutrition along with human rights convention, this project will contribute to a theoretical understanding of three key concepts which are human rights, health and nutrition and incarceration and add to prior research to how incarceration linked with nutrition and health contribute to the theory of human rights.

This study seeks to provide a comprehensive assessment of the current state of health and nutrition provisions within Lebanese prisons, with a particular focus on their alignment with principles of human rights, human dignity and social justice. It aims to identify both strengths and shortcomings inherent in the system, emphasizing the importance of preserving human dignity and social justice within the prison environment. Despite an extensive review of existing literature, no prior research addressing this specific aspect has been identified within the MENA region. Therefore, this pioneering project not only contributes to the body of knowledge concerning prison conditions in Lebanon but also fills a notable research gap within the broader social sciences discourse in the region. By closely examining the intersection of health, nutrition, human dignity and social justice, this study intends to offer close insights into the complexities of the prison environment in Lebanon and its implications for social justice and human rights.

Chapter 1.6 Thesis outline

The introduction sets the stage for the comprehensive exploration of human rights, social justice, health, and nutrition within the context of prisoners, aiming to shed light on the intersectionality of these crucial domains. Beginning with an overview of fundamental concepts such as human rights, prisoners, and the importance of health and nutrition, the introduction explores the rationale and context driving the research. It articulates the key research questions, aims, and objectives, highlighting the intended contribution to the field.

As the chapters unpack, the literature review examines existing knowledge on human rights, prisoners, health, and nutrition, offering insights into historical perspectives, international standards, and specific challenges faced within prison settings. This comprehensive review sets the stage for understanding the complexities at play and informs the subsequent exploration of the Lebanon prison context.

Chapter three researches into the unique dynamics of Lebanon's prisons, contextualizing them within the country's history, socio-political landscape, and judicial framework. It illuminates the challenges faced by both the judiciary system and the prison infrastructure, while also exploring potential solutions to address these issues.

Methodology and ethics, discussed in chapter four, provide a detailed roadmap of the research approach, including strategies, design, data collection methods, and ethical considerations. This chapter ensures transparency and rigor in the research process, laying the groundwork for the subsequent analysis and interpretation of findings.

Chapter five presents the empirical results derived from various data sources, including public data, interviews, and questionnaires. It offers an understanding of the health and nutrition landscape within Lebanon's prisons, highlighting key findings and insights gleaned from the data.

The discussion of findings in chapter six synthesizes the empirical evidence with existing literature, offering critical analysis and interpretation. It explores the implications of the findings in relation to legislation, policies, and practices, while also identifying areas for improvement and future research directions.

Finally, the conclusion and recommendations chapter summarize the key findings, acknowledge strengths and limitations, and provide actionable recommendations for policy, practice, and further inquiry. On top of that, the conclusion section reflects on the significance of addressing human rights, health, and nutrition within prison settings, advocating for holistic approaches to ensure the well-being and dignity of all individuals, including prisoners, for a better and more sustainable society.

CHAPTER 2: LITERATURE REVIEW

The complex relationship between human rights and incarceration poses a fundamental question: To what extent are the needs and rights of individuals within the prison system recognized and protected? This chapter explores into this intricate landscape, meticulously examining the multifaceted connection between the concept of human rights and the health and well-being of prisoners.

I begin by laying the groundwork with a critical exploration of human rights, unpacking the core principles and going deep into the critiques that challenge their universality and practicality. Then, I turn our attention to the Universal Declaration of Human Rights (UDHR), analyzing its relevance to incarcerated individuals and highlighting the tensions between its aspirations and their lived realities. To fully understand the context of healthcare access for prisoners, I tackle the very definition of "prisoner." I explore the evolving legal and social constructions of this term, acknowledging the diverse experiences and circumstances encompassed within it. With this foundation laid, the next section embarks on a historical journey, charting the evolution of punishment and justice systems, illuminating the shifting attitudes towards the purpose and practice of incarceration.

The right to health emerges as a central theme in the subsequent sub-chapter, where I unpack its fundamental nature and look closely into the international and national legal frameworks that uphold it. The next section then bridges the gap by specifically examining the right to health within the context of prisoner populations, highlighting the unique challenges and ethical considerations that arise.

Equipped with this theoretical and legal framework, the following segment observes the international standards that safeguard the health and food security of prisoners. I analyze key instruments and conventions, pinpointing the obligations governments undertake to ensure the well-being of those in their custody. The following sections then zoom in on the practical realities of healthcare within prison walls. Then, a review takes place about the current state of health in prisons globally, identifying common deficiencies and highlighting innovative programs that aim to improve healthcare provision.

The last three segments address access to health care services for prisoners, scrutinizing existing models and identifying systemic barriers that impede equal and timely access to quality care. Then the section focuses on the spotlight to nutrition concerns in prisons, analyzing the importance of adequate and nutritious food for maintaining prisoner health and dignity.

Finally, the last section offers concluding analysis of the intersection between human rights and the health and well-being of prisoners. This synthesis will identify key challenges and opportunities for moving forward towards a more humane and rights-respecting penal system.

Through this comprehensive exploration, this chapter aims to shed light on the intricate connection between human rights and the health and nourishment of individuals in prison. By navigating the legal frameworks, examining practical realities, and critically engaging with ethical considerations, we strive to contribute to a discourse that prioritizes the dignity and well-being of all within the prison system.

Chapter 2.1 Human rights-The concept and critique

c On one hand, it is used as a justification for intervention or policy decisions, framing them as morally imperative to protect women's rights. On the other hand, it may function as a distraction from the broader consequences of the 'war on terrorism,' allowing the political agenda to be advanced while deflecting attention from other critical issues (Hunt, 2002).

Indeed, I believe that it is important to critically examine such situations to distinguish between genuine efforts to promote women's rights and the strategic co-optation of these rights for political purposes. Balancing the advocacy for women's rights with a comprehensive understanding of the broader impact of policies and interventions is crucial for promoting a just and equitable approach to addressing complex geopolitical challenges.

Furthermore, within the framework of women and Afghanistan, Kandiyoti (2007) argues that women are caught in a difficult position where they must simultaneously advocate for and defend their legal rights against societal conservatism while also grappling with the broader societal issues of lawlessness and impunity that compromise their security and dignity. This underscores the multifaceted nature of the challenges women face and the need for comprehensive efforts to

address both legal and societal factors to ensure the well-being and rights of women. This discussion is also framed within the context of human rights and values (Kandiyoti, 2007).

Despite the challenges discussed, human rights are claimed to have irrelevance and predictions of demise in spite of their centrality in late modern era (Langford, 2018). These evaluations, influenced by social science's perspectives, adhere to a common set of criticisms. Issues related to the legitimacy within sociology, practical effectiveness, and equitable distribution are highlighted and supported by a growing body of empirical evidence, particularly from sociology, political science, and anthropology, as well as economics and social psychology (Langford, 2018).

Acknowledging this skepticism, Sen (2004) finds it crucial to acknowledge and address the skepticism surrounding the idea of human rights among legal and political theorists. These doubts are not insurmountable and can be effectively tackled. It is noteworthy, however, that the conceptual understanding of human rights can significantly benefit from considering the rationale behind the actions of activists, including their diverse and impactful practical efforts such as recognition, monitoring, agitation, and legislative advocacy. The author also argued that not only is conceptual clarity vital for practical application, but the richness of real-world activism is also crucial for comprehending the concept and the extent of human rights (Sen, 2004).

Adding another layer to this discourse, Panikkar (1982) adopts a cultural relativism point of view where he considers that concepts, values, norms, and morals are always linked with specific contexts in terms of history, geography, economy, sociology and politics. Thus, human rights are products of societies and are not universal in terms of being pre-existent or God given.

Indeed, we do know that, regardless of the concept of human rights' cruelties and injustice are wrong and thereby we only need a reason to oppose them. Yet, the problem lays in some societies whether they believe in human rights or no and whether there are sufficient and strong arguments to support them. This is actually consistent with how scholars perceive this matter, that human rights are only present "due to the need to discuss them". This notion was discussed by Freeman who argues that this issue calls for a response from the theory of human rights to present a theory that holds justifications (Freeman, 2017). Indeed, the concept of "right" is highly linked to what is right, confirming to the rightness. In reality, many societies have standards of rightness despite the fact that some societies do not have the concept of humans having rights (Freeman, 2017).

In contrast to this, Mende (2019) advocates for a nuanced conception of the universality of human rights—one that acknowledges diverse cultural contexts, rejects abstract colonialist universalism, and avoids reducing universalism to globally shared traits or overlapping consensus alone. This perspective underscores the importance of approaching human rights with sensitivity to context and particularity.

Moreover, Shaheed & Richter (2018) discuss, in view of a session of the Human Rights Council in Geneva, that human rights, despite being presented as universal, may be perceived as expressions of Western values and interests, raising concerns about cultural hegemony and forms of imperialism. They communicate arguments that human rights originate from a European, Judeo-Christian, and/or Enlightenment heritage, which are typically Western, and cannot be enjoyed by other cultures that don't articulate the values of western societies. The ongoing debate reflects a broader discourse on the universality and cultural specificity of human rights (Shaheed & Richter, 2018). On the other hand, Mende (2019) argues that human rights are not only western oriented, and thus can be applied on other non-western societies.

At this level, I perfectly align with Shaheed & Richter (2018) and Mende (2021) that human rights are not culture specific, yet they apply perfectly for all countries, social classes, cultures, races, religions, sects, sexual orientations, societies and communities.

In discussing the intersections of human rights and dignity, sometimes human rights are confused with the concept of dignity. Donnelly (1982) argues the central role of human dignity in non-Western cultural traditions and emphasizes the foreignness of the Western understanding of human rights in these contexts. This observation highlights the importance of recognizing and respecting cultural diversity in philosophical approaches to foundational concepts like human dignity and rights (Donnelly, 1982).

Within this concept, it is also very important to differentiate between human rights and social demands. Thus, we should differentiate human rights from legal rights and social objectives of certain communities or societies (Freeman, 2017). Certainly, human rights are mostly remembered and needed when they are most violated and unfulfilled (Freeman, 2017).

Amid the violations that have happened throughout the years, the UDHR is a milestone document that was created in 1948 by the United Nations (UN) after World War II. It calls for freedom and

equality in the aim to protect the rights of every person everywhere. Indeed, countries agreed on the concept of freedoms and rights that need to be universally protected in an attempt to help every individual live with dignity, freely and equally. Butler (2009) argues that UDHR is the modern era's last achievements as it is aspirational and it does not hold the force of law. Despite the promise of the UN, one cannot understand the gap between the human rights declaration and its violation (Freeman, 2017).

Moreover, human rights have been used in the form of a justification for unhumanitarian interventions. For instance, the invasion of Iraq does not meet the criteria for a humanitarian intervention. Most significantly, the level of killing in Iraq at the time did not reach the dire and exceptional circumstances that would justify military action. Additionally, intervention was not the last reasonable option to halt Iraqi atrocities, and it was not primarily motivated by humanitarian concerns. The execution of the intervention did not maximize compliance with international humanitarian law, lacked approval from the Security Council, and, while initially anticipated to improve the situation for the Iraqi people, it was not designed or carried out with their needs as the primary focus (Roth, 2006).

Human rights and social justice are interconnected as well and these two issues were discussed in the literature. This connection underscores the importance of exploring how these concepts influence each other. Wellman (1997) advocates for social justice and human rights that have often collaborated in addressing pressing issues. For instance, political arguments have been framed around the injustices of affluent societies, where the disparities between the rich and the poor are seen as violating the human right to an adequate standard of living. This highlights the political and ethical dimensions of social justice in relation to the protection of human rights.

Despite the practical connections and shared objectives in activism, Wellman observes a theoretical isolation between the discussions of justice and rights in philosophical and jurisprudential literature. This isolation raises important questions about the underlying principles that inform these discussions. The works cited, such as John Rawls' "A Theory of Justice," are noted for their limited references to natural rights and human rights. Wellman (1997) describes the perceived disconnection between social justice and human rights as a puzzling and important problem. In addressing this, the author expresses an intention to address the question of the relationship between the two concepts.

Wellman (1997) also highlights the paradoxical situation where social justice and human rights, despite being advocated for together in political contexts, seem to be treated separately in theoretical discussions. This separation suggests a need for a more integrated approach to these issues. The author expresses a sense of perplexity regarding the perceived disconnection and aims to explore the relationship between social justice and human rights more deeply (Wellman, 1997).

Hibbert (2017) discusses a normative model that envisions social justice and human rights as interrelated concepts within political societies. This model seeks to bridge the gap between theory and practice. It emphasizes the dynamic and relational nature of human rights and their role in contesting exclusionary practices, ultimately bringing them closer in line with the egalitarian ideals of social justice.

Building on all of the above, I perceive the concept of human rights being rooted in the idea that every individual, regardless of their nationality, ethnicity, or cultural background, possesses inherent dignity and deserves to be treated with respect and fairness. This foundational belief is essential for understanding the universality of human rights. While the modern framework of human rights emerged from Western philosophical and legal traditions, I see the universality of these rights and how they can bring social justice to our societies and that they are applicable to all people worldwide including the Global South. In this context, citizens' human rights should be prioritized over the states' interests. Also, I support the notion that the universality of human rights rests on the belief that certain fundamental values and principles are intrinsic to human nature and should be protected and upheld across all societies.

I recognize that the universality of human rights does not imply a one-size-fits-all approach or an imposition of Western values on diverse cultures. Rather, it emphasizes the need for respect and understanding of cultural differences. Instead, it emphasizes the shared humanity and common aspirations of people worldwide. The principles of human rights provide a framework for promoting justice, equality, and dignity, allowing for the development of societies that respect the rights of individuals while embracing cultural diversity.

When applied in the Global South, the concept of universal human rights can serve as a powerful tool for addressing social injustices, promoting inclusive development, and empowering marginalized communities including women, children, refugees, migrants and prisoners. This

potential for empowerment highlights the critical role of human rights in fostering social change. By acknowledging the universality of human rights, countries in the Global South can draw upon a common set of values to guide their policies and practices, fostering greater accountability and promoting a more just and equitable world. However, it's important to approach the implementation of human rights with cultural sensitivity, recognizing that different societies may interpret and prioritize rights in varying ways. Thus, dialogue and collaboration between different cultures and regions are essential to bridge gaps in understanding and ensure that the application of human rights respects local customs and traditions.

Chapter 2.2 Defining prisoners

Prisoners are typically individuals who are put in prison or jail, deprived of their liberty as a punishment after being found guilty of committing a certain crime. Some prisoners are sentenced for months, years or even for life while other individuals are convicted until trial. This definition sets the stage for understanding the complexities of incarceration. Imprisoning an individual goes beyond limiting their freedom of movement; it typically involves subjecting them to meticulous regulation and surveillance, placing them in a position of dependence. Even in the absence of outright brutality or violence, which has been widespread throughout the history of incarceration, prisons give rise to issues and controversies related to various aspects. These include access to legal representation, the nature of grievance mechanisms and disciplinary processes, communication with families and friends, correspondence, religious practices, personal safety, healthcare, nutrition, work conditions and compensation, as well as discrimination based on race, ethnicity, and gender (Sparks & McNeill, 2009).

As reported by Fair & Walmsley (2021), more than 11 million individuals worldwide are imprisoned either as suspected (pre-trial) or sentenced and the prison population is continuing to grow disproportionately in comparison to the world population.

Chapter 2.3 History of Punishment

Over the previous centuries, punishment strategies passed through many milestones, leading to the current modern prison system. Michel Foucault’s work significantly contributed to academic

debates relating to the discipline of punishment and imprisonment. In discussion of history of judiciary practices, torture and barbarism were key elements in the ancient penal style; the body would be tortured, torn away by horses and then be turned into ashes. Public executions were ceremonial events to show up penal style (Foucault, 1977).

This historical context is crucial for understanding contemporary penal practices. This style decreased the value of human life and its existence in its society and thus detracted the human based approach towards right to health. Towards the end of the seventeenth century, modern laws were put into action and a new moral concept of law of crime was put in place. Most importantly torture has been abolished as public show, which added a touch of humanization. The modern jail system works towards training and rehabilitating the condemned to be socially accepted through exercising power and discipline with a series of humanized controlling, surveilling and regulating procedures, and thus aims to preserve human life and its health.

Nineteenth century brought a turning point with the born of the jury system and corrective aspect of the penalty. Interestingly, a multidisciplinary approach was adopted in order to select correct punishment method; physicians and/or psychiatrics were needed to assess the status of prisoner and this process called for medico-judicial treatment (Foucault, 1977). According to the French philosopher, the ruling class wanted to make the power of punishment more effective in securing their property of ruling rather than adopting the change for the wellbeing of the prisoners. This reflects the underlying power dynamics at play in the penal system. In relation with punishment, Foucault argues that prison is part of a power system that disperse to the society. Power is highly present in society and affects relationships between humans; it is a relationship between people, where one's action affect or alter the other's will to do something resulting in a state of domination. When it comes to discipline, it is a method to control the movement and operations of a body in space and time permanently and is a must technique used to control populations either in prison or outside (Foucault, 1977).

Taken together, Foucault (1977) argues that prison is not a separate part of the outer society; Indeed, it is well integrated. This integration calls for a reassessment of societal norms and policies. Thus, same policies and rules of power knowledge and discipline should be applied the same way in both prison and society.

Michel Foucault's work has been immensely influential, but it's not without its criticisms. These criticisms are essential for a comprehensive understanding of his theories. Olssen (2006) discusses that Foucault's total critique may not address historical and epistemological relativism effectively, especially in non-European countries or ex-colonies, due to cultural differences and power dynamics. Wies & Haldane (2022) also argues that Foucault's work on prisons may be critiqued for its Eurocentrism and lack of consideration for non-European contexts, especially in ex-colonies. Moreover, Edward Said, in his book "Culture and Imperialism," also critiques Foucault for not adequately addressing the power relations inherent in colonialism and how Western knowledge production shapes understandings of non-Western societies (Said, 1994).

Mignolo (2011) criticizes Foucault's analysis as it prioritizes Western systems of knowledge production, neglecting the role of indigenous knowledge systems and local power structures in non-European societies.

In light of these critiques, I advocate for a nuanced understanding that acknowledges the limitations of his theories, particularly concerning historical and epistemological relativism, cultural differences, and power dynamics in non-European contexts. While recognizing the immense influence of Foucault's contributions, it is essential to address criticisms raised by scholars such as Olssen, Wies & Haldane, Said, and Mignolo. These critiques underline the importance of incorporating diverse perspectives into the discourse. These critiques highlight Foucault's tendency towards Eurocentrism and neglect of non-European perspectives and power structures, particularly evident in ex-colonial settings. Thus, I can consider his theories are irrelevant and poorly applicable to the Lebanese context.

Chapter 2.4 Types of Justice

In dealing with crimes and conflicts within a society, three distinct models or philosophies that guide approaches to dealing with crime and conflicts within a society. Understanding these models is crucial for analyzing how societies respond to crime. Each model focuses on different aspects of the justice system and aims to achieve different outcomes.

Retributive justice is based on the principle of punishment as a form of moral retribution or revenge for the wrongdoing. This approach emphasizes the need for accountability. It aims to punish the

offender for the committed crime. The severity of the punishment is often linked to the severity of the crime. Consequently, it is more concerned with the past actions of the offender and seeks to balance the scales of justice by imposing a penalty (Padlilah et al., 2023).

Reformative Justice (or Rehabilitative Justice) emphasizes on the rehabilitation and reintegration of offenders into society. This model contrasts sharply with retributive justice. It views crime as a result of social issues or personal problems that can be addressed through intervention and support. It aims to reform the offender, addressing the root causes of criminal behavior, and help them become law-abiding citizens. Rather than solely punishing, reformative justice focuses on education, counseling, vocational training, and other rehabilitative measures (Arnold et al., 2023).

As for restorative justice, it seeks to repair the harm caused by the crime by involving all stakeholders—victims, offenders, and the community—in a cooperative process. This model promotes a collaborative approach to justice. It aims to restore relationships, promote healing, and address the needs of both victims and offenders. It often involves restitution and community involvement. This type of justice is forward-looking, aiming to create a sense of accountability and empathy. It emphasizes repairing the harm rather than punishing the offender (Arnold et al., 2023).

It is important to note that these justice models are not mutually exclusive, and justice systems often incorporate elements from multiple models. This flexibility allows for a more tailored approach to justice. The choice between these models can depend on cultural, philosophical, and practical considerations within a given society. Additionally, some argue for a balanced approach that takes into account the merits of each model in different contexts.

On the other hand, Scott (2007) argues that the multitude of objectives for imprisonment, frequently conflicting and subject to revision when prior goals lose credibility, has struggled to present a compelling argument on moral and philosophical fronts. This critique highlights the complexities and challenges inherent in the penal system. The various purposes of imprisonment have not effectively justified the deliberate infliction of suffering through incarceration. Also, Ignjatović (2018) underscores the fundamental issues within contemporary correctional systems, encompassing concerns about the facilities themselves, the incarcerated population, the personnel working in these institutions, and the broader societal attitudes towards them. He also highlights

efforts to navigate the crisis within the penitentiary system, ultimately seeking to address the persistent question: Why does society, despite enduring controversies spanning two centuries, still consider the deprivation of liberty and correctional institutions integral to the penal system (Ignjatović, 2018)?

I perceive that imprisonment can be a necessary tool to punish offenders, but for true justice, it must be coupled with rehabilitation programs. This perspective emphasizes the importance of holistic approaches to justice. These programs, offering a variety of activities and therapies, should empower detainees to transform and prepare for a successful reintegration into society. By fostering positive change, these programs can contribute to a stronger, more sustainable society upon their release. period.

When people think about the meaning of the criminal justice system, the immediate association often revolves around police officers. However, this field extends well beyond law enforcement.

The criminal justice system encompasses law enforcement, the court system, and corrections. Understanding each component is essential for grasping the overall functioning of justice. Each component plays a distinct role in maintaining law and order, ensuring due process, and addressing the consequences of criminal behavior (Berry, 2023).

As described by Crowder & Turvey (2013), the criminal justice system is a complex framework encompassing various interconnected components, including academia, law enforcement, forensic services, the judiciary, and corrections. This interconnectedness underscores the collaborative nature of the system. These components are designed to uphold the principles of legal justice. Legal justice emerges from the harmonization of individual rights and the government's responsibility to ensure and safeguard those rights, commonly known as due process. The preservation of these constitutional entitlements relies heavily on the unwavering commitment of professionals within the criminal justice system. Professionals in this field are obligated to adhere to the ethical principles governing the criminal justice system and consistently demonstrate integrity in their conduct. In this context, achieving this involves the implementation of a robust code of professional ethics, which serves as a guide for competence, reliability, accountability, and overall trustworthiness when applied effectively. It is through the conscientious application of

these ethical standards that the individuals within the criminal justice system contribute to the preservation of justice and the protection of individual rights (Crowder & Turvey, 2013).

Chapter 2.5 Health as a Human Right

As individuals, the well-being of ourselves and our loved ones is a daily priority. This emphasis on well-being is universal across different demographics. Regardless of factors such as age, gender, socio-economic status, or ethnic background, we universally regard our health as a fundamental and crucial asset. Sickness, on the contrary, can hinder our ability to attend school or work, fulfill family obligations, or actively engage in community activities (OHCHR, 2008). Accordingly, health is a pre-requisite to enjoy other activities or commitments. This notion aligns with Freeman (2017) on the theory of compossibility of human rights.

Article 25 of the UDHR discusses that every person is entitled to a standard of living that ensures their health and the well-being of themselves and their family. This article highlights the essential components of health-related rights. This includes access to essential elements such as food, clothing, housing, medical care, and necessary social services. Additionally, individuals have the right to security in situations such as unemployment, sickness, disability, widowhood, old age, or other circumstances beyond their control. Special care and assistance are to be provided to both motherhood and childhood. All children, regardless of whether they are born in or out of wedlock, are granted the same social protection. Conversely, we are prepared to make various sacrifices with the hope of ensuring a longer and healthier life for ourselves and our families. In essence, when we discuss overall welfare, health is frequently the focal point (United Nations, 1948). The right to health was then identified as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights.

Subsequently, various international human rights treaties have acknowledged or made reference to the right to health, including specific components such as the right to medical care. This recognition underscores the global consensus on health rights. The right to health is applicable to all nations, as each State has ratified at least one international human rights treaty that recognizes this right. Furthermore, countries have undertaken commitments to safeguard this right through

international declarations, domestic legislation, policies, and participation in international conferences (OHCHR, 2008).

As per OHCHR and WHO, the well-being of individuals, ourselves and our loved ones is a daily priority. This reiteration emphasizes the importance of health across various contexts. Regardless of factors such as age, gender, socio-economic status, or ethnic background, we universally regard our health as a fundamental and crucial asset. Sickness, on the contrary, can hinder our ability to attend school or work, fulfill family obligations, or actively engage in community activities. Conversely, we are prepared to make various sacrifices with the hope of ensuring a longer and healthier life for ourselves and our families. In essence, when we discuss overall welfare, health is frequently the focal point (OHCHR, 2008).

Despite the fact that right to access health is a human right, there is still ambiguity around this matter. This ambiguity necessitates deeper exploration. Ruger (2006) provides a philosophical rationale for establishing a right to health. This involves crafting a theoretical framework that draws upon and synthesizes Aristotle's political theory, the capability approach, and a social choice paradigm referred to as incompletely theorized agreements. Termed the capability and health account, this approach incorporates aspects of various conceptualizations to tackle persistent disagreements concerning the right to health. The goal is to generate practical solutions that go beyond the "discordant positions, irresolution, and an exhausted uncertainty" that have characterized three decades of discussions on medical ethics (Ruger, 2006).

Ruger also underscores the significance of treating the right to health as an ethical imperative for achieving health equity. This perspective frames health as a moral obligation. It advocates for the internalization of public moral norms as a means to gradually actualize this right. Additionally, it encourages a more refined approach to addressing the social determinants of health and supports an integrated, multifaceted strategy to facilitate "human flourishing." Collectively, these principles lay the groundwork for the development of a theory regarding the right to health (Ruger, 2006).

For some, right to health is not perceived as an absolute human right to be fulfilled. This skepticism warrants examination. Sen (2008) in his article discusses the factors that contribute to why the concept of the right to health may appear distant to many. Firstly, there is what we could refer to as the legal question: how can health be considered a right when there is no binding legislation

explicitly requiring it? Secondly, there is the feasibility question: how can the state of being in good health be deemed a right when there is no guaranteed way to ensure that everyone enjoys good health? Thirdly, there is the policy question: why conceptualize health, as opposed to health care, as a right when health care is subject to policy-making rather than being directly linked to the actual health status of the population? (Sen, 2008). Nygren-Krug (2013) reflects that the right to health remains a mere document unless we ensure its implementation by states. This highlights the gap between policy and practice. The effectiveness of this implementation can only be ascertained through meticulous monitoring and evaluation. The employment of well-defined indicators is crucial for tracking progress if we are to make substantial strides in improving human health (Nygren-Krug, 2013).

Yet, Sen (2008) highlights that the right to health encompasses a broad spectrum of demands that extend beyond simply legislating for quality health care, as crucial as that may be. By recognizing health as a right, we affirm the necessity for a robust social commitment to promoting good health—a matter of paramount significance in the contemporary world (Sen, 2008).

Building on the above, I highlight the importance of recognizing and "implementing" the right to health as advised by OHCHR and WHO in 2008 and Nygren-Krug in 2013. This recognition necessitates both ethical and legal considerations. I see the importance of considering the ethical and legal responsibility behind it as discussed by Ruger (2006) and Sen (2008).

Chapter 2.6 Right to Health and Prisoners

Right to health which encompasses the right to access health determinants such as safe water and food, safe housing, healthy working environment and health education, is a system of health protection and freedoms of non-consensual medical treatment (United Nations, 1948). This definition emphasizes the comprehensive nature of health rights. Indeed, the right to health must be insured without discrimination to all regardless of age, gender, social status, religion, politics, economic and disability status, with special focus on disadvantaged populations. Any violation happening on the right to health will definitely affect other human rights especially right to work and right for education, because these human rights are highly interrelated and indivisible (OHCHR, 2008). In 2003, a new concept was put in place to further highlight right to health by

adopting a human rights-based approach. This approach emphasizes a shift in perspective regarding health rights. This approach guides the implementation of this right by making health policies and programming as outlined by human rights standards and developing capacity of duty bearers to meet their obligations and empowering right-holders to seek for their health rights far from discrimination and inequity (OHCHR, 2008).In the context of this entitlement, nations are tasked with three responsibilities. These responsibilities clarify the obligations of states. Initially, they are obligated to abstain from direct or indirect interference with this entitlement, as part of the duty to show respect. Secondly, nations are required to obstruct any interference by third parties that might impede the realization of this entitlement, as part of the duty to ensure protection. Lastly, nations must implement suitable measures from legal, administrative, judicial, and financial standpoints by establishing a national policy or plan applicable to both private and public sectors, in adherence to the duty to fulfill (OHCHR, 2008).

The same factsheet mentioned that women, children and adolescents, persons with disabilities, migrants and persons with HIV (Human Immunodeficiency Virus)/AIDS (acquired immunodeficiency syndrome) are at high risk of ill-health conditions and face challenges in accessing healthcare services and also have issues accessing prevention, treatment and rehabilitation healthcare provisions. This highlights the vulnerability of specific populations. Interestingly, a special rapporteur on the right to health was assigned in order to monitor fulfillment of this right; this is done by gathering requesting and exchanging related information from all sources, maintaining dialogue and cooperation especially between governments UN agencies and other agencies and NGO (Non-Governmental Organizations), reporting on the status of this right worldwide through laws policies and practices and making recommendations on proper actions to better promote and fulfill the right to health. Complaints were reported to the rapporteur about violations in determinants of right to health in prisoners: Absence of access to healthcare, forced feeding and lack of goods and services. Thus, prisoners are another vulnerable group in terms of health access. Consequently, prisoners are another group to be added to the list of disadvantaged populations in terms of access to health services (OHCHR, 2008).

In this regard, Lines discusses the right of health of prisoners in the context of the international law, and what can be done to ensure that persons in detention to realize the best attainable standards of health. This emphasizes the need for accountability in correctional settings. Within this context,

he came up with conclusions concerning the fulfillment of this right on an international scale, while proposing processes to monitor and work towards the promotion of the right to health for the prisoners at both local and international levels (Lines, 2008).

Tran et al. (2018) argues the importance of using the right language and terminology when speaking of health issues of detained individuals. This aspect is crucial for respectful engagement. Moreover, Tran et al. (2018) emphasize on necessity of using the right words in policies, programs and publications without any stigmatization and dehumanization. Tran et al. (2018) also suggest principles that should be used by health professionals, researchers and policy makers when working with prisoners. These principles include engaging people and respecting their preferences, using appropriate language, prioritizing individuals over their attributes and promoting self-awareness (Tran et al., 2018).

Bergh et al. (2011) highlight the importance of addressing gender sensitivity and social discrimination in prison. This recognition of gender issues is essential for comprehensive health care. This issue is especially prevalent for detained women and raises the concerns for more and different health needs as compared with detained men. Thus, governments, prison management and policy makers are urged to take immediate action to manage health discrepancies that lead to unfulfillment of human rights and gender unsensitivity (Bergh et al., 2011).

Chapter 2.7 International standards safeguarding health and food security of prisoners

Additional agreements have been established to ensure fairness in delivering an acceptable standard of healthcare to safeguard the health for all. This commitment is reflected in various international treaties. For instance, Article 5 of the Convention on the Elimination of All Forms of Discrimination advocates for the right to public health, health services, and medical security without discrimination based on race, color, ethnicity, or nationality (United Nations, 1965).

The International Covenant on Economic, Social and Cultural Rights, specifically in Article 12, emphasizes the right to the highest attainable standard of health for everyone (United Nations General Assembly, 1966). To achieve this comprehensive health standard, nations are urged to

focus on several key health initiatives. To achieve this, nations are urged to focus on improving child health, preventing stillbirths and child mortality, enhancing industrial and environmental hygiene, preventing and treating various diseases, and ensuring access to medical care in case of illness.

While the International Covenant on Civil and Political Rights does not directly address health, Article 7 of the covenant emphasizes the right not to be tortured or subjected to punishment. This is significant because it indirectly supports the right to proper health care. It also prohibits medical or scientific experimentation without consent, indirectly advocating for the right to proper and adequate health for all (United Nations General Assembly, 1966)

Additionally, the 2030 Agenda for Sustainable Development Goals (SDGs) includes SDG 2, which aims to end hunger, and SDG 3 and SDG 10, which focus on promoting good health and reducing inequalities in health access. These goals further underscore the global commitment to health equity. SDG 3 encompasses various objectives such as reducing maternal deaths, preventing childhood illnesses, combating epidemics, addressing communicable and non-communicable diseases (NCD), and achieving universal health coverage. SDG 10 emphasizes the importance of reducing inequality, particularly in countries with humanitarian crises and fragile healthcare systems, with a special focus on refugees and migrants (United Nations General Assembly, 2015).

Several trusted international policies and conventions explicitly stated prisoner's right to receive adequate food and water and take advantage of family visits regardless of their gender, background, culture and ethnicity. This recognition is crucial for ensuring the dignity of incarcerated individuals. Prisoners also have the right to access proper nutrition and medical services in order to either manage their disease or to maintain a good health and mental status (ICRC, 2021; ICRC, 2018). Also , the convention on the elimination of all forms of racial discrimination gave the right of public health and medical care under article 5, including inmates (United Nations, 1965).

On this level, it is crucial to highlight the importance of the NMR, which are worth a detailed observation. These rules serve as fundamental guidelines for the humane treatment of prisoners. They are the standard minimum rules for the treatment of prisoners in the World. There are 122 rules that oversee the treatment of prisoners worldwide (UNODC, 2015). The objective was to

establish a set of minimum conditions that would be universally recognized and accepted by the international community, recognizing the substantial variations in prisons and prison management worldwide. For over 60 years, these rules served as globally acknowledged standards for the administration of prison facilities and the humane treatment of prisoners. Their influence is significant in shaping prison laws, policies, and practices on a global scale.

In December 2015, the UN General Assembly unanimously adopted the revised UN Standard Minimum Rules for the Treatment of Prisoners. This revision reflects a collective effort to modernize standards. These rules were aptly named the “Nelson Mandela Rules” in tribute to the late president of South Africa. Nelson Mandela had spent 27 years in prison due to his unwavering commitment to justice and human rights. The adoption of these rules marked a collective effort to further refine and modernize the standards governing the treatment of prisoners, acknowledging their historical significance and the enduring legacy of Nelson Mandela's struggle for justice (UNODC, 2015).

Referring to the rules 22,23 and 35(a) related to food, prisoners should have access to well-handled and served food with good nutritional content. This focus on nutrition is essential for their health. Food served should be recommended by a competent health professional. Water should be available whenever needed. Besides, every prisoner has the right of a minimum one hour of exercise. In terms of health, rules 24 and 25,26,27, 30, 31,33 and 34 advise that prisoners should have access to healthcare services under the state’s responsibility through health professionals without any discrimination and special consideration should be given to women and their children held in prison (UNODC, 2015).

The extent to which these rules are applied globally varies. This variability can be attributed to several factors. Implementation depends on individual countries' commitment to human rights, adherence to international treaties and agreements, and the effectiveness of their legal and penal systems. Some countries may adopt and enforce these rules more rigorously than others. On one hand, generally food provision is always fulfilled regardless of the quantity and quality served. On the other hand, while progress has been made in raising awareness about human rights and improving conditions in many places, challenges and violations persist. These challenges illustrate the ongoing need for vigilance and advocacy. Instances of overcrowded prisons, inadequate healthcare, and violations of prisoners' rights still occur in various parts of the world. The

effectiveness of the NMR depends on the commitment of governments and the international community to uphold and enforce them consistently. In fact, governments and the international community tackled the NMR through a collaborative effort. This collaboration is vital for meaningful reform. The UN General Assembly unanimously adopted the revised SMR, renaming them the NMR after four years dedicated for review (Peirce, 2018). These rules, which are not legally obligatory but help as a solid reference for criminal legislation and judicial reform, stress on protecting prisoners' basic human rights, enhancing the mechanisms of rights protection, improving the conditions of prison health staff, and encouraging the judicious use of disciplinary sanctions (Peirce, 2018). The progress of these rules involved a noteworthy degree of engagement from technical experts, including advocates and prison administrators, who worked altogether to establish evidence-based and pragmatic recommendations (Hailing, 2019; Huber, 2016). This engagement highlights a shift towards more comprehensive and rights-based standards in addressing prison conditions globally.

At this level, I acknowledge the standing and importance of UN NMR and I adopt them as standards to compare to while assessing the status of prisoners in terms of health and nutrition in Lebanon.

Chapter 2.8 Health in prisons

The deprivation of freedom is likely to exacerbate both physical and mental health issues, leading to heightened stress, anxiety, and restricted opportunities for exercise. This context underscores the importance of maintaining health standards within prisons. Typically, prisoners are entitled to maintain optimal physical and mental well-being and should experience an environment that does not worsen their health condition before incarceration, thereby minimizing health risks. This imperative holds true even in challenging economic circumstances (Coyle, 2003).

Commonly recognized is the fact that prison conditions, including overcrowding, exposure to illicit drugs and violence, separation from family, emotional deprivation, and lack of purposeful

activity, contribute to various health issues. These conditions pose significant challenges for inmates' well-being. Moreover, violence, bullying, and intimidation are pervasive in prisons, posing a daily challenge and struggle for inmates. In essence, imprisonment entails a dual punishment: not only does it strip individuals of their liberty, but it also has a profound psychological impact (De Viggiani, 2007).

Yet, prisons might hold an opportunity to improve one's health. This potential is illustrated by some positive findings. In Chile, Osses-Paredes and Riquelme-Pereira (2013) reported a slight improvement in the perception of inmates' current health status compared to their health status before incarceration. A majority of inmates rarely pursued medical assistance, and only a small percentage requested medical care regularly or whenever needed. LaMonaca et al. (2018) emphasize that in wealthier countries with abundant resources, prisons are viewed as an opportunity to provide medical services to vulnerable populations grappling with drug use and diseases. Conversely, in low-income countries, prisons often lack basic necessities, resulting in insufficient access to medical and nutritional services.

According to International Committee of Red Cross (ICRC), health security in prisons involves ensuring the same standards of health care as in the community, providing access to necessary health-care services for prisoners, free of charge and without discrimination. This principle reinforces the importance of equitable health care. ICRC (2021) outlines various determinants, including the quantity and quality of water, diet, ventilation, occupancy, personal and general hygiene, outdoor access, and recreational activities.

Occupancy rates play a crucial role in assessing healthcare systems in prisons. Understanding these rates is vital for evaluating conditions. Ideally, occupancy rate should equal 100%, which means that the number of occupants should perfectly match the capacity. Overcrowding, defined as an occupancy rate exceeding 150%, leads to increased competition for resources, violence, malnutrition, insufficient water supply, and health problems (ICRC, 2021).

For instance, 88% of prisoners in Bangladesh, have a light physical activity level, and prisons were reported to be overloaded with an occupancy rate of 350% (Rahman et al., 2017). In Zambia, both male prisoners and prison staff reported anxiety related to health, nutrition, and sanitation. Over 300% occupancy was reported in prisons where healthy and sick inmates live together (Topp et

al., 2016). In Haiti, occupancy in prisons is 400%, and 87% of prisoners rate their health between poor and fair (LaMonaca et al., 2018).

While addressing such context, space issue plays a crucial role. This is particularly relevant in relation to NMR standards. According to rule 13 of NMR, all accommodations that are provided to inmates, including specifically sleeping units, should fulfill all requirements of health while taking into consideration climatic conditions. The unit of measure of this indicator is m^2 per prisoner, according to the following recommendations. For instance, recommendations in Europe revolves around 6 m^2 while 3 to 3.5 m^2 are quite acceptable. When it comes to Russia, it is recommended to allocate 2.5 m^2 per prisoner. In Africa, Guinea-Conakry recommendations aim for 2 m^2 to be provided for each prisoner. As for ICRC, the committee recommends 20-30 m^2 as a general use space including 3.4 m^2 in multiple occupant cells and 5.4 m^2 in single occupancy cells (ICRC, 2021).

In a broader context, numerous international policies, conventions, and studies explicitly affirm the right of prisoners to receive essential health provisions, food, water, and to benefit from family visits, irrespective of their gender, background, culture and ethnicity. This comprehensive approach highlights the universal rights of prisoners. Prisoners also possess the right to access adequate nutrition and medical services, either to manage their own conditions or to sustain good health and mental well-being.

Chapter 2.8.1 Healthcare Access and Financial Burden

Hospitalization for prisoners poses unique challenges due to the intersection of healthcare and incarceration. This intersection complicates the provision of care. Prisoners often suffer from limited specialist access and burdens of healthcare costs.

McFadzean et al. (2023) argue that prisons often lack the resources for in-house specialists, leading to delays in diagnosis and treatment for serious illnesses. Other studies show a higher prevalence of chronic diseases and mental health issues among prisoners, further highlighting the need for specialized care (Peiró, 2022). Hospitalization of prisoners incurs significant costs for transportation, security, and potentially higher charges from hospitals. These costs can create barriers to necessary care. This can create financial constraints for prisons and impact access to care (McFadzean et al., 2023; Eichelberger et al., 2023). Recent research suggests telemedicine

offers a promising solution to improve access to specialists within prisons (Rubí et al., 2016; Khairat et al., 2023). However, concerns remain regarding data privacy, confidentiality, and equitable access to technology (Hadlington & Knight, 2022).

Understaffing, lack of training, and inadequate resources can severely impact the quality of care provided to prisoners in hospitals (Enggist et al., 2014). These deficiencies highlight the need for systemic reform. Security measures and restrictions on movement can further impede communication and diagnosis (Leonard, 2004). A study by Khandelwal et al. (2019) indicate that incarcerated individuals receive lower quality care compared to the general population, even for similar conditions. This raises concerns about ethical obligations and equal access to healthcare.

Implementing standardized protocols and effective monitoring systems are crucial for ensuring quality of care for hospitalized prisoners (Bellas et al., 2022).

Chapter 2.7.2 Security restrictions and impact on health

Hampton (2023) discusses that guards accompany prisoners 24/7 during hospital stays, raising concerns about privacy, confidentiality, and the therapeutic relationship between healthcare providers and patients. This dynamic complicates the healthcare experience for inmates.

Moreover, movements' restrictions within the hospital can affect patients' recovery and mental well-being, impacting their overall healthcare experience (Appelbaum, 2018). Exploring alternative security measures, such as electronic monitoring or trained healthcare personnel, could potentially improve patient autonomy and therapeutic relationships while maintaining safety.

Certainly, informed consent and respecting prisoners' autonomy in healthcare decisions is crucial, even within the context of security concerns (Enggist et al., 2014). Additionally, prisoners are subject to vulnerability and exploitation. This reality necessitates heightened ethical scrutiny. Prisoners are often vulnerable due to their legal status and dependence on correctional systems. Ethical considerations must address potential for exploitation and ensure informed decision-making throughout the healthcare process (Bai et al., 2014).

Continuity of care is an issue for prisoners. This continuity is essential for effective treatment. Transitioning back to prison healthcare after hospitalization can be disruptive, leading to gaps in

treatment and potentially jeopardizing progress made during the hospital stay (Divakaran et al., 2023 & McFadzean et al., 2023).

Chapter 2.8.3 Healthcare Approvals

Complexities are documented on the level of access to healthcare for prisoners either within the prison facility or at hospital. These complexities highlight the multifaceted nature of healthcare access in correctional settings.

Prisons have formal processes to request healthcare services. Prisons often have established procedures for inmates to request healthcare services, often involving submitting written forms or verbal communication with medical staff (McFadzean et al., 2023). However, there are barriers to request medical care. Fear of retaliation, distrust of prison healthcare, lack of knowledge about procedures, and limited access to communication channels can hinder inmates from seeking needed care (Khandelwal et al., 2019). Certainly, more awareness is needed. Increased access to legal counsel or prisoner advocacy groups can empower inmates to navigate healthcare request processes and challenge potential denials (Rosen et al., 2023).

In terms of approval for hospitalization, decisions to grant hospital access are typically based on medical professionals' assessment of urgency and severity of illness (Enggist et al., 2014). However, this assessment process is not without its challenges. However, there are disparities in approval. Studies suggest implicit bias and systemic factors like race, socioeconomic status, and offense type can influence access decisions, raising concerns about equitable treatment (Veilleux et al., 2022).

To address these disparities, it is recommended to establish avenues for appeal against denials, with impartial review mechanisms, which can ensure fairness and protect inmates' rights to necessary healthcare (Puglisi & Wang, 2021).

Chapter 2.8.4 Financial Barriers

In fact, there are financial barriers on the level of health access. Some jurisdictions require inmates to share costs of hospital care, leading to financial burdens and delaying access for those with limited resources (Lu et al., 2022; Odhiambo & Purity, 2022). This financial strain can significantly impact inmates' health outcomes. Yet, there are alternative funding mechanisms, such as insurance coverage or prison healthcare budgets, could lessen financial barriers and improve access to necessary care (Bartos, 2023).

Moreover, there are ethical concerns in charging inmates for essential healthcare vis-à-vis access to basic human rights and potential exploitation within the correctional system (Eichelberger et al., 2023).

Chapter 2.8.5 Waiting Time

Studies report significant delays for prisoners seeking specialist care or hospitalization, attributed to limited resources and bureaucratic procedures (Rubí et al., 2016; Khairat et al., 2023). These delays can have profound effects on inmates' health. Prolonged waits can worsen health outcomes, increase costs, and contribute to frustration and distrust among inmates towards prison healthcare systems (McFadzean et al., 2023). Strategies for streamlining processes include implementing telemedicine, establishing clear referral pathways, and optimizing scheduling systems could potentially reduce waiting times and improve access to timely care (Khairat et al., 2023).

Chapter 2.8.6 Place of Care

Depending on the severity of illness, prisoners may receive care in dedicated prison clinics or be transferred to external hospitals (Enggist et al., 2014). This decision often hinges on a variety of factors, including security protocols. Yet, security protocols like guards escorting inmates can limit privacy, movement, and interaction with healthcare providers, impacting the quality of consultations (Eichelberger et al., 2023).

Chapter 2.8.7 Duration of Consultation

Concerns exist about insufficient time allocated for consultations in hospital settings due to security protocols, high patient volume, or lack of resources (Khandelwal et al., 2019). This lack of adequate time can lead to negative health outcomes. Shorter consultations can hinder thorough diagnosis, explanation of treatment options, and building patient trust, potentially compromising the quality of care received (Schattner, 2022; Bellas et al., 2021).

Chapter 2.7.8 Source of Medications

Most prisons have on-site pharmacies that dispense medications prescribed by healthcare providers within the facility (Enggist et al., 2014). However, the sourcing of medications can be complex. In some cases, prisons may source specific medications from external pharmacies, particularly for rare or specialized drugs not readily available in-house (Bellas et al., 2021).There are concerns regarding misuse and diversion including secure storage, dispensing protocols, and monitoring systems are crucial to prevent medication misuse, diversion, and potential trafficking within prisons (Hughes et al., 2023).

Chapter 2.8.9 Health Emergencies

Delays in accessing emergency medical care within prisons can have severe consequences, highlighting the need for readily available and rapid response systems (McFadzean et al., 2023). These delays can jeopardize inmates' health and safety. Proper training for correctional officers and other prison staff in recognizing and responding to medical emergencies is crucial for timely intervention and improved outcomes (Hampton, 2023).

Fortunately, telehealth technology can potentially offer quicker access to medical expertise during emergencies, especially in prisons with limited resources (Rubí et al., 2016 & Khairat et al., 2023).

Chapter 2.8.10 Drug/Alcohol Addiction

Studies indicate a significantly higher prevalence of substance abuse disorders among incarcerated individuals compared to the general population (Khandelwal et al., 2019). This high prevalence necessitates focused intervention strategies. In some cases, the prison environment can

inadvertently contribute to the initiation of drug abuse among certain inmates. Lukasiewicz et al. (2007) argue that substance use initiation or continuation occurs during incarceration, with a considerable percentage of French prisoners develop alcohol and drug-related disorders while imprisoned. Also, Sahajian et al. (2017) argue that 15% of first-time incarcerated inmates in Lyon-Corbas prison in France started psychoactive substance use during their custody, indicating a concerning trend of drug abuse initiation within the jail. In Nigeria, prisoners often start substance abuse before incarceration, and many continue it while in prison, posing security risks and hindering rehabilitation efforts (Abuchi et al., 2018).

To mitigate these issues, implementing comprehensive treatment programs within prisons, including medication-assisted therapy, counseling, and support groups, is crucial for addressing addiction and promoting recovery (Eck et al., 2022). Transitioning individuals with addiction back into the community with continued access to treatment and support services is essential for preventing relapse and promoting successful reintegration (Prasetyo & Mufanti, 2022).

Chapter 2.8.11 Health-related Information

In general, prisoners have limited access to health information. This limited access poses significant challenges for informed decision-making.

Ensuring prisoners have access to accurate and understandable information about their health conditions, treatment options, and available services is crucial for informed decision-making and self-care (McFadzean et al., 2023). Providing health information in accessible languages and with cultural sensitivity is essential for effective communication and understanding among diverse prison populations (Enggist et al., 2014).

Chapter 2.8.12 Dental Care Services

Prisoners often face significant disparities in access to dental care compared to the general population, leading to untreated dental problems and potential health complications (Schattner, 2022). This lack of access to dental care underscores broader health access issues within prisons.

Access to healthcare for prisoners is a complex and multifaceted issue with numerous barriers and ethical considerations. Addressing challenges in hospitalization, medical consultations, security measures, medication access, emergency response, addiction treatment, and information provision and dental care is crucial for ensuring the well-being of this vulnerable population.

Chapter 2.9 Nutrition concerns in prisons

In particular, malnutrition is a global worrying issue contributing to a series of diseases and poses a serious issue on the level of public health. In fact, this term does not only include undernourishment, yet it also encompasses overnutrition and inadequate vitamins and minerals uptake. According to WHO, malnutrition has a double burden in populations and individuals characterized by the coexistence of undernutrition along with overweight, obesity or NCDs related to diet (WHO, 2017). Speaking of numbers in 2014, approximately half a billion adults worldwide were underweight, while 1.9 billion were either overweight or obese (Di Cesare et al., 2019). When addressing malnutrition, it is essential to consider marginalized populations. Thoughts of malnutrition often bring to mind several marginalized and disadvantaged populations, among them prisoners, refugees, the homeless, people in poor health, and the elderly. In particular, malnutrition is very common in prisons and makes a major risk factor for mortality and morbidity in both developed and underdeveloped countries (Davison et al., 2019).For instance, 24% of prisoners in Congo suffer from severe malnutrition whereas 62% suffer from moderate malnutrition (Kalonji et. al, 2021).

Fortunately, prison can finally contribute to social justice in terms of health because admission of many prisoners would be a first time in life opportunity to get exposed to adequate nutrition, good health and non-social failure (Enggist et al., 2014).

Chapter 2.9.1 Nutrition and Weight Issues in Prisons

From a sociological perspective, the intersection of weight issues and nutrition concerns in prisons reveals a complex interplay between social determinants, institutional practices, and individual health outcomes. This complexity underscores the importance of examining how these factors

collectively impact prisoner health. The provision of adequate nutritional care to prisoners is not merely a matter of physical sustenance but also a reflection of broader societal values regarding human rights, dignity, and equity. Nutritional care stands out as a fundamental requirement for prisoners, constituting a basic human right akin to the rights to health and food, which uphold human dignity and ethical principles. To ensure these rights are met, adequate nutritional care involves providing prisoners with the right to undergo malnutrition screening and diagnosis, receive regular hospital diets, therapeutic diet, and medical nutrition therapy, administered by health professionals and safeguarded by governmental authorities (Cardenas et al., 2019).

As an integral component of prisoners' health, medical nutrition therapy contributes to the well-being of those who typically experience poor physical, mental, and social health (Davison et al., 2019). Given the context of social disadvantage**,** it is crucial to prioritize nutritional care for prisoners with NCDs like diabetes mellitus, kidney failure, hypertension, cardiovascular diseases, respiratory diseases, anorexia, obesity, and cancer. Additionally, special attention should be given to prisoners with AIDS and tuberculosis (TB) in terms of nutritional care. Furthermore, addressing the nutritional needs of specific population groups such as pregnant women, lactating women, and children residing with their mothers in prison is equally important throughout different stages of the lifecycle.

Overall, apart from grappling with a lower level of physical health, prisoners also tend to exhibit lower levels of mental health compared to the general population (De Viggiani, 2007). This duality of health challenges underscores the urgency of addressing both physical and mental health through comprehensive nutritional care.

In a comprehensive systematic review examining the prevalence of NCDs in prisons globally, Herbert et al. (2012) discovered that male prisoners exhibited a lower likelihood of being overweight or obese (OB) compared to non-imprisoned males. Conversely, female prisoners in the United States of America (USA) and Australia were found to be more prone to obesity than their non-imprisoned counterparts. This disparity highlights the different health challenges faced by male and female prisoners. Another systematic review conducted by Gebremariam et al. (2017), focusing on weight changes during incarceration in developed countries such as the USA, Australia, France, England, and Japan, revealed an overall increase in weight. This trend was attributed mainly to smoking cessation and prolonged periods of incarceration.

A study in Japan by Nara and Igarashi (1998) indicated weight loss among prisoners due to factors like calorie restriction, mandatory work, and thirty minutes of daily physical activity. In contrast, in Mexico, a study involving two large-scale male prisons demonstrated a minor decrease in body mass index and waist circumference, particularly in the initial period after admission and among younger inmates (Silverman-Retana et al., 2015). In South America, various studies have been conducted, with research in Haiti revealing that 17% of the prison population is underweight. These findings reflect the varied nutritional experiences of prisoners across different regions. In Chile, 74.5% of inmates reported weight fluctuations since entering the correctional facility, with 55.2% gaining weight and 44.8% losing weight (LaMonaca et al., 2018; Osses-Paredes & Riquelme-Pereira, 2013).

Abera & Adane (2017) investigated underweight prevalence in nine major prisons in Ethiopia, finding that 25.2% of prisoners reported being underweight, with some prisons reaching a prevalence of 53.7%. Factors associated with being underweight included a lack of family support, poor appetite or respiratory problems, incarceration periods of less than 18 months, previous imprisonment experience, and HIV or TB status. This highlights the multifaceted challenges prisoners face regarding nutrition and health. In Libya, 8% of prisoners were underweight, while 26.5% were classified as overweight or obese (Lalem et al, 2015).

These results propose that prisoners, pre-dominantly male, tend to lose weight in prison, whereas females tend to gain weight. Interestingly, underweight is relatively prevalent in prisons of Africa and South America.

Chapter 2.10 Women and Health in Prisons

Transitioning to the specific health needs of women in prisons, the issue of women in prisons is intricately linked with gender equity, as highlighted by the Convention on the Elimination of All Forms of Discrimination against Women (United Nations General Assembly, 1979). This convention emphasizes the right of women, equal to men, to receive appropriate healthcare services and proper nutrition, especially during pregnancy and lactation (Article 12). It also underscores the importance of providing adequate living conditions, including sanitation and water supply (Article 14), with a direct implication on women in prisons. Recognizing the unique

circumstances women face, globally, approximately half a million females are incarcerated, and it is crucial to recognize that women have unique health needs related to gender sensitivity, often unmet in the prison context (Van Hout and Mhlanga-Gunda, 2018). Due to their reproductive ability, women experience specific nutritional and health milestones such as menstruation, pregnancy, and lactation, which should be addressed even within prison settings.

Pregnant prisoners encounter significant health and nutrition issues. These issues are exacerbated by the prison environment, as research by Ranaut & Babbar (2019) argues that pregnant and lactating women should not be detained unless strong justification exists. Many incarcerated women face imprisonment due to minor offenses, financial difficulties, or discriminatory rules and policies (World Health Organization, 2014). In the USA, around 4% of female prisoners are pregnant upon admission, and challenges faced by pregnant inmates include fear for their baby's safety, lack of healthy snacks and proper bedding, and insufficient support during sickness (Abbott et al., 2020).

Shlafer et al. (2017) found that pregnant women in prisons have limited control over the food provided, with diets falling below recommended daily intake. This lack of control further contributes to the inadequate nutritional support they receive. Adequate nutrition during pregnancy, rich in fruits, vegetables, and whole grains, is often lacking. Pregnant inmates, especially those from underprivileged minorities, experience fear for their child's safety and a lack of support, both from staff and fellow prisoners (Abbott et al., 2020).

In sub-Saharan Africa, women constitute 1-4% of the total prison population, facing food insecurity and inadequate healthcare services. The situation is dire, as studies in 18 out of 49 countries in the region revealed harsh prison conditions, including overcrowding, poor ventilation, and insufficient nutrition for pregnant and lactating women (Van Hout and Mhlanga-Gunda, 2018).

Studies addressing the health situation in women's prisons in sub-Saharan Africa underscore the callous and overcrowded nature of prisons, along with poor ventilation and sanitation (Van Hout and Mhlanga-Gunda, 2018). Nutrition, especially for pregnant and lactating women, is often inadequate in terms of daily provision, highlighting the need for better health services, regular check-ups, and gynecological care (Van Hout and Mhlanga-Gunda, 2018).

Fakhry argues the impact of social factors within prison settings, specifically addressing issues related to food security, basic nutrition and health rights, weight status, diet quality, and medical nourishment therapy. The findings suggest that women and children incarcerated in prisons often face challenges related to inadequate nutrition and health services (Fakhry, 2022).

In summary, women in prisons face discrimination and gender inequity in health and nutrition settings. Addressing these inequities is essential for their well-being. Pregnant and breastfeeding women are particularly vulnerable, necessitating critical evaluation of imprisonment conditions, and a protective environment should be created to support the well-being of infants and children accompanying their mothers in prisons. Addressing the unique health needs of women, especially during menstruation, pregnancy, and lactation, is crucial to ensuring their rights and well-being in the prison environment.

Chapter 2.11 Children and Nutrition in Prisons

Turning to the situation of children, malnutrition is a significant concern for children under five years, especially those living in prisons with their mothers. Specialized support is essential to address health and nutrition needs.

However, disparities exist between institutions, with some having Mother-Baby Units offering special facilities, while others lack such provisions. Nutrition interventions, like the one studied by El Din et al. (2018), show positive effects on both feeding practices and child anthropometrics. The study by Todrys and Amon (2011) in Zambia highlights the lack of special cells, food, and infant formula for mothers and children, leading to mothers sharing portions to feed their children. This situation emphasizes the critical gaps in support for mothers and their children. Contrastingly, some countries like South Africa, Ethiopia, Kenya, and Namibia provide additional food support.

The presented information highlights the critical challenges faced by children accompanying their mothers in prisons, emphasizing the risks of malnutrition and inadequate food security. Overall, this illustrates the need for targeted interventions. Additionally, it provides an overview of the quantity and quality of food in various prison systems globally.

Chapter 2.12 Global Overview of Prison Diets

The ICRC emphasizes on the importance of providing food of acceptable quality tailored to detainees' ethnicities and habits. Inmates have diverse sources of food, including prison kitchens, visitors, canteens, shops, and even produce gardens. However, challenges in prison design and facilities can compromise food safety and quality. Food trading and begging for food are prevalent in prison environments, indicating the difficulties inmates face in obtaining sufficient and nutritious meals.

Studies from around the world reveal that prison diets are generally inadequate. This inadequacy is compounded by regional disparities, as examples include Mexican prisons lacking special dietary considerations, Iranian prisons providing inadequate energy with protein deficiencies, and Australian prisons showing deficiencies in certain nutrients. Developed countries like England and Australia provide inmates with access to a nutritious diet. In contrast, underdeveloped countries like Haiti, Bangladesh, Papua Guinea, and Zambia struggle with low energy sources, limited meals, and deficiencies in essential food groups (Fakhry, 2022).

In Australia, female prisoners in Australia were found to exceed recommended sodium levels, and prisoners, in general, received more energy and macronutrients compared to the general population. This situation reflects broader dietary concerns within prison systems. In Pakistan, a significant percentage of prisoners in Pakistan are dissatisfied with the quality of food, with undercooked meals being a common complaint. In Bangladesh, the daily menu in prisons supplies low calories, lacks fruits and milk sources, and has low meat intake. In Zambia, inmates reported inadequate quantity or quality of food, and some prison facilities did not provide dinner meals or supplied them uncooked. In Haiti, a majority of prisoners reported having less to eat than before imprisonment, with a significant percentage going to bed feeling hungry (Fakhry, 2022).

In Mexican Prisons, Silverman-Retana et al. (2015) found no special consideration for dietary requirements. Nutrition comes from family members and food prepared by prisoners, with cooking and portion control being prisoners' responsibility. This responsibility often leads to inequities in food access and quality. In Iranian Prisons, KhodaBakhshiFard et al. (2014) identified inadequate energy intake, protein deficiency, absence of fruits, and excessive grain supply in the prison food

menu. In Australian Prisons, a study on male prisons found that the menu generally met dietary recommendations but exceeded the upper limit for Sodium. Food sharing practices were common among prisoners (Hannan-Jones and Capra, 2016). Edwards et al. (2007) concluded that prisoners in England generally have access to a nutritious diet, with various menus catering to the diverse prison population. As for Australia, Herbert et al. (2012) noted that female prisoners in Australia exceeded recommended sodium levels, and overall, prisoners received more energy and macronutrients than the general population.

In Pakistan, Qadir et al. (2014) reported high dissatisfaction (98%) with the quality of food in Pakistani prisons, with a significant percentage (99.5%) noting undercooked meals as a common complaint.

These complaints underscore systemic issues in food provision. As for Prison diets in Bangladesh, Rahman et al. (2017) found that the daily menu in Bangladesh prisons supplied low calories, lacked fruits and milk sources, and had low meat intake.

In Zambia, Topp et al. (2016) reported very low levels of protein in Zambian prison food, mainly from Kapenta, and highlighted issues with meal timing not synchronized with medication schedules for HIV patients. Topp et al. (2016) also argued that 96% of prisoners in Zambia find either the quantity or quality of food provided inadequate. Some prison facilities lack dinner meals or offer them uncooked, posing food safety risks.

In Papua New Guinea, Gould et al. (2013) discussed that prisoners relied on prison food or homemade food brought by family members, with fruits and vegetables rarely consumed. The average calorie intake was close to WHO recommendations. However, this still reflects a lack of diversity in nutrition.

In Haiti, LaMonaca et al. (2018) found that 53% of the prison population had lower than the minimum levels of dietary and energy consumption. Having more visitors correlated with lower chances of being underweight. Besides, the same study examined the perception of food security in Haitian prisons, revealing high percentages of prisoners feeling they have less to eat than before imprisonment and often going to bed hungry.

In summary, the challenges in prison food security are evident, with notable differences between developed and underdeveloped countries. These disparities illustrate the critical need for reforms. While some prisons provide adequate nutrition, others face issues of insufficient quantity, low quality, and disparities in dietary content, posing risks to the health and well-being of inmates. Addressing these challenges requires attention to both food quality and the diverse sources from which prisoners obtain their meals.

This principle is especially crucial in the context of vulnerable populations. Adequate nutrition is a fundamental human right where access to proper food and nutrition is essential for maintaining good health, and individuals in prisons should not be deprived of this basic right. The review above suggests that in some cases, particularly in underdeveloped countries, prisoners, especially women and children, may face challenges in accessing sufficient and nutritious food.

Chapter 2.13 Biochemical Tests in Prisons

Biochemical assessments help in understanding the nutritional and health status of prisoners.

In Papua New Guinea, Gould et al. (2013) found that half of the prisoners in Papua New Guinea had blood test results below normal for Retinol, Vitamin C, Zinc, and Folate. Vitamin D levels were low in the prisoner population compared to the general population.

In USA, Nwosu et al. (2014) conducted a study on Vitamin D deficiency in Massachusetts prisons, revealing that 31% of prisoners were Vitamin D sufficient, 33% were deficient, and 34% were insufficient. Black prisoners were more likely to be at risk than white prisoners. These disparities in vitamin levels indicate broader health inequities.

In Kenya, a study addressing Vitamin A deficiency in a male prison found that 25% of prisoners had Vitamin A deficiency disorders, primarily due to a deficiency in the prison diet low in carotenoids and animal sources of retinol (Mathenge et al., 2007).

In general, literature reveals that prisoners suffer from a series of deficiencies in terms of vitamins and minerals in under-developed and developed countries.

Chapter 2.14 Conclusion

In conclusion, upholding human rights is linked to social justice, social progress and sustainable development. Societies that prioritize human rights are more likely to invest in education, healthcare, and infrastructure, contributing to overall well-being. This investment is particularly vital for marginalized populations, including prisoners. I see the necessity of applying human rights in all contexts and for everyone including prisoners. The impact is clear on the level of health and nutrition within the context of prisons.

The findings in this review suggest that prisoners, especially in underdeveloped countries, face challenges related to health security, overpopulation, and inadequate access to health services. To address these challenges, by implementing evidence-based practices, exploring alternative security measures, implementing minimum time standards for consultations, upholding ethical obligations, and promoting access to quality healthcare, we can strive towards a more humane and equitable healthcare system for all, regardless of their legal status.

Addressing challenges within each stage of the process is crucial for ensuring equitable and adequate healthcare for this vulnerable population. Further research, implementation of innovative solutions, and continuous monitoring are necessary to move towards a healthcare system that respects human rights and provides dignified care for all, regardless of legal status.

The impact of these challenges on the overall health and well-being of prisoners underscores the need for attention to human rights, health determinants and proper healthcare infrastructure within prison systems. This underscores the importance of systemic reforms and continued advocacy.

Social justice encompasses the fair and equitable distribution of resources and opportunities within a society. Disparities in the quality of health and nutrition services between developed and underdeveloped countries, as highlighted in the review, may also point to social injustices within the prison system. There is a concerning trend of insufficient nutrition and health services for women and children in prisons, with a particular emphasis on disparities between developed and underdeveloped countries. The call for additional research in uncovered regions in research including MENA region underscores the importance of understanding and addressing potential

variations in the application of human rights standards related to health and nutrition in prison settings globally.

Looking ahead, the next chapters will explore in details how the research took place in Lebanon, a country geographically situated in the region of interest and which is currently going through crisis on multiple levels. The research will prevail qualitatively and quantitatively a close examination of access to health services from many perspectives along with food served in Lebanese prisons, and according will be discussed in terms of human rights, social justice and dignity.

CHAPTER 3: LEBANON PRISON CONTEXT

In the beautiful alleys of Beirut, beneath the shadow of Ottoman-era arches and French colonial balconies, Amin Maalouf's words resonate with tangible truth: “Lebanon is a place where history is always present, whispering in the corners of the streets.*”* This captivating whisper is the melody that dances through my research, for Lebanon's present, with its complex connection between human rights, health, nutrition, and prisons, cannot be unraveled without acknowledging the persistent echoes of its past. By recognizing these historical echoes, we can better understand the complexities of contemporary Lebanon.

The current chapter discusses Lebanon as a research site. It explores its geography, history, geopolitics, crisis, security issues, judiciary system, prisons, problems and solutions to prisons and justice system. To achieve this, I aim to cultivate a deeper appreciation for the complexities that mold Lebanon. By doing so, I lay the groundwork for a research attempt that not only generates empirical findings but also contributes meaningfully to the broader discourse surrounding our

chosen subject matter. Ultimately, this chapter helps embark on a journey of discovery, guided by the conviction that understanding the context is the key to unlocking uncertainties and concerns within the heart of our research inquiry.

Lebanon is a small sized country of 10 452 km^2 on the east coast of the Mediterranean, belonging to the Middle East and North Africa (MENA) region and characterized by its geopolitical importance and a society recognized with its diversity. Mountainous nature and closeness to the sea simultaneously gives it a special geographic attractiveness. Moreover, it is centrally located between Asia, Europe and Africa, within a cluster of countries that constitute a cradle of civilization. It is a strategic and interactive country within its surroundings with a prominent ideological influence. Its political position and openness make it a mediator country in the neighborhood while its vital location make it the center point of the Middle East and West Asia (Khalifeh, 2008). The Lebanese society is highly diverse and hosts different cultures, mentalities, religions, doctrines and ideologies, which makes it culturally distinguished in comparison to other Arab countries. The main ideology that Lebanese people inherited is democracy and freedom, which also differentiates it from the Arab neighborhood (Khalifeh, 2008). Apart from democracy, gender equality and women's empowerment are very well recognized within the Lebanese society.

Being in a disrupted region, Lebanon has always been in a disturbed and complicated status of danger vis-à-vis Israel since 1982, which witnessed the Israeli invasion of Lebanon. Ongoing conflict in the south area has been taking place until the year 2000 that marked the withdrawal of the Israeli forces from the southern areas. Following this withdrawal, tensions remained high along the Lebanese-Israeli border despite Israel's withdrawal from southern Lebanon in 2000. Sporadic clashes, especially involving Hezbollah and Israel, persisted. In 2006, a month-long war erupted between Hezbollah and Israel following the capture of two Israeli soldiers by Hezbollah militants. The conflict resulted in nearly 1,200 people killed in Lebanon, mostly civilians and massive destruction in different areas of the country (Middle east monitor, 2022b).

In the 2010s to 2023, although there have been periods of relative calm, tensions persist between Lebanon and Israel. In October 2023, Lebanon faced a new crisis when Israel initiated its offensive on Gaza in October, leading to heightened tensions. Hezbollah's involvement escalated the situation as it launched attacks on Israel from southern Lebanon. This ongoing conflict has further complicated the regional dynamics. Conflict in the southern region is intensifying, with additional

Palestinian and Lebanese factions joining forces with Hezbollah (Astih, 2023). As of March 19th 2024, the continuing conflicts in south Lebanon have resulted in the displacement of 90,491 individuals, of which females make up 52%. Furthermore, there have been 316 reported deaths and 909 injuries. Among these casualties, at least 54 were civilians, with nearly half of them being females (UN OCHA, 2024).

Another strategic component is the presence of oil resources within the territorial waters of Lebanon, which constitutes another point of conflict with Israel. This further complicates the geopolitical landscape. One more key component that reflects the geo-political status of Lebanon is the presence of Hizbollah, a militant political party, that came to light during Lebanese civil war, backed up by Iran, to oppose Israel and to fight western influence in the middle east (Khalifeh, 2008). In fact, Hizbollah initiated its operations and activities driven by its three-dimensional ideology: establishing an Islamic state in the country (through an aspiration and not currently a policy goal), fighting the existence of Israel and following wilayat al-faqih, which is the doctrine of the Islamic republic of Iran (Blanford, 2017). Consequently, Hezbollah's agenda have a high impact on day-to-day political stability in the country thereby affecting policing, security and safety and therefore prisons dynamics.

Chapter 3.1 Milestones in the History of Lebanon

Lebanon went through remarkable milestones that continue to affect it today across all levels, especially in how Lebanon operates its directorates and systems. From being part of the Ottoman empire until 1918 and then under the French mandate, Lebanon was announced as a state of greater Lebanon in 1920 and later in 1943 it got its independence from France. However, since 1948, Lebanon has been a platform of conflicts between Syria, Iran, Israel, Hizbollah and Palestinians. After the start of conflict with Israel, Palestinians started migrating towards Lebanon and utilized the Lebanese territory as a platform for attacks on Israel (Traboulsi, 2012). In 1975, the civil war began between Christians Muslims and Palestinians due to sectarian political and religion differences. As a response to escalating tensions, Syrians became present in Lebanon in 1976 as an Arab deterrent force for peacekeeping missions. Israel made its first invasion in 1982. The civil war was formally declared over in 1990. At the beginning of the new millennium, Israel withdrew from southern Lebanon. In 2005, Rafic Hariri, a popular politician and past prime minister, was

assassinated in a huge car bomb in Beirut; this attack highlighted anti-Syrian rallies and it was the beginning of a sequence of assassinations of anti-Syrian political figures. Hariri's assassination pushed remaining Syrian troops to leave Lebanon (BBC news, 2018). In summer 2006, a 34-day war happened between Lebanon and Israel, which hit civilian infrastructure heavily. In the aftermath, both Lebanese army troops and UN peacekeeping force i.e., UNIFIL were deployed along the southern borders with Israel. Mid 2007, Palestinian refugee camp Nahr El Bared witnessed clashes between Islamist militants and Lebanese military, which led to the death of more than 200. In 2011, the Syrian conflict began, and a considerable number of Syrians were displaced, which led to a high flow of Syrian refugees to Lebanon (BBC news, 2018).

On the political level, the presence of political tension has always been evident between sects and political parties, that are usually backed up by foreign countries mainly USA, France, KSA, Iran and Russia. This political situation has resulted in several cabinet resignations throughout the years, often leading to political gridlocks. In 2015, a mini revolution against the government kicked off with thousands of protesters organizing a campaign called "you stink" with a list of demands to be met within 72 hours (France 24, 2015). In October 2019, a revolution took place against both the government and banking system blaming them for the deteriorated political and economic situation. Violent confrontations took place between protesters, Lebanese internal security forces, Lebanese army troops and political parties (Khatib, 2022).

Such civil unrest can have significant impacts on the police and judiciary system in various ways. Notably, the impact of civil unrest on the police and judiciary system can vary widely depending on the nature of the unrest, the response of authorities, and the specific socio-political context of the situation. Common challenges include overwhelmed law enforcement, increased police presence, use of force and human rights concerns, legal and judicial challenges, judicial challenges, public trust and perception, reform initiatives and political influence.

Today, ongoing mortar and artillery exchanges, along with airstrikes, are occurring in South Lebanon near the Israeli border. As a result, the situation is tense, and there is a risk of escalation with little advance notice, which may impact or restrict exit options from Lebanon (Foreign Travel Affairs, 2024). At this stage, the security and safety in the country is in question, impacting police and security system, which in turn requires more deliverables from security forces and police through detentions and thereby building up more cases to be resolved on the judicial level.

Overall, the impact on the police and judiciary systems during crises and states of war is complex and context-dependent. Balancing the need for security with the protection of individual rights remains a significant challenge in these situations.

Chapter 3.2 Lebanon today amid multidimensional crisis

Lebanon is a relatively small country with an estimated population of 5 353 930.Out of this population, 23.77% is made of refugees and migrants with 1.5 million Syrian refugees, of which 855,172 are registered Syrian refugees with UNHCR in 2021 along with 477,574 Palestinian refugees in 2020. In terms of demographics, 89% of its population residing in urban areas while 11% reside in rural areas. When it comes to health parameters and access to sanitary services, prevalence of undernourishment is 10.9 % whereas 92.6% have access to basic drinking water and 99.2% have access to basic sanitation services. Moreover ,33% of health expenditure is out of pocket (Arab development portal, 2023). When it comes to economy parameters, there is a 25.91 % decline in GDP, a debt of 150.48% which is general government gross debt as percentage of GDP and 84.88% inflation (Arab development portal, 2023).

An unprecedented tough compounded crisis has been hitting the country since October 2019, and is impacting humanitarian, economic and industrial levels and incurring a high social cost. In reality, the impact of the crisis on the society is rapidly turning out to be catastrophic as half of the population are living below the national poverty line. The burden falls on those who earn their income in LBP, a major fraction of the population, as their purchasing power is rapidly decreasing (The World Bank, 2020). This dire situation led to an economic hardship and a dual exchange rate. In this context, a dual monetary system exists in the form of coexistence of multiple exchange rates where different rates could be applied for specific transactions or sectors, aiming to address economic challenges. Due to the economic turmoil, an informal market for currency exchange emerged in Lebanon. Consequently, the exchange rates in the informal market often diverged from the official peg, contributing to a complex economic environment. Consequently, the Lebanese government and central bank implemented various measures in an attempt to stabilize the economy. These measures included capital controls, restrictions on foreign currency withdrawals, and efforts to manage the exchange rate.

This crisis has different layers including COVID-19 pandemic, overwhelming effect of August 4th 2020 explosion at Beirut port, effect of Syrian refugee crisis, collapsing healthcare system stationary Lebanese regime, decrease liquidity in foreign currency (i.e.,US dollars), decrease in value of the national currency, decline in tourism and lower investments from the gulf countries.

Lebanon's health sector is fragmented and complex, shaped by continuous conflict and waves of refugees. In particular, the system is divided between a mainstream system for Lebanese citizens and a separate humanitarian system for refugees. Financing is a major challenge, with heavy reliance on out-of-pocket payments and limited public insurance. Additionally, decision-making is closed and influenced by powerful stakeholders, with little public participation (Fouad et al., 2022).

In terms of COVID-19 pandemic, like many other countries, Lebanon faced significant challenges in managing the pandemic. The Lebanese government implemented a series of measures to control the spread of the virus. Despite these efforts, the healthcare system was stretched to increase the capacity of hospitals, including setting up additional COVID-19 treatment centers. A vaccination campaign was initiated to inoculate the Lebanese population against COVID-19. However, the pandemic exacerbated Lebanon's pre-existing economic crisis, leading to job losses, business closures, and economic challenges for many residents. Moreover, the economic impact influenced the government's ability to provide support and relief to those affected. Unfortunately, the pandemic exposed a critical vulnerability within Lebanon's prison system due to overcrowding (Human Rights Watch, 2023). Operating at well over capacity, these cramped and unsanitary conditions created a breeding ground for the virus. Authorities implemented measures like hygiene education and some prisoner releases (Amnesty International, 2020), but overcrowding remained a persistent obstacle. The pandemic's impact on prisons highlights the urgent need for prison reform in Lebanon to ensure the health and safety of both inmates and staff (UNODC ROMENA, 2020).

The national currency Lebanese pound (LBP) deteriorated in value as compared with United States Dollar (USD). Until October 2019, the exchange of 1 USD would yield 1500 LBP according to the official exchange rate issued by Banque Du Liban. Since late 2019, the value of LBP decreased progressively with a black-market equivalent today to 89 000 LBP for every 1 USD.As of February 2023, the official exchange rate rose from 1500 to 15 000. This change, taken by the central bank,

which weakened the currency by 90%, is thought to unify an array of rates that have emerged throughout the crisis in the country. Such a step is among many others considered as prerequisites to receive the International Monetary Fund (IMF)'s aid of USD 3 billion to help the country recover from the meltdown. The national currency has indeed crashed following a financial meltdown due to decades of corruption, wasteful spending and a mismanagement by the political elites that were running the country, which led to a multidimensional crisis, including a prevalent poverty (Reuters, 2023).

On one hand, The World Bank published that nearly 50% of the population in Lebanon lives in poverty (The World Bank, 2022).

On the other hand, ESCWA reported that 82% of the population in Lebanon live in multidimensional poverty out of which 40% live in extreme poverty, highlighting the painful reality and uncertain prospects of the multidimensional poverty. Within this context, the facets of deprivation include access to health care and medications, services, education, employment, housing and assets (ESCWA, 2021).

In fact, this financial and economic crisis can possibly be classified among the top three crises episodes around the world since mid-nineteenth century. This situation stems from inadequate public policy response as related to knowledge gaps and quality advices along with absence of political consensus over two issues: proper and effective policies and protection of a bankrupt economic system (The World Bank, 2021).

Accordingly, this crisis has intensified the country's fragility and fragmentation, leading to more social and civil unrest. Moreover, the crisis increases the national deficiencies including disastrous economic and social policy, weakness in institutions and miserable public policy (The World Bank, 2021).

In general, crisis situations can have profound effects on both the police and judiciary systems. Indeed, the nature and impact of these effects can vary depending on the type of crisis, its intensity, and the response of authorities.

The police system can go through increased workload as crises often lead to increased demands on law enforcement agencies. This can include managing public safety during natural disasters,

responding to civil unrest, or addressing security threats. The police may need to deploy additional resources to handle the heightened workload. Furthermore, the demands of a crisis can strain police resources, both in terms of personnel and equipment. Thus, adequate training, equipment, and manpower become critical to effectively respond to the crisis and maintain public order. Consequently, law enforcement agencies may need to adapt their strategies to address the unique challenges presented by the crisis. For example, this can involve changes in tactics, deployment, and collaboration with other emergency response agencies. Lebanon has been able to respond to crisis through numerous initiatives. Notably, the most important one which is Lebanon Crisis Response Plan (LCRP). Lebanon has introduced a subsidiary strategy under the 3RP[1] known as the LCRP. This plan encompasses humanitarian assistance, protection, livelihoods and Socio-economic Support, education, healthcare and nutrition, shelter and non-food items, water, sanitation, and hygiene, coordination and capacity building, resilience and community empowerment (United Nations, 2021). In collaboration with national and international partners and stakeholders, such a plan is designed to implement humanitarian and stabilization measures to assist both refugees and host communities (Beaujouan & Rasheed, 2020). Moreover, the Lebanese government and the IMF team have reached an initial agreement on a comprehensive economic plan that could be backed by a 46-month Extended Fund Arrangement (EFF) with a requested access of approximately US$3 billion. However, this agreement is contingent upon approval by the IMF management and Executive Board, provided that all prior actions are executed in a timely manner and international partners confirm their financial support. The EFF's primary objectives are to support Lebanon's reform strategy aimed at revitalizing economic growth and financial stability, enhancing governance and transparency, and boosting social and reconstruction spending. Achieving these goals will necessitate restructuring of external public debt, ensuring adequate creditor involvement to restore debt sustainability and address funding shortfalls (IMF, 2022). As of today, the Lebanese government has been unable to enact reforms due to ongoing political discord and internal strife.

[1] The 3RP (Regional Refugee and Resilience Plan) is a strategic framework established to address the humanitarian and resilience needs of refugees and host communities in response to the Syrian crisis. It involves coordination between several countries hosting Syrian refugees, including Lebanon, Turkey, Egypt, and Jordan.

Additionally, during crises, the use of force may become more prominent, especially in situations where public safety is at risk. Balancing the need for force with respect for human rights is crucial, as abuses can lead to public outcry and legal challenges. In such context, the police system, may need to coordinate with other emergency response agencies, such as medical services and disaster relief organizations. Effective coordination ensures a comprehensive and efficient response to the situation. Certainly, the way law enforcement handles crises can significantly impact public perception and trust. Transparent communication, community engagement, and the protection of civil liberties and the right to protest are crucial to maintaining public trust during challenging times.

Likewise, the judiciary system faces many challenges during crises. In particular, crises can lead to a surge in legal cases, including those related to emergency measures, public safety, and potential violations of the law. The judiciary may face challenges in managing a higher caseload, which can result in delays in legal proceedings. Moreover, a government may introduce emergency measures or enact legal changes during crises. These changes can affect legal procedures, the rights of individuals, and the overall functioning of the judiciary. Balancing the need for public safety with the preservation of individual rights becomes crucial. Furthermore, crises may lead to challenges to the independence of the judiciary. As such, political pressures, emergency measures, or the need for swift action can potentially compromise the impartiality and autonomy of the judiciary.

Yet, according to UN human rights experts, Lebanon's security forces have allegedly employed disproportionate force and inadequately safeguarded protesters from violent assaults by external parties, despite the predominantly peaceful nature of the demonstrations that have unfolded across the nation over October and November 2019 (OHCHR, 2019).Simultaneously, an article by CNN argued that ISF(Internal Security Forces) are accused of deploying excessive force against demonstrators, when security personnel unleashed numerous rounds of tear gas on the protest site outside Beirut's governmental headquarters, causing chaos and prompting most protesters to disperse (Qiblawi, 2019).

In the situation of crises, legal professionals, including judges, lawyers, and court staff, may face security concerns during crises. This, in turn, can impact their ability to conduct proceedings and administer justice effectively. In such a case also, the judiciary may need to adapt to new legal

realities created by the crisis. This includes interpreting and applying emergency measures, considering the context of the crisis in legal decisions, and addressing legal challenges arising from the crisis. When considering human rights, upholding their standards becomes particularly crucial during crises. The judiciary plays a critical role in ensuring that emergency measures and crisis responses adhere to constitutional and international human rights principles.

Crises, including health emergencies like pandemics, can also place additional strain on healthcare systems, including those within prisons. Thus, studying prisons during crises helps assess the state of health emergency preparedness, ensuring that adequate measures are in place to address health risks and prevent the spread of diseases. Moreover, crisis situations can lead to an increased risk of human rights violations, including arbitrary detentions, torture, or ill-treatment.

In essence, crises can significantly impact both the police and judiciary systems, posing challenges that require effective adaptation, coordination, and a commitment to upholding the rule of law and human rights.

Chapter 3.3 Security Issues in Lebanon

Since long time, security issues of Lebanon have been in the headlines of the news worldwide.

This ongoing attention underscores the complexity of the security landscape in the region. Being a hub for tourism in the middle east with its service industry, entertainment, historical heritage, mixed identity between the Westerns and Arabs, the country has been a target of violence, crimes and wars since the late 60s (Nashabe, 2009).

Attempts took place to make reforms to the security sector during the early 1990s through constitutional reforms based on Taif agreement after peace restoration and the establishment of a government characterized by a national reconciliation with the support of the Americans, French, Saudis and the Syrians. This marked a significant shift in Lebanon's approach to governance. This milestone was characterized by a fair allocation of key positions in the government between Christians and Muslims. Also, throughout this stage, the adoption of UDHR (paragraph B of its preamble) took place (Nashabe, 2009).

Some progress was achieved especially during the first half of the 1990s.However, some issues are still unsolved on different levels. First, the majority of the governmental institutions witnessed a considerable damage during war and the internal security institutions were not rebuilt according to correct standards of ethics and processes for accountability and inspection. Consequently, corruption increased further due to the financial difficulties evolving from the economic crisis. Staff including officers from ISF, GS and ST entered into innovative strategies to collect money from Lebanese citizens and companies through the "wasta[2]" system. Indeed, this phenomenon is very common in the security sector of Lebanon. It relies on a network of affiliations and connections with officers with high ranks or with influential politicians. Moreover, some religious, sectarian or other ideological figures often try to influence the law enforcement by asking some key staff to be more lenient with certain law violators or to improve the conditions of detention of some individuals (Nashabe, 2009). In terms of staff development, officers working for ISF lack suitable training and specialization as compared with their work tasks. This gap in training leads to significant challenges in law enforcement effectiveness. Officers who are allocated for a certain job and functions do not have the adequate skills and technical knowledge. This issue is especially evident in the case of officers appointed to work at prisons, street patrols or for detective purposes. For instance, reports of investigations, which are handwritten without a tailored style, show a lack of professionalism. Moreover, methods that are used for investigation are inefficient and primitive and often tend to use violence or threats to use violence during questioning suspects (Nashabe, 2009). In the near term, it is crucial for the MOIM to introduce a mandatory training program for ISF personnel serving as prison guards. Implementing such training could greatly enhance their operational effectiveness. Additionally, alternative measures to pre-trial detention, such as geographic confinement and supervision by a designated office, should be implemented. Ultimately, government policies need to address the root causes of crime by lifting significant portions of the population out of poverty. The primary focus should be on investing in education, employment opportunities, healthcare, and housing. By addressing these underlying issues, only through these comprehensive measures can we genuinely disrupt the cycle of crime and pave the

[2] Wasta: A Lebanese term that highlights the presence of a good connection or intermediary in the government (or a person of influence in society at large) to seek approval for a completely legal act or procedure

way for community rehabilitation alongside improvements in correctional facilities (Minkara & Boswall, 2021).

When it comes to equipment used for work purpose, both ISF and GS lack necessary equipment. This deficiency hampers their ability to effectively enforce the law. Most police stations of ISF lack prerequisites for proper enforcement of law. Most cars and trucks that are used to transport detained people do not fulfill constitutional standards for such process. For example, patrols or trucks do not have special seats for detainees, thus they are placed in the trunk section (Nashabe, 2009). When it comes to the role of civil society, CSO (civil society organizations) and security institutions are interacting in a very productive way in the context of security sector reform, which is leading to a growing role for CSOs in expressing concerns and taking initiatives with different policy makers and security services. This collaboration is vital for addressing security challenges effectively. Several NGOs have been actively engaging in crucial areas like protection missions, prison reform, advocating for the rights of marginalized groups, addressing gender-based violence, and providing training services. These efforts are significant as they contribute to the broader goal of enhancing the effectiveness, accountability, and human rights standards within the security sector (El Mufti, 2015).

Civil society faces challenges related to its perceived expertise and credibility, particularly in interactions with security officials. This struggle for recognition impacts the effectiveness of their initiatives. This dynamic is resulting in a fragmented landscape, indicating a lack of cohesion or unity within the relationship between civil society and security entities (El Mufti, 2015).

Chapter 3.4 Judiciary System's issues and Rule of Law in Lebanon

The rule of law in Lebanon faces significant hurdles, including the impact of the Ta'ef Agreement, a focus on economic recovery over institutional reforms, and persistent political and economic crises. Addressing these obstacles is critical for fostering a stable legal environment. Overcoming these challenges would likely require a comprehensive and sustained effort to address both the legal framework and the broader socio-political context. The rule of law in Lebanon is characterized by inconsistencies and a disparity between the law and its actual practice. This

inconsistency undermines public trust in legal institutions. This suggests that there may be a lack of uniform application and enforcement of laws.

The amendments made to the Lebanese Constitution in 1990 laid the groundwork for the rule of law. However, simultaneously, the introduction of the Ta'ef Agreement, a confessional system, distributed political and institutional power among different Christian and Muslim sects. This distribution complicates governance and legal application. This system aimed to accommodate religious and sectarian diversity but has been criticized for compromising the prevalence of the law. Initially designed as a temporary mechanism for partnership and coexistence, confessionalism has evolved into a tool that undermines the rule of law. It appears to have shifted from fostering collaboration to impeding the establishment of a 'State of Law'. After the war, the Lebanese government prioritized rebuilding infrastructure and promoting economic growth rather than implementing top-down reforms to strengthen institutions. This prioritization has significant implications for legal reform. This approach might have hindered the development of a robust legal framework.

Successive and prolonged political and economic crises have further impeded the strengthening of the rule of law. Despite political discourse emphasizing the rule of law as a solution, the practical implementation seems to be hindered (Hamd, 2016).

The implementation of the rule of law in Lebanon has been caught in a vicious circular track. This cycle perpetuates instability and insecurity. Challenges such as political instability, economic difficulties, and the confessional system contribute to a cycle that inhibits progress toward a more effective rule of law.

Moving forward on the reform of the legal and judicial sector in Lebanon will require progress on three tracks. First, progress toward specific technical goals, such as the training of court staff in case management techniques and the start of continuing education for judges. Second, and equally critical, is an ongoing commitment for legal and judicial reform, particularly related to the independence of the judiciary. Third, efforts are needed to update legislation both for the judiciary as well as to promote private sector development, which requires an enhanced capacity to draft and review proposed legislation. Achieving these reforms will demand collaboration among various stakeholders. There is a broad spectrum of reforms that are critical and it appears that the

current Government is interested in reforming the sector. There appears to be enthusiasm by all branches of government, as well as the private sector and the Bar Associations, to take concrete actions. Thus, clarity in action plans will be essential. However, such actions may be limited. It will be critical that a plan of action with defined goals and stages is adopted. Sustainable reform requires a long-term program to ensure that the legal and judicial sector in Lebanon is based on principles of efficiency, quality, independence, integrity and transparency (The World Bank, 2016).

The rule of law and the judiciary system are closely intertwined, and the relationship between them is fundamental in ensuring a just and orderly society. Certainly, the judiciary is a cornerstone of the rule of law. Its role in interpreting, enforcing, and safeguarding the law, as well as providing checks and balances, is essential for maintaining a just and orderly society based on the principles of fairness, equality, and legal certainty.

Given the uncertain and fragile context of the country and the uncertainty around the security and the judiciary system, it is worth having a closer look on operations within public institutions like prisons, which are institutions managed by the government.Examining these operations can reveal deeper insights into systemic issues.

Chapter 3.5 Prisons of Lebanon in a Nutshell

In Lebanon, the prison's directorate manages 28 prisons located in all geographical districts with approximately 6399 inmates excluding those held in local police jails and immigration detention facilities. Among these facilities, three prisons are allocated for female adults, one prison for male juveniles, one prison for female juveniles and 23 prisons are solely reserved for male adults (Ministry of Interior and Municipalities , 2022).The central prison of Roumieh (RCP) holds 60% of the country's prison population. Furthermore, the majority of prisoners are males (93%) and 60% of the prison population is Lebanese. Interestingly, prisons in Lebanon hosts detainees from 35 nationalities including Syrian migrants/refugees (27%) and Palestinians (8%) in addition to some stateless prisoners (Ministry of Interior and Municipalities , 2022). The prison population

rate[3] in Lebanon is 98, which is lower than in other Arab and Muslim majority countries in the MENA region, such as Saudi Arabia (207), Iraq (145), Bahrain (234), United Arab Emirates (104), Jordan (174), Tunisia (197), Morocco (232), Libya (139), Egypt (118) and Algeria (153) (Fair & Walmsley, 2021).

In Lebanon, prisons are still managed by the ministry of interior and municipalities through the directorate ISF, even though there is a national decision that was taken to transfer the authority of prisons to ministry of justice (MoJ) upon a decision of the council of ministers No.34 dated 4 March 2012.

Chapter 3.6 Prisons in Lebanon between Punishment and Rehabilitation

Prison's system in Lebanon primarily aims to maintain security rather than rehabilitation and justice for prisoners. Normally, imprisonment aims to raise the detainee in a suitable environment to positively impact his welfare and reintegration into society after release. However, it is known that Lebanese prisons, especially RCP, do not meet the minimum requirements in terms of human rights, health, food, education and rehabilitation (Nashabe, 2003).

Moreover, fair trial and due process standards are frequently disregarded in regular courts. Individuals who lack the financial resources to hire their own legal representation often do not receive adequate legal assistance, and the duration of pretrial detention is largely uncontrolled, contributing significantly to the overcrowding issue in Lebanon's prisons (El Bejjani & Roccatello, 2020).

Thus, this situation and the harsh treatment that prisoners receive are likely to evolve and nurture more violence. In fact, many factors contribute to this catastrophic fact, among them, is the political and sectarian influence on the prison and judiciary system, making it unable to make reforms (Nashabe, 2003).

[3] The prison population rate is the number of prisoners per 100,000 people in a population.

In 2023, Amnesty International published a report examining the death of a prisoner in Lebanese prisons caused by septic shock. Notably, the report was titled “INSTEAD OF REHABILITATION, HE FOUND DEATH” (Amnesty International, 2023).

Attempts to improve prisons’ system took place after end of war in 1990; however, more was needed to attain serious reforms. Lebanese prisons suffer from unfavorable and poor conditions related to hygiene, nutrition, health, accommodation and correspondence of prisoners. Furthermore, prisons are managed by ISF who exercise a military style with poor qualifications and trainings related to prison management and interaction with prisoners (Nashabe, 2003).

Consequently, the development of prisons’ system relied largely on the developments at the political level.

The Lebanese government has persistently resisted calls for reform despite prolonged advocacy efforts from rights groups and civil society. Legislative attempts to transfer control of the prison system from the MOIM to the MoJ have been stalled for over fifty years. Even if control were transferred, doubts remain regarding the MoJ's capacity due to its limited budget allocation, which is significantly smaller than that of the MOIM. As a result, the current budgetary constraints result in insufficient funding for basic necessities and rehabilitation programs in prisons. Additionally, the lack of proper training for prison staff, many of whom view their positions as punishment, exacerbates the problem, leading to a higher risk of abuse and torture of prisoners (Minkara & Boswall, 2021).

Historically, during Ottomans’ era of time in Lebanon between years 1516 and 1918, prisoners were kept in the basements of the government’s building without any specific system similar to regular prisons. The treatment of detainees encompassed humiliation and oppression. At that time, the purpose of such imprisonment was to separate offenders to protect the society from them (Nashabe, 2003).

Moreover, Olson also argues that imprisonment wasn't the primary form of punishment. Corporal punishment, exile, and execution were more common. Prisons served mainly for pre-trial detention or holding those sentenced to death (Delatolla, 2021).

After the collapse of the empire of the Ottomans, the allied forces were in charge of controlling Lebanon. In this context, upon order number 242 in April 1919, the governor of the allied forces introduced some signs of reform to the prisons in the territories that were under his control in the near east. These reforms included some work to be done on the level of prisons and administration's bureaucracy. However, the treatment style of prisoners remained the same. Following order number 242, two prisons were established in Beirut: One in Al-Borj Serail for convicted individuals and another one in the Grand Serail for the pre-trial detainees. Subsequently, upon Sykes-Picot agreement, the French mandate was imposed on Lebanon and the French governor issued the resolution 1488 during august 1921 to regulate Lebanese prisons and the prison's administration (Nashabe, 2003).

The Central Prison of Beirut, established in the 1920s, housed both political prisoners and those convicted of common crimes. Nevertheless, accounts also point to harsh realities within these French-run prisons, including overcrowding, harsh treatment, and political repression (Hosni, 1970).

The resolution included revolutionary changes that were mainly related to the detailed instructions for proper management, healthcare provision to the detainees, change of punishment methods and hiring civilian staff to manage the prisons. Indeed, this resolution was pioneering and innovative in comparison with neighboring countries in the Middle East (Nashabe, 2003).

The French Mandate ushered in a more centralized legal system in Lebanon, with imprisonment becoming a more prominent form of punishment compared to the Ottoman era. During this period, prisons served as a crucial tool for the French to maintain order. This era also saw significant development in the prison system, with the French constructing new facilities and implementing standardized conditions (Hosni, 1970).

In 1926, the Lebanese constitution was created. The decree number 6780 was issued in June 1930, based on resolution 1488, in a manner that standardized Lebanese prisons while documenting the rights, duties and function of both prisoners and staff. Consequently, prisons, which are placed under the authority of ministry of interior, are managed in a military style with a strict military structure. The professional civilians are not granted official duties and responsibilities and prison staff are supposed to obey orders without any discussion (Nashabe, 2003).

It is significant to note some ambiguity shown in the fact that prison staff from ISF are not trained to work in prisons, and they might be assigned to another position outside the prisons at a later stage.

Upon Lebanon's independence in 1943, decree number 14310 was created based on decree number 6780 to regulate prisons and its administration and it was approved in 1949. Thus, this law rules today's prisons' system (Nashabe, 2003). In fact, Lebanon inherited the French prison system, facing issues like overcrowding, inadequate infrastructure, and limited rehabilitation programs (Human Rights Watch, 2019).

This law introduced many advanced reforms including rights of prisoners such as recreation time, visitation, correspondence, access to religious services, medical services, access to library, prohibition of obligatory labor, regulation of disciplinary measures. However, the law adheres to a strict punitive course by imposing a quasi-military system of prison management under the authority of the minister of interior. Accordingly, the main concern is to preserve security of the society rather working towards justice and rehabilitation. Some minor changes took place between 1957 and 1997 mainly by closing close prisons and opening new ones (Nashabe, 2003).

As per Rizk (2020), in the era preceding civil war, efforts were put to reform prisons and they were directed towards 3 goals: construction of modern prisons that can function properly, establishment of detention centers that can perform their social duties and development of new penitential legislation (Rizk, 2020). Unfortunately, throughout the reform journey, reforms were interrupted due to the civil war that erupted in 1975, and the judicial system was the first to collapse. During civil war times, prisons' conditions deteriorated along with human rights' violation (Nashabe, 2003).

After the war, constitutional revisions of Taif agreement brought political stability, which facilitated the way for the gradual enforcement of the rule of law. Yet, little considerable attention was given to prisons' reform and conditions, which remained well below the UN NMR for the treatment of prisoners (Nashabe, 2003).

The brutal civil wars exacerbated prison problems, resulting in increased detentions and politicization of the system (Human Rights Watch, 2019). El Bejjani & Roccatello (2020) had a similar perspective on this matter. Taif agreement brought some stability and opened the way to

gradual reimplementation of rule of law. However, it also strengthened sectarianism in its power sharing agreement. This sectarian system of politics contributed to paralysis of administrative authorities and led the way to near total impunity to political elites. This agreement planned for many reforms including institutional reforms; however, most of these reforms were not enforced.

Notably, the post-civil war agreement did not give attention to prisons reforms and their conditions, which were well below Nelson Mandela SMR for the treatment of prisoners. After Taif agreement an amnesty was passed against all political and war crimes that happened before March 28, 1991, excluding attempts and assassinations of religious figures, political leaders and Arab and foreign diplomats. This law granted amnesty against political elites during civil war whereas prosecutions against citizens are prevented. In this context, Samir Geagea[4] was granted pardon under law 677 after being prosecuted for political assassinations committed during the Lebanese civil war. Indeed, this attitude weakened accountability and granted unequal and discriminatory legal protection (El Bejjani & Roccatello, 2020).

Building RCP started on March 17,1962 in the aim to have an exemplary correctional institution in the Arab area. The plan encompassed a central hospital and separate wards allocated for each of the following: juveniles, women and elderly. According to the plan, RCP was supposed to have special sections for religious services, sports, workshops, small sized factories and segregated spaces for solitary confinement. Upon its construction, RCP was planned to become the only prison in Lebanon located in a building that was built for that purpose (Nashabe, 2003).

However, Kallas argues that the inadequate rehabilitation facilities in prisons, particularly focusing on Roumieh prison where overcrowding has rendered these facilities akin to mere cells. Tatiana Nassar, a criminal psychologist, emphasizes the critical importance of rehabilitation in reducing re-offending risks and helping prisoners find new purpose in life. She points out that rehabilitation motivates and equips prisoners with emotional management tools, leading to social improvement and accountability. The absence of rehabilitation not only increases re-offending chances but also

[4] Samir Geagea was arrested in 1994 and put on trial for bombing a church and political killing in the war. He spent 11 years in solitary confinement, the only war leader to go to jail in Lebanon.

fosters chaotic behaviors such as anger, social isolation, and boredom among prisoners, eroding their hope and future vision, ultimately leading to more aggression (Kallas, 2023).

Lebanon's prison system primarily relies on two main correctional facilities: Roumieh and Zahle prisons, which were purposefully constructed as official jails. However, it is important to note that the country faces a challenge with many other facilities that are utilized as prisons but were not initially intended for such purposes. These include buildings originally designated as horse stables, army barracks, police stations, or warehouses. Despite these efforts, attempts to adapt some of these structures for prison use through structural modifications, many of them remain ill-suited for housing inmates. Issues persist even after alterations, ranging from inadequate facilities for basic needs like ventilation and lighting to broader problems related to overcrowding and security. Furthermore, the ongoing maintenance of these facilities is often neglected, which ultimately leads to deterioration and exacerbates the challenges faced by both prisoners and staff. Thus, the failure to address these issues seriously undermines the effectiveness of rehabilitation programs within the prison system in Lebanon (Khatib, 2022).

Judge Ghantous's judicial committee attempted in 2002 to introduce some modernization to the prison law 14310; however, it was not approved by the parliament (Nashabe, 2003).

In a related development, some amendments were introduced to the law in 2002 through adding an additional article which allows representatives of the ICRC to visit all prisons and inmates without the presence of any censor including the right to do any medical examination (Nashabe, 2003).

In a 2016 study report, Balshi et al. proposed that the optimal solution would involve creating a new prison on a different site in the country. Conversely, if implementing this option proves impractical, an alternative plan could be pursued through the renovation of the existing prison (Balshi et al., 2016).

Chapter 3.7 Problems of Judiciary System and Prisons

In recent days of Lebanon, Rizk (2020) argues that the judicial and penitentiary system holds failures and corruptions in an unpredictable way. As a result, the current system stands well below

the international standards and conventions of human rights. Deviations are prevalent at the core of the constitution on many levels including overcrowded prisons, below standard conditions of prison facilities, unqualified staff. Consequently, corrective actions should take place to save prisoners from the chaos taking over the system and to restore justice and the actual order. Indeed, many factors are playing a key role in rendering the current local system paralyzed such as incompetency of the staff, biased decisions, trials without fairness, random detentions of pre-trial individuals along with inappropriate allocation of resources for maintenance of facilities (Rizk, 2020).

Furthermore, as per Tamimova (2019), the criminal justice system in Lebanon needs to be reformed knowing that individuals are usually accused of arbitrary offenses coming from an outdated and vague terrorism's definition and description. Also, some individuals are not allowed to attend their own court sessions or stay behind the bars for months, resulting in no alternative actions to detention and backlog cases to be processed. Plus, some detained individuals who are accused and put in detention with a documentation in their legal records without significant evidence, while, conversely, others, who have enough political connections to "bypass" the legal system, are released from detention regardless of the weight or severity of their charges. All these factors lead to feelings of powerlessness and injustice, which further enrich the platform for more actions of violent extremism against the state of Lebanon (Tamimova, 2019).

According to Nashabe (2003), two main problems are present in prisons in Lebanon: Prison administration and overcrowding. Despite efforts for reform, today prisons are still managed by ISF despite series of decrees emphasizing transfer of management to MoJ without specifying a date: decree 17, article 232 dated September 6 1990 and decree number 24 dated 7 March 2012.In this context, ISF are a military style police force responsible of applying law all around the country. Within their responsibility to preserve security in prisons, ISF soldiers and officers apply orders without discussion. Moreover, staff are not trained on the proper way to deal with prisoners. Consequently, those soldiers are not fixed in prisons as job assignment. They have poor skills and competencies and also lack staff development and specialization. Unfortunately, the Syrian presence in Lebanon and the dominance of intelligence services have further prevented reforms at the levels of ISF. In addition, on the investigation level, there is absence of professionalism. Investigative procedures are very basic and insufficient, and the system still uses violence and

polygraph. Moreover, there is a gap in conformance with constitutional standards. For instance, trucks used to transport prisoners are inadequate. Also, conditions in detention facility at police station are not adequate. Furthermore, most police stations do not possess computers and photocopy machines and archiving system is not done properly. To illustrate, four-wheeler's cars of ISF do not have special seats for detainees, thus they are put in trunk (Nashabe, 2009). Until our recent days, the infrastructure of the prisons is still notably deficient, with inadequate facilities and decaying equipment such as transport vehicles and ambulances. Consequently, overcrowding undermines the delivery and efficacy of rehabilitation programs, vocational training, and cultural activities (Khatib, 2022).

Moreover, organizational challenges plague prison systems, including issues with unskilled, poorly compensated, and frequently changing prison staff. In addition, high levels of corruption and outdated legislation also contribute to these barriers.

According to Nashabe (2003), the second problem in prison systems in Lebanon is overcrowding. To put this in perspective, speaking of occupancy rate, numbers are alarming. As per prisons' data in 2019, RCP accommodated 3859 inmates while its capacity is up to 1950 prisoners. In this regard, the policy brief by Tamimova (2019), pre-trial and convicted are accommodated together due to random distribution of prisoners in CPR. Moreover, moderate crime prisoners live in same cells with more influential prisoners (ex the Islamist extremist prisoners who reside in block B of RCP).In fact, juvenile inmates in some prisons are placed within same building of adults prisoners, which might expose them to interaction with the offensive environment of adults(Rizk, 2020).Consequently, when the occupancy rate is higher than acceptable there will be shortage on human rights and health determinants such as proper ventilation, heat system in winter, toilets, sleeping space, dining area, medical care. Najem (2023) also reports dire experiences of prisoners living under a failing infrastructure, a precarious and overcrowded space especially during the coronavirus pandemic.

Moreover, overcrowding can cause delay in correspondence due to overload in letters and circulars (Nashabe, 2003).

Theoretically speaking, judiciary system is independent under article 20 of the Lebanese constitution; however, in practice, the system does not have administrative and financial

autonomy. Judicial council, which in its mandate, handles cases of state security, does not possess authority to try president and ministers. Thus, the council of ministers appoints 8 out of 10 members of the high judicial council that is responsible of selection, appointment, promotion, transfer and discipline of judges. Accordingly, by implementing institutionalization, the council of ministries has direct influence on actions of judiciary system. Furthermore, it is important to elaborate on military courts. Military courts usually handle disciplinary cases with military staff.

According to El Bejjani & Roccatello (2020), these courts do not adhere to basic fair trial principles. In fact, they throw out arbitrary sentences and they still have authority to try civilians and juveniles in non-military cases, which makes it incompatible with obligations under international covenant on civil and political rights.

Prisons in Lebanon, mainly RCP, host a considerable number of Islamist prisoners. Notably, some of those Islamist prisoners are connected to violent extremist entities and/or are connected to reform groups who are oriented by certain ideologies. In RCP, the bloc B encompasses convicted and non-convicted prisoners who are sharing same small cells. Consequently, due to this chaotic organization, moderate “convicts” have the tendency to be controlled and led towards radicalized ideas by more influential and senior cellmates (Tamimova, 2019). Ultimately, on site radicalization stands as a crucial concern in the Lebanese prisons’ settings. Additionally, in case of harsh and punitive treatment by prison staff, prison can lead to further violence and hate.

Thus, in the absence of corrective prison programs and lack of support on the psychosocial level brings prisoners to a reality that is no different than their current occupation and practice as prisoner (Tamimova, 2019).

In April 2011, prison uprisings led by inmates took place. These protests were significant as they were demanding improvement of prison conditions along with a general amnesty. This uprising caused some reforms in the prison sector including increase of budget allocated for the prisons from the government along with promises for future reforms (Lebanese Center for Human Rights, 2011). Moreover, these achievements were made by the uprising and they exceeded what has been done in this subject since 1991. Following 2019 revolution, there was a call for an amnesty law to release thousands of prisoners arrested for non-critical crimes like drug use and marijuana production. In April 2020, following covid-19 positive cases in Lebanese prisons, there was plenty

of demands for granting amnesty for prisoners who are suffering from drastic overpopulation and hygiene conditions in the prisons (Lewis, 2020).

Similarly, the same findings were reported by Najem (2023) as documented by circulated images, videos, and sound bites. In addition, the situation in Lebanon highlights the perilous and lethal circumstances brought about by neocolonial states and their penal institutions, showcasing the subversive impact of such oppressive spaces. Constrained within an inadequate infrastructure and grappling with the challenges posed by a global pandemic, prisoners resorted to illicit media practices as a means of expression.

Of course, such demands and manifestations increase the burden and pressure on the government to take initiative in applying reforms to prisons to solve many issues including overpopulation.

Chapter 3.8 Solutions to Judiciary System and Prisons' Problems

Rizk (2020) presents a series of solutions to properly develop the prison management and decrease deviations, at many levels. First and foremost, there is a need for commitment from local authorities to shift the management from MOIM to MoJ. In this regard, NGOs and UN agencies can provide technical and financial support for such initiatives aiming for correction. Moreover, human resources managing the prisons should be educated on the proper way of handling of prisoners. To facilitate this, educational material should also be developed to develop the skills of the prisoners. Furthermore, infrastructure should be addressed through building new prisons and improving the current prisons. Also, prisoners should be placed in prisons according to age, gender, crime time and sentence periods. Moreover, pre-trial detentions should be reduced and prosecutions should be speeded up to reduce overcrowding and other violations.

In addition, prison managers can resort to other short-term solutions according to the nature of the crime to release on bail and personal recognizance basis. Additionally, following good behavior, Rizk (2020) recommends early release or a recommendation to deliver community work. As a last resort, privatization of prisons can be considered, provided it can be managed correctly with enough managers and guards. Thus, such a solution can create new job opportunities and ease some burden on the Lebanese prisons. Yet, concerns arise around the feasibility of the suggested solutions from the side of the Lebanese government to commit and to keep these concerns as a

priority to improve the system amid the current multilayer crisis that the country is witnessing (Rizk, 2020).

Following a needs assessment in 2022, ARCS have listed multisectoral recommendations. These recommendations include provisions for accommodation and hygiene, water and food supply, healthcare services, legal aid, rehabilitation and reintegration programs, support for prisoners with disabilities, maintenance and rehabilitation of infrastructure, prison administration improvements, and advocacy efforts by civil society for legislative reforms and increased funding for prison improvement projects. Overall, these initiatives aim to enhance the well-being of prisoners, ensure their access to essential services and rights, and facilitate their successful reintegration into society upon release (Khatib, 2022).

Balshi et al. (2016) argues that after thorough investigations and careful analysis of various alternatives, adhering to specific criteria, and considering the pros and cons of each option, it appears that the most viable course of action is to construct a new prison facility at a different location in Lebanon. However, should this be unattainable due to constraints such as funding, the next best approach would be to refurbish the existing prison while expanding it to accommodate the growing inmate population, thereby allowing for other necessary enhancements to be implemented (Balshi et al., 2016).

Chapter 3.9 Conclusion

In summary, this chapter helped unfold the layers of Lebanon's context systematically. In doing so, it explored the historical backdrop that has shaped the nation's identity, going through key milestones and transformative events. Subsequently, we have investigated the socio-cultural dimensions, including the judiciary and security system, and the crisis' dimensions that underpin the daily lives of its populace. Additionally, the political landscape has also come under scrutiny, shedding light on the governance structures and policies that shape the nation's trajectory and highly impact its prison system. As we pivot toward the methodology chapter, the insights gained from the country context analysis serve as a compass, guiding the formulation of a research approach deeply rooted in the realities of this sole setting.

CHAPTER 4: METHODOLOGY AND ETHICS

This current chapter serves as a comprehensive guide to the research strategies, designs, and methods employed in the pursuit of addressing the research objectives. To achieve this, the chapter goes into the intricacies of data collection, encompassing a variety of methods, with a particular emphasis on the utilization of self-administered questionnaires, conducted meetings, and the process of participant recruitment. Additionally, it examines potential biases inherent in the research process, elucidates the essential role of gatekeepers, and outlines the meticulous steps taken to ensure participant anonymity. In conjunction with these considerations,ethical considerations that underpin the entire research project are explored, culminating in a detailed examination of the data management procedures employed to uphold the integrity of the study. This chapter is designed to provide a vigorous foundation for understanding the methodological framework guiding this research, ensuring transparency, rigor, and ethical conduct throughout the research journey.

Chapter 4.1 Research strategy, Design and Methods

In order to address the research questions and contribute to the goals of the project, a mixed method strategy of both quantitative and qualitative research was employed.

This approach is significant because the division between both strategies opened the way for the mixed method to rise, due to the pragmatic philosophical position and which explains the social realities with quantitative and qualitative research tools for data collection within the same research study (Haq, 2015). The mixed method strategy is characterized by the following: the aim to both explain and generalize, have some one-to-one relationship with some of the respondents and not all the sample, interpretation and analysis is hard, generalizability is high, triangulation is done with trustworthiness and rigor (Haq, 2015).

Similarly, Bryman agrees that the mixed research strategy yields a high level of triangulation, offset, completeness, explanation, illustration, credibility and diversity of views (Bryman, 2016).

Chapter 4.1.1 Quantitative Strategy

In the context of this project, a quantitative strategy was followed through a cross-sectional design and a questionnaire methodology to answer Q1 how do current prison policies and practices in Lebanon regarding food and healthcare access align with international human rights conventions and other relevant standards? Furthermore, this approach helps answer Q4 in what ways does the prison nutrition and healthcare system in Lebanon addresses the specific needs and potential vulnerabilities of diverse prisoner populations, including women, migrants, and refugees? Quantitative research focuses on quantification during phases of data collection and analysis. It encompasses a deductive approach in regards with the relation between theory and research. Its epistemological orientation is positivism while its ontological orientation is objectivism. In a typical survey research setup, data is collected mainly by a questionnaire or through an interview on a sample of cases retrieved from a bigger population at one point of time in order to collect quantitative data with variables to be analyzed and to consequently locate patterns of association (Bryman, 2016).In fact, the cross sectional design includes some key elements and concepts: the variation in the sample of cases, collection at a single point in time, quantifiable data and patterns of association. Additionally, replicability and external validity are typically strong whereas internal validity is weak in the cross-sectional design.

Chapter 4.1.2 Qualitative Strategy

Shifting focus to the qualitative approach, a case study design and research methodology based on interviewing and examination of documents was carried out. Qualitative research strategy focuses on words rather than quantification and numbers. This approach is crucial as it employs a high level of authenticity and trustworthiness (Bryman, 2016). This research strategy, which its epistemological orientation is interpretivism and its ontological orientation is constructionism, tends be inductive and yields to a theory.

Importantly, the two ontologies of interpretivism and constructionism work in tandem within this research project. Interpretivism emphasizes understanding social phenomena through

interpretation and subjective experiences, while constructionism posits that reality is socially constructed through language and interaction. Thus, in this qualitative research, the case study design and methodology of interviewing and document examination align with both ontologies. The focus on words and subjective interpretations in qualitative research resonates with interpretivism, as it seeks to understand the meanings individuals attribute to their experiences. Moreover, the acknowledgment of reality being constructed through social interactions and language aligns with constructionism.

In terms of my own ontological position, I lean towards a constructivist perspective. I believe that reality is socially constructed and shaped by individual perceptions and societal norms. However, I also recognize the importance of interpreting these constructed realities to understand underlying meanings and patterns. Therefore, the combination of interpretivism and constructionism in this research aligns closely with my ontological position. The emphasis on subjective interpretations and the understanding of social constructions through language and interaction resonates with my perspective on reality. Additionally, the inductive nature of the research strategy, leading to theory development, aligns with my belief in the importance of exploring and understanding complex social phenomena through qualitative inquiry.

Simultaneously, Mishra and Alok agree that qualitative research observes carefully non-numerical data in a more anthropological or naturalistic manner. It concentrates on a qualitative phenomenon that relates with quality or variety. Consequently, this type of research is typically descriptive and its results are usually harder to analyze than data obtained from quantitative research (Mishra & Alok, 2017).

Importantly, the qualitative strategy serves to answer three research questions. Q2 that answers to what extent do international standards for prison healthcare reflect the lived experiences and diverse needs of prisoner populations, including considerations of human dignity? Q3 that answers how effectively does the prison health system in Lebanon addresses the specific physical, mental, and social health needs of its prisoner population, beyond just meeting minimum international standards and Q5 answering that are the key strengths and weaknesses of the current prison health system in Lebanon, and what interventions could be implemented to address identified shortcomings.

The choice was made to employ qualitative research for various reasons. First, I wanted to invest in qualitative method as this study encompasses interdisciplinary research, and usually rarely do health research employ this strategy. Thus, I want this research study to fill the gaps in methodology and knowledge, on national and international level. Second, I intended to reach a more textured analysis of the dynamics of healthcare and food system and modalities of healthcare access in prison context in times of tough crisis in Lebanon (Bryman, 2016).

As part of this research, the study included document analysis. The analyzed documents are public documents and data sets about demographics of prisons in Lebanon (number of prisoners, gender, distribution among prisons, nationalities), Lebanese prison law and diet menus and other non-digital sources from ISF. These documents are crucial as they serve to answer Q1 How do current prison policies and practices regarding food and healthcare access in Lebanese prisons align with international human rights conventions and other relevant standards and Q2 to what extent do international standards for prison healthcare reflect the lived experiences and diverse needs of prisoner populations, including considerations of human dignity

Chapter 4.1.3 Case Studies with Interviewing and Documents Analysis

Focusing on the case study aspect, the case study design is based on an intensive examination of two prisons: one for males which is RCP (Roumieh Central Prison) and one for females which is BWP (Baabda Women's Prison), that is managed by the same administration managing RCP. These prisons were chosen as case studies because they host prisoners from different nationalities, including Lebanese, Syrian, and Palestinians. These features add a complexity and high interest to the chosen case studies (Bryman, 2016).

Moreover, Eisenhardt & Graebner (2007) also highlight the unique opportunities case studies offer for theory building as they allow researchers to explore phenomena in detail, identify patterns, and build theories grounded in rich empirical data.

In this light, the same authors argue that multiple case studies can be used as "distinct experiments", each exploring the same phenomenon in different contexts. This approach strengthens the theoretical generalizability beyond the specific cases studied. Case studies can also

reveal unanticipated relationships and mechanisms, challenging existing theories and pushing the boundaries of knowledge.

Additionally, Flyvbjerg (2006) addresses common issues about case studies. While single cases may not be directly generalizable, they can offer valuable insights and generate hypotheses for further research. Thus, case studies involve rigorous analysis and interpretation, leading to theoretical explanations and not just mere descriptions. Conducting and analyzing case studies requires careful planning, data collection, and interpretation, demanding significant research skills. In essence, case studies can be used for various purposes, including theory building, evaluation, and testing existing theories (Flyvbjerg, 2006).

According to Bryman (2016), this design provides us with an in-depth and intensive understanding of system and schemes for health, food and diet of communities in question in addition to their observation on the services received through this case study. Furthermore, this study design contributes to the relevancy of my research while saving resources and time of performing the research study on a larger scale (Bryman, 2016).

In terms of methodology, the methods that I employed are interviewing and examination of official documents derived from the organization taken as a case study, which is RCP. Here, interviewing helped me answer partially all the research questions. The method of interviewing helps in making a detailed and intensive examination of the case and its performance. As a result, it leads to a high level of reliability and validity in measuring key concepts of the research study. It also seeks to filter interviewees' observations and opinions in a flexible and unstructured manner without any standardization (Bryman, 2016). The interviews began with a simple guide and continued with new questions as a continuation to interviewees' answers.

In this regard, according to Gilbert (2008), interviewing yields to better and more accurate data, according to the research questions and objectives, by locating emotions and body language of respondents in addition to what they verbally say (Gilbert, 2008). Due to COVID-19 and security restrictions, interviews were conducted remotely. However, face to face semi structured interviews is the most common data collection method on the level of qualitative research (Eisenhardt and Graebner, 2007).

In parallel, Lucic-Catic (2011) raises the issue of persistence of emotions in interviewing by all research stakeholders including prison staff, prisoners and even researchers themselves (Lucic-Catic, 2011). In a similar manner, emotions were notably widespread and articulated in the interviews with the two prison officials expressing their frustration and displeasure with the present conditions in Lebanese prisons, influenced by the country's crisis.

On the other hand, as a researcher, I find the examination of documents from the organization selected as a case study in the research to be significant for several reasons. Primarily, it carries data that has been already collected, it saves time and financial resources, and it reflects the bigger picture (as it is not based on a sample). Plus, the issue of reactivity is less pronounced here as the data doesn't come from respondents' responses (Bryman, 2016).

In support of this Bowen also agrees that this method is a low-cost way to collect data. However, he highlights a crucial issue about authenticity and usefulness of specific documents taking into consideration the context in which the document was actually produced along with the target audience (Bowen, 2009).

Additionally, it is worth mentioning some issues around ethnography in prison settings, despite the fact that it was not used as a method for data collection in this research study. Ethnography is conducted when the researcher or observer dips in a group for a long period of time in order to observe their behavior and attitude, listen to the conversations and sometimes ask questions (Bryman, 2016). In this context, Jewkes (2011) argues that ethnography, being a research method used in criminology settings, encompasses emotions on the level of the researcher in light of the differential views of authority, vulnerability, despair and power and, also as it tackles public sentiments, populist punitiveness and expressive motivations behind offending (Jewkes, 2011). Also, within the same context of ethnography, Rowe discusses the connectedness that arises from the encounters between the researcher and the participant (Rowe, 2014). Similarly, Drake & Harvey (2013) discuss the notion that ethnographers are subject to emotional costs. Thus, the outputs of the ethnographic practice are better analyzed and processed when the emotional costs are well understood (Drake & Harvey, 2013).

Finally, in considering the possibilities and practical aspects of conducting ethnography in prisons, Cerbini (2022) explores the extent to which researchers can immerse themselves in the research

process while observing instances of violence and brutality. She also delves into reflections on socioeconomic disparities, racial discrimination, and structural violence, along with their implications for the actual realization of prisoners' rights (Cerbini, 2022).

Chapter 4.1.4 Data Collection Methods

It's crucial to highlight that my data collection methodology is designed to circumvent the challenges associated with observing violence, brutality, and punitive measures. To achieve this, four research tools were used in order to collect data:

Chapter 4.1.4.1 Examination of Documents

The following documents were examined for the purpose of this study:

- Samples of RCP weekly meal plans from 2019 and 2021
- Lebanese prison law
- Sample of prisoners' medical file
- Statistical reports from public data available from website along with other public data handed to me from the directorate of prisons.

Chapter 4.1.4.2 Interviews

In addition to document analysis, two virtual interviews took place with two key health officers. The first interview was conducted virtually via MS Teams with the advisor of the minister of interior and municipalities (MOIM) for prison issues as a representative of the prison authorities at the local and central levels designated by the MOIM. The second interview was also conducted virtually via MS Teams with the highest medical position overseeing the health center that provides health services for Internal Security Forces (ISF) and prisoners held under their responsibility.

These interviews provided valuable insights, raising knowledge and information on agreements with health coverage entities, the organization of healthcare in the prison, gaps and challenges, and opportunities for improvement. Furthermore, these interviews tackled the interviewees' views and experiences on how services related to health and nutrition are usually provided in prisons. Both

interviews were conducted in Arabic, and then the notes and answers were translated to English by me, as both the interviewer and the researcher.

Unstructured interviews are characterized by a certain flexibility while addressing questions. Indeed, such type of interviews do not follow a sequence of pre-determined questions and usual techniques of recording. This flexibility allows for a more natural flow of conversation, as the interviewer has a greater freedom to ask more questions, change sequence of questions and omit some questions, all according to the situation (Kothari, 2004). Yet, this sort of flexible interviews results in a difficulty in comparing interviews to each other and a complexity and time consumption during analysis phase. Additionally, this kind of interview requires a strong knowledge and a high level of skills on the level of the interviewer (Kothari, 2004).

To ensure focused discussions, an aide memoire is the base of the questions of the interview guide in order to tackle the topics in question (Bryman, 2016). In this research study, topics that were tackled are leadership and governance, health service delivery, respect for medical ethics and determinants of health. This aide memoire is specifically adapted from ICRC's interview guides from Health care in Detention Health Systems and Needs Assessments in Prisons Practical guide and Toolkit by International Committee of Red Cross (Refer to Appendix 1, Appendix 2.1 and Appendix 2.2 for interview guides).

Notably, despite the virtual medium, the interviewed Lebanese prison authorities showed a sense of authenticity and engagement. Their insights into the challenges faced within the prison system and the impact of the country's crisis were articulated with a vividness that transcended the limitations of the digital interface. Moreover, facial expressions and tone were not lost but instead became keystones in understanding the complexities of their point of views and experiences.

Chapter 4.1.4.3 Self-administered Questionnaires by Key Health Practitioners

Three questionnaires were used, and each questionnaire was filled by the relevant key health practitioner. The questionnaires were communicated with the concerned parties via email, and they were filled out and sent back to me also via email.

Compared to interview-based methods, self-administered questionnaires require fewer resources and manpower. No interviewers are needed to be hired and trained, no venues are needed to be

booked, and data collection can be automated, which significantly reduces costs (Readex Research, 2014).

Self-administered questionnaires offer respondents privacy and anonymity, encouraging more honest responses, especially on sensitive topics (Wallace Foundation, 2023).

This privacy is crucial because without the presence of an interviewer, respondents are less likely to feel pressure to conform or be influenced by social desirability bias, leading to more accurate data (Readex Research, 2023). Moreover, eliminating the interviewer removes the risk of unintentional bias influencing the questioning process or interpreting responses, which can occur in face-to-face interviews (Readex Research, 2023). Voxco agrees on this and adds that this ensures that the collected data is more reliable and objective, reflecting the genuine perspectives of the respondents (Voxco, 2021).

In addition to these changes, electronic distribution allows reaching large audiences simultaneously, maximizing data collection efficiency and minimizing time limitations (Voxco, 2021). Respondents can complete self-administered questionnaires at their own pace, in their preferred location, and at a convenient time, increasing participation rates and improving data quality (Voxco, 2021).

Furthermore, compared to fixed interview schedules, questionnaires offer greater flexibility in terms of reaching geographically dispersed populations and individuals with busy schedules (Wallace Foundation, 2023). Self-administered questionnaires can be easily distributed online or through paper forms, reaching a wider range of participants compared to traditional methods (Wallace Foundation, 2023). This flexibility allows researchers to access diverse populations, including those who might be difficult to reach through conventional means, leading to more representative samples and generalizable findings (Voxco, 2021).

The first questionnaire, which is the checklist for health-care providers at prisons was self-administered by the medical authority (with a General military rank) overseeing health services provided to prisoners within RCP. Specifically, this questionnaire aims to collect data from the prison's physician about governance and leadership, physical and social determinants of health, health information system, healthcare financing, human resources for health care, medical supplies, health service delivery including primary health services, health promotion and disease

prevention, specific groups like those with TB or HIV, secondary or tertiary healthcare and suggestions for improvement.

Similarly, the second questionnaire, which is the checklist for the head of the central pharmacy, was filled by the physician (with a Major military rank) responsible of the central pharmacy providing medications for both security forces and prisoners. The questionnaire focuses on collecting data about the structure, budget, request and delivery system, availability, management, TB and HIV treatment, roles of families and suggestions for treatment.

In a related context, the third questionnaire, which is the checklist for health-care providers at referral health facilities, was self-administered by the physician acting as the chief of emergency department at a hospital in Beirut that operates as the main referral center for prisoners who need hospital's admission. This questionnaire is designed to collect data about agreement with referral centers, communication with prison management, referral process, patient transportation, management of deceased prisoners, common health issues at the level of detainees, management in case of death of detainee, gaps and suggestions for improvement. Notably, these three questionnaires are also adapted from the same ICRC's guide published in 2018. (Refer to Appendices 3,4 and 5 for self-administered questionnaires by participants who are not prisoners).

Chapter 4.1.4.4 Self-administered Questionnaires by Prisoners

As the main data collection tool, this self-administered questionnaire aimed to collect data from a sample consisting of 300 to 400 prisoners as heterogenous as possible. To achieve this goal, arrangements were made with concerned authorities to recruit prisoners according to a selected inclusion and exclusion criteria along with a need to approach detainees that are English educated besides Arab detainees. In this process, the officers, who played the role of gatekeepers to prisoners, were assigned by the government authorities, to facilitate the data collection process on the field. Specifically, those officers, who are ranked as Captains or Majors, were responsible for the data collection in the designated prisons/sub departments (Refer to Appendices 6.1,6.2,6.3 and 6.4 for self-administered questionnaires respectively for male prisoners in English, for male prisoners in Arabic, for female prisoners in English and female prisoners in Arabic) for self-administered questionnaire by the prisoner).

It is important to note that the used questionnaire is adapted from the same ICRC guide while adding only a couple of questions related to food and nutrition. While the original intent of this questionnaire was for interviews, it is unlikely that a researcher would be able to allocate the time and other resources to conduct a survey or an interview with a big population, such as the sample in question. Moreover, the complexity of acquiring access and approval from both Research Ethics Committee (REC) at UEL and Lebanese authorities for the choice of self-administered questionnaires rather than interviewing.

Chapter 4.1.4.5 Meetings and Trainings

In order to inform them and train them about the project and process, I met with the designated officers face to face at the ISF's headquarters. These meetings were essential for facilitating approval and training procedures through three visits conducted between 2021 and 2022. During these visits, I always received a warm welcome at the offices, and everyone went out of their way to assist in streamlining the process for my research. In particular, I explained in details the project title, researchers' profile, goals of the project, confidentiality of data, ethics and disclaimer. In this effort, I aimed to cooperate and build capacity of gatekeepers to do the correct sampling of participants according to inclusion criteria, I aimed to minimize sampling bias. However, it is very difficult to completely disregard bias and derive a truly representative sample. Therefore, efforts were put to ensure that followed procedures and protocols minimize the bias (Bryman, 2016).

Chapter 4.1.6 Bias

Various concerns loomed over the process of selecting prisoners for self-administrative questionnaire participation, particularly with regard to potential biases that could impact the integrity of the research. One primary concern was non-response bias, posing a threat of incomplete participation from prisoners of diverse nationalities. This situation introduces the potential for errors in the research, highlighting the need for careful consideration in ensuring a representative sample. In addition to this, undercoverage bias emerged as another noteworthy challenge in the sampling strategy due to the exclusion of illiterate prisoners from the research. This exclusion could lead to an incomplete and skewed representation of the prison population, a concern emphasized by Kirn et al. (2023).

In addition to this, the manner in which participants were pre-screened and the call for their participation through prison officers raised concerns about potential biases in the sample. This concern is consistent with findings of Blake et al. (2023). The reliance on officers to identify and recruit participants introduced the possibility of unintentional partiality, emphasizing the need for transparency and a careful evaluation of the screening process to mitigate any biases that could compromise the study's objectivity (Louden et al., 2023; Kirn et al, 2023; Blake et al.,2023).

Navigating these concerns demanded a meticulous approach to sample selection, acknowledging the potential pitfalls and actively working to minimize biases. To achieve this, I focused on several key aspects of the recruitment and data collection procedures, which included:

- Recruitment of the prisoners according to an inclusion and exclusion criteria, of prisoners
- A link sheet that documents each participant's name and the code (P1, P2, P3…)
- Provision of information sheets for the interested participants
- Forms that should be filled by the prisoners, which are the consent forms and self-administrative questionnaires.
- Prisoners to file their questionnaire with its consent form in an envelope, seal it, code it by the officer and then insert it in the locked box.
- Confidentiality agreement to be filled by each officer or guard who was involved in the process (Refer to Appendices 7,8,9 and 10 for link sheet, Arabic information sheet, Arabic consent form and confidentiality agreement respectively)

For more detailed information, refer to Appendices 7, 8, 9, and 10 for the link sheet, Arabic information sheet, Arabic consent form, and confidentiality agreement respectively. Regarding the self-administered questionnaires by the prisoners, further details can be found in Appendices

11, 12, 13, and 14 for the Arabic information sheet, English information sheet, Arabic consent form, and English consent form respectively.

Figure 1: Wooden Box for prisoners' self-administered questionnaires (Source: Pinterest)

Chapter 4.2 Participants

In this study, participants represent a diverse spectrum of stakeholders crucial to the operation and management of prisons and healthcare delivery within them. The participant pool encompasses officers from ISF, tasked with the security and administration of the prison environment. In addition to these officers, I engage with health professionals, including the Head of the Medical Center in RCP, head of central pharmacy, and a heterogeneous sample of male and female prisoners deriving from various nationalities across two distinct prison settings. Each participant group offers unique perspectives and insights essential for understanding the complex dynamics at play within prison systems and the provision of nutrition healthcare within them.

Chapter 4.2.1 Officers and Health Professionals

Five participants non-prisoners (officers and health professionals involved in the health provision of the prisons) were recruited to either fill a self-administered questionnaire or to be interviewed. The selection process was deliberate and the choice of matching each data collection tool with the corresponding officer or physician was carefully discussed with one of the senior retired officers who was closely overseeing the overall prison health system throughout his career.

Chapter 4.2.2 Prisoners

Population(N) under study is the prison population in Lebanon, which is 6399 prisoners (MOIM, 2022). According to the usual calculator of sample, I aimed for a heterogeneous sample of 262 prisoners out of a population size of 6399 (from the data collection process from two prisons) with a 5% margin of error and a 90% confidence level. Furthermore, my objective was to ensure the inclusion of a minimum 10% representation of female participants from BWP in the overall study. This deliberate effort to incorporate women into the sample was motivated by the recognition that gathering data from a diverse group, including women, would provide insights into specific issues related to women's health, such as menstruation, pregnancy, childbirth, lactation, and more. Consequently, the selected sample size was considered sufficient as it aimed to capture a diverse range of perspectives and opinions stemming from varied backgrounds within the prison population. This approach aimed to enhance the comprehensiveness of the research findings by acknowledging and addressing the unique experiences and challenges faced by women in the prison environment.

Moreover, due to the complexity of sampling, ethics issues and the high-risk context, the minimum sample was aimed to be 290 and the maximum to be 350.The upper limit is thought to compensate in case many participants decided to withdraw within the four weeks period after data collection.

The number of received responses was 291 out of 360 questionnaires sent for the authorities to be filled by potential participants. However, around 15% of the questionnaires lacked full demographic information for the participants, but other questions were properly filled. Additionally, another fraction of participants had incomplete answers on many questions, which I see it as result of relatively complicated questions. Fortunately, no requests for withdrawal were received in the given four-week period following data collection.

Chapter 4.3 Recruitment and Training

When conducting research in prisons, gatekeepers play a crucial role in facilitating access and ensuring the ethical and logistical considerations of the study. Gatekeepers are individuals or entities that control access to a particular group or setting, and in the case of prison research, they are often prison authorities, administrators, or personnel who manage the institutional environment. In this context, gatekeepers hold strong power and control.

In the context of this research study, gatekeepers from ISF were the main player in the recruitment and facilitation of data collection from prisoners.

Chapter 4.3.1 Gatekeepers and their roles

Gatekeepers are the middle persons who serve as the link between the researcher and the participant, and thus are the ones who provide access to participants. Consequently, their position has a powerful and influential role on participants to volunteer for participation. Within this context, ethical considerations must be tackled. Moreover, the gatekeepers have the right to review the questions to be addressed to the participants, in order to protect their emotional and mental status (Evans, 2012). Similarly, Bryman perceives gatekeepers as being able to influence how the study will be conducted through questions to be asked, inclusion and exclusion in terms of focus of the study, time to be spent with participation along with publication of results especially in the police domain, which is quite a similar context to criminology (Bryman, 2016).

Marquart discusses that prison guards are insiders whose participation and involvement in research taking place in prison constitute a viable and needed method of participant observation (Marquart, 1986). Similarly, Newman argues that any research to be conducted behind the walls of the prison must be done in full cooperation with the personnel and guards of the prison (Newman, 1958).

Networking with the first key gatekeeper through personal connections was a significant achievement in my research endeavor. Indeed, it is known in the context of Lebanon that connections with individuals who work for the government is crucial to facilitate administrative processes to reach one's aim due to power and control dynamics. In my case, the initial point of entry and support came from the Ministry of Interior and Municipalities represented by the Minister Rayya El Hassan, as facilitated by General Mahmoud Kobrosly a high-ranking manager from ISF officers. Establishing a connection and a positive rapport with a high-profile gatekeeper like the minister and the high ranking ISF officer can influence the perceptions of other gatekeepers, creating a foundation of trust that is essential for successful collaboration.

Furthermore, other advantages are identified in the context of prison research. As the head of the MOIM, Minister Rayya El Hassan holds a position of authority, power, control and influence. Gaining support and endorsement from such a key figure can lend credibility to my research and facilitate smoother access to resources within the ministry and the associated prison facilities.

Additionally, this endorsement can also serve as a signal to other gatekeepers and stakeholders within the prison system that my study has been recognized and approved at a high level of authority.

Moreover, networking with the ministry can help navigate bureaucratic processes more efficiently as the minister's involvement may facilitate the smooth progression of administrative procedures, reducing potential barriers that researchers often encounter in prison-related studies.

In general, from my point of view as a researcher in prisons, I perceive gatekeepers as crucial stakeholders and partners to research in prison settings for many reasons. First, they control entry to the prison facility, and researchers like me typically need their approval to conduct studies within the institution. They play a key role in granting access to the research team, ensuring that necessary permissions are obtained from relevant authorities. Second, they are also responsible for evaluating the ethical implications of the proposed research. They may assess the research design, the potential impact on prisoners, and the adherence to ethical standards. This oversight helps ensure that the research is conducted responsibly and with due consideration for the well-being of our participants. Third, gatekeepers can assist in the recruitment of participants by providing access to the target population. They may help identify eligible participants based on the criteria set by the research study, ensuring that the selection process aligns with the objectives of the research. Fourth, gatekeepers can offer logistical support for the research process. This may include coordinating interview schedules, providing a suitable space for data collection, and facilitating communication with participants. Their assistance streamlines the operational aspects of the study. Fifth, gatekeepers can offer insights into the cultural dynamics within the prison, helping researchers navigate potential challenges related to the unique context of the institution. Their input can enhance the cultural sensitivity of the research. Sixth, gatekeepers serve as a communication bridge between researchers and the prison community. Their collaboration helps build trust and rapport, addressing potential concerns and fostering a cooperative environment for the research. However, little communication between the two can negatively impact research.

Lastly, given the controlled nature of prison environments, gatekeepers play a crucial role in ensuring the safety and security of both researchers and participants. They may provide guidance on navigating the prison setting and complying with security protocols; however, sometimes they might be the obstacle to access certain facilities at certain points of time.

Chapter 4.3.2 Critique of Gatekeepers in Prison Research

While the importance of gatekeepers in facilitating prison research is evident, it is imperative to consider the potential misuse of their power to safeguard their own positions. Gatekeepers may employ various tactics to achieve this end. Firstly, gatekeepers may selectively grant access to participants who are less likely to expose issues or misconduct within the prison system, thus favoring compliant individuals over those who could provide critical perspectives. Secondly, by controlling information flow, gatekeepers may review and censor research questions that delve into sensitive areas such as guard behavior or prisoner abuse. This censorship could distort the data and present a skewed picture of reality. Thirdly, gatekeepers may exert pressure on prisoners to participate in research, exploiting the power dynamics inherent in the prison environment. This coercion could undermine the voluntary nature of participation and compromise the integrity of the research. Fourthly, gatekeepers may hesitate to endorse research that could shed light on problems within the prison system, fearing repercussions from higher authorities. This reluctance could stifle research efforts aimed at addressing human rights violations, systemic issues and attempts for reforms. Fifthly, researchers reliant on gatekeepers for access may inadvertently become influenced by them, potentially compromising the objectivity of the research and reinforcing existing power dynamics within the prison.

Nevertheless, this research acknowledges the transparency concern and the potential influence of gatekeepers, and outlines measures taken to mitigate their bias. These measures include triangulation with other data sources, seeking access to a broader range of participants, and negotiating with gatekeepers for access and freedom to ask relevant questions. Additionally, exploring alternative platforms to access prisoners through prisoner rights NGOs or independent advocacy groups can provide an avenue for bypassing gatekeeper influence.

Chapter 4.3.3 Process between Gatekeepers and Prisoners

Nominees to participate were selected by our gatekeepers who are the prison security officers and guards. They briefed them about the study and also had in hand a sample of the information sheets to give to prisoners ahead of time in order to read carefully and decide whether they want to participate in the study or not. The role of the guards is to facilitate the process as insiders'

perspective and to familiarize prisoners who fulfill our inclusion criteria to our research's purpose and requirements.

In this process, officers signed the "confidentiality agreement" to make sure participants' data and information are safely handled. Accordingly, those who accepted to participate went in the process of signing the consent form and fill in the questionnaire.

In fact, prison guards and officers managed the "link sheet" for a certain duration of 4 weeks. This sheet served as a temporary link between signed consent forms and filled questionnaires until all data was entered (within 4 weeks) and thus participants were no longer able to ask to be withdrawn from the study.

Navigating the communication phase revealed a commendable level of cooperation from the gatekeepers, despite the challenges they faced. Many of them were dealing with overwhelming workloads, resource constraints, and the demanding task of managing prisons during challenging circumstances reflected in the crisis at the level of the country, each grappling with these issues at their respective levels of responsibility. Despite these obstacles, their collaborative efforts played a fundamental role in streamlining processes and expediting the research, even in the times of limited resources and budget constraints.

Throughout the research processing time, it became evident to me that decision-making at the theoretical level was centralized among high-ranking officers. However, the repercussions of these decisions were acutely felt by the guards operating on the front lines, directly engaging with the prisoners. The impact on these guards was substantial, as they found themselves grappling with additional responsibilities and efforts to facilitate the research. Consequently, the unique challenges faced by the guards underscored the importance of acknowledging and addressing potential biases in the research process. The added burden placed on them could influence the way participants were chosen and how data was collected, potentially impacting the overall validity and reliability of the study.

Chapter 4.3.4 Training on Anonymity Process

Training sessions took place at the two chosen case study facilities. These sessions were designed to provide comprehensive knowledge about the research process. The focus was on educating key

personnel about the research objectives, the potential impact on the prison system, confidentiality considerations, and, most importantly, their roles in the data collection process. Ethical issues related to the research were also addressed, aiming to build awareness and ensure a standardized approach to data collection.

Following the training sessions, I provided RCP with 270 sets, each consisting of questionnaires, information sheets, and consent forms. Of these, 20% were in English, and 80% were in Arabic. This careful preparation ensured that language barriers were minimized. Additionally, 270 envelopes were handed over for secure and organized data collection. After the conclusion of the data collection phase, the prison guards returned a locked box containing 224 envelopes, each labeled with identifiers, accompanied by the link sheet.

The remaining 46 envelopes along with blank forms were also returned to me.

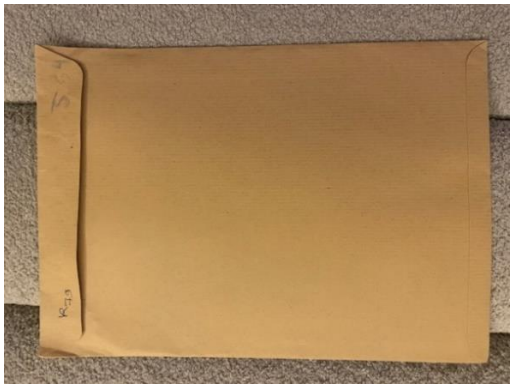

Figure 2: Sample Envelope with identifier (Source: Yasmine Fakhry)

In the case of BWP, I personally handed over 90 sets of questionnaires (20% were in English, and 80% were in Arabic), consent forms, and information sheets, along with 90 envelopes, to the high-ranking female officer. After the completion of the data collection phase, the women's prison returned a locked box containing 67 envelopes, each labeled with identifiers, along with the link sheet. This process mirrored that of RCP to maintain consistency across the two facilities. The remaining envelopes and blank forms were handed to me as well.This thorough process aimed to ensure the integrity of data collection, maintain participant confidentiality, and adhere to ethical

standards. Overall, the collaboration with prison guards and officers was essential for the successful execution of the research within the prison environment.

Certainly, the prison guards did not affect the anonymity of those who decided to participate as officers themselves did not have control over the box in which prisoners inserted their filled questionnaires. To further protect anonymity, I made available a wooden box that is locked and cannot be opened except with the key (that the officers did not possess). In fact, the box is actually similar to the one used in elections where there is a small space just for a thin envelope to be inserted inside. For the purpose of this research, two boxes were fabricated as follows: one for males' prison in RCP and one for Females' prison, that is in Baabda women prison.

Chapter 4.3.5 Recruitment Criteria

Criteria for recruitment of prisoners as participants are as follows:

1) Inclusion criteria:

•Older than 18 years old

•Males and females (including pregnant and lactating)

•Reads and writes either Arabic and/or English language.

•All nationalities

•Refugees

2) Exclusion criteria:

•Prisoners currently infected with COVID-19

•Minors (<18 years) (they will be excluded from the beginning of the study).

•Participants hospitalized at time of data collection (they will be excluded at the time of data collection).

•Prisoners with cognitive impairment or aggressive attitude (they will be excluded at the time of data collection).

•Prisoners residing for less than 3 months at the designated prison (they will be excluded at the time of data collection).

It is important to note that exclusion criteria did not impact the research study in any way. This ensured that the study maintained a clear focus on suitable participants. The same criteria were applied for both males and females' prisons, yet in females' prison, selection process encouraged prisoners who are either pregnant, lactating or those who have their child living with them behind the bars to participate.

In fact, if any of the nominees for participation were seen to have mental issues or were not able to give informed consent for any reason (including being pressured by prison guards), they had been excluded during the recruitment phase, and thus they did not advance to the stage of reading information sheet and signing consent to participate. This rigorous exclusion process aimed to uphold ethical standards. Consequently, any obstacle faced by the participant in order to give consent for participation was considered as an exclusion from the beginning. Unfortunately, I was not able to monitor this myself, and this process was under the responsibility of the gatekeeper.

Chapter 4.4 Ethical issues

Issues related to ethics arise in this study as human participants are required during the data collection stage of the study. In this regard, four matters are classified and should be considered in order to manage the ethical dilemma in and for research in social sciences (Bryman, 2016). The following sections will elaborate on these ethical considerations. This part of the chapter will give a close consideration to the four areas which are the following: causing harm to participants, breaching of privacy of participants, deception and informed consent matters. Plus, these ethical issues serve as an organizing tool for the relation between me (as a student researcher) and the participants (Bryman, 2016).

Roberts and Indermaur (2008) argue that research in criminology setting is filled with ethical challenges despite the fact that it stands as an invaluable and important source of information. Such challenges highlight the need for careful planning and execution. A series of conditions affect the prison research setting including interviewing. Roberts and Indermaur agree with Schlosser (2008) that going through the review and approval from committees of human research ethics might be of insufficient information due to the dilemmas and challenges in question. Consent forms serve

as a tool to cover legal issues, yet they place both researcher and participant in a series of risks and disclosures that do not benefit any of both parties (Roberts and Indermaur, 2008). Schlosser also discusses other issues encompassing the interviewing method for data collection, which are the approval to access prisons, creation of the research's concepts and instruments, prisoner's identity, influence of the institution along with negotiation with institutional review boards (Schlosser, 2008).

In fact, incarceration places prisoners under challenges and constraints that may affect their ability to make truly voluntary and un-coerced decisions about whether or not to participate as subjects in research. Recognizing this reality, I implemented various strategies to ensure informed consent. In order to mitigate this issue, several verbal communications were circulated including research proposal and information sheet. Also, meetings and information sessions were held with prison authorities through key officers who are in direct involvement in recruitment of participants in order to highlight the project's aims and guidelines and importance of confidentiality. At this level, three officers from RCP attended the information sessions whereas only one officer attended during the encounter with BWP. These meetings were crucial for fostering understanding and collaboration. These steps helped in reaching the research's goals and thereby bringing benefit to the general prison population on the long run.

As the study deals with human participants, ethical approval was secured from the REC of UEL (Refer to Appendix 15 for REC approval). Approval from the administration of Lebanese prison authorities was also acquired and documented through a signed letter (Refer to Appendix 16 for approval of Lebanese authorities).

Study participants were informed of the purpose of the study through information sheets and consent forms and they were assured confidentiality. This transparency was key to gaining their trust. For virtual meetings with officers of ISF, recording of neither video nor voice was planned. In fact, recording was expected to reduce participation due to the fact that a recorded video or voice, captured as a personal identifier, will be a demotivator for participation fearing that their experiences and perspectives about health system in Lebanese prisons will be revealed somewhere. Consent forms were signed by participants accepting to enroll in research.

Self-administered questionnaires (for prisoners) and checklists (for key authorities) did not have any identifiable information including their name to be collected at the first place. This further protected participant anonymity and encouraged honest responses. Those data collection tools were analyzed and stored by the student researcher.

Moreover, the participants were informed through information sheets in Arabic and English language that he/she has the right to withdraw from this research study at any point of time within two weeks after data collection. This emphasized their autonomy and right to choose. Evidently, participants were also informed that if they decide to withdraw from the study or those who do not even feel like participating will not be discriminated, penalized or punished. They were also informed that their decision does not affect their relationship with neither prison authorities, prison guards nor with UEL. Plus, the participants knew that they had the right to omit any question or query whenever they didn't feel comfortable in answering.

Recognizing that certain questions involved participants sharing their perceptions regarding the treatment and services received in terms of health and nutrition, I acknowledge the possibility that some participants might that have felt that their involvement could impact their relationships with gatekeepers along with "colleagues". This highlights the need for sensitivity in addressing these issues. In the context of prison's colleagues, a concern is particularly relevant, where power and control dynamics rule and a distinct social hierarchy often prevails, and inmates may feel compelled to align with a leader, known as the "Shawish," who influences various aspects of their daily activities and decisions. The unique dynamics within Lebanese prisons, characterized by a quasi-mafia environment, add a layer of complexity to participants' perceptions and willingness to engage in the research process.

Chapter 4.5 Data Management

For this research project, data was carefully handled before, during and after the completion of the study. A data management plan (DMP) was prepared and followed for this purpose (Refer to Appendix 17 for DMP). This plan ensured systematic organization and integrity of the data.

In reality, data collected is segregated into four categories as follows:

- Data set 1: Data sets related to demographical distribution of prisoners in Lebanese prisons, which are prison name, gender distribution and nationalities' distribution
- Data set 2: Data sets related to virtual interviews' notes with high rank officials and officers
- Data set 3: Data sets of weekly menu plans of Roumieh central prison
- Data set 4: Data sets related to general information of prisoners
- Data set 5: Data sets related to access to health care and services, disseminated through self-administered questionnaires

This categorization allowed for easier analysis and reporting.

Chapter 4.5.1 Data set 1

The first set of data is non-personal public data, which were retrieved from the directorate of prisons' website of the MoJ of Lebanon (www. pa.justice.gov.lb). This data provided essential context for the study. These data include number, gender, nationality of prisoners in all prisons along with capacity of each prison.

Chapter 4.5.2 Data set 2

The second set of data was retrieved from two unstructured virtual interviews that were conducted with two high ranks officials involved in the healthcare system of the prisons in Lebanon. These insights were invaluable for understanding systemic issues. The data come in the form of qualitative notes from the respective interviews.

Chapter 4.5.3 Data set 3

The third type of data were obtained through printed menus from the RCP kitchen's supervisor. This information was crucial for analyzing dietary practices.

Chapter 4.5.4 Data set 4

The fourth type of data is comprised of general information about the participating prisoners in the self-administered questionnaires. This foundational data is highly important for drawing meaningful conclusions. These data include the age, gender, status and length of stay in prison.

Chapter 4.4.5 Data set 5

The fifth type of data is comprised of information disseminated from self-administered questionnaires filled by prisoners and officers involved in health prison management.

Concerning data sets 4 and 5, the following describe the process of management of data from self-administered questionnaires for prisoners specifically.

After recruitment of prisoners (after their approval) by the prison officer, participants were given the questionnaire to be filled with neither direct nor indirect identifiers. This anonymity was essential for honest feedback. The participants' answers were pseudo anonymized and their data were only connected to consent and information sheets for four weeks. During the study, participants were identified(labeled) as Participant 1 P1, participant 2 P2 …

Regarding data handling and storage, files are password locked individually and they will be OneDrive accessed on a password locked and encrypted laptop. This security measure protects sensitive information. On one hand, sharing of data within the UEL supervisory team is being through secure links on OneDrive. Hard copies of data collection sheets and consent forms were transferred in a locked suitcase by the student researcher’s car. On the other hand, external collaborators were given access to appropriate information through secure UEL one drive. This system ensured controlled access to data. Indeed, files were neither stored on USBs nor shared through emails.

Figure 3: Suitcase containing responses (Source: Yasmine Fakhry)

Within four weeks of data collection, participants willing to withdraw from the study were able to do so (a fact they are aware of through the information sheet), given the fact that I was able to

identify them through the “link sheet”. This flexibility allowed for ethical participant management. After four weeks, I made sure that the data was properly entered and that participants who did not want to continue participation withdrew. After this stage, the link sheet along with the filled questionnaires were destroyed.

The electronic version of the link sheet was stored in the UEL OneDrive separate from the pseudo anonymized data. This separation enhances data security**.** In general, data collected from checklists, questionnaires, menus and virtual interviews were transferred to excel in the form of coded data and data entry happened after completion of data collection for every prison. Data collected was stored in password locked files (excel sheets) and stored on UEL’s one drive.

Signed consent forms were stored separate from filled questionnaires in two different drawers in my locked office in Lebanon, and there was a” link sheet” between the signed consent forms and the filled questionnaires. This thorough organization maintained data integrity. It is important to note that raw data were not and will not be transcribed by any external party, and will only be handled by the student researcher.

Chapter 4.6 Conclusion

This chapter has outlined the careful methodology employed in this research, providing a transparent roadmap for interpreting the findings presented in the next chapter. The methodology not only serves academic purposes but also reinforces ethical research practices. My research strategies, encompassing mixed methods, were carefully tailored to address the central research question and the five research questions. I utilized a multifaceted approach to data collection, including public data from ISF, self-administered questionnaires, interviews, document analysis, ensuring diverse perspectives and a rich understanding of the phenomenon under investigation. Acknowledging inherent biases and the way I intended to mitigate them through comprehensive training for gatekeepers and controlled data collection process, I recruited participants, through a detailed recruitment process according to criteria. This structured approach ensured robust participant selection. The whole process was facilitated by the gatekeepers, who represent the population of prisoners in Lebanon. Strict ethical procedures, including REC and Lebanese authorities' approvals and consents of participants, were implemented to protect participants and uphold research integrity. Finally, robust data management strategies through careful data handling pre, during and post data collection and storage of data on UEL OneDrive, guaranteed data accuracy and facilitated rigorous analysis. Together, these methodologies enhance the study's validity and reliability. With its thoroughness and transparency, this methodological framework lays the foundation for the compelling findings and insightful interpretations presented in the following chapters.

CHAPTER 5: RESULTS

> Negligence, negligence, negligence and absence of quality - Please take care of us like a human being who is entitled to rights.

This heartfelt plea echoes the struggles within the confines of Lebanese prisons, where the bare minimum for life is often uncertain.

“There are no minimum determinants for life inside the prison.” These words resonate deeply, encapsulating the harsh reality faced by inmates and underscoring their vulnerability. These powerful quotes, drawn from the voices of prisoners themselves, serve as a compelling introduction to the silent battle unfolding within Lebanese prisons. They reflect a broader narrative of neglect and deprivation that requires urgent attention. They open the way for a comprehensive examination of collected data and diverse perspectives from various stakeholders, which will be explored in detail in the subsequent sections.

Chapter 5.1 Introduction

This chapter researches the lived experiences and perspectives of those involved, illuminating the complex reality of healthcare and food provision for incarcerated individuals. **By analyzing these experiences, we can better understand the systemic issues at play.** The aim of this research project is to comprehensively evaluate the fulfillment of human rights and social justice related to health and food of prisoners in Lebanese prisons, focusing on dietary adequacy, healthcare access, and system effectiveness. My research questions directly relate to the aim and objectives offering specific, measurable inquiries that guided my investigation.

Objective 1: To assess the degree of conformity between current prison policies and practices in Lebanon regarding food and healthcare access and international human rights conventions and other pertinent standards.

Research Question 1: How do current prison policies and practices in Lebanon regarding food and healthcare access align with international human rights conventions and other relevant standards?

Objective 2: To analyze the extent to which international standards for prison healthcare consider the lived experiences and diverse needs of prisoner populations, with particular emphasis on aspects related to human dignity.

Research Question 2: To what extent do international standards for prison healthcare reflect the lived experiences and diverse needs of prisoner populations, including considerations of human dignity?

Objective 3: To evaluate the effectiveness of the Lebanese prison health system in addressing the comprehensive physical, mental, and social health needs of incarcerated individuals, going beyond minimum international standards.

Research Question 3: How effectively does the prison health system in Lebanon address the specific physical, mental, and social health needs of its prisoner population, beyond just meeting minimum international standards?

Objective 4: To identify the specific measures undertaken by the prison nutrition and healthcare system in Lebanon to cater to the needs and vulnerabilities of diverse prisoner populations, including women, migrants, and refugees.

Research Question 4: In what ways does the prison nutrition and healthcare system in Lebanon address the specific needs and potential vulnerabilities of diverse prisoner populations, including women, migrants, and refugees?

Objective 5: To identify the key strengths and weaknesses inherent in the current prison health system in Lebanon and propose feasible interventions aimed at addressing the identified shortcomings to enhance the overall quality of healthcare provision within prison settings.

Research Question 5: What are the key strengths and weaknesses of the current prison health system in Lebanon, and what interventions could be implemented to address identified shortcomings?

Chapter 5.2 Data Collected

In order to meet the study's aim and objectives, several instruments were used to collect four types of data to help answer the five research questions as follows:

	Statistics	Documents analysis: Lebanese prison law	Documents analysis: Diet menus	Documents analysis: Sample of a medical file	Interviewing	Self-administered questionnaires non- prisoners	Self-administered questionnaires prisoners
RQ1		X	X		X	X	
RQ2		X		X	X	X	
RQ3	X				X	X	
RQ4			X		X	X	X
RQ5					X	X	

Table 1: Research Objective-to-Research Question Relationship Matrix

To address the project's aim and objectives and to answer research's questions, data collection took place at the chosen case study prisons during the period between December 2022 and April 2023.

Four types of data have been collected through the methodology plan listed in the previous chapter, as follows:

- Public data: The first type of data consists of documents in the public data from the directorate of prisons, health and nutrition sections from the Lebanese prison law, sample of prisoners' medical files and weekly menu plans from RCP. These data will lead qualitative content analysis for the documents of the Lebanese prisons. This approach, which is the most used in this context, highlights the underlying topics and themes in the documents to be analyzed (Bryman, 2016).

- Qualitative interviews: The second type of data is the data retrieved from qualitative interviews with two officials involved in the health system of prisoners. These interviews provide firsthand insights into the operational challenges and the effectiveness of health services within the prison system.

- Self-administered questionnaires by prison health authorities: The third type of data consists of data obtained from self-administered questionnaires by two categories of participants, who are non-prisoners. The first category of participants includes persons overseeing health services provided to prisoners in Lebanon. The first is a high rank medical authority whereas the second is the head of the central pharmacy and the third is a physician at a referral hospital. This diverse perspective helps illuminate the broader healthcare context affecting prisoners.

- Self-administered questionnaires by prisoners: The fourth type of data is obtained directly from self-administered questionnaires filled out by prisoners themselves. These responses are crucial for understanding the inmates' personal experiences and perceptions regarding healthcare and nutrition.

  I will commence my exploration by examining the general statistics pertaining to Lebanese prisons, aiming to provide a comprehensive overview of various demographic factors.

These statistics encompass the total number of prisoners, their gender distribution, nationality breakdown, legal status (whether pretrial detainees or convicts), and the prevailing occupancy rates within these detention facilities. Understanding these factors is essential, as they provide a context for interpreting the data collected from other sources. This analytical approach is instrumental in gaining deeper insights into the diverse demographics and characteristics of individuals within the Lebanese prison system.

Chapter 5.2.1 Results from Public Data

The public data pertaining to Lebanon's prison system presents a wealth of figures essential for understanding its dynamics. At its core, the total number of incarcerated individuals across various facilities serves as a foundational statistic, offering insight into the magnitude of the prison population and the challenges faced by correctional authorities. To further comprehend these challenges, researching deeper, an examination of gender distribution sheds light on potential disparities within the system. By discerning the proportion of male and female inmates, one can identify gender-specific issues and recommend tailored interventions. Similarly, analyzing the nationality breakdown of prisoners provides valuable insights into the diversity within Lebanese prisons, highlighting potential disparities in treatment or legal proceedings between locals, foreigners, migrants or refugees. This analysis is critical for understanding how different backgrounds may affect inmates' experiences Distinguishing between pretrial detainees and convicts offers critical insights into the reasons behind incarceration and the efficiency of the judicial process. Moreover, monitoring the occupancy rate reveals the degree of overcrowding, which is vital for assessing the adequacy of prison infrastructure and potential impact on health security. By comprehensively analyzing these statistics, a good understanding of the demographic dynamics within Lebanese prisons emerges. This foundational understanding serves to inform subsequent discussions and analyses. This understanding serves as a foundational step along with other indicators towards formulating evidence-based policies and interventions aimed at addressing systemic challenges and promoting justice and reform initiatives within the Lebanese prison system.

Chapter 5.2.1.1 General Statistics

District	Under trial	Convicted	Total	% of under trial prisoners	% of convicted prisoners	Capacity (min)	Capacity (Max)	Occupancy Rate (%)	
Mount Lebanon	2538	1166	3704	68.52051836	31.47948164	1135	1640	326.3436123	225.8537
North Lebanon	935	112	1047	89.30276982	10.69723018	430	680	243.4883721	153.9706
Bekaa	797	83	880	90.56818182	9.431818182	371	655	237.1967655	134.3511
South Lebanon	414	37	451	91.79600887	8.203991131	225	320	200.4444444	140.9375
Total	4684	1398	6068	77	23	N/A	N/A	N/A	N/A

Table 2:Male Prisoner Statistics by District, Panel Status, Capacity, and Occupancy Rate

This table presents the number of male prisoners categorized by district, their panel status (pretrial detainee or convict), the capacity of each facility, and the corresponding occupancy rates.

Prison	District	Under trial	Convicted	Total	% of under trial	% of convicted	Capacity (min)	Capacity (Max)	Occupancy Rate(%)	
BWP	Mount Lebanon	96	6	102	94.11764706	5.882352941	40	60	255	170
Kobbe Women	North Lebanon	60	20	80	75	25	60	80	133.3333	100
Barbar Khazen	Beirut	27	25	52	51.92307692	48.07692308	N/A	N/A	N/A	N/A
Zahle Women	Bekaa	32	9	41	78.04878049	21.95121951	25	35	164	117.1429
Total		215	60	275	78.18181818	21.81818182	N/A	N/A	N/A	N/A

Table 3:Female Prisoner Statistics by District, Panel Status, Capacity, and Occupancy Rate

This table provides an overview of female prisoner statistics disaggregated by district, panel status (pretrial detainee or convict), the capacity of the prisons, and the respective occupancy rates.

Nationality	Number of prisoners	Percentage

Lebanon	3717	59.60%
Syria	1693	27.14%
Palestine	475	7.62%
Egypt	70	1.12%
Sudan	5	0.08%
Iraq	12	0.19%
India	6	0.10%
Jordan	12	0.19%
Bangladesh	29	0.46%
Ethiopia	26	0.42%
Germany	1	0.02%
UK (United Kingdom)	1	0.02%
Iran	4	0.06%
Bahrein	1	0.02%
Turkey	5	0.08%
Tunisia	2	0.03%
Algeria	2	0.03%
Rohol (bedouin like)	2	0.03%
Russia	1	0.02%
Sri Lanka	4	0.06%
KSA	4	0.06%
Sweden	1	0.02%
Oman	1	0.02%
France	2	0.03%
Philippines	5	0.08%
Venezuela	1	0.02%
Under study	12	0.19%
Unregistered	123	1.97%
Nepal	1	0.02%
Yemen	2	0.03%

Kuwait	1	0.02%
Albania	1	0.02%
Turkmen stan	1	0.02%
Mauritania	1	0.02%
Uzbekistan	1	0.02%
Nigeria	4	0.06%
Sierra Leone	3	0.05%
Kenya	6	0.10%
Total		**6237**

Table 4: Distribution of Prisoners by Nationality

This table illustrates the distribution of prisoners categorized by nationality, offering insights into the diversity of the prison population in terms of citizenship status.

Figure 4:RCP Complex (Source: Reuters)

Figure 5:Entrance to RCP complex (Source: Reuters)

Figure 6:Baabda Women Prison (Source: Yasmine Fakhry)

Chapter 5.2.1.2 The Health Policy

This section highlights the results derived from the analysis of Lebanese prison law, particularly focusing on the health policy outlined within it. Embedded within the Lebanese prison law, specifically decree 14310 of 11/02/1949, is a comprehensive four-article health management policy that establishes the framework for healthcare provision within Lebanese prisons. To begin with,, the first article, article 52, delineates the oversight of health management, stipulating the involvement of physicians assigned by MOIM, government-employed physicians in the absence of assigned ones, and municipal physicians where governmental provision is lacking. Additionally, it mandates the provision of dental care by an MOIM-appointed dentist on a weekly basis, with a specified ratio per prisoner (Refer to appendix 22 for the section of health policy in Lebanese prison law).

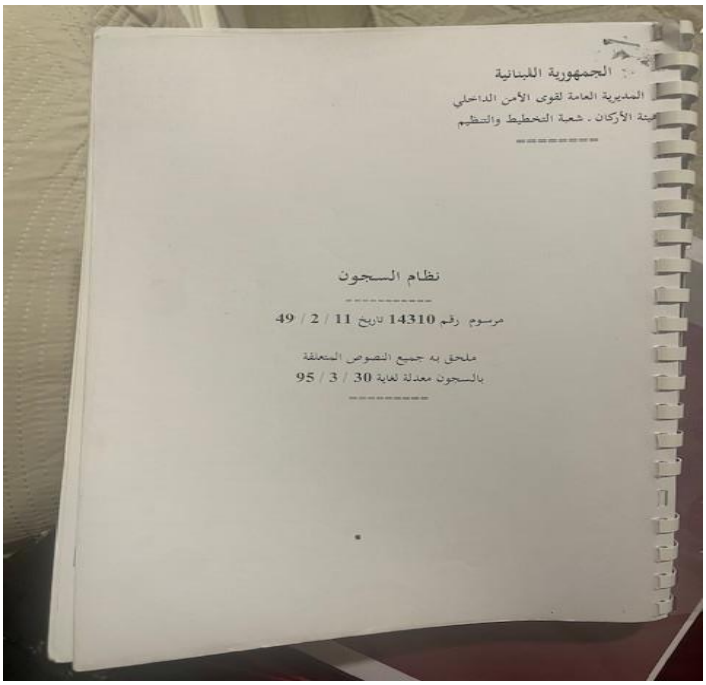

Figure 7:Lebanese Prison Law Document Photograph (Source: Yasmine Fakhry)

Building upon this foundation, article 53, amended on 6/1/1967, mandates a vigorous healthcare system within prisons, requiring frequent in-person health checks, proactive measures to prevent infectious diseases, dedicated medical care, physician consultation on health matters and food quality, and standardized documentation. Furthermore, Article 54 emphasizes a collaborative approach to healthcare, requiring appointed physicians to submit quarterly reports detailing adherence to health regulations, inmate well-being, and potential disease outbreaks. These reports are disseminated to prison chiefs and relevant ministries, facilitating coordinated interventions. In addition to healthcare, article 55 highlights the support system for medical centers within prisons, involving dedicated officers with specialized expertise and, under specific circumstances, well-behaved inmates assisting physicians, in accordance with Article 59 of the Lebanese prison law.

Chapter 5.2.1.3 The Nutrition Policy

This section focuses on the nutrition policy outlined within the Lebanese prison law, as established under decree 14310 of 1949, which encompasses a seven-article framework (refer to Appendix 18 for the complete section of nutrition policy).

Specifically, the first article, article 75, amended in 1963, dictates the procurement process for raw materials for prison meals, stipulating that outsourced contractor are selected through competitive bidding, with delivery schedules managed by the prison chief. Article 76 emphasizes the strict separation between contractors and prisoners, prohibiting any direct interaction. Furthermore, Article 77, amended in 1993, sets forth guidelines regarding food quantities and types categorized based on recommended daily allowances. To ensure compliance with these standards, it assigns the kitchen officer the responsibility of preparing a weekly menu in accordance with these guidelines, ensuring adherence to nutritional standards within the prison system.

The following table discusses the categories and quantities to be allocated for each prisoner:

Food category	Quantity
Labneh or cheese	100 g 4 times/week
Jam or Halawa	100 g 3 times/week
Grains (beans, green peas, rice, lentils, chickpeas, dry beans, bulgur)	150 g per day
Beef (fresh not frozen)	150 g twice per week
Chicken	200 g twice per week
Potatoes	300 g per week
Pasta	100 g once per week
Eggs	2 eggs/week
Arabic bread	500 g/day
Vegetables (tomato, zucchini, green beans, eggplant, swiss chard, spinach, cauliflower, carrots, cabbage and green peas)	180 g/day

Olive oil, vegetable oil, vegetable ghee and sugar	15 g of each per day
Salt, spices, onion, tomato paste, lemon juice, garlic, coriander	To be added according to the dish to be prepared
Fruits (apples, oranges, bananas and grapes)	100 g per day

Table 5:Food allowances per prisoner as articulated by Article 77 of Lebanese prison law

Article 78 outlines the dietary provisions for prisoners beyond daily rations, detailing the weekly allocation of various food categories for each individual. Furthermore, it specifies the quantity and quality of food to be included in three meals throughout the week, following a predetermined schedule set by the prison chief. In continuation of these dietary regulations, article 79 mandates that prison authorities ensure a diverse range of food options for inmates, even in situations where contractors may be unavailable. These guidelines recommend alternative sourcing and supply strategies, including specific quantities of arabic bread, halawa, figs, dates, yogurt, akkawi cheese, and olives. Moreover, in article 80, attention is given to sick prisoners, pregnant women, and lactating mothers, who have distinct dietary requirements. The chief physician of the prisons is responsible for issuing a special notice delineating appropriate meal plans tailored to each group's needs. In addition to these provisions, article 81 permits detainees to bring food from outside into the prison, albeit within the confines of specific policies and established protocols outlined in the article, ensuring compliance and security within the prison environment.

Figure 8: Chicken 200 g Portion Photograph (Source: www.cornerstoneweightloss.com

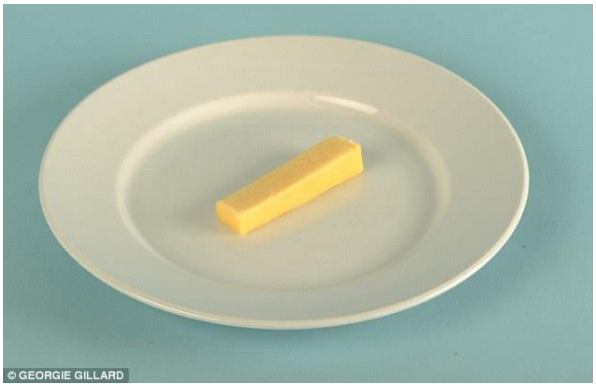

Figure 9:Cheese 100 g Portion Photograph (Source:https://www.dailymail.co.uk/health/article-3059330/What-DOES-100-calories-look-like-muffin-sliver-cheese-reveal-favourite-foods-eat.html)

Figure 10:Pasta 100 g Portion Photograph (Source: www. Dreamstime.com)

Figure 11:Oil 15 g Portion Photograph (Source: www. Dreamstime.com)

Figure 12: Butter 15 g Portion Photograph (Source: www. Dreamstime.com)

Figure 13:Apple 100 g Portion Photograph (Source: https://100-grams.blogspot.com/2013/09/100-grams-of-apple.html)

Figure 14:Banana 100 g Portion Photograph

(Source: https://100-grams.blogspot.com/2013/

08/100-grams-of-banana.html)

Chapter 5.2.1.4 Results from analysis of prisoners' medical files

Prisoners' medical files are kept very organized, just like those of ISF personnel. These records follow a certain template that covers various aspects of their health, such as personal details, routine health check-ups, lifestyle information, and medical history. In addition to these components, beyond basic identification, prisoners' records delve into their backgrounds to provide context. Regular health check-ups are conducted to catch any health issues early, while lifestyle information helps identify potential risks. Consequently, the complete medical history documented in these records includes past illnesses and treatments, offering a comprehensive overview of their health journey (Refer to appendix 19 for copy of the medical file)

Chapter 5.2.2 Results from analysis of RCP weekly menu plans

The findings in this section are based on the weekly menu plans from 2019 and 2021(Refer Appendices 20 and 21 for the diets provided in RCP for years 2019 and 2021 respectively).

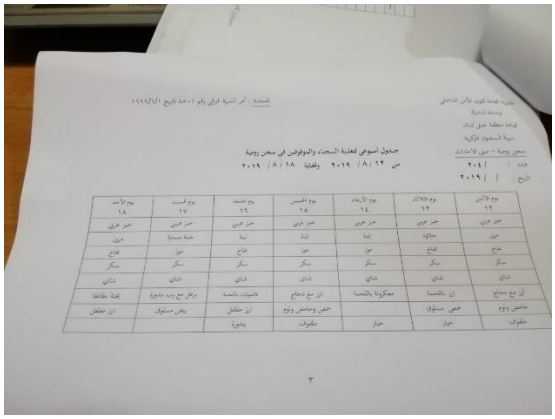

Figure 15:Sample of a weekly menu - 2019(Source: Yasmine Fakhry)

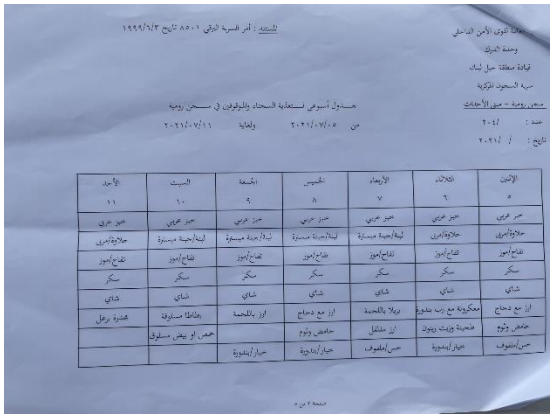

Figure 16:Sample of a weekly menu-2021(Source: Yasmine Fakhry)

The selection of these particular years is deliberate, as it allows for comparison between the menu before and after the crisis. This comparison is crucial for understanding the impact of external factors on dietary provisions. For diet analysis, the decision to focus solely on calories (Kcal), protein (g), carbohydrates (g), fat (g), saturated Fat (g), fiber (g), sodium (mg), potassium (mg),

calcium (mg), and iron (mg) holds strong justification for several compelling reasons. First and foremost, these nutrients are deemed essential for maintaining overall health and vitality. In this context, calories serve as the fundamental units of energy, while protein, carbohydrates, and fats are indispensable macronutrients vital for various bodily functions. Meanwhile, the intake of saturated fat, fiber, and sodium plays a critical role in cardiovascular health, with potassium, calcium, and iron essential for balancing electrolytes, fortifying bones, and facilitating oxygen transport within the body. Moreover, these nutrients align closely with common dietary concerns prevalent among individuals. For instance, many are primarily focused on managing their calorie intake to achieve weight management goals, while closely monitoring protein, carbohydrates, and fats for their impacts on muscle development, sustained energy levels, and feelings of satiety. Saturated fat and fiber are often scrutinized to mitigate the risk of heart disease and maintain digestive well-being, while sodium intake is carefully regulated due to its association with hypertension and related health issues. By focusing on these specific nutrients, the diet analysis enables an evaluation of the overall nutrient density of one's dietary intake in general and on prisoners' diet in specific. This focus is particularly relevant, as ensuring adequate consumption of protein, essential fats, fiber, and key vitamins and minerals like potassium, calcium, and iron can profoundly support overall health and minimize the likelihood of nutrient deficiencies and thus the nutrition security of the prisoners. Additionally, focusing on these essential nutrients offers a practical and simplified approach to diet assessment, particularly for individuals who may lack access to comprehensive nutritional data or advanced analytical tools. As a result, it streamlines the process of evaluating dietary quality and facilitates straightforward adjustments to improve dietary patterns.

While acknowledging the importance of other nutrients such as vitamins (e.g., Vitamin A, Vitamin C) and minerals (e.g., magnesium, zinc) for overall health, directing attention towards Calories, Protein, Carbohydrates, Fat, Saturated Fat, Fiber, Sodium, Potassium, Calcium, and Iron provides a robust foundation for assessing and enhancing dietary habits of Lebanese prison population.

As demonstrated in both Table 4 and Table 5, the nutritional analysis of the 2021 and 2019 menus offers a comprehensive representation of the caloric content, macronutrient composition, and micronutrient levels provided to prisoners. To illustrate, in terms of caloric intake, both menus presented a similar picture with 2021 menu providing 2330 calories, while the 2019 menu

providing an average of 2352 calories. These figures line up with the nutritional needs of a middle-aged man, as per the Lebanese food-based guidelines and WHO guidelines (WHO , 2018). When it comes to the fat content, it is noteworthy that both the average total fat content, 18% and 20% of total energy, and saturated fat ratios, 3.8% and 4.5% of total energy, were within the requirements as compared to both the WHO and Lebanese food-based guidelines (WHO, 2018; The Food Based Dietary Guideline Manual for Lebanon, 2013).

As for fibers, the findings indicate that the average fiber content of 21g was considerably inferior than the suggested ranges of 25 and 31g, even though on very few days of the week especially when legumes are served, recommended levels are fulfilled (WHO , 2018).

The average amounts of other micronutrients such as potassium and calcium levels were 2025 mg and 732 mg respectively. These levels indicate that they were found to be also significantly lower than recommended levels and prisoners rarely reach the recommended levels of 3500 mg of potassium and 1200 mg of calcium. Sodium consumption ranged between 3100 mg per day and 3200 mg per day which notably exceeds recommended levels by the Lebanese food-based guidelines of 2300 mg/day (The Food Based Dietary Guideline Manual for Lebanon, 2013).

On the contrary, it is reassuring to note that the average iron content of 19 mg was found to be adequate to fulfill the recommended need of 8 mg for males and 18mg for females of child-bearing age (WHO , 2018).

As for the free sugar content, the menus generally adhere to the recommendation of less than 10% of total daily energy (WHO , 2018). However, this recommendation is exceeded only twice a week when prisoners are provided with sugar, jam, and halewe, which are observed as rich sources of free sugar (WHO , 2018).

In terms of servings from food groups, a detailed classification was done and presented in table 3. To summarize, prisoners receive a daily provision of 16 servings of white bread, in addition to 0.75 to 2 servings of rice, potatoes, or pasta. Moreover, inmates are provided with 6 servings of chicken or meat twice a week, 2 servings of eggs once a week, and 2 servings of legumes daily. They also received half a serving of labneh or 2 servings of full fat cheese 5 days a week. In addition, 1 to 2 serving of vegetables and 1 serving of fruits were offered daily.

It is important to note that dairy products served were presumed to be sources of full fat. Furthermore, unsaturated fats coming from oils were provided as 2 servings daily and up to 4 only once a week. Finally, free sugar intake averaged around 60 calories daily, increasing to 300 calories two times per week.

Food Group	Item	Standard Servings (g)	Serving Frequency
Item 1	Yogurt or cheese served with tea	100g	4 times per week
	Halewe or jam served with tea	100g	3 times per week
Item 2	Pulses (red beans, green peas, rice, lentils, chickpeas, fava beans, bulgur) served together or separately	150g	Daily
Item 3	Fresh beef Fresh chicken	150g 200g	Twice per week
Item 4	Potato Pasta Eggs Arabic bread	300g 100g 2 500g	once per week once per week once per week Daily
Item 5	Vegetables (tomato, zucchini, spinach, cauliflower, eggplant, green beans, swiss chard, carrots, cabbage, green peas) served together or separately	180g	Daily
Item 6	Olive oil, vegetable oil, vegetable ghee, sugar Tahini Tea	15g 5g 5g	Daily
Item 7	Salt, pepper, onions, tomato paste, lemon juice, garlic, coriander based on the recipe	—	—
Item 8	Fruits (apples, orange, banana, grapes) served together or separately	100g	Daily

Table 6:Food Groups, standard servings and serving frequency as listed in Article 77 of the Lebanese prison law

Nutrient analysis										
	Calories (Kcal)	Protein (g)	Carb (g)	Fat (g)	Sat Fat (g)	Fiber (g)	Na (mg)	K (mg)	Ca (mg)	Iron (mg)
Lebanese food based Guidelines	2000-2800 for adults aged 19 to 60	--	--	25-35% of total energy	< 7% of total energy	Men: 31g/d Women: 25g/d	2300 mg/d	--	1000mg/d	Men 8mg Women 18 mg Max limit 45
WHO Guidelines	--	--	--	<30% of total energy	<10% of total energy	--	<2g per day Salt should be iodized	>3.5 g per day		--
PM menu Average 2021	2330	91	387	48 (18% of total energy)	10 (3.8% of total energy)	21*	3219**	2025*	732*	19
PM menu Range 2021	2000-2500	54-126	334-428	19-63	1-21	14-31	2800-4400	2200-2500	460-1140	16-21
PM Menu Average 2019	2352	95	384	54 (20% of total calories)	12 (4.5% of total energy)	21*	3103**	2001*	718*	20
PM menu range 2019	2088-2686	56-129	327-468	27-70	4-19	18-24	2700-4445	1300-2600	482-1131	16-25

Table 7:Lebanese Food Based Guidelines and WHO "Healthy Diet" Guidelines as compared to PM nutrient analysis
* Less than Recommended
** Exceeding recommended Levels

Servings							
	Cereals	Lean meats, legumes, unsalted nuts	Low fat dairy	Fruits	Vegetables	Oil	Free sugar
Lebanese food based Guidelines	6 servings per day (at least half whole grain)	5 - 6.5 servings (at least 2 servings of fish per week)	3	2	2-3	Limited	Limit to <10% of total energy
WHO Guidelines	---	---	---	At least 400g of fruits and vegetables		---	Limit to <10% of total energy
PM menu Approximate servings 2019 and 2021	16 (only white bread) daily + 0.75-2 (rice potato or pasta daily) **	6 serving of chicken (twice per week) **OR** 6 servings meat (twice per week) **OR** 2 servings eggs **Or** 2 servings legumes per day	½ labneh – 2 servings cheese (not low fat) 5 days a week *	1 daily (100g) *	1-2 daily (180g) *	2 from unsaturated fats daily up to 4 (once per week)	60 calories (3%) daily up to 300 calories (10%) twice per week

Table 8:Lebanese Food Based Guidelines and WHO "Healthy Diet" Guidelines in servings as compared to approximate PM servings

* Less than Recommended
** Exceeding recommended Levels

Chapter 5.2.3 Results from Interviews

Two remote interviews shed light on healthcare in Lebanese prisons following the same interview guide. Both the advisor to the Minister of Interior and Municipalities and the Head physician in

RCP provided insights on leadership, governance, service delivery, and medical ethics. Collectively, both interviews provided a wealth of information and demonstrated consensus on all issues and concerns.

Starting with strengths, the system boasts robust referral networks with specialized hospital wards, proficient emergency management protocols, and effective control of communicable diseases. Specifically, both interviews agreed that the system has a good referral system to many hospitals. One interviewee mentioned the following details:

> The contracted hospitals are HAYAT, Beirut Nawfal, Elias Hrawi Hospital Zahle, DAHR Bacheq where prisoners are placed in special wards.

An interesting issue was clarified about the budget of food where it was mentioned that it was nearly ten milliard LBP (approximately USD 6 600 000), before 2019. Moreover, it was mentioned that documentation was digitalized, which adds reliability and sustainability to the used documents. Also, it was highlighted that all stakeholders work as a team, and real teamwork was revealed during the COVID-19 pandemic:

> Covid-19 gave us a lesson. The reality is that WHO, ICRC, UNODC, UNDP, International organizations helped us, also OUSANED and Adl w rahme – all [worked as] one team.

Speaking of COVID-19, it was mentioned in the interviews that an isolation building was assigned for quarantine and it was handed to WHO for management.

Another strength was identified about efforts to ensure prisoners receive comparable healthcare to ISF personnel, even prioritizing them for crucial interventions like vaccinations:

> Prisoners usually are prioritized in terms of hospitalization, vaccines, and medications. For instance, during the cholera outbreak, prisoners received the vaccine. Also, during the COVID-19 pandemic, all prisoners, including those waiting for their trial, received the Pfizer vaccine at an early stage.

Fortunately, the system is backed up with partnerships with local NGOs and international organizations. One of the officers emphasized the solid partnership with other parties. He said:

> Health provision for prisoners comes in support and partnership with many stakeholders including WHO, ICRC, UNODC, UNDP, and MoPH along with local NGOs such as OUSANED, ADL w Rahme.

However, these strengths are counterbalanced by a series of weaknesses, including outdated regulations, scarce resources, medication shortages, and financial constraints. One of the two interviewees summarized the weaknesses in a direct and concise way, as follows:

"Overpopulation and outdated prison law coupled with a low number of medical staff."

A major weakness that was highly agreed upon is the governing law, explicitly mentioned as follows:

> It is a 1949 prison law; of course, we need judiciary reform and health when it is about a law that is 70 years old.

Another tackled issue in the weaknesses is the issue of breaching medical ethics and the privacy of prisoners. During the interviews, it was expressed that:

> We cannot ignore the fact that the guards are present during check-up with the physician. Plus, for the sake of investigation, the Department of Public Prosecution within the judiciary system has the full right to dig into the prisoner's medical status and other related details.

Also, the shortage in requirements for women's health was explicitly discussed through the following: "Shortage in hygiene requirements for women", which I can relate to menstruation, pregnancy, and breastfeeding essential needs including menstrual pads. On the other hand, despite the fact that many organizations support the system including ICRC, there was a concern about sustainability: "ICRC's support is not sustainable for prisoners, so we need a plan B". Transitioning to challenges and reforms, the healthcare system grapples with inherent limitations, knowing that it is governed by a 1949 prison law. Consequently, the recommendation was the following:

"However, this law is outdated and needs corrections and reforms".

In this purpose, one of the two interviewees mentioned that “there is a committee working to come up with a decree to update the prison law”. This initiative signifies a step towards modernization and improvement.

Insufficient staffing and an outdated legal framework hinder effective implementation of healthcare policies. In response, modernization efforts are underway, focusing on the adoption of electronic medical records and alignment with the broader national health strategy. This alignment is crucial for enhancing overall healthcare delivery. Collaborative partnerships with key stakeholders such as the Ministry of Public Health (MoPH), WHO, and NGOs play a key role in providing essential support for these reform initiatives. Moving forward, proposed solutions aim to address the identified shortcomings in prison healthcare. These solutions would include leveraging donations, accessing resources from entities such as ISF, ICRC, and the MoPH, and prioritizing preventive measures to mitigate treatment costs and alleviate the strain on limited resources.

In examination of prison healthcare, a detailed analysis reveals a blend of strengths and weaknesses, accompanied by a set of distinct challenges and a call for reform. However, amidst these discussions, ethical concerns loom large. Two major ethical dilemmas have surfaced: the presence of guards during medical consultations and the sharing of medical information with the Department of Public Prosecution within the judiciary system. Such issues compromise patient confidentiality and challenge the ethical framework of the healthcare system. These breaches of medical ethics compromise the confidentiality of prisoners and raise pertinent questions regarding the ethical standards upheld within the prison healthcare system.

In essence, as the discourse surrounding prison healthcare continues to evolve, it is imperative to acknowledge the complex interplay of strengths, weaknesses, challenges, reforms, proposed solutions, and ethical considerations that shape the landscape of healthcare delivery within correctional facilities. Only through a comprehensive understanding of these dynamics can meaningful progress be achieved in fostering a healthcare system that upholds the rights and dignity of incarcerated individuals.

Chapter 5.2.4 Results from Self-administered Questionnaires by Non-Prisoners

This section discusses the data compiled from self-administered questionnaires from three parties. Three different questionnaires were filled by a healthcare provider at RCP, a responsible officer in the central pharmacy and a physician responsible of healthcare services of the prisoners in a referral hospital in Beirut. These diverse perspectives provide a comprehensive overview of the current healthcare landscape within the prison system. Fortunately, self-administered questionnaires offer a cost-effective, convenient, and reliable way to gather data while providing valuable insights into respondents' genuine opinions and experiences.

Chapter 5.2.4.1 Questionnaire Filled by a Healthcare Provider

Chapter 5.2.4.1.1 Physical and Social Determinants of Health

The health conditions within Lebanese prisons are shaped by various factors encompassing physical, social, and administrative dimensions. Among these factors, access to resources plays a critical role. Drinking sterile water is available, nutrition is provided, but space is limited, hindering outdoor recreation and personal hygiene:

> Access to potable water and basic nutrition is assured, but challenges arise due to overcrowding, with each prisoner allocated less than 2 m^2 of space, hindering adequate outdoor recreation and personal hygiene.

Chapter 5.2.4.1.2 Leadership and Governance

Leadership and governance structures play a pivotal role in the delivery of healthcare services within prisons. Effective leadership is essential for managing the complexities of prison healthcare.

> A medical center is available in many prisons to treat different medical conditions and cases. This hospital is not affiliated with MoPH, yet treatment of communicable diseases including Hepatitis C(HCV), HIV and TB is through the support of MoPH.

Medical centers, although not directly affiliated with the MoPH, are instrumental in addressing various medical conditions among detainees, with support from MoPH particularly for managing communicable diseases such as HIV, HCV, and TB.

It is noteworthy that there is an adherence to international standards and conventions which ensures a baseline for healthcare quality:

> Health services are provided according to the following standards: Malta declaration, Istanbul Protocol and Nelson Mandela Standards. These standards are fully implemented.

Collaborations with local and international organizations further enhance healthcare provision, facilitated through formal agreements covering medication supply, disease treatment, and health infrastructure development. These collaborations are vital for resource mobilization and effective service delivery:

> There are several organizations on a local and international level including WHO, ICRC and other NGOs that cooperate for healthcare provision in the prisons- several agreements are there with different local and international entities to facilitate the cooperation and agreement.

There are several agreements in this context as follows:

> First, there is an agreement with MoPH to provide medications through PHC. Second, there is an agreement with MoPH to treat communicable diseases (HCV, HIV and TB) and during pandemics and epidemics including COVID-19 and cholera). Third, there is an agreement with WHO for health provision and making medical files electronic. Fourth, there is an agreement with ICRC to provide medical equipment and nitrogen oxygen gas.

Chapter 5.2.4.1.3 Health Information System

However, challenges persist in the health information system and medical filing:

> There are paper medical files that document the process including diagnosis and treatment. Two third of the files are well documented. Medical files are archived in the prison's clinic and are accessed only by the medical team.

There is a comprehensive statistical tracking of consultations, referrals, and mortality rates:

> There are statistics about number of consultations, referrals, death toll- these data are not shared with MoPH.

Moreover, data collection about communicable diseases takes place:

> There are statistics related to communicable diseases like TB and cholera that are communicated to MoPH, yet there is no data collection related to substance abuse.

A good communication channel is seen within the hierarchy: “Regular meetings take place with supervisors, prison authorities and district health managers”.

While strengths lie in the management of urgent cases, breaches in medical confidentiality underscore areas for improvement:

> Strengths include the management of urgent cases and life-saving protocols and weaknesses include the non-compliance with confidentiality.

Chapter 5.2.4.1.4 Health-care Financing

When it comes to finance, a budget specifically allocated for healthcare is available:

> There is a yearly budget for healthcare provision in prisons and it is calculated according to previous years’ budget.

One strength is easily identifiable with open budget for health of prisoners: “There is no upper limit for the budget for each detainee”.

Financial constraints also affect healthcare financing, with delayed payments to medical referral centers exacerbating resource shortages: “There is late redemption of debts to medical referral centers that are affiliated.”

Chapter 5.2.4.1.5 Human Resources for Healthcare

Human resources constitute a critical aspect, with shortages in healthcare workers exacerbating challenges due to low salaries and adverse working conditions. This situation creates a significant barrier to effective healthcare delivery.

> There are 30 healthcare workers working for Roumieh central prison’s medical center, and there is a shortage in staff. Fortunately, NGOs and WHO support in providing healthcare services. The available staff are not enough as they are related to the low number of existing staff on the level of ISF. Plus, many nurses and physicians are refusing to work in the prison settings. This can be ameliorated with a salary raise.

Recruitment follows a specific process, with health staff typically sourced from ISF personnel holding degrees in nursing or pharmacy and appointed through the medical officer on a quarterly

basis. This structured recruitment process aims to maintain a level of professionalism in healthcare delivery.

> Health staff are recruited from ISF personnel who hold a degree in nursing or pharmacy. They are appointed through the medical officer. They are recruited by the council of ministers quarterly.

Challenges in this area include difficulties in contracting with health professionals due to the demanding working environment and relatively low salaries. These challenges can deter qualified professionals from seeking employment in the prison system.

> Challenges due to the difficulties in contracting with health professionals due to the tough working environment and relatively low salaries.

Healthcare workers within prisons receive better benefits compared to their counterparts in the public health system but endure worse working conditions. Despite these challenges, healthcare workers are available around the clock, ensuring continuous coverage: “Healthcare workers’ coverage is 24/7”. Supervision of staff falls under the centralized authority of the ISF's health sector as follows: “Health staff are supervised by health sector in ISF.” However, training opportunities remain limited and are usually outsourced, primarily occurring during pandemics and epidemics through WHO and MoPH initiatives, as articulated by the interviewee: “WHO and MoPH provide training only during pandemics and epidemics.” Strengths of the system include fast access to healthcare providers, but weaknesses persist in medical follow-up due to the shortage of medical staff:

> Strong points are fast access to healthcare providers. However, there is a weakness in medical follow-up due to the shortage in the number of medical staff.

Chapter 5.2.4.1.6 Medical Supplies

Despite other challenges, medical facilities are adequately equipped:

> Machines for xray and echography are available. The ENT and ophthalmology clinics are fully equipped. Also, there is a phlebotomy section where blood samples are taken for laboratory tests.

In terms of medication, the process of request, supply, delivery and budget allocation is very clear:

> Drug supply is made under the supervision of MoPH. Medications are supplied according to what is available in the Lebanese market. The budget is allocated within the budget for ISF. This budget is part of the budget for health and medical needs. It is actually allocated depending according to the previous year's expenditures. As for drugs and medical items, their supply needs are calculated according to monthly and yearly prescriptions.

Within the same context, orders and delivery are explained as follows:

> Drugs are usually delivered following an order request. Delivery might take several days. In normal settings there is no shortage of medications. However, with the current crisis, there is a difficulty to make medications and medical equipment available. In case of shortage, health professionals make substitutions or the treatment is changed for this matter.

As for their storage, the following takes place*:*

> Drugs are stored in special drawers, overseen by the pharmacy technician. Use of medications is within shelf life. However, action is taken for all medications that are expiring in 3 months.

Moreover, a minority of medications is supplied by NGOs:" Five per cent of drugs are provided by NGOs. They are stored according to the usual protocols." The process of ordering medications is clear and straight forward:

> When a medication is ordered for a certain prisoner, a documentation takes place with the prisoner's name, prescription date and #.

When it comes to whether families support in medications, families are not a major player:

> Rarely do families buy medications for their detained relative. Plus, there are specific medications that are prohibited to be provided from outside unless with a direct supervision from MoPH. Those drugs are classified as illicit drugs.

In relation with communicable diseases, prisoners have access to medications:

> Detainees have access to medications for TB and AIDS. They are supported by MoPH and are completely free of charge.

Chapter 5.2.4.1.7 Health Service Delivery

Coming to strengths and weaknesses of the system, answers are quite straightforward and clear:

> The strength of the system relies in the fact that same medications are provided for both ISF staff and prisoners. However, prisoners have priority in terms of medications' access. On the other hand, drug companies stopped selling the drugs to ISF after the recent crisis.

The healthcare system within the detention facilities encompasses a range of services aimed at addressing the medical needs of detainees. This breadth of services is crucial for maintaining the health of the population.

> Medical physical facilities include dental clinics and isolation sections. However, surgeries and related procedures take place only in the contracted medical centers.

Despite efforts, maintaining privacy and confidentiality proves challenging: "It is very hard to respect privacy and confidentiality of prisoners".

Essential requirements like water, electricity, and furniture are not lacking, but medical waste disposal relies on burning:

> There is no shortage of essential requirements such as running water, electricity, lights and office furniture. For waste management, medical wastes are currently burned.

Reusable medical tools are sterilized according to international standards: "Sterilization of reusable medical tools are subject to the international and known standards."

Screening for tuberculosis, AIDS, Hepatitis B, and syphilis is mandatory within 48 hours of admission:

> Every detainee is subject to obligatory screening within 48 h upon admission for TB, AIDS, Hepatitis B and cephalus.

Chronic conditions prompt consultation with a physician, while mental health and addiction screenings are lacking for most detainees:

> A physician is consulted if the prisoner suffers from chronic diseases. Detainees are screened for TB and immunodeficiency. However, they are not screened for drug or alcohol

addiction. Moreover, mental health screening is not done unless for the detainees that are known to have mental health issues/diseases.

Accessing healthcare involves submitting requests through security guards, with no consistent medical staff presence in cells:

> The security guard is the one in contact with the detainee and who receives the request from the prisoner in case of sickness. Accordingly, the guard takes the prisoner to the medical center within the campus. There is no health staff tour to all cells in a consistent way.

Healthcare is available 24/7, and medication distribution is supervised by nurses:

> Physicians and nurses are available 24/7 in the medical center of the RCP. The service is available 24/7.

However, medical confidentiality is not always upheld, and follow-up appointments rely on prisoners coordinating with guards:

> Medical confidentiality is not respected. Follow up with the physician is done according to appointments. Accordingly, the prisoner should arrange with the guard to come on time for the appointment.

Specialties in the medical center have dwindled post-crisis, with limited services and resources affecting dental care and specialized consultations:

> The medical center used to have the following specialties: ophthalmology, ENT (Ear, Nose, and Throat Doctor), orthopedics, cardiology, mental health, radiology. Yet, after the crisis, only physicians from ENT and ophthalmology are available according to a preplanned schedule.

Referrals for emergencies occur promptly, but non-urgent cases face delays due to hospital refusals to accept ISF beneficiaries:

> For urgent cases, the referral process takes place immediately. For non-urgent cases, the referral could take up to one week. However, currently hospitals are refusing to laboratory

tests or x-ray for ISF beneficiaries. They are asking to be redeemed for the service by cash. This issue is causing delays.

Chapter 5.2.4.1.8 Specific Situations

Despite challenges, the system adheres to protocols for specific situations like solitary confinement, life-threatening illnesses, deaths, hunger strikes, and torture:

> In specific situations, medical management is done properly. For prisoners in solitary confinement, their medical treatment is covered and their status does not impact fulfillment of his treatment. For life-threatening diseases, detainees are transferred to contracted hospital for care. In case of death during detention, a judiciary investigation takes place to identify any responsibility. Also, when a hunger strike takes place, Malta declaration on hunger strike is followed. In case of torture, Istanbul protocol is followed.

Chapter 5.2.4.1.9 Suggestions for Improvement

Opportunities for improvement lie in digitizing medical records to enhance treatment follow-ups and communication among healthcare providers: “Opportunities for improvement are around digitalizing medical files, which will certainly bring progress on many levels.”

This transition could significantly streamline processes and improve patient care.

Chapter 5.2.4.2 Questionnaire filled by a Responsible Officer in the Central pharmacy

Medications within prisons are sourced from in-house pharmacies, supplied by the office of medications and medical supplies under the health department of ISF-MOIM:

> The medications are sourced from the pharmacies that are located inside the prisons. They are actually supplied by the office of medications and medical supplies under the health department of ISF-MOIM.

However, there are no standards to equip health facilities within prisons, and there is no unified medication list.

> There is no unified system to equip health facilities in prisons. Also, there is no unified medication list for the prisons.

Despite this, similar medications as those in Primary Healthcare Centers (PHC) are supplied in prisons. “As compared with the medications in PHC, same medications are supplied in prisons.” Orders for medication replenishment occur on a quarterly basis, based on monthly consumption and prisoners' needs:

> Stock of medications is usually replenished on a quarterly basis. Orders are made according to the monthly consumption and the prisoners’ needs.

However, due to recent financial crises, shortages in medications, particularly those for chronic diseases, have emerged:

> In the past years, the stock of medications was always as needed. However, recently because of the financial crisis, there has come a shortage in the medications, especially those for chronic diseases.

The documentation process occurs on the pharmacy's file based on physician prescriptions, ensuring all medications are consumed within their shelf life without breaching expiry dates.

> When it comes to documentation process, it takes place on the pharmacy’s file according to the physician’s prescription. All medications are consumed within their shelf life and no expiry date is breached.

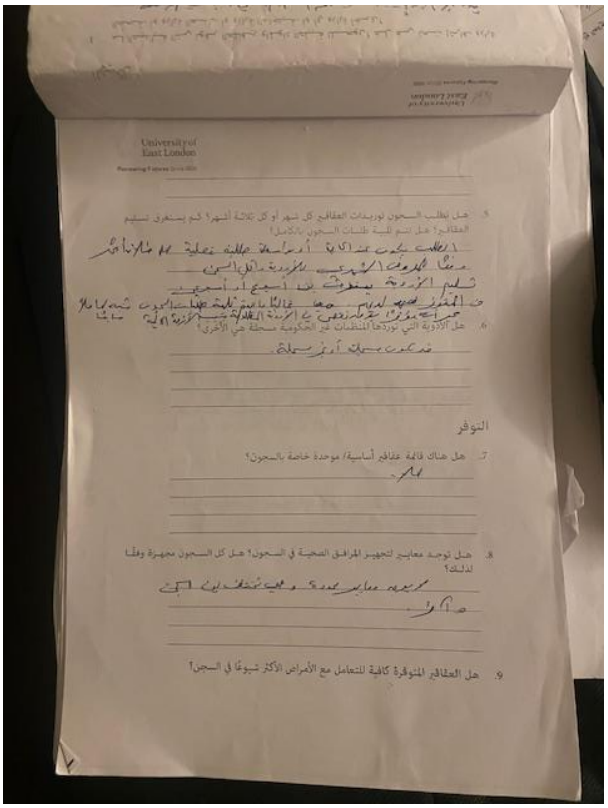

Figure 17: Questionnaire filled by a responsible officer in the central

Chapter 5.2.4.3 Self-administered questionnaire by Physician in Referral Center

The referral center plays a crucial role in providing healthcare services to detainees, offering a specialized ward equipped with security systems and isolation rooms. This specialized environment is vital for addressing the unique healthcare needs of detainees.

> The referral center is a private hospital that contains a special ward for detainees, which is equipped with a security system and includes isolation rooms.

Communication between prison facilities and the referral center occurs through landline phones and telegrams/circulars.

> Prison facilities communicate with this referral center through landline phone and telegrams/circulars.

Urgent referrals from RCP and other detention facilities are admitted promptly without any waiting period. “All urgent referrals from RCP and other prisons or detentions are admitted without any waiting.” There are no limitations on the number of detainees admitted, contingent upon available beds and the urgency of the case.

> There is no quota for how many detainees we can admit - It is all subject to available beds in the hospital and the extent of the urgency of the case.

The hospital treats a variety of conditions commonly observed among detainees, including scabies, cardiovascular diseases, COPD (Chronic Obstructive Pulmonary Disease), dermatological issues, eye diseases, and food poisoning.

> The most common manifestations for admission to hospital are scabies, cardiovascular diseases from stress, COPD, dermatology, eye diseases, food poisoning issues including vomiting and diarrhea.

Upon discharge, the admitting physician provides guidelines and prescriptions for both acute and chronic medications. These instructions are essential for ensuring continuity of care after hospitalization.

> Upon discharge from hospital, the admitting physician provides guidelines and prescription for treatment with acute and chronic medications.

The hospital adheres to civil and religious protocols in issuing death certificates and handling cases of detainee fatalities. This adherence to protocol underscores the importance of respecting the dignity of deceased detainees.

> The hospital issues death certificates according to the same civil and religious protocols for the general community. If a prisoner passes away due to violence, the parents are informed and the physician investigates. The judiciary system comes with a decision. If a prisoner passes away, the body is handed over to parents according to normal and usual protocols.

However, challenges persist, including limited access to healthcare services due to the scarcity of referral hospitals and deficiencies in medical center assessment methods and first aid delivery expertise. These limitations create significant barriers to effective healthcare delivery.

> Detainees are not able to access health services the proper way because hospitals that are referral centers are very few. This lowers the chance to get treated the proper way. The situation also depends on the detainee's medical case and its urgency. When it comes to treatment of dangerous detainees or terrorists, the whole process takes place under strict supervision.

In discussion of gaps, many were highlighted as follows:

> There is no proper assessment method at the level of the medical center of the prison. There is also a gap in communication with the hospital and also in the process of transferring the detainee (which is not necessarily always taking place by ambulance). Also, there are no expert person in delivering proper first aid.

Chapter 5.2.5 Results from Self-administered questionnaires by prisoners

Statistical analysis was performed using Stata software version 13 for Windows. To effectively analyze the data, descriptive analysis was used to summarize the study variables and to check for out of range values. Frequencies and percentages were used to represent categorical variables. Furthermore, the normality of the age variable was assessed using the Shapiro-Wilk test, which yielded a significant result. Accordingly, the variable was categorized into 3 groups as per WHO recommendations to account for potential age-related differences in the study variables and this categorization allows for more accurate interpretation of the results. Participants aged 19 to 39 years were grouped under "young adults," individuals aged 40 to 59 were classified as "mid-age," and those aged 60 years and above were referred to as "older adults." To compare various demographics, $\chi 2$ test was used to assess the difference between age, gender, nationality and the main study variables mainly panel status, length of stay in prison, pre-existing medical conditions, treatment continuity, healthcare during prison, access to healthcare during prison stay, support services and health-related information provided in prison as well as satisfaction with healthcare and nutrition services.

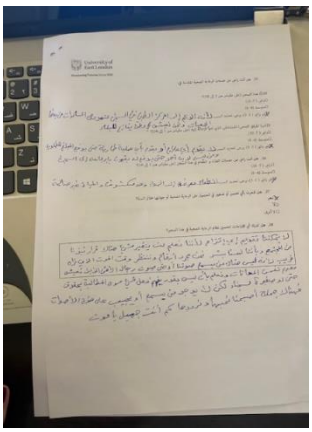

Figure 18:Self-administered questionnaire by prisoners - Sample 1 (Source: Yasmine Fakhry)

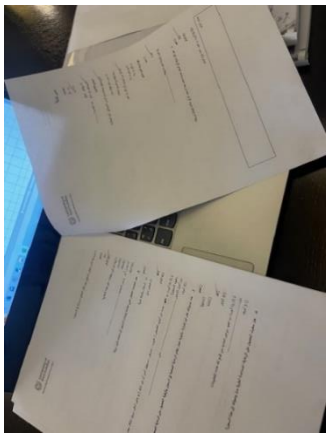

Figure 19:Self-administered questionnaire by prisoners - Sample 2 (Source:Yasmine Fakhry)

Chapter 5.2.5.1 Participants and Characteristics

A total of 291 participants were enrolled in the study. Characteristics and pre-existing medical history are presented in table 9 (page 143). The majority of the participants were Lebanese (65.20%), young adults (65.96%), males recruited from Roumieh prison (76.98%), were awaiting trial (74.67%) and had been in prison more than 1 year (74.62%). There was a significant difference between males and females in terms of panel status and length of stay in prison. Females were more likely to be awaiting trial (p= 0.001*)* and had been in prison for more than two weeks but less than a month (p= 0.005). Moreover, those who have received their sentence/convicted were more likely to be older adults compared to young adults (p= 0.045). There was no significant distinction in age concerning the length of time spent in prison (p= 0.090), nationality (p= 0.148), or across genders (p = 0.211). Similarly, there were no variations in nationality based on panel status (p = 0.392) or the duration of prison stay (p = 0.989).

In terms of health conditions, approximately one-quarter of the prisoners had pre-existing medical conditions before entering prison (23.44%). The most prevalent medical conditions were hypertension (14.75%), psychological conditions (14.75%), orthopedic fractures (9.84%), asthma and hypersensitivity (8.19%), allergies/eczema (8.19%), dyslipidemia and heart problems (8.19%), migraine/chronic headaches (6.55%), cancer (6.55%), neurological conditions (4.91%)

and diabetes (3.3%). Notably, only 17.86% of these individuals had health insurance coverage and 33.33% were able to continue their treatment in prison. **Among the treatment sources,** family (47.83%) and the prison clinic (28.26%) were the primary sources. Other reported sources of treatment included NGOs (10.87%), physicians/psychiatrists at mental health centers (8.70%), the Red Cross (2.17%), and UNICEF (2.17%). Additionally, there was no significant difference in terms of preexisting medical conditions based on nationality (p = 0.891) or between males and females (p= 0.183).

	N (%)
Age	
Young adults	155 (65.96%)
Mid-age	66 (28.09%)
Older adults	14 (5.96%)
Gender	
Male	224 (76.98%)
Female	67 (23.02%)
Nationality	
Lebanese	163 (65.20%)
Syrian	64 (25.6%)
Palestinian	8 (3.2%)
Egyptian	2 (0.8%)
Kenyan	2 (0.8%)
British	1 (0.4%)
Unspecified	9 (4.0%)
Panel Status	
Awaiting trial/under trial	168 (74.67%)
Sentenced/Convicted	57 (25.33%)
Length of Stay in Prison	
More than 2 weeks but less than a month	10 (5.08%)
More than 1 month but less than one year	40 (20.30%)
More than 1 year	147 (74.62%)
Medical Condition prior to prison entry	
Yes	64 (23.44%)
No	193 (70.70%)
Do not remember	16 (5.86%)

Treatment Continuity during prison Yes No	 21 (33.33%) 42 (66.67%)
Treatment Source Prison/prison clinic Family Other	 13 (28.26%) 22 (47.83%) 11 (23.91%)

Table 9:Characteristics and Pre-existing Medical History of participants (N=291)

Chapter 5.2.5.5 Healthcare during prison stay

Irrespective of their pre-existing medical history, half of the inmates reported undergoing a medical assessment upon entering the prison. This assessment was administered by various healthcare personnel, including nurses (30%), physicians (21%), lab technicians (4%), or security officers (2%). However, 35% of the participants were uncertain about the specific title of the personnel who conducted the examination. This evaluation took the form of a medical interview involving questions (59.04%), a physical examination (18.07%), or a combination of both (22.89%). Moreover, the timing of these assessments varied, occurring within either one week (35%), two weeks (21.25%), or one month (18.75%) following entry. Only 12.5% of individuals underwent their examination within three days after admission, while the same percentage underwent it anywhere from four months to one year later. Significantly, there was a notable gender difference in the likelihood of receiving a medical examination upon prison entry, with males exhibiting a higher likelihood than females ($p < 0.001$). However, no significant difference was noted based on nationality ($p = 0.217$).

Upon their arrival at the prison, 23.57% of individuals were informed about the functioning of the healthcare system within the facility. This information was conveyed through oral communication (79.55%), written instructions (4.55%), or a combination of both (15.91%). Interestingly, here was no disparity noted in this practice between male and female prisons ($p= 0.555$) or when considering differences based on nationality ($p = 0.138$). For those who did receive information, it was typically imparted by various sources, such as nurses (26%), security officers (18%), prison administration and/or the clinic (8%), fellow inmates (6%), or NGOs (4%). However, a significant portion of the participants (34.00%) were uncertain about the specific title of the individuals who provided this information.

When questioned about seeking medical care or assistance since their admission to prison, 28.84% of respondents indicated that they had done so. The primary reasons prompting them to seek medical attention included blood pressure concerns (11%), orthopedic issues (8%), infections (6%), gastrointestinal conditions encompassing reflux and hemorrhoids (5%), neurological disorders such as seizures (4%), psychological conditions (4%), vision problems (4%), eczema (4%), migraines (3%), scabies (3%), liver and spleen-related problems (3%), food allergies (2%), kidney problems (2%), cancer (2%), anemia (2%), dental issues (2%), ear, nose, and throat (ENT) concerns (2%), surgical interventions (2%), diabetes (1%), pancreas-related problems (1%), and urological conditions (1%). Furthermore, 32% of participants did not provide information regarding their condition. The timing of the last episode of the disease varied between ≤ 1 week (19.44%), 2 weeks (8.33%),1 – 3 months (30.56%), 4 – 9 months (8.33%), 1 - 2 years (19.44%), more than 2 years (13.90%). Regarding the process utilized to see the doctor/nurse, 60.15% of the participants were not aware/did not remember the process and 3.76% expressed dissatisfaction, stating that their attempts to seek medical help were either denied, rejected, or entailed prolonged waiting times. For instance, a Kenyan female prisoner aged 21 said: “They refused permission because of lack of money”. Another 25-year-old Lebanese prisoner expressed when asked about satisfaction with health services “there is insufficient healthcare”.

Chapter 5.2.5.3 Access to healthcare during prison stay

Among those who provided insight into the process, the responses centered around “submitting a request to the prison administration to see a doctor” (9.77%) or “visiting the prison clinic for lab tests and medication” (4.51%). This indicates a lack of awareness or accessibility regarding healthcare procedures among prisoners.

	N (%)
Sought medical care/assistance since prison arrival	
Yes	77 (28.84%)
No	168 (62.92%)
Do not remember	22 (8.24%)
Payment to access prison clinic or for medical consultation/procedure	
Yes	34 (12.32%)
No	228 (82.61%)
Do not remember	14 (5.07%)

Wait time to see Dr after request	
Same day	47 (20.09%)
2 – 5 days	38 (16.24%)
More than 5 days	57 (24.36%
Did not see a doctor or nurse	61 (26.07%)
Do not remember	30 (12.82%)
Permission refused to access prison clinic	
Yes	72 (26.67%)
No	182(67.41%)
Do not remember	16 (5.93%)
Nurse/Doctor Consultation location	
Prison clinic	229 (85.76%)
Inside the cell	9 (3.37%)
Prison yard	4 (1.50%)
Do not remember	13 (4.87%)
Other:	
Medical center	10 (3.75%)
Hospital	2 (0.75%)
Presence of individuals other than Dr/Nurse during consultation	
Yes	129 (49.43%)
No	107 (41.00%)
Do not remember	25 (9.58%)
Individuals present during consultations	
Security officer	50 (40%)
Other detainees	49 (39.2%)
Do not remember	6 (4.80%)
Other:	
Nurse	14 (70%)
Red cross	3 (15.00%)
Another Doctor	1 (5.00%)
Dentist	1 (5.00%)
NGO	1 (5.00%)
Length of the consultation	
Less than 10 minutes	120 (49.18%)
10 to 20 minutes	48 (19.67%)
More than 20 minutes	38 (15.57%)
Do not remember	38 (15.57%)
Source of Medications after consultations	
Prison clinic	135 (49.45%)
Prison clinic and family members	42 (15.38%)
Family	71 (26.01%)
Do not know	13 (4.76%)
Others:	
NGO	7 (2.56%)
NGO and donations	3 (1.10%)

NGO and red cross	2 (0.73%)
Individuals who provided the medications	
Doctor/Nurse	132 (52.18%)
Security Officer	41 (16.21%)
Detainee	14 (5.53%)
Do not remember	25 (9.88%)
Others:	
Family	31 (12.25%)
NGO	6 (2.37%)
Donations	4 (1.58%)
Duration to receive medications	
Same day	88 (33.59%)
2 -5 days	50 (19.08%)
More than 5 days	57 (21.76%)
Did not receive any medications	43 (16.41%)
Do not remember	24 (9.16%)
Health Emergency during prison stay involving self or others	
Yes	85 (31.84%)
Never had or witnessed an emergency	149 (55.81%)
Do not remember	33 (12.36%)
Referral to Hospital and/or specialist	
Yes	48 (18.11%)
No	212 (80.00%)
Do not know	5 (1.89%)

Table 10:Access to Medical Care/Assistance during prison stay

Hence, a 43-year-old Lebanese male prisoner wrote sarcastically: “Here no one responds to the other party if he requests something - The situation is catastrophic”.

Nonetheless, individuals necessitating hospitalization or further examination reported a distinct procedure. Initially, approval from relevant prison authorities is mandated, followed by a family member settling the hospital fees for any procedure, ensuring the inmate's discharge back to the prison (3.01%). This process highlights the significant role that family support plays in accessing healthcare for prisoners. When questioned about payments for access to the prison clinic or medical consultations/procedures, 12.32% acknowledged having made payments, with the majority (82.75%) specifying that these payments pertained primarily to medical consultations and procedures (53.57% of which occurred at the hospital). The payments ranged from 500,000 – 1,000,000 (20%), 1,000,001 – 3,000,000 (40%), 3,000,001 – 4,000,000 (13.3%) in LBP or 100 (20%) and 1000 (6.7%) in USD. This financial burden can exacerbate the already challenging circumstances of imprisonment. The 21-year-old female Kenyan prisoner commented: “I paid

100$ to hospital to access care". Another prisoner, a 21-year-old Lebanese male said:"I paid to access healthcare in the form of a bag of Nescafe". A female prisoner from Syria mentioned in her questionnaire "I paid 600 000 LBP [equivalent to nearly USD 6] for obstetrician/gynecologist consultation".

The time individuals had to wait before seeing a doctor after requesting medical assistance varied. Some reported being seen on the same day (20.09%), while others had to wait for 2 to 5 days (16.24%), and a significant portion waited for more than 5 days (24.36%). These waiting times reflect the systemic delays often experienced within prison healthcare systems. Notably, the majority of those who requested and received medical assistance experienced delays of more than 5 days. This pattern did not significantly differ between the two prisons (p= 0.2027), across age groups (p= 0.915), or among individuals of different nationalities (p= 0.938). However, 26.07% of respondents indicated that they did not receive medical attention or consultation at all, and 26.67% reported being denied permission to access the prison clinic center. Such denials further illustrate the barriers to healthcare faced by prisoners. It's important to note that males were more likely to face refusal when trying to access the clinic center compared to females (p= 0.011). Age and nationality did not appear to significantly influence the likelihood of refusal (p= 0.231 and p= 0.924, respectively). Regarding the individuals responsible for denying access to medical care, 62.07% of the respondents stated that they did not know the title or position of the person who denied their request. Others mentioned the security officer in charge of the clinic or medical center (17.24%), and some cited the unavailability of an on-call doctor (10.34%). This lack of clarity surrounding the responsible parties adds another layer of frustration for inmates seeking care. Within the same context, a 38-year-old female Syrian prisoner wrote: "I had to wait until I was able to secure the cost of tests".

Concerning the location of doctor and nurse consultations, the majority of these consultations primarily occurred in the prison clinic (85.76%) and consisted of questions and medical interviews (44.86%) that typically lasted less than 10 minutes (49.18%). The brevity of these consultations raises questions about the quality of care provided. The patterns of practice were consistent between the two prisons, and there were no notable differences observed based on nationality or age (p= 0.4014, p= 0.607, p= 0.361 for location; p= 0.273, p= 0.131, p= 0.167 for type of consultation and p= 0.3072, p= 0.419, p= 0.221 for length of consultations, respectively). Nearly

half of the respondents (49.43%) indicated that their consultations involved individuals besides the nurse or doctor. This involvement of additional individuals may affect the privacy and comfort of the consultations. There was a notable gender-based disparity in terms of privacy during these consultations. Specifically, females were more likely to have a private consultation with the nurse or doctor compared to males, and this difference was statistically significant ($p < 0.001$). For male consultations, the main individuals reported as present were security officers (36.43%) and other detainees (35.72%), while for female consultations, nurses (40.00%) were more commonly present. This difference underscores the varying experiences of male and female prisoners in accessing healthcare. No difference was noted based on age ($p= 0.846$) and nationality ($p= 0.054$).

The primary provider of prescribed medications after the consultations was mainly the prison clinic, accounting for 49.45% of cases. This reliance on the prison clinic suggests a lack of alternative sources for medications. This trend was particularly noticeable in the male prison and among non-Lebanese inmates. In contrast, in the female prison, the primary sources were family members, or a combination of family members and the prison clinic, and this difference was statistically significant ($p= 0.005$). The reliance on family support for medications in the female prison highlights gender differences in healthcare access. Lebanese prisoners, on the other hand, were more inclined to obtain their medications through a combination of the prison clinic and family members, as opposed to non-Lebanese inmates ($p= 0.001$). No difference was noted based on age ($p= 0.078$). The individuals responsible for distributing the medications were primarily doctors and nurses, making up 52.17% of the cases. This distribution indicates a level of involvement from healthcare professionals in medication management. This practice was consistent in both prisons, but with the addition of security officers in the male prison and family members in the female prison, respectively ($p= 0.006$). No variations were observed based on age ($p= 0.508$) or nationality ($p= 0.767$). Regarding the time it took to receive medications, there were differences between the two prisons. Males were more likely to receive their medications on the same day, whereas females often had to wait more than 5 days ($p= 0.047$). Such delays can have serious implications for the health of female prisoners. However, no significant differences were noted based on age ($p= 0.722$) or nationality ($p= 0.1059$). In this context, the Kenyan female prisoner shared the following “Prison clinic provides the medications, but not all medicines…Panadol only”. Another prisoner, who is 32-year-old British male, wrote: “There is

no healthcare and medication". Also, a 43-year-old Lebanese male prisoner mentioned: "There is shortage in medications". Another 21-year-old Lebanese male prisoner commented: "There is negligence in terms of medications". However, a 29-year-old Syrian prisoner said clearly:" When we get sick, we go to the prison clinic and we receive the treatment, it is available from the clinic or through the family". This contrast in experiences suggests a disparity in the healthcare system's effectiveness. A Kenya female prisoner sadly wrote:" My breast even thou I saw the prison nurse no help at all am poor no medication".

When questioned about personal experiences or witnessing health emergencies during their time in prison, 31.84% of respondents reported they were either directly involved or observed such incidents. In contrast, a substantial majority (34.33%) couldn't recall the specific details of the process. Among those who did provide insights, the most frequently reported scenarios included fainting or loss of consciousness (8.95%), seizures or epilepsy, some of which necessitated hospitalization within hours (10.44%), injuries to the hands and feet that required hospital admission for treatment (8.95%), experiencing a nervous breakdown (5.97%), instances of death (5.97%), hypertensive crises leading to hospital transfers (4.48%), abdominal surgeries (2.99%) and kidney-related disorders (2.99%). Interestingly, no differences were noted with regards to emergencies based on nationality (p= 0.373), gender (p= 0.435), or age (p= 0.674).

Answering this question, a 43-year-old Syrian male inmate said: "I cannot describe what actually [happened] because we live in a forgotten place". This sentiment was echoed by a 35-year-old Lebanese female prisoner mentioned:

> One urgent case happened in front of me- it was my friend she was going through a stroke, and after four hours they took her to hospital.

Regarding referral to a hospital/specialist, 18.11% of respondents indicated that they had received such referrals while in prison. However, the same 43-year-old Syrian prisoner said "I have been waiting for the past year because I cannot afford paying the expenses". Similarly, another prisoner, a Lebanese male prisoner wrote:

> An emergency happened to me when my blood pressure increased to 21/19 and I was about to have a myocardial infarction, and they asked me to pay in order to transfer me to the hospital.

In a related account, a 38-year-old Syrian female prisoner said: “Concerning the referral, I had to wait until I was able to secure the cost of tests”.

Chapter 5.2.5.4 Detainees with conditions and support services provided

Prisoners from both facilities reported that nearly half of the inmates (48.19%) were dealing with drug and/or alcohol addiction, 41.20% had experienced or were currently dealing with mental health issues, and 23.26% had disabilities.

	N (%)
Detainees addicted to drugs and/or alcohol	
Yes	133 (48.19%)
No	143 (51.81%)
Support Sought for drug and/alcohol addiction	
Yes	38 (30.89%)
No	50 (40.65%)
Do not know	35 (28.46%)
Drug and/or alcohol addiction support	
Moral support by family and friends	4 (13.33%)
NGO	3 (10.00%)
Psychological aid	2 (6.67%)
Neurological medications	19 (63.33%)
Prison doctor	2 (6.67%)
Detainees with mental health issues	
Yes	110 (41.20%)
No	157 (58.80%)
Support Sought for mental health issues	
Yes	41 (39.05%)
No	47 (44.76%)
Do not know	17 (16.19%)
Mental Illness support	
Psychologists/psychotherapists	7 (20.00%)
Moral support by family and friends	2 (5.71%)
Medications	6 (14.28%)
NGO	12 (34.29%)
Isolation in a separate building on treatment	7 (20.00%)
Detainees with Tuberculosis (TB) and/or living with HIV/AIDs	
Yes TB	33 (12.69%)
Yes HIV/AIDs	6 (2.31%)
No TB or HIV/AIDs	221 (85.00%)
Detainees with disabilities	
Yes	60 (23.26%)
No	198 (76.74%)

Support Sought for disabilities	
Yes	22 (37.93%)
No	23 (39.66%)
Do not know	13 (22.41%)
Detainees with disabilities support	
Help from fellow prisoners	7 (50.00%)
NGO	4 (28.57%)
Moral support	2 (14.28%)
Prosthetic foot	1 (7.14%)

Table 11:Type of Support provided to Detainees with Conditions

Among those struggling with addiction, 30.89% were receiving medical assistance for their condition, while 39.05% were getting mental health support and 37.93% were obtaining aid for their disabilities. Neurological medications were the most common type of support provided to addicted inmates, with 63.33% receiving them. In contrast, individuals with mental health issues were mainly supported by NGOs at 34.29%, and psychologists/psychotherapists at 20.00%. For inmates with disabilities, the prevalent support came from fellow prisoners (50.00%). A 21-year-old Lebanese male prisoner said “Prisoners with disabilities do not receive support at all”.

A detailed description of the other support modalities can be found in table 3. Furthermore, there were no notable variations observed based on age, gender, or nationality (p= 0.831, p= 0.068, p= 0.720 for drug and/or alcohol addiction; p= 0.718, p= 0.118, p= 0.582 for mental illness and p= 0.065, p= 0.744, p= 0.820 for disabilities, respectively).

Chapter 5.2.5.5 Health-related Information

Regarding health conditions, inmates revealed that 12.69% of detainees had been affected by tuberculosis, and 2.31% were living with HIV/AIDS. In light of this, inmates were asked whether they had ever received information about tuberculosis and HIV/AIDS and were requested to describe the protective measures they were advised to take. The findings showed that 24.34% of inmates reported receiving information about tuberculosis, while 17.52% reported receiving information about HIV/AIDS.

	N (%)

Information and/or instructions about Tuberculosis	
Yes	65 (24.34%)
No	163 (61.05%)
Do not remember	39 (14.61%)
Description of process to protect him/herself from Tuberculosis	
Personal hygiene	22 (23.66%)
Personal hygiene and adequate room ventilation	21 (22.58%)
Personal hygiene, social distancing and wearing masks	14 (15.06%)
Social distancing and wearing masks	12 (12.90%)
Using only personal belongings and avoid sharing razor blades and toothbrushes	7 (7.54%)
There is no way to protect ourselves due to high number of prisoners	5 (5.38%)
Vaccination	3 (3.23%)
Eating healthy food, exercising and avoid smoke	3 (3.23%)
Avoiding contact with blood from injuries/wounds and blood transfusions	2 (2.15%)
Information and/or instructions about HIV/AIDS	
Yes	41 (17.52%)
No	161 (68.80%)
Do not remember	32 (13.68%)
Description of process to protect him/herself from HIV/AIDS	
Personal hygiene	16 (34.04%)
Personal hygiene, social distancing and wearing masks	9 (19.15%)
Using only personal belongings and avoid sharing razor blades and toothbrushes	9 (19.15%)
Safe sexual practices	6 (12.77%)
Avoid needle sharing, sharing razor blades and blood contact with infected personnel	4 (8.52%)
Source of Health-related Information/instructions	
NGOs	40 (30.07%)
Nurse	74 (55.64%)
Security officer/prison administration	9 (6.77%)
Red Cross	6 (4.51%)
Doctor	4 (3.01%)
Dental Care Access	
Yes	53 (19.41%)
No	182 (66.67%)
Do not know	38 (13.92%)
Treatment Availability	
Tooth removal	17 (53.13%)
Clinic outside prison	8 (25.00%)
Medications	3 (9.38%)
Dentist in prison	4 (12.50%)
Source of dentures	
Prison clinic	14 (12.61%)
Family	46 (41.44%)
Do not know	41 (36.95%)
Others:	
Donor	5 (4.50%)
NGO	5 (4.50%)

Table 12:Health-related Information and Dental Care Services

Among those who provided details about the protective measures for TB and HIV/AIDS, the responses were categorized as outlined in Table 13. Significant differences were noted in terms of information provision in prison, particularly for HIV/AIDS, but not for tuberculosis. Notably, females were more likely to report receiving information about HIV/AIDS compared to males ($p < 0.001$). However, there were no significant differences based on age ($p = 0.480$ and $p = 0.589$) or nationality ($p = 0.082$ and $p = 0.886$) for the provision of information regarding HIV/AIDS and tuberculosis, respectively. Furthermore, 10.10% of inmates reported receiving health information on additional topics such as COVID-19, cholera, diabetes, scabies, and eczema. The information/instructions were primarily provided by nurses (55.64%) and NGOs (30.07%).

When discussing dental care, 19.41% indicated they had access to dental care within the prison, primarily for tooth extraction (53.13%). In terms of dentures, the primary source is family members, accounting for 41.44%. Notably, there were no disparities observed in terms of access to dental services between the two prisons ($p= 0.098$), nationality ($p= 0.159$), or age groups ($p= 0.495$). For instance, a 21-year-old Lebanese male inmate revealed that "You receive whatever dental care you want if you pay".

Chapter 5.2.5.6 Satisfaction with Healthcare and Food Services

Prisoners were asked to rate their satisfaction with the healthcare services offered at both the clinic and the referred health facility or hospital. The results, presented in table 13, revealed that the majority of prisoners expressed dissatisfaction with the healthcare services provided at the clinic (71.81%) and the referral facility or hospital (66.12%).

	N (%)
Healthcare services	
Satisfied	23 (8.88%)
Average	50 (19.31%)
Not satisfied	186 (71.81%)

Reasons	
Negligence	48 (35.56%)
Lack of care	38 (28.15%)
Poor health services	17 (12.59%)
Lack of specialist doctor/staff	10 (7.41%)
Lack of treatment availability except Panadol	13 (9.63%)
Economic situation	2 (1.48%)
Bad prison conditions	3 (2.22%)
Others	4 (2.96%)
Referral Health facility/hospital	
Satisfied	24 (9.92%)
Average	58 (23.97%)
Not satisfied	160 (66.12%)
Reasons	
Negligence	48 (45.71%)
Lack of care	37 (35.24%)
Lack of hospital access	6 (5.71%)
Bad conditions	3 (2.86%)
Lack of treatment/treatment on own expenses	7 (6.68%)
Shortage of physicians and essential services	2 (1.90%)
Others	2 (1.90%)
Food and Nutrition Services	
Satisfied	10 (3.92%)
Average	40 (15.69%)
Not satisfied	205 (80.39%)
Reasons	
Bad quality	72 (52.17%)
Negligence	24 (17.39%)
Lack of care	15 (10.87%)

Insufficient quantities	16 (11.59%)
Unhealthy food choices	10 (7.25%)
Can not buy food from outside prison	1 (0.72%)
Improvement or worsening of access to/ quality of healthcare during the year	
Yes	57 (29.53%)
No	90 (46.63%)
Do not know	46 (23.83%)
Suggestions for improving the healthcare system	
Respect our human rights and provide care for us	71 (50.71%)
Coverage for all types of medications and free access to organized healthcare facilities	23 (16.42%)
Availability of specialized doctors and medications the prison clinic	21 (15%)
Better food quality and quantity	10 (7.14%)
New prison to reduce crowdedness	4 (2.85%)
Do not know	11 (7.85%)

Table 13:Healthcare/Food Satisfaction and Suggestions for improvement

The primary reasons for this dissatisfaction included perceived negligence (35.56%), insufficient care (28.15%), limited availability of treatments (9.63%), and a shortage of specialist doctors or staff (7.41%) at the clinic. Similar concerns were reported for the referral health facility or hospital, along with additional issues like the absence of certain treatments or the need to cover treatment expenses (6.68%), as well as challenges related to accessing the hospital (5.71%). There was a significant difference between males and females in their satisfaction ratings for healthcare services in the clinic and the referred facility (p=0.004 and p= 0.013) respectively. In particular, males tended to express more dissatisfaction with the services in the clinic compared to females (76.26% versus 57.38%). Conversely, females tended to be more satisfied with the referral to the referred health facility compared to males (19.67% versus 6.63%). However, there were no significant variations in the ratings based on nationality (p=0.756 and p=0.892), length of stay in prison (p= 0.907 and p= 0.736), panel status (p= 0.062 and p= 0.322), and age (p=0.907 and p=0.146) for healthcare services provided in both the clinic and the referred health facility or hospital, respectively.

One 38-year-old Lebanese male prisoner said “there is no care”. Another 35-year-old Lebanese male prisoner highlighted his dissatisfaction by*:* “There is no medication nor physicians”. A 42-year-old Palestinian male prisoner said*:* “There is no healthcare, there is mistreatment”. Similarly, a 47-year-old male Lebanese prisoner said: “Same issue as the general governmental hospital cannot be compared at all with known standards”.

One female respondent From Kenya said “If my health problem persists, I pray. Only God [can help]”. A 21-year-old Lebanese male prisoner answered “There is no health services at origin”.

Moreover, most of the prisoners were dissatisfied with the food and nutrition services provided within the prison (80.39%), primarily attributing their discontent to concerns about the quality of the food (52.17%). A 38-year-old Lebanese male prisoner said “Food is not healthy” whereas another 21-year-old Lebanese prisoner argued “Garbage is cleaner than the food served”. In addition, another 53-year-old Lebanese male respondent also highlighted issues concerning the food hygiene “the food is not enough and is not hygienic”.

Reflecting on the diversity of opinions, another 27-year-old female respondent said “the food that the government provides doesn't suit everyone” while another female prisoner of the same age remarked “It has a bad smell and cannot be eaten”. Further illustrating the problem, a 42-year-old Palestinian male prisoner said: “There is no enough food and it is very bad”. n a stark evaluation, a Lebanese male prisoner aged 64 years commented: “The food rating is 1/10”. Additionally, a 42-year-old Syrian male prisoner noted: “Little hygiene in the way food is prepared/cooked”. Echoing similar concerns, a 56-year-old male Lebanese prisoner stated: “Little food, and when available it is bad”. Another 34-year-old male Syrian prisoner criticized the situation by saying: “There is no quality”. In line with these grievances, a 47-year-old Lebanese male said:” The food is no good, food segregation and food transfer are not hygienic/healthy”. Finally, a 50-year-old Lebanese prisoner expressed his discontent by stating: “Dissatisfied due to absence of fulfillment of prerequisites of human rights”. Adding to this grim picture, a 35-year-old female Lebanese prisoner said: “One meal only is provided during the day and sometimes it is not enough for the prisoners”.

When prisoners were asked whether they noticed any improvements or deterioration in their access to or the quality of healthcare over the past year, 46.63% of the responses indicated a negative

trend. In light of these findings, prisoners offered suggestions to enhance healthcare within the prison. These included providing coverage for all types of medications and ensuring free access to organized healthcare facilities (16.42%), as well as ensuring the availability of specialized doctors and medications within the prison clinic (15%).

Interestingly, there was a significant difference in the ratings regarding the observation of improvement or deterioration in access to or quality of healthcare based on nationality (p= 0.021), but not for the food and nutrition services (p= 0.137). Specifically, non-Lebanese respondents were more likely to answer affirmatively to this question compared to Lebanese respondents (46.00% versus 24.55%). No significant differences were noted based on age (p=0.588 and p=0.143), length of stay in prison (p= 0.950 and p= 0.168), panel status (p= 0.313 and p= 0.738), or gender (p=0.164 and p= 0.191) for the food and nutrition services and the responses to the improvement or deterioration question, respectively.

Turning to the qualitative aspect of the responses, when it comes to subjective recommendations for improvement, answers were quite rigid coming from prisoners from both gender and from different nationalities, focusing mainly on improving health services, making physicians available on duty all the time and providing medications for free.

To illustrate these recommendations, the following selection comes from prisoners from both gender and from five nationalities. A 43-year-old Syrian male prisoner commented:

> We cannot propose any recommendations because nothing will change- there is a decision to reject us from the society-we are just numbers we are not human beings-we are waiting for our death time that we see it soon because no one is hearing our voice or even security officers who are going through the same misery-There is a saying that we now like to use it very much here: Death, how beautiful you are.

Another 43-year-old Lebanese male prisoner answered:

> Support the medical center of RCP first with qualified physicians and provide the medications, because many medications for specific health conditions are not available and this led to a crisis inside the prison and thank you.

A 37-year-old Syrian male prisoner recommended the following:

> There should be a general practitioner all the time inside the prison and the provision of the needed medication for every disease or health situation and care should be done by the physician directly and there should be a dentist all the time also as most of the prisoners cannot afford to pay to fix their teeth on their own.

A 21-year-old Lebanese male prisoner said: “Fully shut down prison and thank you”. A 38-year-old Lebanese male prisoner said:” There should be detailed care/follow up for each patient by the physicians”. A 33-year-old Lebanese prisoner answered: “Take care of us like a human being who is entitled of rights”.

Expanding on the need for systemic change, a 35-year-old Lebanese female prisoner said*:*

> The system of healthcare provision in this prison and all prisons in the country need restructuring, a new building and the provision of medications for all.

Furthermore, a 37-year-old male Syrian prisoner said:

> There should be a general practitioner all the time inside the prison and the provision of the needed medication for every disease or health situation and care should be done by the physician directly and there should be a dentist all the time also as most of the prisoners cannot afford to pay to fix their teeth on their own.

Highlighting the urgency of the situation, a 43-year-old male prisoner said:

> Support the medical center of RCP first with qualified physicians + and provide the medications because many medications for specific health conditions are not available and this led to a crisis inside the prison and thank you.

A 42-year-old male prisoner further reiterated the need for better resources, saying: “Provision of the medication, a physician on duty, appropriate nutrition”. Moreover, a 50-year-old male Lebanese prisoner said:

> There should be specialist physicians like a cardiologist, a specialist for the bones and a specialist for ENT.

In agreement, a 47-year-old male Lebanese prisoner said*:*

> All time availability of a specialist including cardiologist and experienced nurses and improving the disinfection.

Reflecting a shared sentiment, a 34-year-old Syrian male prisoner said: “To take care of us, for us to feel that there is someone who cares about us”. Additionally, a 38-year-old Lebanese prisoner said*:* “To follow up on each patient in a very concise way by the physician”. A 56-year-old male Lebanese prisoner said:

> Presence of a physician on duty, make available medications and do what is needed for the prisoners who do not have someone to support them to sit for a surgery.

Moreover, 42-year-old male prisoner further reiterated the need for better resources, saying: “Provision of medications for all medical conditions and reopening of the dental clinic”. Finally, a 64-year-old male Lebanese prisoner said: “Have physicians available and in a consistent way”.

It is important to mention that nearly 15 male prisoners from Lebanese, Syrian and Palestinian nationalities answered nearly the same answer for improvement “Take care of us like a human being who is entitled of rights”. This act sounds like a collective decision to make their voice be heard outside the walls of the prison.

Chapter 5.2.5.7 Women’s Health Services in Prison

Most female respondents indicated a lack of access to health services or support during pregnancy or post-delivery (50.98%). In terms of child services, when asked about access to child services, only 9.52% reported having such access. Regarding service providers in prison, the most common response was a combination of the prison, family, and NGOs, accounting for 13.64%. For instance, one Lebanese female prisoner answered “I am provided with menstrual pads and a pain killer for menstruation (after delivery)”.

	N (%)
Access to women's health services	
Yes	6 (11.76%)
No	26 (50.98%)
Do not know	19 (37.25%)

Support received during pregnancy and after delivery	
Yes	6 (11.76%)
No	26 (50.98%)
Do not know	19 (37.25%)
Access to child needs	
Yes	6 (9.52%)
No	6 (9.52%)
N/A	51 (80.95%)
Who provides services	
Prison	2 (3.03%)
Prison, Family and NGOs	9 (13.64%)
Do not know	3 (4.55%)
N/A	52 (78.79%)

Table 14:Services in Women's Prison

Chapter 5.3 Conclusion

By triangulating data from diverse sources, this chapter paints a multifaceted portrait of the Lebanese prison healthcare system. The methodologies employed—insightful interviews, revealing questionnaires, and meticulous document analysis—collectively unveil the realities, challenges, and potential solutions surrounding healthcare access for incarcerated individuals.

The insights gleaned from interviews shed light on the state of healthcare within Lebanese prisons. Notably, the existing legal framework governing healthcare traces back to 1949, rendering it outdated. However, efforts are in progress to modernize the system, incorporating electronic medical records and aligning with the national health strategy. In this context, partnerships with governmental bodies such as MoPH, international organizations like WHO, and NGOs play an essential role in bolstering support. Noteworthy strengths mentioned by prison authorities and health authorities at both local and central levels are the robust referral networks, effective emergency management, and communicable disease control. However, the system suffers from several weaknesses including outdated regulations, resource constraints, medication shortages, and financial limitations including delayed payment to referral center and inability to offer competitive

salaries to prison's health care. Proposed solutions by the interviewees encompass seeking donations, leveraging resources from other agencies, and prioritizing preventive measures. However, ethical concerns loom over consultations conducted in the presence of guards and the sharing of medical information with the Department of Public Prosecution, both of which breach medical confidentiality protocols. Thus, these narratives collectively underscore the multifaceted challenges and potential avenues for reform within the healthcare system for prisoners in Lebanese prisons.

Further corroborating these insights, questionnaires from healthcare providers highlight limitations in outdoor space, hygiene, and medical data confidentiality. Conversely, strengths include proper management of urgent cases and access to medications for communicable diseases. Nevertheless, staff shortages pose a crucial challenge, attributed to low salaries and tough working conditions.

Additionally, data from central pharmacy officer questionnaire revealed that medication supply is made under MoPH supervision, but shortages occur due to the current crisis. Interestingly, prisoners have priority access to medications compared to ISF personnel.

Moreover, the questionnaire filled by the physician representing the referral hospital revealed that medical screenings upon admission to Lebanese prisons are limited, overlooking assessments for drug/alcohol addiction and mental health issues, with women detainees lacking specialized screenings. This raises critical concerns about healthcare access and the role of security guards, which needs improvement. Information on healthcare access and the role of security guards needs improvement. Despite guarantees of healthcare access for prisoners, challenges persist. On a positive note, strengths include adherence to human rights agreements, a referral system to a dedicated hospital for urgent cases, and meticulous medication management. In contrast, weaknesses encompass limited medical resources, restricted specialist access, communication inefficiencies, and a lack of emergency expertise within prisons. These issues highlight areas needing improvement for better healthcare provision in Lebanese prisons.

A comprehensive statistical analysis was done based on data sourced from self-administered questionnaires by prisoners. To facilitate this analysis, the study utilized Stata software version 13 for Windows to explore various facets of healthcare within the prison context. Descriptive analysis was employed to summarize study variables, and meticulous checks for out-of-range values were

conducted. To better understand participant demographics, categorical variables were represented using frequencies and percentages, providing a detailed overview of the characteristics and healthcare experiences of the 291 participants enrolled in the study. In addressing age-related differences in the study variables, the age variable underwent categorization into three groups based on WHO recommendations—namely, "young adults," "mid-age," and "older adults." The utilization of the Shapiro-Wilk test assessed the normality of the age variable, leading to this categorization to facilitate accurate interpretation of results. Furthermore, the statistical tests, particularly the $\chi 2$ test, were instrumental in assessing differences among variables such as age, gender, nationality, and various aspects of healthcare experiences. The analysis delved into key areas, including panel status, length of stay in prison, pre-existing medical conditions, treatment continuity, healthcare access and information provision within the prison, as well as overall satisfaction with healthcare services. Notably, the study revealed insightful findings regarding the characteristics of participants, with a majority being Lebanese, young adults, male, awaiting trial, and having a prison tenure of over a year. Moreover, significant gender-based disparities were noted in panel status and length of stay, emphasizing the importance of considering these factors in the analysis.

Moreover, detailed insights into pre-existing medical conditions, healthcare utilization, and the challenges faced by prisoners in seeking medical assistance were elucidated. This analysis provided a valuable understanding of the prevalence of medical conditions, treatment continuity, and the various sources of healthcare within the prison environment. Healthcare during prison stay was thoroughly examined, encompassing medical assessments upon entry, information dissemination about healthcare systems, and the complexities involved in seeking medical care. Importantly, notable gender differences were identified, particularly in the likelihood of receiving a medical examination upon entry, shedding light on potential disparities in healthcare access.

In addition to these findings, the study also explored access to healthcare, including the process of seeking medical care, payments involved, waiting times, and reasons for denial. It also investigated the locations and privacy of doctor and nurse consultations, sources of prescribed medications, and satisfaction with healthcare services. Gender-based variations were evident in these aspects, underscoring the need for gender-sensitive healthcare provisions within the prison system.

Furthermore, insights into detainees with specific conditions and the support services provided, as well as health-related information dissemination, painted a comprehensive picture of the multifaceted healthcare landscape within prisons. Participants expressed dissatisfaction with healthcare services, citing negligence, insufficient care, and limited treatment availability as primary concerns. This dissatisfaction extended to food and nutrition services, highlighting the need for improvements.

The statistical study concluded with a focus on healthcare within women's prisons, unveiling challenges related to access to health services during pregnancy, post-delivery, and child services.

Overall, the accumulated collected data from statistics, prison law, interviews and questionnaires reveal a complex picture of the prison healthcare system in Lebanon. This narrative has uncovered not only the dynamics of food provided, the perception and experiences of key health officers but also the bottlenecks faced by prisoners in seeking medical care and nutrition. Moreover, the gender-based shades in healthcare access, the intricacies of medical assessments upon entry, and the multifaceted process of seeking assistance are threads that weave into a complex system of healthcare within prison walls.

While commendable efforts are being made to improve the situation, significant challenges remain regarding overpopulation, resource limitations, outdated regulations, and ethical concerns. Addressing these issues through comprehensive and collaborative efforts is crucial to uphold the human rights of prisoners and ensure they receive adequate healthcare services.

As I transition into the next discussion chapter, the rich findings serve as a compelling backdrop for a deeper exploration of the underlying dynamics and sharp answers to the research questions.

The next chapter will include interpretation of the results along with comparison with existing literature, some theoretical implications, practical implications, methodological reflections, alternative explanations, significance of findings, strengths, limitations and future directions.

CHAPTER 6: DISCUSSION OF FINDINGS

This current chapter discusses and reflects on findings of the study that investigates how effectively does the prison healthcare system in Lebanon meets international human rights standards, addresses the diverse needs of its prisoner population (including considerations of human dignity, physical, mental, and social health), and ensures equitable access for vulnerable groups, while considering potential shortcomings and opportunities for improvement. To achieve this, I have gone through articles from Lebanese prison law, a sample of medical record of prisoners, samples of RCP diet, self-administered questionnaires by officers, a referral physician and 291 prisoners, as well as interviewing two key officers overseeing the health system in prisons. Through this process, I have developed an understanding of the main themes that demonstrate the current nutrition and health situation in Lebanese prisons vis-à-vis human rights and international standards.

Hence, this chapter is the platform for an interdisciplinary dialogue—one that goes beyond the boundaries of documents, interviews, questionnaires and statistical analysis and embraces insights from sociology, human rights, ethics, and public health and directly tackle the research questions. In particular, I will navigate the ethical considerations surrounding food provision and healthcare in prisons, explore the systemic challenges that give rise to disparities, and envisage a future where nutrition and healthcare within the prison system in Lebanon is synonymous with human rights dignity, equity, and compassion.

Along with presenting the relevant discussions and analysis, this chapter also includes reflections on the encountered issues at Lebanese prisons and implications for the current situation of health and nutrition in Lebanese prisons from a human rights' angle. Moreover, this chapter will also serve as a call to action. In essence, it is an invitation to engage in a discourse that extends beyond the towers of research institutions and resonates with policymakers, practitioners, and advocates.

Chapter 6. 1 Legislation, law and policies

Lebanon's prison law has a healthcare policy that includes regular checkups and medical care for prisoners. The law also has a nutrition policy that ensures prisoners have access to food. Overall, these policies reflect some consideration for prisoners' basic human rights and dignity.

Furthermore, examining the overall Lebanese prison legislation and, more specifically, the provisions related to health and nutrition offers a fundamental grasp of the legal framework that influences the factors determining health and nutrition in the prison environment. This examination not only helps identify areas where legal provisions align with or deviate from international standards, but it also contributes valuable insights for advocacy, policy reform, and improvements in the overall well-being of incarcerated individuals.

Unfortunately, findings from this research indicate that numerous articles within Lebanese prison law are either not enforced or only partially implemented. Crucially, provisions requiring significant human or financial resources for execution face heightened risk due to the ongoing financial crisis and limitations in mobilizable resources. As a result, despite efforts by the Lebanese government and its local and international partners, the current prison policies and practices in Lebanon regarding food and healthcare access do not properly align with international human rights conventions and other relevant standards. Consequently, the current situation negatively impacts the fulfillment of fundamental human rights and the upholding of human dignity within the prison system.

Moreover, the current prison health system in Lebanon also fails to properly address the specific physical, mental, and social health needs of its prisoner population, beyond just meeting minimum international standards.

Upon thorough examination, I could say that there is a lack of consideration for extenuating circumstances. The law doesn't account for how crises like COVID-19 or economic hardship can impact prisoners' well-being and rehabilitation potential. Additionally, overcrowding due to economic strain on the justice system can worsen health conditions and hinder access to proper healthcare, especially during pandemics. Furthermore, the Lebanese prison law encompasses inflexibility in response to crisis. The law lacks mechanisms to temporarily release low-risk inmates during crises to alleviate overcrowding and protect vulnerable populations.

This inflexibility, therefore, can exacerbate existing problems within the prison system and hinder its ability to respond effectively to emergencies. In contrast, the Lebanese government released nearly 600 prisoners in pre-trial stage as an attempt to relieve overcrowding during the pandemic (Amnesty International, 2020). This current status raises a potential conflict with international standards, that often advocate for considering extenuating circumstances when making decisions about incarceration.

Moreover, the lack of provisions for exceptional circumstances might raise concerns about Lebanon's compliance with international human rights standards regarding humane treatment of prisoners including UDHR, NMR and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Furthermore, the law doesn't address the specific needs and potential vulnerabilities of prisoners during potential conflict situations, such as the possibility of escalating conflict with Israel. This lack of preparation could endanger the lives and well-being of prisoners in case of attacks or disruptions to essential services. In fact, the current conflict in south Lebanon further exacerbates these risks. Prisons in the area such as prisons of Nabatieh, Marjeyoun, Tebnin and Bent Jbeil are located in close proximity to military targets, making them vulnerable to shelling or other attacks. Thus, in case of escalation of conflict to the areas where the prisons are located, I wonder to what extent would the authorities be able to evacuate the prisoners and have available the needed vehicles for transport and find accommodation in other prisoners while taking into consideration the acceptable occupancy rate. Moreover, disruptions to essential services, such as water and electricity supplies, could also have a devastating impact on prisoners' health and well-being. Additionally, overcrowding and poor sanitation in prisons could create ideal conditions for the spread of disease in the aftermath of an attack.

Chapter 6.1.1 Nutrition Policy

The nutrition policy, consisting of seven articles, governs the supply of food in terms of acquisition, preparation, and menu planning, allocating food groups on a weekly basis. In addition to its logistical aspects, it implicitly recognizes the right of prisoners to food provision, ensuring they are not subjected to hunger, as emphasized in various conventions such as the UDHR, NMR, and SDGs. However, this recognition is not comprehensive, as it does not address issues of equality

and nondiscrimination among prisoners regarding access to food. For instance, there is no explicit mention in any article of the policy about the right of prisoner to access food on equality basis between prisoners and without any discrimination on the basis of nationality, race and sexual orientation.

Moreover, the nutrition policy does not mention the notion of calories, energy needs or other terms that refer to needs and meals, thus it neglects to consider prisoners' caloric needs and the distribution of food groups in three meals per day, a globally recognized practice (Mahan, 2016). Furthermore, it also fails to emphasize the importance of menu setting by a qualified professional like a nutritionist, dietitian, or physician, leaving this responsibility to the kitchen chief. However, there's uncertainty about whether the chief has received training in this regard.

In addition, I can note absence of food safety guidelines that are crucial precursors to ensure food security and wellness of prisoners.

Chapter 6.1.2 Health Policy

The Lebanese prison health policy includes positive elements in line with the NMR and WHO guide. Nevertheless, it could benefit from incorporating provisions on confidentiality, mental health, substance abuse, continuing care, and establishing clearer standards and monitoring mechanisms. Thus, a deeper analysis of policy implementation and actual practices within Lebanese prisons along with comparison with other contexts is crucial for a comprehensive evaluation.

For example, USA has many policies related to prisoners' medical confidentiality, Standard H-02 protects patient privacy by controlling access to their medical records (written, electronic, or verbal). In this framework, the responsible authority must manage access and keep updated information on confidentiality rules. Standard C-08 ensures healthcare continuity when professionals are unavailable. A trained non-medical staff member (liaison) coordinates basic tasks like reviewing health forms, non-emergency requests, and following doctor's instructions on different matters including diet and housing. These measures prioritize patient privacy and do not provide medical care (National Commission on Correctional Health Care, 2016).

Conversely, in Indian prisons, providing adequate healthcare to undertrial prisoners faces various challenges such as limited resources, overcrowding, and insufficient mental health services. Consequently, these challenges impact both the physical and mental well-being of prisoners, exacerbating existing health conditions and neglecting mental health needs. Thus, ensuring proper healthcare services is essential to uphold human rights, support rehabilitation, address public health concerns, and fulfill legal and ethical obligations outlined in the Indian Constitution and international standards (Sarraf, 2023).

In comparison with the NMR and WHO Health in Prisons Guide, the Lebanese prison health policy encompasses both strengths and areas for improvement.

In particular, this policy demonstrates several strengths in upholding the health and well-being of inmates. Assigning dedicated physicians by MoPH aligns with the NMR (Rule 24) and the WHO guidelines. As a result, this ensures qualified healthcare professionals manage prison health. The program surpasses the recommended frequency of checkups, exceeding the NMR's one visit per week with a minimum of three visits. This increased frequency aligns with the WHO guide's emphasis on routine checkups. Proactive measures against infectious diseases echo the NMR (Rule 30) and the WHO guide's focus on preventing outbreaks. Guaranteed scheduled visits and on-call physician access fulfill the NMR (Rule 24) and the WHO guide's requirement for timely healthcare. Moreover, engaging physicians in assessing prison food quality aligns with the NMR (Rule 22) and the WHO guide's emphasis on adequate nutrition. Submitting quarterly reports to both the prison and MoPH facilitates transparency and coordination, as encouraged by the Nelson Mandela Rules (Rule 78) and the WHO guidelines. Finally, choosing specialized officers and trained prisoners as assistants addresses staffing limitations, potentially aligning with the WHO guide's suggestion for innovative solutions.

Despite these strengths, Lebanon's prison healthcare policy has some gaps that could be addressed to better respect prisoners' human rights and dignity. For instance, the policy doesn't explicitly mention patient confidentiality or obtaining prisoner consent for sharing medical information, which are crucial aspects of patient autonomy highlighted by international standards. Additionally, there is no specific mentioning of provisions for mental health neither through the policy nor through assessments and treatment, even though mental healthcare is a recognized need in prison settings according to international guidelines.

Furthermore, the policy has more limitations. There's no mention of pre-release healthcare planning or collaboration with external providers, which could be beneficial for prisoners transitioning back into society. In addition, the policy lacks clear standards for how often health checks occur or how disease prevention measures are implemented. Finally, there is no system in place to monitor how effectively these policies are being carried out, making it difficult to identify and address any shortcomings. Therefore, a recommendation is to have a system in place for monitoring, evaluating, accountability and learning throughout the processes.

Chapter 6.2 Documentation of Medical Care

Despite the fact, that a medical file is available for use for prisoners, just like the one used for ISF staff, only half of prisoners have their medical care documented despite the presence of a policy and the urgency to document through standardized documentation of all observations and recommendations that should be done on form #14 including extensive personal information, routine health screening and checks, lifestyle details and full medical history. This discrepancy is mainly due to shortage of staff. Fortunately, the use of medications by the pharmacy is well documented.

Nevertheless, the issue of incomplete medical records for prisoners, despite a policy and standardized forms, highlights a need for improvement. The NMR (Rules 24, 27, 28, 31, 78), which emphasize a prisoner's right to proper healthcare (Rule 24), dictate how medical records are managed. Additionally, the rules require comprehensive files (Rule 78) with complete medical history, diagnoses, medications, allergies, immunizations, surgeries, and mental health assessments (Rule 24). Importantly, these files should be readily available for continuous care by authorized healthcare providers (Rule 24), with information exchange facilitated for pre-release planning and post-release care (Rule 31) (UNODC, 2015).

Thus, Lebanese prisons violate the NMR regarding medical record keeping. Despite a policy and standardized forms, nearly half of prisoners lack complete medical documentation due to staffing shortages. This situation creates issues with confidentiality, comprehensiveness, accessibility, and continuity of care as mandated by the rules. While medication use is well documented by the pharmacy, overall medical records are incomplete. Consequently, several improvements are

needed to address these shortcomings. Here are some recommendations to address the situation. First there is a need to increase staffing to ensure proper documentation and patient care. Second, technology use can ease processes by implementing electronic medical records that reduce time spent recording information and improve data accessibility. Third, if budget limitations exist, training volunteers or community health workers from NGOs can support prisons in Lebanon to assist with basic documentation tasks under qualified medical supervision.

Chapter 6.3 Medical Confidentiality and Privacy

A major concern in Lebanese prisons is the lack of privacy and medical confidentiality for prisoners. In many cases, other inmates or security guards accompany patients inside the consultation room. This practice mirrors McFadzean et al. (2023) findings where guards constantly monitored prisoners during hospital stays, raising concerns about privacy, confidentiality, and the doctor-patient relationship.

This issue was openly discussed in interviews and questionnaires. The conflict lies in balancing prisoner privacy and medical confidentiality with public safety. Many inmates' medical information is disclosed to the department of public administration for investigation and trial purposes, which probably constitutes a breach of confidentiality.

The current situation in Lebanese prisons undermines informed consent and respect for prisoners' autonomy in healthcare decisions. This is a critical failing, even considering security concerns (Enggist et al., 2014). Interestingly, female prisoners receive slightly more privacy than males. Only nurses, not other inmates or guards, accompany female patients. This practice suggests some level of gender discrimination, granting females more privacy rights.

While not directly addressed in this research, it's reasonable to assume that the lack of privacy extends beyond medical situations. Limited resources and overcrowding likely infringe upon privacy during sleep, showering, and toilet use. The root cause of these inadequacies is the absence of legislation governing prisoner privacy and medical confidentiality. This directly contradicts the NMR (Rules 27 & 28) which emphasize confidentiality (only authorized healthcare personnel access information) and patient autonomy (prisoners control information sharing) (UNODC, 2015). Similarly, ICRC (2021) advocates for “confidential discussions and privacy during patient examinations”.

Little privacy and medical confidentiality in Lebanese prisons raise serious concerns about social justice and adherence to fundamental human rights. The right to health, protected by the UDHR, extends beyond access to medical care. It encompasses dignity, autonomy, and the ability to make informed decisions about one's well-being. By failing to guarantee these principles, the Lebanese prison system perpetuates a system of inequality. Prisoners, already vulnerable due to their legal status, become susceptible to exploitation and manipulation in healthcare decisions. This not only violates their human rights but also creates a stark disparity in healthcare experiences compared to the general population. Ensuring privacy, confidentiality are essential steps towards achieving social justice and upholding the right to health for all, regardless of incarceration.

The first step towards reforms is to strengthen the legal framework. This can be achieved by comprehensively revising the outdated prison legislation currently in place. The current law, established in 1949 with very few amendments made until 1995, fails to address contemporary human rights standards.

Chapter 6.4 Nutrition Adequacy

As mentioned in the previous chapter, the Lebanese prison law fully acknowledges the right of prisoners in proper nutrition, without going into the technical details of meal planning, macronutrients and micronutrients. However, prisoners have access to both potable water and nutrition.

Yet, despite this acknowledgment, current prison policies and practices regarding proper food access do not properly align with international human rights conventions and other standards.

In Lebanese prisons, the provision of nutritional food, as assessed through the caloric content of cycle menus, seems to align with the dietary needs of the average middle-aged male inmate. In contrast, inmates in Iranian, Pakistani, and Haitian correctional facilities experience insufficient energy intake (KhodaBakhshiFard et al., 2014; Qadir et al., 2014; LaMonaca et al., 2018). Surprisingly, Australian prisons present a different scenario, with female inmates often exceeding recommended energy levels by two to three times (Hannan-Jones and Capra, 2016). Conversely, inmates in Zambia report inadequate food quantity, contributing to low energy intake (Topp et al., 2016). In other locations like Papua New Guinea, daily caloric intake appears in line with WHO recommendations, assuming inmates consume the entirety of provided food (Gould et al., 2013).

Moreover, significant disparities in nutritional quality are evident, leading to repeated failures in meeting macronutrient targets. Inmates are typically served excessive amounts of white bread and 1-2 servings of rice, potato, or pasta daily, surpassing WHO and Lebanese guidelines (WHO, 2018; The Food Based Dietary Guideline Manual for Lebanon, 2013). The absence of whole wheat options contributes to the overall low fiber intake. This is a concern, as despite lacking global data on inmates' consumption of whole grain carbohydrate sources, existing studies indicate a trend of excess grain servings in countries like Iran, Pakistan, and Australia (KhodaBakhshiFard et al., 2014; Hannan-Jones and Capra, 2016; Qadir et al., 2014). This raises concerns, particularly when energy from grains replaces essential food groups like meat, as observed in Pakistani and Iranian prisons (KhodaBakhshiFard et al., 2014; Qadir et al., 2014). In Bangladesh, although carbohydrate quantities are sufficient, the general menu lacks protein and dairy sources (Rahman et al., 2017).

Furthermore, protein provision in Lebanese prisons meets recommendations only four times a week, creating a gap in adequate sources on the remaining days (The Food Based Dietary Guideline Manual for Lebanon, 2013). Similar patterns are noted globally, with inmates often falling short of recommended protein levels, as seen in Iran, England, and Zambia (KhodaBakhshiFard et al., 2014; Edwards et al., 2007; Topp et al., 2016). Lebanese prison menus lack fish or nuts, impacting essential polyunsaturated fatty acid intake, while in England, vegan, vegetarian, and Halal options are available, unlike in Lebanese prisons (Edwards et al., 2007).

In addition, dairy servings in Lebanese prisons are significantly below recommended levels, leading to low calcium levels, a pattern also observed in Bangladesh and Australia (Rahman et al., 2017; Hannan-Jones and Capra, 2016). Low calcium intake in adults can adversely affect bone health, possibly leading to osteoporosis and increased risk of fractures in the long term (Balk et al., 2017). Likewise, Cairoli et al. (2021) argue that low calcium intake in adults can cause high bone turnover, secondary hyperparathyroidism, and higher fracture risk due to inadequate peak bone mass maintenance (Cairoli et al., 2021).

Additionally, fruit and vegetable servings fall short of recommendations, contributing to low fiber intake, a pattern globally observed, including in Iran, Papua New Guinea, and Pakistan (KhodaBakhshiFard et al., 2014; Qadir et al., 2014; Gould et al., 2013). Mathers (2022) discusses that low fiber intake in adults is linked to higher risk of chronic diseases like gastrointestinal issues, cardiovascular conditions, type 2 diabetes mellitus, and colon cancer (Mathers, 2022). Moreover,

Ning et al. (2014) argue that low fiber intake in adults is associated with higher predicted lifetime of high risk for cardiovascular disease and elevated C-reactive protein levels (Ning et al., 2014).

Another concern is sodium levels, which, due to potential underestimation, exceed recommended levels, observed not only in Lebanese prisons but also in developed countries like Australia and England (Herbert et al., 2012; Edwards et al., 2007). Notably, no data on sodium intake is available for developing countries. In fact, high sodium intake in adults can lead to hypertension, a major risk factor for heart disease (Clarke, 2021; Emmerik et al., 2020).

The analysis diet reveals excessive amounts of starch, which might lead to obesity, and high risk of diabetes mellitus. Moreover, there is an insufficient amount of fibers, potassium and calcium. Consuming a diet high in starch and lacking in fiber, potassium, and calcium can lead to a cascade of health problems. For instance, the excess starch can contribute to weight gain, increased risk of type 2 diabetes, and potential digestive issues (Khan, 2022).

Despite these concerns, the nutrition policy mentions specific diet alterations for inmates with chronic diseases or pregnant women, the system lacks specific dietary plans for individuals with chronic health conditions such as diabetes, heart disease, and kidney failure.

Moreover, the lack of fiber further disrupts digestion and may increase the risk of colorectal cancer (Keillor, 2021; Pedrosa & Fabi, 2023). Low potassium intake can lead to high blood pressure, muscle weakness, and fatigue (Weaver, 2013). Finally, insufficient calcium weakens bones and increases the risk of osteoporosis, while also potentially causing muscle cramps and abnormal heart rhythms (Goyal et al., 2023; NIH, 2023). Addressing these deficiencies through dietary changes or supplements is crucial to maintain overall health and well-being.

Additionally, it is noteworthy that there is no mention of specialized diets for pregnant or lactating women. This omission suggests a significant gap in fulfilling the unique nutritional needs of these vulnerable populations. Without proper dietary adjustments, these individuals are at increased risk of health complications, potentially placing a greater strain on the prison's healthcare resources.

According to Procter & Campbell (2014), ensuring proper nutrition is vital for favorable pregnancy outcomes. For instance, sufficient intake of folic acid either through supplements or fortified foods during early pregnancy and throughout gestation can shield the fetus from neural tube defects, low

birth weight, and premature birth (Timmermans et al., 2009). Additionally, adequate levels of omega-3 fatty acids have been linked to prolonged pregnancies and increased fetal weight gain (Larqué et al., 2012). These nutrients are critical for both maternal and fetal health. Furthermore, deficiencies in these fatty acids, as well as other essential nutrients like protein, zinc, and iron, have been demonstrated to disrupt brain development and predispose children to behavioral issues (Liu, 2011).

Prisoners in Lebanon eat within their cells or recreational areas, receiving meals in large pots, with portioning and serving being their responsibility. This system raises concerns regarding fairness and adequacy. The absence of standardized food portions and the fact that inmates, rather than authorities, distribute meals creates a vulnerability based on the power dynamics discussed in Chapter 4. Inmates who are not affiliated with the dominant group or the leader (Shawish) may face unequal treatment in terms of receiving food or the amount they receive. Additionally, some collected data from the self-administered questionnaires filled by the prisoners revealed that food is perceived of bad quality, hygiene and small quantity.

Moreover, dissatisfaction was noted among the prisoners in the two case study prisons among 80% of the sample with reasons including bad quality, negligence, lack of care, insufficient quantities and unhealthy food choices. Such dissatisfaction is very common in prisons where such situation is consistent with Pakistan, where 98% of prisoners express dissatisfaction with food quality (Qadir et al., 2014). Also, LaMonaca et al. (2018) 's research in Haiti showed that 94% off prisoners answered 'I have less to eat than I did before I was brought to prison' from the food insecurity scale, 77% picked 'I often go to bed feeling hungry', and 22% selected 'I get enough food from the prison alone to feel satisfied'. This highlights a pervasive issue across various prison settings, particularly in underdeveloped countries.

Furthermore, food safety guidelines that are not established usually oversee temperature control and personal hygiene while receiving, storage, handling, cooking and serving of both raw materials and ready to serve food. This gap in guidelines poses significant health risks. ICRC (2018) advocates for the importance of personal hygiene and general hygiene for the overall wellbeing, which could practically be applied to food provision.

This lack of oversight is particularly alarming, as evidenced by findings in Zambian prisons, where a majority of prisoners find the quantity of food provided inadequate, and some are served food uncooked, which poses a food safety risk (Topp et al., 2016).

Concerns arise regarding special consideration or meal changes for inmates with specific nutrient needs. This is crucial for maintaining health among vulnerable populations. While the nutrition policy mandates special food for patients with chronic diseases, no modified diet plan was presented for analysis, potentially leading to health issues. This concern aligns with findings in Mexico, where inmates with special nutritional needs receive no special consideration (Silverman-Retana et al., 2015).

Considering that 5% of Lebanon's prison population consists of foreigners, it is essential to recognize the cultural context in dietary provisions. An article by Bafitos in July 2022 highlights a crisis impacting the quality and quantity of food in Qobbeh prison, Northern Lebanon. The author's judgment, based on 17 years of observation, suggests inadequacy compared to NMR, although quantitative or qualitative analysis is not mentioned anywhere in his article (Bafitos, 2022).

In summary, while Lebanese prisons provide enough calories for the average male inmate, their current dietary practices raise concerns about social justice and adherence to fundamental human rights. The overreliance on carbohydrates and lack some of essential nutrients violate the principles of equity enshrined in the UDHR, particularly Article 25 which guarantees the right to adequate food. This right extends beyond just caloric intake, encompassing the quality and variety of food necessary for health and well-being.

As per ICRC (2021), prison authorities are obligated to provide detainees with sufficient nutrition, which necessitates serving at least two meals daily due to the inadequacy of meeting nutritional needs with just one meal. The energy content of detainees' rations should be a minimum of 2,400Kcal, with adjustments based on individual profiles such as age, gender, physical activity, health status, and environmental conditions. Rough estimates for nutritional requirements include 400g of carbohydrates, 130g of protein, and 65g of fat, which quite fall within what is mentioned in the nutrition policy

By failing to provide a balanced diet with protein, fiber, calcium, and healthy fats, the prison system perpetuates health inequalities and disregards the right of all inmates, regardless of gender or health status, to the highest attainable standard of health.

Thus, the current prison system in Lebanon do not align with the notion of medical nutrition therapy that aims to improve medical status of prisoners and promote for their wellness. Thus, the specific physical, mental, and social health needs of its prisoner population are not properly tackled, beyond just meeting minimum international standards of just feeding the inmates. This not only harms individual well-being but can also lead to a vicious cycle of health complications, further straining the prison's resources.

Chapter 6.5 Overcrowding and minimal space

In the heart of Lebanon's judicial system lies a troubling reality: overcrowded prisons and limited space. These conditions are a pressing concern for human rights advocates. These facilities, designed to uphold justice and rehabilitation, have become breeding grounds for injustice, where the rights and dignity of inmates are compromised under the weight of limited space to be allocated for each prisoner with excessive occupancy rates. As per 2023 statistics, the occupancy rates for male prisoners range from a staggering 134% to an alarming 326%, while for female detainees, the figures fluctuate between 100% and 255%. These numbers paint a grim picture of a system struggling under the strain of overcrowding. However, these high numbers are consistent with occupancy rates found in low-income countries such as Bangladesh, Zambia and Haiti with 350%,300% and 400% respectively (Rahman et al., 2017; Topp et al., 2016; LaMonaca et al., 2018).

ICRC (2021) sets forth clear recommendations regarding prison occupancy rates, advising that they should not exceed 100% with a critical limit of 150%. This benchmark is crucial in ensuring humane conditions of detention, facilitating effective rehabilitation, and upholding fundamental human rights. However, the reality within Lebanese prisons starkly deviates from these guidelines, with occupancy rates soaring well beyond the recommended threshold, often surpassing even the critical mark of 150%.

Moreover, each prisoner is allocated less than 2 m^2 which doesn’t align with any recommendations including ICRC, Russia, Europe and Africa (ICRC, 2021).

The consequences of overcrowding are profound. When resources are scarce and demand is high, power dynamics and leaders' control over those resources become a harsh reality. Such tough circumstances lead to overuse and high competition for resources including space, water and food. It might lead to more violence, malnutrition, insufficient water, disease transmission, vector-borne and fecal oral transmission, which are all due because of dirty toilets, minimal personal hygiene. Overcrowding not only compromises access to healthcare but also undermines the quality and effectiveness of medical services available (ICRC, 2021). Chronic illnesses go untreated, infectious diseases spread rampantly, and mental health issues spiral out of control in an environment ill-equipped to provide adequate care and support.

Additionally, the right to proper nutrition, a cornerstone of human dignity, is systematically violated within overcrowded prisons. Inadequate food supplies, coupled with substandard meal quality, leave inmates vulnerable to malnutrition and related health complications. This not only undermines their physical well-being but also strips away their inherent dignity, relegating them to a state of perpetual deprivation and vulnerability.

In light of these challenges, due to overcrowding and impact on vital resources, the current prison health system in Lebanon fails to address the specific physical, mental, and social health needs of its prisoner population.

The ramifications of this neglect extend beyond prison walls. The impact of this failure and neglect extends far beyond the prison walls, permeating into the very fabric of society. It perpetuates cycles of poverty and marginalization, exacerbating existing inequalities and deepening social divisions. Moreover, it erodes trust in the justice system, casting doubt on its ability to uphold the principles of fairness and equality for all.

Addressing this crisis demands urgent action on multiple fronts. Firstly, there must be a concerted effort to alleviate overcrowding within prisons through the expansion of infrastructure and the implementation of alternative sentencing measures. A critical component of this effort is the reform of trial procedures. When it comes to sentencing measures, it is very important to highlight a root cause to most of the issues within Lebanese prisons which is the delay in trials for most of prisoners. On average, more than 70% of prison population in Lebanon are not sentenced and are waiting for trial. This staggering figure underscores the urgency of addressing the systemic issues

within the judicial process. Generally speaking, scheduled trials are always postponed by judges due to inefficiency and corruption in the MoJ. Besides, ISF do not have the required resources including police officers or guards and transport vehicles to regularly send the prisoners to their trials. In a press release for the Lebanese minister of interior and municipalities Bassam Mawlawi, he disclosed that the country's prisons are overcrowded by a staggering 300%, with 75% of inmates awaiting conviction while efforts are underway to address this crisis, including proposals to reduce penalties (Middle East Monitor, 2022a).

Human Rights Watch has highlighted the alarming deterioration of prison conditions in Lebanon amidst the country's economic crisis. This further complicates the situation, as resources are strained. Overcrowding has become widespread, healthcare is inadequate, and the government's failure to settle outstanding bills has jeopardized the food supply for prisons. Approximately 80% of Lebanon's prison population is in pretrial detention, with RCP, originally designed for 1,200 inmates, now accommodating around 4,000 (Human rights watch, 2023).

Measures should be taken to ensure that all inmates have access to comprehensive healthcare services, including preventive, curative, and mental health care. Without these measures, inmates' well-being remains at risk. Similarly, steps should be taken to improve the quality and nutritional value of meals provided to prisoners, in line with international standards and guidelines.

At its core, the issue of health and nutrition rights in Lebanese prisons is not merely a matter of policy or logistics; it is a question of basic humanity and social justice. Recognizing this, as a society, we must understand that the treatment of prisoners reflects our collective commitment to upholding human rights and fostering a culture of compassion and empathy. Only through concerted efforts to address the root causes of overcrowding and neglect can we create a future where the rights and dignity of all individuals, regardless of their circumstances, are respected and upheld.

Chapter 6.6 Health Education and Awareness

Health information and education are integral components of the healthcare system in Lebanese prisons. The provision of health awareness sessions, although infrequent and typically occurring only during pandemics, is highly valued among the majority of prisoners.

Additionally, upon admission to prisons, both oral and written information sessions about the functioning of the healthcare system are provided, without regard to gender or nationality. This approach aims to create an equitable environment for all inmates. These sources of health orientation primarily involve nurses or NGOs, but security officers and other inmates also contribute to providing information. However, there is room for improvement in delivering health education through expert individuals such as nurses or NGOs. Furthermore, there is a potential for training other inmates, particularly those with a higher level of education or a background in healthcare disciplines, through a Train-the-Trainer process. Moreover, there should be a planned annual education plan for inmates which may include topics like personal hygiene, prevention of NCDs and basic life support. This structured approach would enhance health literacy among inmates. The importance of providing health information in Lebanese prisons is supported by the findings of McFadzean et al. (2023) and WHO (2014). While ICRC (2021) explicitly acknowledges the importance of access to nutrition and health information for prisoners, NMR do not explicitly focus on health awareness programs in prisons. However, they do indirectly promote health awareness through various provisions related to healthcare.

Ultimately, addressing health education in prisons has significant implications for the right to health, social justice, and human rights, emphasizing the need for comprehensive and accessible healthcare services within correctional facilities.

Chapter 6.7 Screening and Assessment

As a researcher interested in prisoner health outcomes, I found it concerning that the Lebanese prison law, while outlining a health policy section, makes no mention of mandatory inmate screening upon admission. This oversight is critical, as such practices do not align with international standards and thus fail to properly address the specific physical, mental, and social health needs of its prisoner population.

Interviews and questionnaires revealed that some screening is conducted, primarily for inmates with suspected substance abuse or mental health issues. However, this practice appears inconsistent. This inconsistency raises questions about the reliability of health assessments. From the prisoners' perspective, nearly half reported undergoing some form of assessment within the

first month of admission, typically performed by medical personnel such as doctors, nurses, or lab technicians.

This aligns with ICRC (2021) recommendations that advocate for nurses or health assistants to conduct initial screenings and refer patients as needed. However, a concerning number of screenings are reportedly performed by security guards, who supposedly lack the proper training for such tasks. The lack of qualified personnel raises ethical concerns, as untrained individuals conducting screenings could miss important health issues.

On another note, HIV testing is mandatory upon admission, and positive cases are grouped for easier treatment and follow-up care. This aspect of screening is crucial for managing public health.

Following screening, information should be documented in medical records. However, as previously discussed, record-keeping practices are often inadequate. This lack of thorough documentation makes it difficult to track trends and ensure continuity of care.

Disparities also exist in screening by gender. Male prisoners, housed in facilities with medical centers, are screened more frequently than females. This discrepancy highlights systemic inequalities in healthcare access. Notably, women's health screenings appear to be entirely absent. This suggests a potential gender bias within the system, neglecting the specific healthcare needs of female inmates. One positive aspect is the mandatory screening for HIV, TB, Hepatitis B, and syphilis infections for all detainees. It is suggested to formalize a comprehensive screening process, including malnutrition assessments as outlined by Cardenas et al. (2019), could significantly improve prisoner health outcomes by facilitating early detection and treatment of various medical issues. This aligns with my core belief that all people, regardless of incarceration status, deserve access to quality healthcare.

Chapter 6.8 Mental Health

Mental health screening is only conducted for detainees known to have existing mental health issues, neglecting screening for others, particularly women. This selective approach to screening highlights a significant gap in mental health care. The absence of legislation and current practice does not line up with international standards and thus do not help tackle the specific physical, mental, and social health needs of its prisoner population.

Treatment sources for mental health issues vary, with family and prison clinics being primary, while NGOs and mental health centers also play a role. Despite this, nearly half of detainees reporting mental health issues, only a fraction receive help, mainly from outside organizations like NGOs. The situation is further strained by a lack of mental health checks during intake at referral hospitals.

NMR recognize the importance of mental health care in prisons. Specifically, Rule 27 states that prisoners who require psychiatric treatment or specialized mental health care should receive it promptly. Additionally, Rule 28 emphasizes the necessity of qualified mental health professionals in prisons to provide appropriate mental health services. These rules are crucial as they underscore the importance of addressing mental health needs within the prison system to ensure the well-being and dignity of all prisoners.

ICRC (2021) discusses that individuals with mental health issues face an increased risk of imprisonment, either due to their condition contributing to criminal behavior or simply because of societal intolerance or lack of mental health services. Poor conditions in prisons exacerbate mental health challenges, including reduced social support, limited activities, violence, and loss of freedom. This context illustrates how imprisonment itself can lead to or worsen mental health problems, resulting in symptoms like psychosomatic issues, depression, anger, and increased rates of self-harm and suicide. Hunger strikes, a common occurrence in prisons, further impact health. Imprisonment itself can lead to or worsen mental health problems, resulting in symptoms like psychosomatic issues, depression, anger, and increased rates of self-harm and suicide. Hunger strikes, a common occurrence in prisons, further impact health.

In the Lebanese prisons, I see that the inadequate mental health screening and limited access to treatment have serious implications for the well-being of detainees and the overall functioning of the prison system. These shortcomings contribute to a larger crisis in which the mental health needs of incarcerated individuals are neglected. Moreover, the reduction of medical specialties to only ophthalmology and ENT (Ear, Nose, and Throat doctor) services further underscores the lack of prioritization for mental health care, leading to a systemic failure to address the mental health needs of incarcerated individuals.

A fact sheet report by WHO in 2019 revealed a varied landscape of mental health services within European prisons. Screening for mental health disorders occurs in a majority of countries, with 32 out of the listed nations implementing this practice. However, access to treatment paints a less comprehensive picture. However, this progress is not uniform across all regions. While 27 countries offer some form of support or treatment, the availability differs significantly (WHO, 2019).

Some nations like Albania, Azerbaijan, and Italy provide both support services (with limitations) and full treatment options. Conversely, several countries solely offer support services, excluding comprehensive treatment plans. These discrepancies highlight a critical gap in the provision of mental health care. These include Czech Republic, Denmark, Finland, and several others. France, Iceland, Italy, and Serbia offer screening in a limited capacity within their prison systems, while access to treatment varies within their institutions (WHO, 2023).

To address these pressing issues, urgent action and reforms are necessary. First and foremost, there must be a comprehensive overhaul of mental health protocols within Lebanese prisons, including mandatory mental health screening for all detainees upon admission. This foundational change is essential for establishing a more humane and effective prison system. This screening should be conducted by trained professionals and include assessments for common mental health disorders, substance abuse issues, and trauma histories. This protocol should be incorporated into Lebanese prison legislation, which has previously been advised for revision.

Additionally, the availability of mental health services within prisons must be expanded, with investment in specialized mental health staff, resources, and facilities. This expansion is vital for providing detainees with the support they need. This includes providing access to counseling, psychiatric care, and psychosocial support programs tailored to the unique needs of incarcerated individuals.

Moreover, collaboration between prison authorities, healthcare providers, specialized NGOs like Embrace and IDRAAC, and mental health organizations is crucial to ensure holistic care and support for detainees with mental health issues. Such partnerships can leverage resources and expertise to enhance care delivery. Also, it would be interesting to incorporate the prison population in the national mental health programme (NMHP). NMHP, initiated in May 2014 under

the MoPH with backing from WHO, UNICEF, and International Medical Corps, seeks to overhaul mental health care in Lebanon. The program aims to expand services beyond medical treatment by focusing on community-based interventions, aligning with Human Rights principles, and incorporating the latest evidence-based best practices. This may involve partnerships to facilitate referrals for specialized treatment outside the prison system, when necessary, as well as the provision of ongoing support and follow-up care for individuals transitioning back into the community.

Furthermore, I strongly believe that there should be greater awareness and education within the legal and healthcare sectors about the importance of addressing mental health within the criminal justice system. Increasing awareness can drive necessary reforms and improve outcomes for detainees. This includes training for prison staff on identifying and responding to mental health needs, as well as advocacy for policy reforms that prioritize mental health care and human rights within Lebanese prisons.

Ultimately, the provision of adequate mental health care within Lebanese prisons is not only a moral imperative but also essential for promoting rehabilitation, reducing recidivism, and safeguarding the dignity and rights of all individuals within the criminal justice system. This multifaceted approach requires a concerted effort from various stakeholders. It is incumbent upon government authorities, civil society organizations, and international partners to prioritize and invest in mental health reform within Lebanese prisons to ensure the well-being and rights of detainees are upheld.

Chapter 6.9 Main actors for health access

Lebanon faces a complex situation where both government and private organizations struggle to deliver essential services. This challenge is particularly pronounced in the prison system, where existing structures are often inadequate. Local and international NGOs step in to fill the gaps, providing welfare and assistance when government structures are inadequate. In the case of prisons, the dire situation calls for more action. MoPH commendably strives to provide medications through PHCs and treatment for communicable diseases. However, the Ministry of Social Affairs (MoSA) appears less active in securing vaccinations, creating a critical need that local NGOs are fortunately able to address.

Several NGOs play a crucial role in supporting healthcare delivery in prisons. Their involvement is vital to mitigating the shortcomings of the existing system. Dar Al Amal, Mouvement Social, and Adl w Rahma are prominent examples, actively involved in providing health information, conducting awareness sessions, and offering mental health services. These NGOs mirror successful models from around the world. For instance, in Iraq, NGOs lighten the burden on prison staff by teaching inmates' new skills, providing legal aid, and improving healthcare through education and training programs (UNODC, 2022). Similarly, in India, NGOs address crucial health issues and reach out to neglected communities by organizing educational campaigns, setting up temporary medical facilities, and directly providing medical care (Team Give, 2023).

Access to healthcare is not a privilege; it's a fundamental right for everyone. This principle underscores the need for collective responsibility in healthcare delivery. Governments, international organizations like ICRC and WHO, and NGOs all share a responsibility to collaborate and ensure this right is upheld, as mandated by international treaties.

The current legislation and practice in Lebanese prisons concerning mental health do not properly go along international standards and thus do not address the mental needs of its prisoner population. This misalignment exacerbates existing issues and highlights the urgent need for reform. The lack of access to mental healthcare in Lebanon is a critical source of social tension and injustice, demanding urgent solutions through combined efforts.

Chapter 6.10 Health Services

Despite a previously diverse range of medical specialties available, including mental health, the crisis has resulted in a reduction to only ophthalmology and ENT services. This significant reduction illustrates the dire state of healthcare in prisons. Thus, currently, the prison health system in Lebanon is unable to appropriately address the specific physical, mental, and social health needs of its prisoner population.

Amid the ongoing crisis within the country, particularly within the prison system, numerous strengths can be readily identified. Recognizing these strengths is crucial for potential improvement efforts. These strengths include the effective management and provision of life-saving treatments for urgent cases, as well as adherence to international standards such as the Malta Declaration, Istanbul Protocol, and NMR in delivering health services.

Health services are primarily administered either through medical centers or referral centers. However, there exists a prevalent sense of dissatisfaction, particularly among female detainees, regarding reproductive health, encompassing pregnancy and post-delivery care, as well as child services. This dissatisfaction highlights critical gaps in care that must be addressed. This dissatisfaction stems from perceived negligence, insufficient care, limited treatment availability, and staffing shortages, all of which are symptomatic of constrained resources resulting from the multidimensional crisis affecting financing and staff salaries. Likewise, a study by Vandergrift & Christopher (2021) revealed that inmates in USA do not trust the healthcare system due to inadequacy of healthcare that encompasses discrimination.

It's important to acknowledge that my understanding of the dissatisfaction among female detainees is informed by available data and reports, which may not fully capture the experiences of individuals within the system. This nuance is essential for a comprehensive analysis of the situation. Additionally, my interpretation is influenced by a desire to highlight systemic issues that contribute to these challenges.

Nevertheless, it is imperative to pause and consider the implications of the challenges faced by detainees in covering expenses or accessing hospitals. These challenges reflect broader societal issues that extend beyond the prison walls. These issues strike at the core of social justice and human rights, directly impacting detainees' ability to access health services and ensure health security. These findings are congruent with the arguments put forth by Peiró (2022), who highlighted the limited specialist access and the financial burdens of healthcare costs for prisoners. Similarly, the WHO (2014) has raised concerns about understaffing, inadequate training, and insufficient resources, all of which can detrimentally affect the quality of health services. The findings of this study also align with the assertions made by Khandelwal et al. (2019), who contend that prisoners receive subpar healthcare, a conclusion which is likely reinforced by the findings of this study.

My interpretation of the findings is influenced by a commitment to advocating for improved healthcare access and human rights within the prison system. This commitment drives the need for systemic change. Nevertheless, it is imperative to underscore that addressing these challenges is not merely a matter of healthcare provision but a fundamental issue of social justice and human

rights, demanding systemic reforms to ensure equitable access to healthcare for all detainees, regardless of their circumstances or background.

Chapter 6.11 Medications

The primary provider of prescribed medications after consultations being the prison clinic aligns with findings from other studies. For example, a study conducted by Kouyoumdjian et al. (2014) in Canadian prisons similarly found that the majority of prescribed medications were provided by prison healthcare facilities. This consistency suggests a common trend in many prison systems where healthcare services, including medication provision, are primarily managed within the prison setting.

NMR address the provision of medications in prisons. Rule 24 stipulates that adequate medical care, including necessary medication, should be provided to all prisoners without discrimination. This means that prisoners requiring medication for physical or mental health conditions should have access to it as part of their medical treatment. Additionally, Rule 27 emphasizes the importance of prompt medical attention for prisoners with psychiatric needs, which may include the provision of psychotropic medications as deemed necessary by qualified healthcare professionals.

However, the implementation of these rules is not uniform across all facilities. The variation in medication sources between male and female prisons, as well as between Lebanese and non-Lebanese inmates, underscores the importance of considering demographic factors in medication provision within prisons. While this specific demographic variation may not have been extensively studied globally, studies such as the work of Binswanger et al. (2007) in USA have highlighted disparities in healthcare access and medication provision based on gender and ethnicity within correctional facilities. Such findings emphasize the need for tailored approaches to medication management that address the unique needs and circumstances of different demographic groups within prison populations.

The involvement of doctors and nurses in distributing medications, coupled with challenges such as limited medical resources and medication shortages, echoes findings from studies conducted in various countries. These challenges highlight systemic issues that affect healthcare delivery. For instance, an article by Magola-Makina et al. (2022) on healthcare provision in prisons across

multiple countries highlighted common challenges such as staffing shortages, limited resources, and medication supply issues. These challenges are often exacerbated by systemic factors such as budget constraints and understaffing, leading to disparities in healthcare access and quality within prison settings.

In Lebanon, the prioritization of prisoners over ISF personnel in accessing medications illustrates an effort to maintain equity. The efforts to ensure medications are consumed within their shelf life reflect principles of equitable healthcare provision within the prison system in Lebanon. Similar practices have been documented in studies examining medication management in prisons globally, emphasizing the importance of prioritizing the health needs of incarcerated individuals to uphold their rights to healthcare access and quality. Thus, despite the crisis situation, the Lebanese government is doing really good efforts in terms of medications provision in their prisons. However, these efforts may not be sufficient to address all health needs effectively. This issue affects the extent to which the prison health system in Lebanon is able to always address the specific physical, mental, and social health needs of its prisoner population through medications.

Relating the findings to human rights and social justice underscores the significance of equitable healthcare provision within the prison system. This connection is vital for understanding the broader implications of healthcare access. The provision of medications primarily through the prison clinic highlights the importance of ensuring equal access to healthcare services for incarcerated individuals, consistent with principles of human rights. Access to essential medications is a fundamental aspect of the right to health, as recognized by international human rights instruments such as the UDHR and the International Covenant on Economic, Social and Cultural Rights. The variation in medication sources based on gender, nationality, and other demographic factors underscores the need to address disparities in healthcare access within the prison population. Such disparities can perpetuate social injustices and violate the principle of non-discrimination protected by human rights law. Failure to do so can perpetuate social injustices and violate the principle of non-discrimination protected by human rights law. Efforts to identify and address these disparities are essential for promoting equality and justice within the prison healthcare system. The involvement of doctors and nurses in medication distribution, coupled with challenges such as limited resources and medication shortages, highlights the importance of accountability and oversight in ensuring the right to health for incarcerated individuals.

Chapter 6.12 Human Resources

Lebanon's prisons suffer from shortage of staff. This chronic understaffing presents significant challenges for healthcare delivery. This shortage, especially of personnel with emergency response expertise, creates a dangerous environment where basic healthcare needs may not be met. Such reality indicates that the prison health system in Lebanon is unable to appropriately address the specific physical, mental, and social health needs of its prisoner population mainly due to shortage in resources including human resources.

Furthermore, this chronic understaffing is also coupled with inadequate technical expertise among guards and security officers, as raised by Nashabe (2003). While NGOs and WHO provide valuable assistance on the short term, their staff cannot fully compensate for the systemic and chronic shortcomings on the long term. The low salaries and harsh working conditions within the prison system act as significant deterrents, even though government employees receive benefits, which are not very much appreciated amid the current crisis.

The current situation in Lebanese prisons not only violates detainees' rights but also creates a burden on existing staff, hindering proper medical follow-up. In light of this, a critical reassessment of prison staff compensation and working conditions is essential. A critical reassessment of prison staff compensation and working conditions is essential to ensure adequate healthcare and uphold the human dignity of those incarcerated. However, I would like to highlight the fact that the current situation in Lebanese prisons in terms of staffing is quite aligned with the same indicator in many developed countries.

For instance, UK prisons also experience similar understaffing issues, which have devastating impacts on various aspects of prison life. The shortage of staff in prisons is a critical issue affecting the operational efficiency and educational opportunities within the prison system, as highlighted by numerous inspection reports and the ongoing Justice Select Committee inquiry. The lack of prison officers impedes access to education, preventing inmates from attending classes and engaging in learning activities, particularly affecting those reliant on distance learning courses. Furthermore, insufficient staffing levels diminish the ability of officers to provide individualized support and encouragement to inmates pursuing education, hampering their self-discipline and motivation (Collins, 2023).

Siddique (2023) argues that prisons in England have implemented emergency “red regimes” 22 times this year due to staffing shortages, with one prison resorting to this extreme measure on 15 occasions. A red regime, considered unsustainable by HM Prison and Probation Service, is enacted when staffing levels fall below the minimum required, resulting in limited access to activities such as work, library, and rehabilitation programs for inmates. Experts caution that these restrictions foster a culture of hopelessness among prisoners, with reports of individuals being locked up for most of the day without access to basic amenities like showers, highlighting the severe impact of staffing deficiencies on prison operations and inmate well-being.

In examining the broader context of prison healthcare, it is essential to consider the insights from the Council of Europe questionnaire survey. Pont & Harding (2019) argue and discuss the main weaknesses identified regarding prison healthcare, which were the shortage of healthcare professionals and inadequate training and professional development opportunities. Some member states also noted a general scarcity of healthcare workers in the community, exacerbating the challenges faced in prisons. Reasons for the shortage of prison healthcare staff included difficult working conditions, low recognition, and inadequate pay. Salary discrepancies between healthcare staff in prisons and those in public health institutions varied among countries, with 11 reporting lower salaries, 7 reporting higher, and the rest reporting equal pay (Pont & Harding, 2019).

Moreover, the issue of inadequate mental health support is particularly pronounced in many facilities. In particular, many jails and prisons lack sufficient mental health professionals (MHPs) to adequately support the incarcerated population's mental health needs. This analysis explores various strategies employed to tackle MHP shortages in U.S. correctional facilities. These include offering compensation incentives, implementing telemental health services, fostering interdisciplinary healthcare approaches, providing flexible work schedules, and incorporating training rotations in correctional settings. While these initiatives may mitigate MHP shortages to some extent, addressing the issue fundamentally requires broader policy reforms. Such reforms could involve reducing the size of the U.S. correctional populations or increasing the overall number of mental health professionals nationwide (Morris & Edwards, 2022). U.S. prisons and jails are facing a critical staffing crisis. This isn't a recent problem; correctional facilities have long grappled with understaffing. While the number of people behind bars has skyrocketed by 500% in

the past 40 years, the prison workforce hasn't kept pace. This rapid growth has led to a system with a high turnover rate, where most staff barely reach five years on the job (Taylor and Cooper, 2008).

Addressing the well-being of prison officers is also crucial for the overall health of the prison system. Clements and Kinman argue that ensuring the well-being of prison officers goes beyond moral obligations; it significantly impacts prison operations. Their research study has shown a direct link between officer well-being and their approach to rehabilitation and prisoner treatment (Clements & Kinman, 2020).

Stöver (2016) discusses that prison staff experience widespread stress due to various physical, emotional, and occupational factors. Balancing punitive and rehabilitative duties, along with organizational culture, contributes significantly to this stress. Therefore, health promotion initiatives, including the establishment of working groups focused on stress reduction, are vital for addressing these challenges and promoting staff well-being. Health promotion initiatives, including the establishment of working groups focused on stress reduction, are vital for addressing these challenges and promoting staff well-being.

Addressing the crisis of understaffing in prison healthcare systems is crucial not only for ensuring basic human rights but also for advancing social justice. Chronic shortages of healthcare professionals in prisons in Lebanon, which is also seen in developed countries like UK, and USA, flagrantly violate detainees' rights to adequate medical care and dignity. By prioritizing comprehensive policy reforms, governments can take meaningful steps toward rectifying these issues. By prioritizing comprehensive policy reforms, such as reassessing compensation and working conditions for prison staff, investing in recruitment and training of healthcare professionals, and implementing innovative healthcare delivery models, governments can uphold the principles of human rights and social justice. Collaboration with NGOs and international organizations can provide crucial services and support, bridging short-term gaps while addressing systemic issues in the long run (Team Give, 2023). Perhaps current supportive NGOs can take on a role in training new staff. By ensuring equitable access to healthcare and prioritizing the well-being of both inmates and staff, societies can foster a more just and equitable criminal justice system, promoting dignity and fairness for all individuals involved.

Lastly, it's essential to recognize that healthcare in prisons should be on par with that available in the community. In larger prisons or areas with accessible healthcare, full-time doctors may be stationed, while smaller prisons may rely on part-time doctors or intermittent visits. Nurses or health assistants may handle initial screenings and treat minor ailments, but they should be able to refer patients to a doctor when necessary. Access to healthcare should be equal for all detainees, with acute cases reviewed promptly and regular follow-ups for chronic illnesses. This equality is fundamental to ensuring effective healthcare delivery. Rationing of healthcare should be based on clinical need determined by medical staff, not by non-medical personnel who lack expertise and may have ulterior motives. Detainees should have direct access to healthcare staff without interference from non-medical personnel, ensuring confidentiality and non-discrimination (ICRC, 2021).

Chapter 6.13 Substance Abuse

In Lebanese prisons, inmates are not screened for substance addiction, despite reports indicating that nearly half of the population deals with drug and/or alcohol addiction. Additionally, approximately 30% are receiving medical assistance. This gap in screening suggests that the prison health system in Lebanon is unable to appropriately address the specific needs of prisoners suffering from substance abuse, underscoring the necessity for both medical and psycho-social support.

The NMR address substance abuse, including alcohol and drugs, in prisons. Rule 37 emphasizes the need for measures to prevent and address substance abuse among prisoners. This includes implementing programs for prevention, treatment, rehabilitation, and social reintegration. Additionally, Rule 25 states that medical services in prisons should include appropriate treatment for drug addiction and other substance abuse disorders. Collectively, these rules underscore the importance of a comprehensive approach to tackling substance abuse issues within the prison system. ICRC (2021) discusses that women in prison generally have greater mental-health needs, including drug and alcohol dependency. Donnir et al. (2023) argues that despite attempts to deter substance abuse in correctional facilities, approximately one out of every ten inmates were found to be using alcohol or illegal drugs at a level indicative of substance use disorders. This finding emphasizes the critical need for focused interventions. Thus, implementing brief assessments could be beneficial in identifying individuals who require clinical intervention to address their

alcohol and drug-related issues effectively. Fazel et al. (2006) also agree with Donnir et al. (2023) about the importance of screening for substance abuse and dependency upon entry into prison, providing effective treatment during incarceration, and ensuring follow-up care upon release. These strategies highlight a necessary framework for improving the management of substance abuse within prison settings. In their study, Donnir et al. (2023) discussed the occurrence of substance abuse and dependency varies significantly but is generally substantially higher among prisoners compared to the general populace, especially among women dealing with drug-related issues.

The situation in Lebanese prisons, where inmates are not screened for substance addiction despite a significant portion of the population dealing with drug and alcohol addiction, raises serious concerns about the violation of human rights and social justice. This lack of screening and inadequate treatment for substance abuse disorders in prisons exacerbates the health and social disparities faced by inmates. The issue is particularly pronounced for women, who often have greater mental health needs, including addiction issues. To address this pressing issue, several actions can be taken. Firstly, policy reform is essential, advocating for the implementation of screening protocols aligned with international standards such as the NMR. This would serve as a foundational step toward improving health outcomes. Collaboration with relevant stakeholders to enhance medical services within prisons, ensuring they include appropriate treatment for substance abuse disorders, is crucial. Additionally, specialized addiction treatment programs tailored to the unique needs of prisoners, especially women, should be established. Such programs are necessary to meet the specific challenges faced by this demographic. Training programs for prison staff on identifying and addressing substance abuse issues among inmates, along with raising awareness about the importance of early intervention, are necessary steps. These training initiatives can empower staff to provide better support for affected inmates. Research initiatives to gather data on substance abuse prevalence and impact in Lebanese prisons, as well as monitoring implementation of screening and treatment programs, are imperative. Lastly, fostering community support networks and resources to assist individuals in maintaining recovery and preventing recidivism upon release is essential. By integrating these components, Lebanon can better uphold human rights principles and social justice while addressing the challenge of substance abuse within its prison system.

Chapter 6.14 Dental Services

In Lebanese prisons, access to dental services is limited despite the presence of dental clinics within medical facilities. This limitation indicates a systemic failure to adequately meet the needs of prisoners suffering from dental issues, highlighting a disconnect between existing resources and actual care provision. Surgeries and related procedures are only conducted in contracted medical centers, posing challenges for detainees seeking comprehensive dental care. A small proportion (2%) of detainees reported seeking medical assistance for dental issues since admission to prison. This statistic reflects broader issues related to access and awareness of available dental services. Of those surveyed, 19.41% indicated access to dental care within the prison, primarily for tooth extraction. Dentures are predominantly obtained through family members due to limited resources, with no disparities observed in access between prisons, nationalities, or age groups. However, this situation overlooks the needs of vulnerable populations within the prison system. Detainees lack access to dental implants, exacerbated by equipment malfunctions, resource shortages, and reluctance from dental laboratories to contract with prisons due to financial constraints.

In a scoping review of availability and accessibility of dental services in prisons, Amaya et al. (2023) argue that the absence of oral health services within prison facilities not only impacts individuals residing in prisons but also undermines their prospects for successful reintegration into society. This connection highlights the broader implications of inadequate dental care on public health and social reintegration. The authors recommend immediate and tangible international interventions are imperative to guarantee the provision, accessibility, and standard of oral health services for incarcerated individuals (Amaya et al., 2023).

Moreover, drawing parallels with international contexts can provide insights into the scale of the issue. In India, a study by Reddy et al. (2012) found that caries prevalence was high at 97.5%. with 21.6% exhibited severe periodontal issues. Additionally, 41.1% of prisoners suffered from significant attachment loss, while 8.8% required dentures. Oral submucous fibrosis affected 9.9% of the inmates. The majority (97.4%) required oral hygiene instruction, 87.6% needed dental restoration, 62.1% required tooth extraction, and 32.2% needed prosthetic devices. These findings underscore a global pattern of neglect in dental health for incarcerated populations.

Improving access to dental services within Lebanese prisons is imperative for upholding the human rights and social justice of incarcerated individuals. This need for improvement stems from the significant challenges posed by current limitations. Despite the presence of dental clinics within medical facilities, limited access to comprehensive dental care poses significant challenges for detainees. Surgeries and related procedures are restricted to contracted medical centers, hindering access to necessary treatments. This restriction creates a barrier to adequate healthcare that directly affects inmates' well-being. While a small proportion of detainees seek medical assistance for dental issues, only a fraction has access to dental care within prisons, primarily for tooth extraction.

Dentures, frequently acquired through family members, serve as the primary solution due to resource constraints. However, it's essential to recognize that this option may not be available to all, particularly to migrant or refugee prisoners, who often reside independently in the country. The absence of dental implants exacerbates the situation, compounded by equipment malfunctions and reluctance from dental laboratories to contract with prisons. Thus, addressing these challenges requires a multifaceted approach. Increased resources, expanded coverage of dental services, and efforts to overcome contracting obstacles are necessary. Ensuring access to dental care not only upholds detainees' rights to health and dignity but also supports their successful reintegration into society post-release. Therefore, immediate action and tangible interventions are necessary to guarantee the provision, accessibility, and quality of oral health services for incarcerated individuals in Lebanese prisons.

The NMR emphasize the importance of ensuring access to dental services for detainees. Specifically, Rule 22 underscores the principle that prisoners should receive healthcare services, including dental care, that are on par with those available to the general population. This principle is crucial for maintaining fairness and equity in healthcare access. By recognizing the significance of dental health in maintaining overall well-being and dignity, the NMR advocate for the provision of timely and adequate dental services to incarcerated individuals, aligning with broader human rights principles.

Chapter 6.15 Disabilities

In both prisons, a substantial proportion of prisoners—23.26%—reported having disabilities, yet only 37.93% were receiving aid for these disabilities. This discrepancy highlights a critical gap in support and resources for inmates with disabilities. The current prison system with its policies lacks any considerations for prisoners with disabilities in terms of their health, access to facility and support.

Notably, among inmates with disabilities, peer support emerged as the primary form of assistance (50.00%). This reliance on peer support indicates the inadequacies of formal support systems. Strikingly, no significant variations were observed based on age, gender, or nationality ($p= 0.820$) regarding disabilities.

Regrettably, no additional data related to disabilities beyond what was collected for this research study is available. This lack of data underscores the need for comprehensive research to better understand the challenges faced by this demographic. Nonetheless, it is anticipated that the prisons in Lebanon lack the necessary infrastructure, tools, equipment, and facilities to adequately accommodate individuals with disabilities.

Disabilities and health in prisons are pressing issues addressed by the NMR, which stress the importance of tailored healthcare services for prisoners with disabilities, as well as the provision of accessible facilities and accommodations to ensure equitable access to healthcare without discrimination. This focus on tailored services is essential for upholding the rights of disabled inmates. Additionally, these rules underscore the necessity of providing aids and appliances to support the well-being of prisoners with disabilities, thereby upholding their rights and dignity in correctional settings.

Schlanger (2017) highlights the sluggish pace of interventions to accommodate prisoners with disabilities within prisons. This highlights a systemic failure to address the needs of a vulnerable population. Beyond legal frameworks, Schlanger advocates for supplementary policies aimed at bolstering medical and mental health provisions for incarcerated individuals with disabilities. Key to these initiatives is bridging internal prison dynamics with external factors such as record-keeping, staffing, and financial resources, collectively promising to improve the quality of care and enhance future opportunities for prisoners with disabilities.

Furthermore, Whittingham et al., (2020) conducted a study in Canada revealing widespread inadequacies in treatment and accommodations for prisoners with disabilities, alongside lengthy wait times for services. Such findings resonate with the challenges faced in Lebanese prisons, indicating a need for urgent reforms. Whittingham et al., (2020) emphasize on the importance of considering incarcerated individuals' perspectives on accommodations, assistance, and the quality of healthcare they receive, underlining the urgent need for reforms to uphold the rights and well-being of prisoners with disabilities.

In essence, addressing the needs of prisoners with disabilities requires a multifaceted approach encompassing policy reforms, resource allocation, and a commitment to listening to and respecting the voices of incarcerated individuals. This holistic approach can facilitate meaningful change within the prison system. By aligning with international standards, supplementing legal frameworks with comprehensive policies, and prioritizing the holistic well-being of all prisoners, correctional systems can strive towards upholding human rights and social justice principles for this vulnerable population.

Chapter 6.16 Women in Prisons

While the Lebanese prison law acknowledges the specific dietary requirements for pregnant and lactating women, there is a lack of implementation or adjustment to accommodate their needs. This gap highlights a significant oversight in the treatment of vulnerable populations within the prison system. Additionally, the health policy fails to address any specific healthcare requirements for women. Such shortcomings contribute to the broader issue of inadequate healthcare access for female inmates. The study sheds light on concerning disparities in healthcare access and treatment within the prison system, particularly impacting women and pregnant detainees. These individuals lack screenings for illnesses, access to female physicians, and encounter challenges in accessing healthcare during pregnancy and post-delivery. This lack of access poses significant risks to the health and well-being of both mothers and their children.

A critical gap in access to healthcare was identified, with a staggering 50.98% of respondents reporting a lack of health services or support during pregnancy or post-delivery. This statistic

underscores the urgent need for systemic reforms. This issue is further compounded by the limited access to child services, with only 9.52% of respondents confirming such access.

The findings resonate with previous research by Bergh et al. (2011), which highlighted gender sensitivity and social discrimination against detained women regarding their health, emphasizing the urgent need for action to address health disparities and uphold human rights and gender sensitivity. These issues reflect a broader pattern of neglect within the system. Similarly, the consistency in diet provision for pregnant and lactating women in Lebanese prisons, as noted in the study, aligns with findings from Shlafer et al. (2017). Moreover, the need for improved health services, including gynecological check-ups, parallels findings by Van Hout and Mhlanga-Gunda (2018). Collectively, these findings indicate systemic flaws in addressing women's health needs. Overall, these findings reflect the global impression of women's health and nutrition in prisons, as observed in Fakhry's (2022) study.

Lebanese authorities must prioritize action in addressing these issues. This prioritization is essential for safeguarding the rights of female prisoners. The reliance on NGOs for vaccine provision instead of the MoSA contradicts the NMR, particularly rules 24, 25, 26, 27, 30, 31, 33, and 34, which advocate for equality in healthcare services under the state's responsibility without discrimination, with special consideration for women and their children held in prison.

Current conditions in Lebanese prisons fall far short of the recommendations outlined by the ICRC regarding women's health in detention facilities. This disconnect highlights the need for urgent reforms. The ICRC's practical guide on healthcare in detention emphasizes the specific needs of incarcerated women. These needs include access to clean water, adequate hygiene facilities, and appropriate sanitation products – factors that become even more critical during pregnancy, menstruation, and childcare. Addressing these basic needs is fundamental to ensuring the health and dignity of female prisoners. The guide underscores the importance of respecting cultural and religious norms related to hygiene practices. Additionally, it highlights the need to ensure free and readily available sanitary products for women and diapers for children within these facilities (ICRC, 2021).

The ICRC further points out the disparity in prison design and prioritization, often neglecting the needs of women who, in most countries, comprise less than 10% of the prison population. This

statistical reality calls for a more equitable approach to prison design and resource allocation. To address this disparity and mitigate the risks of violence and sexual abuse faced by incarcerated women, the ICRC advocates for adherence to the Bangkok Rules. These rules establish specific healthcare protocols for women in prison (ICRC, 2021).

Furthermore, the ICRC recommends exploring alternatives to imprisonment for pregnant women whenever possible. This recommendation underscores the importance of considering non-custodial options for vulnerable populations. For those who are incarcerated while pregnant or breastfeeding, the ICRC emphasizes the importance of providing adequate healthcare, proper nutrition, and privacy. Additionally, ensuring proper documentation for newborns is crucial (ICRC, 2021).

In conclusion, there is a need for significant improvements for women in Lebanese prisons. Such improvements are not only essential for the well-being of women but also reflect a commitment to upholding human rights. Policies and practices must prioritize the health, safety, and dignity of women in these facilities. This presents a critical opportunity for Lebanese authorities to bridge the gap between current realities and internationally recognized standards. Addressing these discrepancies is vital for ensuring equitable treatment of all inmates. Discrepancies within Lebanese prisons, notably the absence of medical centers in facilities like BWP, exacerbate disparities between men and women, particularly considering that RCP includes a medical center for male prisoners. This situation highlights systemic inequalities within the prison system. The discrepancies stem not from a lack of recognition of women's rights, as evidenced by Lebanon's ratification of the Convention on the Elimination of All Forms of Discrimination against Women, but rather from resource and capacity limitations. Furthermore, global implementation of the NMR varies, contingent upon countries' commitment to human rights, adherence to international treaties, and effectiveness of legal and penal systems. While progress has been made in some areas, challenges persist, including overcrowded prisons, inadequate healthcare, and violations of prisoners' rights.

To effectively address these issues, it is crucial to implement customized healthcare protocols for female detainees, bolster the presence of female healthcare professionals, and strengthen collaboration between prison authorities and the MoPH to ensure equitable healthcare provision. These measures will enhance the quality of care and support for female inmates. Additionally,

consistent support and partnership with NGOs should remain accessible until state authorities have sufficiently built their capacity. Additionally, addressing gender disparities in healthcare access and treatment is crucial to upholding prisoners' rights and advancing social justice within correctional facilities.

Chapter 6.17 Nationality

In line with the diverse demographics of Lebanon's population, Lebanese prisons accommodate individuals of various nationalities, as outlined in Chapter 3. The sample of respondents accurately mirrors this diversity, with the majority (65%) being Lebanese, followed by Syrians (25%). This demographic representation is critical for understanding the healthcare dynamics within the prison system.

The analysis of data from Lebanese prisons demonstrates that nationality does not significantly influence many aspects of health and nutrition access for inmates. This observation aligns with the principle of non-discrimination outlined in Article 5 of the Convention on the Elimination of All Forms of Discrimination. Factors like age at imprisonment, pre-existing medical conditions, information on the healthcare system, location and type of consultations, medication distribution (except for female involvement of family members), emergency access, support for disabilities, dental services, and overall service ratings (both within the prison clinic and external facilities) all seem to be consistent across nationalities.

However, the nuances in perceptions of healthcare access reveal deeper insights into the lived experiences of inmates. Additionally, non-Lebanese respondents were more likely to perceive improvements in healthcare access or quality compared to Lebanese inmates. This suggests potential areas for investigation, such as potential bias in medical procedures and the reasons behind the differing perceptions of healthcare improvement based on nationality. Further analysis into specific nationalities within the prison population might also be valuable to identify if any particular groups face unique challenges within the healthcare system.

While the data suggests a relatively consistent approach to healthcare access regardless of nationality for most aspects, the differing perceptions raise concerns about social justice and human rights within Lebanese prisons. The principle of equal treatment before the law, regardless of origin, is a cornerstone of human rights. This principle is vital in ensuring that all inmates

receive equitable treatment. The fact that some inmates perceive improvements while others don't, suggests a potential lack of transparency or clear communication regarding healthcare within the prison system. This could disproportionately disadvantage certain nationalities, particularly those unfamiliar with the system or lacking fluency in Arabic.

At this level, I can conclude that the current system properly addresses the vulnerability of non-nationals in terms of refugees and displaced, which aligns with the international conventions. Nonetheless, the need for continuous improvement remains essential to ensure that all vulnerabilities are adequately addressed.

These findings underscore the importance of ensuring equal access to healthcare for all prisoners, regardless of nationality or gender. Opportunities for improvement would include steps to resolve communication gaps and potential biases, and ensure transparency in healthcare practices to uphold social justice and human rights within Lebanese prisons.

Chapter 6.18 Conclusion

Lebanon's prison system encompasses both strengths and shortcomings in healthcare access, treatment, and policy implementation. Understanding these strengths and weaknesses is crucial for informing future reforms. In general, the current system does not properly address the vulnerability and the diversified needs of prisoners at all levels. Despite existing legislation aimed at safeguarding prisoners' rights to healthcare and nutrition, challenges such as financial constraints and inadequate resources hinder effective implementation. Deficiencies in medical documentation, privacy, and confidentiality further compound issues within the system. Additionally, disparities in healthcare access for women and prisoners with disabilities underscore the need for urgent action to uphold human rights and promote social justice specifically for these vulnerable groups.

Addressing these disparities is not only a matter of compliance but also of moral responsibility. Recommendations include legal reform, policy enhancement, and systemic reforms to ensure compliance with international standards and address the diverse healthcare needs of incarcerated individuals. The discussion also emphasizes the importance of transparency, communication, and equal access to healthcare for all prisoners, irrespective of nationality or gender, to promote dignity and fairness within the criminal justice system.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

This chapter concludes the exploration of Lebanon's prison healthcare system by offering a synthesis of key findings and charting a course for improvement. In this context, the analysis acknowledges existing strengths while highlighting critical shortcomings. Building on these observations, the chapter concludes by proposing a series of actionable recommendations. These recommendations are designed to prioritize upholding human rights and social justice within the prison system, ultimately fostering a more dignified and well-being-focused environment for all individuals.

Chapter 7.1 Summary of Findings

The examination of Lebanon's prison healthcare system reveals a complex landscape characterized by both strengths and shortcomings. While it is important to note that existing legislation aims to uphold prisoners' rights to healthcare and nutrition, outdated rules and implementation challenges persist. Specifically, issues such as overcrowding, understaffing, and inadequate access to healthcare services are prevalent, particularly among vulnerable populations like women and prisoners with disabilities. In particular, gaps were easy to identify at the level of the outdated legislation, overcrowding, quality of diet served, absence of guidelines regarding food safety and personal hygiene, screening and assessment, confidentiality of medical data, provision of gender specific services for women, provision of mental health services and transfer to referral centers. Despite efforts to address these challenges, significant disparities persist especially due to the current crises dynamics in the country, reflecting broader social injustices within the prison system. Thus, the findings underscore the urgent need for comprehensive multidisciplinary reforms involving Lebanese government, MoJ, MoSA, MOIM, MoPH, international organizations, local NGOs along with academic institutions. Such multidisciplinary work is essential to ensure

equitable access to healthcare, uphold human rights standards, and promote the well-being of all individuals within the Lebanese prison system.

Chapter 7.2 Strengths

This pioneering study stands as an example of innovation, including a groundbreaking subject matter, forging new paths where health, nutrition, human rights, and social justice converge. Moreover, it marks the inaugural attempt to comprehensively explore these critical intersections, illuminating the complex dynamics at play. Employing a mixed-method approach, blending the precision and objectiveness of quantitative analysis with the depth and subjectiveness of qualitative insights, this study transcends traditional boundaries, offering a holistic understanding. Furthermore, supported by an extensive array of data collection tools, it navigates the complex shades of these multifaceted domains with precision and thoroughness. Notably, the inclusion of diverse participants spanning various societal strata, from prisoners to officers and physicians, enriches the study's breadth and depth, ensuring a comprehensive exploration of perspectives and experiences.

Chapter 7.3 Limitations

In the current study, the inability to conduct face-to-face interviews with prisoners due to COVID-19 restrictions and Institutional Review Board (IRB) protocols necessitated the utilization of a system overseen by gatekeepers for data collection through self-administered questionnaires. As a result, concerns persist regarding the accuracy and potential biases inherent in questionnaire responses, particularly within the confines of the prison environment. These concerns are primarily due to power control dynamics. Additionally, the study's scope was confined to a specific time and location, selected as a case study for its distinctive attributes, limiting the generalizability of findings to the broader prisoner population in Lebanon. Importantly, the chosen case studies, namely RCP and BWP, primarily accommodated detainees of Lebanese, Palestinian, and Syrian nationalities, suggesting that the majority of findings may be applicable to this demographic subset. Moreover, language posed another limitation, as the predominant use of Arabic (with a few questionnaires in English) during interviews and questionnaire completion may have obscured nuances and cultural meanings, particularly within the Lebanese context. Furthermore, the volatile

exchange rate between LBP and USD posed challenges, impacting the interpretation of reported monetary values. Additionally, nearly half of the collected data relied on self-reported responses through questionnaires, introducing subjectivity without control measures. To address these issues, future research endeavors should prioritize institutions and organizations where IRB or ethics committee guidelines permit interviews with vulnerable groups like prisoners. Moreover, emphasis should be placed on conducting nutritional and medical assessments through clinical and biochemical evaluations, including vital signs, weight measurements, and laboratory tests, to provide a more comprehensive understanding of prisoners' medical and nutritional status. Furthermore, future studies should consider examining other prisons across different regions of the country, such as Zahle and Qobbeh, in a purposive and selective manner to enable meaningful comparisons with the selected case studies.

Chapter 7.4 Concluding Reflections and Recommendations

In essence, the Lebanese prison law theoretically acknowledges the need to fulfill the basic needs of prisoners without digging into technicalities. However, the law is outdated and urgently require updating to reflect contemporary needs in terms of social justice and human rights, aligning with international conventions. For instance, a study by Bowman et al. (2012) discusses that since public policy is critical for both overall public health and disease control, implementing evidence-based policies has proven challenging. The difficulty arises partly from the complex and context-specific nature of the relationship between research and policymaking. While evidence is crucial, other factors, like political pressure from interest groups, can sometimes outweigh it. I am very concerned that these valuable insights from the study of Bowman et al. (2012) seem so applicable to the current state of Lebanese prisons.

Moreover, international standards such as NMR, ICRC guidelines, and other pertinent conventions serve as guiding principles, offering invaluable insights into best practices.

Moreover, international human rights standards for prison healthcare are aspirational, aiming to paint a world where every prisoner receives dignified treatment and access to essential care. However, applying these standards in a real-world context can be like trying to live life through rose-colored glasses (“voir la vie en rose”). This is because financial constraints, geopolitical

realities, and diverse cultural contexts present significant hurdles. Therefore, a more pragmatic approach is necessary, one that acknowledges these limitations while still striving for continuous improvement. This ensures a balance between upholding human dignity and navigating the complexities of the prison environment. Accordingly, some of these international rules may seem idealistic within the context of Lebanon's current crisis-ridden environment. Nevertheless, efforts must be made to adhere to the minimum standards set forth by these conventions, ensuring that human rights and social justice remain at the forefront of prison operations.

Perhaps the most significant contribution of this research lies in giving voice to prisoners, allowing their concerns to be heard beyond the confines of their cells. By including 291 prisoners and offering them a platform to raise any issue, even those outside the study's initial focus on health, nutrition, human rights, and social justice, we gained invaluable insights. While the questionnaires themselves have limitations, the raw emotions, fears, and reflections that echoed beyond the pages hold immense value. This experience underscores the crucial need to expand prison research and directly involve incarcerated individuals throughout the entire research methodology. By incorporating their perspectives and experiences, we can develop more effective and relevant research that informs and guides impactful policy changes.

Despite the challenges posed by limited resources and the ongoing crisis, the Lebanese prison system strives to address the physical, mental, and social health needs of its inmate population, driven by a commitment to human rights and social justice. Notably, there are endeavors to provide gender-specific services for women inmates, supported by local and international NGOs, further emphasizing the importance of equitable treatment and dignity for all individuals within the system. Similarly, refugees receive comparable provisions in terms of nutrition and health care, albeit with limited familial support. Upholding human rights and social justice principles ensures that every individual, regardless of their status or background, receives the necessary care and support they deserve.

Throughout the research study, several strengths within the prison system were evident, including compliance with human rights agreements, a referral system for urgent medical cases, and effective management of communicable diseases. However, weaknesses such as limited human resources, inadequate specialist access, medication shortages, communication inefficiencies, lack of

emergency expertise within prisons, and underdeveloped dietary systems overseen by non-experts were identified, underscoring the ongoing need for reform and improvement.

To achieve lasting improvements, several key recommendations are proposed, all centered on promoting human rights and social justice within the prison system. First, judicial reform stands as the cornerstone of this approach. An efficient and well-functioning judicial system holds the key to reducing overcrowding, which is a major strain on resources. By expediting trials and minimizing the number of pre-trial detainees, we can alleviate overcrowding and optimize the use of essential resources like healthcare and food. This will not only improve prison conditions but also ensure fair and timely justice.

Moreover, focusing on renovations within existing facilities, particularly at RCP, offers a more strategic approach than building entirely new prisons. This strategy would prioritize improvements like cell refurbishments, sanitation revision and upgrades including toilets and show, and the creation of communal dining areas and recreational spaces. Such efforts would not only enhance the physical environment but also promote the dignity and respect due to all inmates. By strategically allocating resources towards renovation, we can create a more humane prison system that fosters positive rehabilitation outcomes.

Furthermore, a comprehensive contingency plan should be devised to effectively manage crises such as pandemics, security threats, or economic collapse while safeguarding the rights and well-being of all individuals within the system.

Additionally, a comprehensive revision of prison laws, particularly those pertaining to health and nutrition, is crucial. Collaboration with international organizations, local universities like AUB, LAU, and USJ, and professional bodies such as physicians' and dietitians' associations, is essential to ensure these updates align with human rights principles and guarantee adequate care and support for all inmates. At the level of meal planning, updated nutrition policy would include guidelines for adequate yet efficient diet with specification of calories and macronutrients. Furthermore, this policy should include a section for special populations that require special attention and specific nutrition guidelines including pregnant and lactating prisoners, detainees suffering from chronic diseases such as diabetes, hypertension, renal failure, heart failure, hyperlipidemia and food allergies. Additionally, the establishment of a PHC facility within RCP could provide inmates and

staff with essential medical services, consultations, and mental health support, further promoting dignity and well-being. Collaboration with NGOs like Caritas, AMEL, Premiere Urgence, the Order of Malta, and the Lebanese Red Cross could further enhance this initiative, fostering a culture of compassion and solidarity within the prison system.

A promising opportunity for improvement lies within telemedicine as proposed by Rubí et al., 2016 & Khairat et al., 2023. Investing in such a strategy to improve health services in an efficient manner sounds very promising. However, Fouad et al. (2021) examined the impact of use of technology on mental health and found out that political, economic, and cultural barriers stand in the way of the potential of technology-based mental health services (TMH) to bridge the gap in care for Lebanon's vulnerable communities struggling during COVID-19. Lebanon's past neglect of mental health policies and its current fight against corruption further complicate establishing TMH systems (Fouad et al., 2021). Such results make it likely that implementing such programs in a complex and critical environment like Lebanese prisons will face even greater challenges. These findings likely translate to even greater challenges when implementing such programs in a complex and critical environment like Lebanese prisons.

Reflecting on the Lebanese prison context, I realize that healthcare and nutrition aren't merely basic needs, but prerequisites to have a healthier and sustainable life. Accordingly, any reforms play an essential role beyond just health. Such reforms would significantly improve the society as a whole. Without good health, prisoners struggle to engage meaningfully in rehabilitation programs or hold onto hope for a better future. This recognition underscores the essential role the prison system plays within the broader community. By prioritizing healthcare reforms, we're not just upholding human rights and social justice, but also fostering a more successful reintegration process. This translates to a reduction in violence and resentment towards the government upon release, ultimately contributing to a healthier and more sustainable Lebanese society. Thus, prioritizing these reforms is not just an act of compassion, but a strategic investment in a brighter future for the Lebanese society as a whole.

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APPENDICES

Appendix 1: Interview guide for use with prison authorities at the ministry in charge of prisons

	Prison authorities
Leadership and governance	1-Can you describe the organization of healthcare in the prisons? 2-What are the laws/regulations/SOP related to the prison health system? Does a prison healthy policy/strategy exist? 3-How is it linked to the country's health strategy? 4-Do you have any agreements or MOHs with partners (MoPH, Ministry in charge of prisons, NGOs, etc…?
Health-service delivery	1-What aspect of healthcare provision works well in the prison? 2-What are the shortcomings, gaps or challenges in the current system for keeping detainees healthy? 3-What can be done to improve the system?
	To what extent are medical ethics respected?
Physical and social determinants	Elaborate about access to healthcare (referrals) and health staff
	Elaborate about access to drugs and equipment
	Elaborate about burden of disease
	Elaborate about healthcare financing (how the budget is prepared,by whom, and what it includes salaries, medicines, equipment, etc…
	Accomodation, food, water, hygiene, outdoor access, occupational and educational activities

Appendix 2.1: Interview guide with senior members of the management team at prison health services

	Senior members of the management team at prison health services
Leadership and governance	1-Can you describe the organization of healthcare in the prisons? 2-What are the laws/regulations/SOP related to the prison health system?Does a prison healthy policy/strategy exist? 3-How is it linked to the country's health strategy? 4-Do you have any agreements or MOHs with partners(MoH,Ministry in charge of prisons,NGOs,etc…?
Health-service delivery	1-What aspect of healthcare provision works well in the prison? 2-What are the shortcomings,gaps or challenges in the current system for keeping detainees healthy? 3-What can be done to improve the system?
	To what extent are medical ethics respected?
Physical and social determinants	Elaborate about access to healthcare (referrals) and health staff
	Elaborate about access to drugs and equipment
	Elaborate about burden of disease
	Elaborate about healthcare financing (how the budget is prepared,by whom,and what it includes salaries,medicines,equipment,etc…
	Accomodation,food,water,hygiene,outdoor access,occupational and educational activities

Appendix 2.2: Interview guide with senior members of the management team at prison health services

	Prison authorities	Health authorities at local and central levels
Leadership and governance	1-Can you describe the organization of healthcare in the prisons? 2-What are the laws/regulations/SOP related to the prison health system?Does a prison healthy policy/strategy exist? 3-How is it linked to the country's health strategy? 4-Do you have any agreements or MOHs with partners(MoH,Ministry in charge of prisons,NGOs,etc…?	1-Can you describe the organization of healthcare if prisons?Does it differ from the way the national health system provides healthcare? 2-What are the policies,strategies and SOP related to the prison health system and how are they implemented?Are they connected to the national health system? 3- Do you have any agreements or MOHs with partners(MoH,Ministry in charge of prisons,NGOs,etc…?
Health-service delivery	1-What aspect of healthcare provision works well in the prison? 2-What are the shortcomings,gaps or challenges in the current system for keeping detainees healthy? 3-What can be done to improve the system?	1-What aspect of healthcare provision works well in the prison? 2-What are the shortcomings,gaps or challenges in the current system? 3-What can be done to improve the system?
	To what extent are medical ethics respected?	To what extent are medical ethics respected?
Physical and social determinants	Elaborate about access to healthcare (referrals) and health staff	Elaborate about access to healthcare (referrals) and health staff
	Elaborate about access to drugs and equipment	Elaborate about access to drugs and equipment
	Elaborate about burden of disease	Elaborate about burden of disease
	Elaborate about healthcare financing (how the budget is prepared,by whom,and what it includes salaries,medicines,equipment,etc…	Elaborate about healthcare financing (how the budget is prepared,by whom,and what it includes salaries,medicines,equipment,etc…

	Accomodation,food,water,hygiene,outdoor access,occupational and educational activities	Accomodation,food,water,hygiene,outdoor access,occupational and educational activities

Appendix 3: Checklist for healthcare providers

؟؟الإصحيوالغنطئي و ؟؟؟النظامالغنطئيلمسليجن في
السجونالسنطية من المقارنات ؟؟نية ؟جتماعية الصحية

استمارةتقييمئة مقبل مقدمي الرعاية الصحية في السجون

محددات الصحة البدنية والاجتماعية

1. ما المحدد الأكثر صعوبة في الصحة في هذا السجن؟
   - كمية المياه المتاحة وجودتها.
   - مساحة المعيشة، والإشغال، والتهوية.
   - التغذية: الكمية والجودة.
   - النظافة الشخصية والنظافة العامة (مواد النظافة، ومواد التنظيف.. إلخ).
   - الوصول إلى الأماكن المفتوحة: التواتر، والمدة، وممارسة الرياضة البدنية، والأنشطة الترفيهية.
   - أخرى.

القيادة والحوكمة

2. كيف يتم تنظيم الخدمات الصحية في هذا السجن وما علاقة النظام الصحي بوزارة الصحة؟

3. هل تحصل على أي دعم من وزارة الصحة (التدريب، أو الإشراف، أو البرامج الرأسية.. إلخ)؟

4. من المسؤول عن صحة المحتجزين؟

5. هل لديك إجراءات تشغيل قياسية محددة لتقديم الرعاية الصحية؟ كيف يتم تطبيقها؟

6. هل لديك أي اتفاقيات أو مذكرات تفاهم مع الشركاء (وزارة الصحة، أو الوزارة المسؤولة عن السجون، أو المنظمات غير الحكومية.. إلخ)؟

7. هل هناك منظمات صحية تعمل في شراكة معك في السجن؟

نظام المعلومات الصحية

السجلات الطبية والسرية الطبية

8. هل لدى عيادة السجن سجلات فردية للمرضى (ملفات طبية) وتحتفظ بها؟

- ما مدى اكتمال الملفات (التشخيص، والعلاج.. إلخ)؟ ما النسبة المئوية للملفات الكاملة من عينة من 30 مريضًا تم اختيارهم عشوائيًا؟
- كيف يتم حفظ السجلات الطبية للمرضى؟
- من يحق له الوصول إلى الملفات الطبية؟
- ماذا يحدث للسجلات الطبية للمرضى المحالين إلى المرافق الصحية؟

9. ما أنواع أدوات/ استمارات التسجيل والإبلاغ المستخدمة؟

10. هل هناك إحصائيات لعدد الاستشارات والإحالات، والإصابة بالأمراض والوفيات في الأسبوع أو في الشهر أو في السنة؟ هل يتم تجميعها بالطريقة نفسها التي تتبعها وزارة الصحة؟ هل تتم مشاركة هذه الإحصائيات مع وزارة الصحة؟

11. هل الإحصائيات المتعلقة بالأمراض التي يجب الإخطار بها (مثل السل، والإسهال المائي الحاد، والحمى النزفية) والإدمان، مسجلة بشكل منفصل ويتم تشاركها مع البرنامج الوطني الرأسي؟

12. هل يبدي رؤساؤك ملاحظاتهم بانتظام؟ هل تجتمع بانتظام مع المشرفين لديك ومع سلطات السجون ومديري الصحة في المناطق؟

13. ما نقاط القوة ومواطن الضعف في النظام؟

تمويل الرعاية الصحية

14. هل تعرف ما إذا كانت هناك ميزانية محددة للرعاية الصحية في السجون أم لا؟ كيف يتم حسابها (على أساس الإنفاق اليومي لكل محتجز)؟

15. هل ميزانيتك سنوية أم أنها مقسّمة على مدار السنة؟ هل هناك تأخير في تلقي الأموال؟

16. ما نقاط القوة ومواطن الضعف في النظام؟

الموارد البشرية اللازمة للرعاية الصحية

17. كم عدد العاملين في مجال الرعاية الصحية في السجون وما مؤهلاتهم؟ هل يشارك العاملون في مجال الرعاية الصحية من الخارج في توفير الرعاية الصحية في السجون؟

18. هل يوجد ما يكفي من موظفي الرعاية الصحية؟ إذا لم يكن الأمر كذلك، فلماذا، وماذا يمكن عمله لعلاج هذا الأمر؟

19. كيف يتم تعيين موظفي الرعاية الصحية وتكليفهم بالمسؤوليات؟ هل هناك أي صعوبات؟

20. هل رواتب موظفي الصحة في السجون والمزايا التي يحصلون عليها مماثلة لما يحصل عليه نظراؤهم في نظام الصحة العامة؟

21. هل ظروف عمل موظفي الصحة في السجون مماثلة لظروف عمل نظرائهم الذين يعملون خارج السجون؟

22. هل هناك نظام مناوبات لموظفي الصحة؟ هل يشمل مناوبات ليلية وفي عطلات نهاية الأسبوع؟

23. هل يعقد الموظفون اجتماعات داخلية منتظمة؟ من يشارك فيها؟

24. هل يحصل موظفو الصحة على التدريب؟ إذا كانت الإجابة نعم، فهل يشمل التدريب موضوعات تتعلق على وجه التحديد بالرعاية الصحية في السجون؟ من الذي يقدم التدريب عادة؟

25. هل يتم الإشراف على موظفي الصحة؟ إذا كان الجواب نعم، من يقوم بالإشراف؟ وهل الإشراف ممنهج؟

26. ما نقاط القوة ومواطن الضعف في النظام؟

المستلزمات الطبية

27. ما المعدات الطبية المتوفرة (في قسم المرضى الخارجيين، وقسم المرضى الداخليين، والمختبر)؟ هل السجون مجهزة على أساس قائمة موحدة؟

28. ما الجهة أو الهيئة الحكومية المسؤولة عن توريد العقاقير؟ هل هناك قائمة عقاقير أساسية/ موحدة؟

29. هل هناك فرق بين العقاقير المتوفرة للسجون والعقاقير المتوفرة في مراكز الصحة العامة؟

30. ما ميزانية المستلزمات الطبية في هذا السجن؟ كيف يتم حسابها؟

31. ما الإجراء المتبع لطلب العقاقير والمواد الطبية؟ كيف تحسب الاحتياجات؟ هل تستند حساباتك إلى الاستهلاك؟

32. كيف يتم تسليم العقاقير؟ كم يستغرق هذا الأمر؟ هل يتم التوصيل دون انقطاع؟ هل تحصل دائمًا على ما تطلبه؟

33. هل العقاقير المتوفرة كافية للتعامل مع الأمراض في السجن؟

34. هل العقاقير مخزنة في السجون؟ كيف يُدار هذا الأمر؟ من المسؤول؟ هل يتم الالتزام بتواريخ انتهاء الصلاحية؟

35. هل تحصل على بعض العقاقير مباشرة من خلال المنظمات غير الحكومية؟ هل يتم تسجيل عمليات التوريد هذه؟

36. هل يتعين على الأسر شراء العقاقير للأقارب المحتجزين؟

37. هل يمكن للمحتجزين الحصول على عقاقير علاج السل وفيروس نقص المناعة البشرية/ الإيدز مجانًا؟

38. ما نقاط القوة ومواطن الضعف في النظام؟

تقديم الخدمات الصحية

39. ما نقاط القوة ومواطن الضعف في النظام؟

الخدمات الصحية

40. ما المرافق المادية المتاحة (قسم المرضى الخارجيين/ قسم المرضى الداخليين/ المختبر/ عيادة الأسنان/ قسم الجراحة/ قسم العزل/ غرفة تبديل الملابس/ الصيدلة/ منطقة الانتظار.. إلخ)؟

41. هل من السهل أو الصعب ضمان السرية/ الخصوصية؟

42. هل تواجه أي نقص في المياه الجارية، أو الكهرباء، أو الإضاءة، أو الأثاث المكتبي.. إلخ؟

43. كيف تتخلص من النفايات الطبية؟

44. ما الإجراء الخاص بالتعقيم؟

الرعاية الصحية في السجون/ خدمات الرعاية الصحية الأولية

45. هل يخضع كل محتجز جديد لفحص طبي عند وصوله؟

46. هل يُجرى هذا الفحص الطبي الأولي في غضون 24 ساعة من دخول المحتجز؟

47. من الذي يُجري الفحص الطبي؟

48. هل يتم تسجيل تاريخ طبي كامل للمريض؟ هل يُجرى فحص بدني؟

49. هل يتم فحص المحتجزين لتحديد إصابتهم بمرض السل/ فيروس نقص المناعة البشرية، ومعرفة إدمانهم المخدرات والكحوليات؟ هل يتم تقييم صحتهم النفسية؟ هل يتم فحص النساء لاكتشاف أنواع معينة من الأمراض؟

50. أين يتم تسجيل النتائج؟

51. هل يجري فتح ملف طبي لكل محتجز لدى وصوله؟

52. هل يتم إخبار المحتجزين، شفهيًا أو كتابيًا، بكيفية الحصول على الرعاية الطبية؟

53. من الذي يقرر أيًا من المحتجزين يحتاجون استشارات طبية؟ الممرض؟ الحارس؟ محتجز اخر؟ (صف الإجراء المتبع لزيارة الطبيب/ الممرض).

54. هل يقوم موظفو الصحة بجولات في جميع الزنازين كل يوم، أو مرة في الأسبوع، أو مرة في الشهر، أو لا يقومون بهذا الأمر على الإطلاق؟ وأي من الموظفين يفعل ذلك؟

55. هل يمنع أفراد الأمن المحتجزين من الحصول على الرعاية الصحية؟

56. كيف يتواصل المحتجز مع موظفي الصحة خارج ساعات العمل؟

57. أين تتم الاستشارات الطبية؟

58. من الذي يقدم الاستشارات؟ ممرض؟ طبيب؟ بعض الأشخاص المؤهلين الآخرين؟

59. هل تُحترم السرية الطبية في هذه الاستشارات؟

60. هل تحدد للمحتجز موعدًا ثانيًا أو موعدًا للمتابعة، أو هل يجب على المحتجزين الاتصال بك مرة أخرى إذا استمرت مشكلتهم؟

61. هل يأتي اختصاصيون إلى السجن؟ هل يتبعون جدولًا محددًا؟ ما تخصصاتهم؟ كم مرة يأتون في الشهر؟

62. هل توجد مبادئ توجيهية محددة لتشخيص الأمراض أو علاجها، أو لأي إجراءات طبية؟ كيف تُستخدم؟

63. من يحق له وصف العقار؟ الأطباء فقط، أم الممرضون أيضًا؟

- هل العقاقير مجانية؟
- هل حدث أنه كان على المحتجزين أو أقاربهم شراء العقاقير الموصوفة من خارج السجن؟ إذا كان الأمر كذلك، يرجى التفسير.

64. من الذي يوزع العقاقير؟ هل يوجد نظام؟ ما هو؟

65. كيف يتصل المحتجزون بموظفي الصحة عندما تكون هناك حالة طوارئ؟ كم يستغرق هذا الأمر؟ صف الإجراء في أثناء النهار، وفي الليل، وفي عطلات نهاية الأسبوع.

66. هل استمرارية الرعاية مكفولة؟ لدى دخول السجن؟ عند نقل محتجز إلى سجن آخر أو مستشفى عام؟ في حالة الإفراج عنه؟

67. كيف يتواصل مقدمو الخدمات الصحية في السجون ومقدمو الرعاية الصحية في المنطقة المحيطة مع بعضهم البعض؟

خدمات تعزيز الصحة والوقاية من الأمراض

68. ما الخدمات الوقائية (التطعيمات، وفحص الإصابة بالتهاب الكبد، وفحص مرض السل، والعلاج بالإيزونيازيد لوقاية المحتجزين المصابين بفيروس نقص المناعة البشرية من الإصابة بمرض السل، ورعاية الأم والطفل.. إلخ)؟ كيف يمكن للمحتجزين الحصول على هذه الخدمات؟

69. هل تتم مراعاة الاحتياطات العامة؟

70. هل يتم تنظيم أنشطة تعزيز الصحة/ التثقيف الصحي؟ من المشاركون؟ المحتجزون؟ موظفو الأمن؟ ما المجالات التي تغطيها هذه الأنشطة؟

71. هل يحصل المحتجزون على مشورة صحية روتينية (عن التغذية، وممارسة التمارين الرياضية، والمخدرات، والتطعيم، والمشورة والفحص الطوعي)؟

72. ما خدمات تعزيز الصحة وإدارة الضغوط المتاحة لموظفي الصحة والأمن؟

خدمات الرعاية الصحية لمجموعات محددة

73. كيف يتم تنظيم الكشف عن مرض السل وتشخيصه وعلاجه (داخل السجن وعند الإفراج عن المريض)؟

- هل من الممكن عزل المرضى؟
- إذا كان الأمر كذلك، ما مدة العزل؟
- أين يمكن عزلهم (السجن، أم المستشفى)؟
- هل تستخدم المعالجة قصيرة الأمد الخاضعة للمراقبة المباشرة لعلاج المرضى؟

74. كيف يتم التعامل مع فيروس نقص المناعة البشرية (المشورة والفحص الطوعي، الربط مع البرامج المعنية على مستوى المجتمع المحلي)؟

75. هل يتم عزل المحتجزين المصابين بفيروس نقص المناعة البشرية؟

76. هل هناك طبيبة للنساء؟

77. كيف تتم المتابعة للنساء الحوامل؟

78. هل يُسمح للنساء بإبقاء أطفالهن الرضع/ حديثي الولادة معهنّ في السجن؟ وإلى أي سن؟ هل يتلقى الأطفال الرضع/ حديثي الولادة تطعيمات؟

79. هل تتم متابعة حالات الصحة النفسية؟ ما أنواع العلاج والدعم المتاحة؟

80. هل تتم متابعة حالات الإدمان (المخدرات/ الكحوليات)؟ ما أكثر أنواع إدمان المخدرات

81. هل تتم متابعة المحتجزين المعاقين؟ ما أنواع الخدمات المتاحة لهم؟

82. هل يمكن للمحتجزين الحصول على خدمات العناية بالأسنان؟ إذا كان الأمر كذلك، فما الخدمات المتاحة؟

الرعاية الثانوية والرعاية من المستوى الثالث (حالات الطوارئ، والاستشارات المتخصصة، والفحص الطبي، والعلاج في المستشفيات)

83. صف إجراءات الإحالات. هل يمكن الوصول بسهولة إلى مرافق الإحالة؟ هل يتوفر النقل دائمًا؟ كيف تتعامل مع المسائل الأمنية؟

84. هل تتمتع جميع فئات المحتجزين بالدرجة نفسها من حيث الحصول على هذه الخدمات؟ هل هناك بعض العلاج التفضيلي؟

85. ما الإجراء المتبع لإحالة الحالات الطارئة؟ خلال اليوم؟ في الليل؟ في العطلات؟

86. كيف تتم إدارة الإصابات الجماعية (المرضى أو الجرحى)؟ ما الإجراءات المتبعة؟

87. كيف يتم تنظيم الإحالة إلى الاستشارات المتخصصة، أو إجراء مزيد من الفحص (مثل التحاليل في المختبرات، أو الفحص بالأشعة، أو الأشعة السينية) أو الإدخال إلى المستشفى؟ من المخول بعمل الإحالات؟

88. كم يستغرق الوصول إلى المرافق الصحية الخارجية؟ هل هناك قائمة انتظار؟ إذا كان الأمر كذلك، كيف تتم إدارتها؟

89. هل الاستشارة المتخصصة/ الفحص/ العلاج في المستشفى مجاني؟ إذا كان الأمر كذلك، هل يستند إلى اتفاق بين السجن و/ أو أنظمة صحية خاصة؟

90. هل توجد غرفة خاصة للمحتجزين في المستشفيات العامة؟ كم عدد الأسرَّة المتوفرة للمحتجزين؟

91. ما الذي يجب على الأخصائيين فعله لضمان متابعة المرضى المحتجزين؟

92. ما مواطن الضعف في النظام؟

حالات محددة

93. ما الإجراءات المتبعة للتعامل مع الحالات التالية؟

- الحبس الانفرادي
- الأمراض المميتة
- الوفاة أثناء الاحتجاز
- حالات أخرى محددة، مثل حالات الإضراب عن الطعام

اقتراحات لتحسين النظام

94. كيف يمكنك تحسين النظام؟

Appendix 4: Checklist for the head of central pharmacy

؟؟الصحي والغذائي و ؟؟؟النظام الغذائي للمسجونين في السجون الليبية من المقاربات □ ؟؟انية ؟؟جتماعية والصحية

استمارة للتعبئة من قبل مرجعة لمدير الصيدلية المركزية

الهيكل

1. ما الصيدلية التي توفر العقاقير والمواد الطبية للسجون؟ هل هي تحت إشراف وزارة الصحة، أو وزارة العدل، أو وزارة الداخلية، أو أي وزارة أخرى؟

2. هل هناك فرق بين العقاقير المتوفرة في السجون والعقاقير المتوفرة في مراكز الصحة العامة؟

الميزانية

3. ما الميزانية السنوية؟ كيف يتم إعدادها؟ هل تكفي لتغطية الاحتياجات؟

نظام الطلب والتسليم

4. كيف تطلب مستوصفات السجون العقاقير وتقوم الصيدلية المركزية بتسليمها؟ هل يوجد نظام لهذا الأمر؟

5. هـل تطلـب السـجون توريـدات العقاقـير كل شـهر أو كل ثلاثـة أشـهر؟ كـم يسـتغرق تسـليم العقاقـير؟ هـل تتـم تلبيـة طلبـات السـجون بالكامـل؟

6. هل الأدوية التي توردها المنظمات غير الحكومية مسجلة هي الأخرى؟

التوفر

7. هل هناك قائمة عقاقير أساسية/ موحدة خاصة بالسجون؟

8. هـل توجـد معايـير لتجهيـز المرافـق الصحيـة في السـجون؟ هـل كل السـجون مجهـزة وفقًـا لذلـك؟

9. هل العقاقير المتوفرة كافية للتعامل مع الأمراض الأكثر شيوعًا في السجن؟

10. هـل حـدث في أي وقـت مـضى انقطـاع في توريـد العقاقـير؟ هـل هنـاك عقاقـير غـير متوفـرة بصفـة دائمـة؟

الإدارة

11. كيف يتم تسجيل استهلاك العقاقير؟ لمن تُرسل هذه المعلومات؟

12. كيف يتم حساب الاحتياجات؟

13. هل يتم الالتزام بتواريخ انتهاء الصلاحية؟

14. كيف تتم إدارة المخزون؟

15. من المسؤول عن متابعة إدارة العقاقير والإشراف عليها؟

علاج مرض السل وفيروس نقص المناعة البشرية

16. هل يمكن للمحتجزين الحصول على عقاقير علاج فيروس نقص المناعة البشرية/ الإيدز مجانًا؟ كيف تتم إدارة الحصول على هذه الأدوية؟

دور العائلات

17. هل حدث في أي وقت مضى أن طُلب من عائلات المحتجزين شراء عقاقير لهم؟

18. ما نقاط القوة ومواطن الضعف في النظام؟

Appendix 5: Checklist for health-care providers at referral health facilities

ي ف ن ج س م ل ي ئ ط غ ن ظ ا م ظ ن ؟ ؟ ؟ و ي ئ ط غ ن ي و ا ل ص ح ؟ ؟
ة ي ح ص ا ق ي ع ا ت ج ؟ ة ي ن ا ؟ ؟ ت ا ب ا ق ا م ن ة ي ط ن ت س ا ل ن و ج س ل ا

ة ي ح ص ل ا ق ف ا م ي ف ة ج ي ص ل ل ي ع ا ر ل ا م د ق ي ل ب ق م ة ئ ي ع ت ب ل ا ت ا م ا ر ت س ا
ى ض ر م ل ا ه ا ي ا ل ا ح ي ي ت ا ل ا ة ي ح ص ل ا

1. هـل مرفـق الإحالـة (مستشـفى المقاطعـة أو المنطقـة، أو المركـز الصحـي.. إلـخ) مسـؤول بـأي شـكل مـن الأشـكال عـن تقديـم الخدمـات للمحتجزيـن؟ هـل وقّـع أي مذكـرات تفاهـم/ اتفاقيـات مـع السـجن/ السـجون؟

2. ما طبيعة الاتصال مع فريق إدارة السجن/ السجون وتواتره؟

3. هل يدير مرفق الإحالة أي أنشطة داخل السجن/ السجون؟

4. كيـف تتـم إدارة الإحـالات مـن السـجن/ السـجون إلى المرفـق الصحـي في المجتمـع المحـلي (مـن وجهـة نظـر المرفـق الصحـي)؟ هـل هنـاك قائمـة انتظـار لدخـول المرفـق؟

5. هـل مـوارد مرفـق الإحالـة مسـتنزفة بسـبب عـدد المحتجزيـن الذيـن يتـم إرسـالهم للفحـص/ العـلاج في المستشـفيات؟ هـل هنـاك تحديـد لعـدد المحتجزيـن؟ مـا التكاليـف، إن وجـدت؟

6. ما الحالات الصحية الأكثر شيوعًا بين المحتجزين؟ هل تشبه ما يمكن أن يوجد بين عامة السكان؟

7. هل لدى المرفق الصحي للإحالة أماكن آمنة/ منفصلة لإقامة المحتجزين؟ كيف تتم إدارة الأمن؟ هل يخضع المحتجزون لتقييد حركتهم في أثناء وجودهم في المرفق؟ خلال الإجراءات الطبية؟ عندما تكون إحدى المحتجزات في حالة وضع؟

8. من الذي يقدم الطعام للمحتجزين؟ من الذي يدفع ثمنه؟ وكيف يتم توصيله ومن الذي يقوم بذلك؟

9. ماذا يحدث عند خروج محتجز من المرفق الصحي؟ كيف يتم تنظيم علاج المتابعة؟

10. هل يصدر المرفق شهادات ميلاد؟

11. ماذا يحدث عندما يموت محتجز في المرفق؟ ما إجراءات التعامل مع هذا الموقف؟

12. هل تعتقد أن المحتجزين يحصلون على خدمات صحية بقدر ما يحصل عليها أفراد المجتمع المحلي؟

13. ما أفضل جانب من جوانب تقديم الخدمات الصحية في السجن/ السجون؟ أين ترى الثغرات؟

Appendix 6.1: Self-administered questionnaire for male detainees- English version

Health security, food security and adequacy of diet

From the human, social and health perspectives

Self-administered questionnaire for the prisoner

Age:

Categories: □ Male

□ Female

□ Lebanese

□ Non-Lebanese Please specify nationality:

Status: □ Awaiting trial/Under trial

□ Sentenced/Convicted

Length of stay in the selected prison:

□ More than 2 weeks but less than a month

□ More than a month but less than one year

□ More than one year

Do you have health insurance? □ Yes □ No If yes, what type?.....

1. **Did you have any sicknesses/diseases when you entered this prison, any preexisting conditions?**

□ Yes

□ No

□ Do not remember

1a. If yes, specify what kind of disease or illness

Description of disease or illness:

1b. If you were being treated, was the treatment continued in prison?

□ Yes

□ No

□ Do not remember

1c. Where did you get this treatment?

□ Prison

□Family

□Other(specify) …….

□Do not know

2. **Were you given a medical examination when you first arrived at or entered this prison?**

□ Yes

□ Questions/Medical interview

□ Physical examination

□ No

□ Do not remember

2.a If you answered Yes:

Specify by whom: …….

□ Doctor

□ Nurse

□ Security officer

□ Other

Specify when: How many days after arrival:……

3. **Upon arrival, were you told how the prison healthcare system worked and how to get access to healthcare?**

□ Yes

□ Oral

□ Written

□ No

□ Do not remember

3a. If you answered yes, specify who gave you this information
Who…….

□ Do not know

4. **Have you sought medical care/assistance since your arrival in this prison?**

□ Yes

□ No

□ Do not remember

4a. If yes, please specify for what disease and when (take the last episode of disease)

Description of disease or illness:
When last time…….
What disease…….
□ **Do not remember**

5. **What did you have to do to see the doctor/nurse? Whom did you contact first, second…?Please describe the process**

Description of the process of gaining access to healthcare:

……..

…….

□ **Do not remember**

6. Have you ever had to pay (in cash or kind or in the form of services) for access to the prison clinic or for a medical consultation or procedure?

□ Yes

□ Access to clinic

□ Medical consultation or procedure

□ No

□ Do not remember

6a. If yes, specify to whom and how much.

To whom……..

How much……..

□ Do not remember

7. **How long did it take to see the doctor after your last request for medical care/assistance?**

□Same day
□ 2-5 days
□ More than 5 days
□ Did not see a doctor or nurse
□ Do not remember

8. **Have you ever been refused permission to go to prison clinic?**

□Yes
□No
□Do not remember

8a. If yes, who turned down your request? Who……
□ Do not know

9. **Where do you usually see the doctor/nurse for a consultation? (Select the most common option)**

□Prison clinic
□ Inside the cell
□ Prison yard
□ Other (specify)……
□ Do not remember

10. **What did the doctor/nurse do during your last consultation? (Select all options that apply)**

□Questions/medical interview

□ Physical examination

□ Only took vital signs(pulse, blood pressure, temperature)

□ Took samples (e.g. blood,urine,stool,sputum) for laboratory tests

□ Other (specify)…….

□ Do not remember

11. Is anybody other than the doctor/nurse usually present during a consultation?

(Select the most common option)

□Yes
□No
□Do not remember

11a.If yes, specify who. (Select all options that apply)

□ Security officer

□ Other detainees

□ Other (specify)……

□ Do not remember

12. How long does a consultation normally last?

□ Less than 10 minutes

□ 10 to 20 minutes

□ More than 20 minutes

□ Do not remember

13. If you needed medicines, who usually provided them after a consultation or when they were prescribed?

(Select all options that apply)

□Prison clinic

□ Family

□ Other(specify)……..

□ Do not know

13a. Specify who provided the medicines

□ Doctor/nurse

□ Security officer

□ Detainee

□ Other(specify)……..

□ Do not remember

14. How long did it take for you to receive your medicines after the last consultation or the last time they were prescribed?

□ Immediately

□Same day

□ 2-5 days

□ More than 5 days

□ Did not receive any medicines

□ Do not remember

15. What happened if your health problem(s) persisted after treatment or after a consultation? What did you usually do?

Describe the process.

Description of the process □ Do not remember

16. Have you, or has anyone in your cell, ever had a health emergency?

□Yes
□Never had or witnessed an emergency
□Do not remember

16 a. If yes, describe what happened

□ Do not remember

17. Have you ever had to be referred to a hospital /specialist?

□ Yes
□ No
□ Do not know

17 a. If yes, describe the process and how long you had to wait.

Description of the process: Waiting time: □ Do not remember

17b. If you needed medicines after being referred to a hospital / specialist, who provided them after the consultation or after they were prescribed? (Select all options that apply.)

□Hospital

□Prison clinic

□Family

□Other(specify) …….

□Do not know

18. Do you know or have you heard of detainees at this prison who are / were addicted to drugs or alcohol?

□ Yes
□ No

18a. If yes, did they get medical support?

□Yes What support (specify).....

□ No

□ Do not know

19. Do you know or have you heard of detainees in this prison who are / were mentally ill?

□ Yes
□ No

19a. If yes, did they get medical support?

□Yes What support (specify).....

□ No

□ Do not know

20. Do you know whether anyone in your cell is suffering from Tuberculosis(TB) and / or living with HIV /AIDS?

□ Yes TB
□ Yes HIV / AIDS
□ No TB or HIV / AIDS

21. Are there any detainees with disabilities in your cell?

□ Yes
□ No

21a. If yes, did they get medical support?

□Yes What support (specify).....

□ No

□ Do not know

22. While at this prison, have you been given information about or instruction of any kind with regard to:

22a. Tuberculosis

□Yes

□ No

□ Do not remember

Describe how you would protect yourself:

22b. HIV/AIDS

□Yes

□ No

□ Do not remember

Describe how you would protect yourself:

22c. Other topics

□ Other (specify)……..

□ Do not remember

22d. Who usually provided such information or instruction?

Specify: …….
□Do not remember receiving any information about or instruction in any of the matters listed above, or with regard to any other health-related subjects

23. Do you have access to dental care at this prison?

□Yes

□ No

□ Do not know

23a. If yes, specify what treatment is available

Treatment: ……..

23b. If yes, who provides dentures.

□Prison clinic

□Family

□Other(specify) …….

□Do not know

24. What do you do to preserve your health?

25. Are you satisfied with the health-care services provided at:

25a. This prison (on a scale of 1 to 10)?

□Satisfied (7-10)
□Average (4-6)
□Not satisfied (1-3), specify reason.....

25b. The referral health facility / hospital (on a scale of 1 to 10)?

□Satisfied (7-10)
□Average (4-6)
□Not satisfied (1-3), specify reason.....

26. Are you satisfied with the food and nutrition services provided at the prison?

□Satisfied (7-10)
□Average (4-6)
□Not satisfied (1-3), specify reason.....

27. Have you experienced any improvement or worsening of access to / quality of health care during the year?

□Yes
□ No
□ Do not know

28. Do you have any suggestions for improving the health-care system in this prison?

Appendix 6.2: Self-administered questionnaire for male detainees- Arabic version

العمر:.....

الفئات:

□ ذكر

□ أنثى

□ مواطن يمني

□ مواطن غير يمني حدد الجنسية: .....

الوضع القانوني:

□ في انتظار المحاكمة / تحقيق جاري؟ سجن

□ صدر حكم نهائي/ مدان

مدة الاحتجاز في السجن:

□ أكثر من سنة ولكن أقل من عشر سنوات

□ أكثر من عشر سنوات

هل لديك أي تصنيف آخر

□ نعم

□ لا

إذا كانت الإجابة نعم، ما نوعه؟.....

1. **هل كان لديك أي أمراض عند دخولك هذا السجن، أو أي حالة إصابة حقيقية؟**

□ نعم

□ لا

□ لا أعلم

1)أ(إذا أجبت بنعم ، حدد نوع المرض.

وصف المرض:

1)ب(إذا كنت تتلقى العلاج، هل كان العلاج مستمراً في السجن؟

☐ نعم
☐ ؟
☐ لا أتذكر

1)ج(من أين حصلت على هذا العلاج؟
☐ السجن
☐ العائلة
☐ مصدر آخر يرجى التحديد...
☐ ؟؟ا

2. هل خضعت لفحص طبي عندما وصلت للسجن أو دخلته ؟ل مرة؟
☐ نعم
☐ أسئلة/ مقابلة طبية
☐ فحص بدني
☐ ؟
☐ لا أتذكر

2)أ(اذا أجبت بنعم ، حدد من أجرى الفحص)طبيب ، ممرض ، مسؤول أمن أو غير ذلك (و متى)على سبيل المثال بعد كم يوم من دخول السجن(
من أجرى الفحص .... متى ....
☐ ؟؟ا

3. عند وصولك، هل تم إخبارك بكيفية عمل نظام الرعاية الصحية في السجن وكيفية الحصول على الرعاية الصحية؟
☐ نعم
☐ شفهيًا
☐ كتابة
☐ ؟
☐ لا أتذكر

3)أ(إذا أجبت نعم، يرجى تحديد من قدم لك هذه المعلومات
من:..
☐ ؟؟ا

4. هل سعيت للحصول على الرعاية/المساعدة الطبية منذ وصولك إلى هذا السجن؟

☐ نعم
☐ ؟
☐ لا أتذكر

4)أ(إذا أجبت بنعم يرجى تحديد المرض، ومتى كان ذلك (التاريخ الوقائع العجيرة.)

وصف المرض:

متى كانت آخر مرة ..... ما المرض.....

□ ؟ أعرف

5. ما الذي كان يجب عليك فعله لزيارة الطبيب/ المرض؟ بمن اتصلت أولاً ثانيًا ..يرجى وصف الحالة

يرجى وصف حالة الحصول على الرعاية الصحية :

□ ؟ذكر

6. هل سبق لك أن دفعت (نقدًا أو عينيًا أو شيك خدمات) من أجل الوصول إلى عيادة السجن أو الحصول على استشارة طبية أو إجراء طبي؟

□ نعم

□ الوصول إلى العيادة

□ الحصول على استشارة طبية أو إجراء طبي

□ ؟

□ ذكر

6)أ(إذا أجبت بنعم، يرجى تحديد المبلغ الذي دفعته كم كان المبلغ.

المبلغ: .....كم:.....

□ ذكر

7. كم من الوقت يمر لزيارة الطبيب بعد آخر طلب قدمه للحصول على الرعاية/ المساعدة الطبية؟

□ في اليوم نفسه

□ 2-5 أيام

□ أكثر من 5أيام

□ لم أتمكن من زيارة الطبيب أو المرض

□ ذكر

8. هل سبق أن رفض طبك الحصول على إذن للتوجه إلى عيادة السجن؟

□ نعم

□ ؟

□ لا أتذكر

8) إذا أجبت بنعم، من الذي رفض طلبك؟
من: .....

□ لا أعرف

9. أين تم زرع الأعضاء التي تحتاج إلى زراعة؟ (يرجى الإشارة إلى أول مكان زرع فيه إذا كان هناك أكثر من عضو واحد.)
□ السجن العادي
□ الحجز داخل المنزل
□ السجن في الخارج
□ أخرى يرجى التحديد.....
□ لا أتذكر

10. ما هي الأعضاء التي تحتاج إلى زراعة؟ (يرجى الإشارة إلى أول عضو تم زرعه في المريض/ المريضة الذي تحتاج إلى زراعة أعضاء.)
□ الكبد
□ القلب
□ الرئتان
□ البنكرياس
□ الأمعاء (الأمعاء الدقيقة، الأمعاء الغليظة، المستقيم)
□ أخرى يرجى التحديد.....
□ لا أتذكر

11. هل كان أي شخص آخر غير المريض/ المريضة موجودًا في نفس الغرفة أثناء الإشارة إلى الحاجة إلى زراعة أعضاء؟ (يرجى الإشارة إلى أول شخص تم ذكره.)
□ نعم
□ لا
□ لا أتذكر

11) إذا أجبت بنعم، يرجى تحديد هذا الشخص. (يرجى الإشارة إلى أول شخص تم ذكره.)
□ مسؤول أمني
□ مسجون آخر (مسجونون آخرون)
□ أخرى يرجى التحديد.....
□ لا أتذكر

12. كم استغرقت الفترة الزمنية قبل الحصول على عضو؟
□ أقل من 10 دقائق
□ بين 10 و 20 دقيقة
□ أكثر من 20 دقيقة
□ لا أتذكر

13. إذا كنت بحاجة إلى أدوية فمن لذي عادة ما يمكنك اللجوء إليه للحصول على المساعدة أو النصائح؟ (يرجى تحديد جميع الخيارات التي تنطبق)

□ عضو الأسرة
□ الأصدقاء
□ أخرى يرجى التحديد.....
□ لا أعلم

13)أ(هل هناك أي من الذين قمت بذكرهم في السؤال السابق يعانون من أي مشاكل صحية؟

□ طبيب/ ممرض
□ مسؤول؟ من؟
□ معالج
□ أخرى يرجى التحديد.....
□ لا أعلم

14. هل تواجه أي عوائق تحول دون حصولك على الأدوية أو الإمدادات الطبية التي تحتاجها؟ إذا كان الأمر كذلك، فما هي؟ (حدد كل ما ينطبق)

□ لا توجد عوائق في الوصول إليها
□ 2-5 أيام
□ أكثر من 5 أيام
□ لم أحصل على أدويتي
□ لا أعلم

15. هل سبق وأن تعرضت أنت، أو أي شخص في منزلك، لحادث أو إصابة خطيرة تطلبت الحصول على مساعدة طبية؟ إذا كان الأمر كذلك، فيرجى وصف الحادث.

وصف الحادثة
□ لا أعلم؟

16. هل سبق وأن تعرضت أنت، أو أي شخص في منزلك، لحالة طارئة صحية؟

□ نعم
□ لم يسبق لي التعرض لهذا النوع من الحالات الطارئة
□ لا أعلم

16)أ(إذا أجبت بنعم، يرجى وصف ما حدث.

لا وصف

□ ؟ئ ك ر

17. ه ل س ب ق ل ك ت ا ح إ ت ش س م ل ى ف ت ش ى / أ خ ر ئ ي ؟

□ ن ع م
□ ؟
□ ؟ □ ؟

17)أ(إ ذ ا أ ج ا ب ت ن ع م ج ر ي و ص ف ا ل ع ل ي ة ا ل م د ة ا ل ز م ن ي ة ا ل ت ي ا ن ت ظ ر ت ه ا.

وصف العملية

وقت الانتظار.....

□ ؟ئ ك ر

17)أ(إ ذ ا ك ن ت ق د ب د أ ت ا ل ر ح ل ة إ ل ى أ د ن ى ف ت ش س م ل ك ت ا ح إ ع ب ي ، م ن ا ل ذ ي ك ا ن ي ر ا ف ق ه ؟ ؟ ؟ أ ل ب ع د ا ل ف ح ص ؟)ح د د ك ل ا ن ط ب ق.

□ ا ل م ف ت ش ى
□ ا ل س ج ا ن
□ ا ل ع ا ل ة
□ أ خ ر ى ي ر ج ى ا ل ت ح د ي د.....
□ ل ا ئ ك ر

18)ه ل ت ع ل م ب و ج و د م ج ر م ي ن ف ي ه ذ ا ا ل س ج ن م ن ه م / ك ا ن و ا م ن ه م ي ح م ل و ن أ س ل ح ة أ و م ع ت ا ت ي ل ك ن ه م ؟

□ ن ع م
□ ؟

18)أ(إ ذ ا أ ج ا ب ت ن ع م ف ه ل ح ص ل و ا ع ل ى د ع م ط ب ي / ل ل ح ص و ل ع ل ى ه ذ ا ا ل د ع م ؟

□ ن ع م م ا ه ذ ا ا ل د ع م:.....
□ ؟
□ ؟ ؟ |

(18 هل تعتقد بوجود مجتمعات في هذا السجن من المرضى النفسيين أو المعاقين عقليًا؟

□ نعم

□ لا؟

19) أ(إذا أجبت بنعم/ هل تحصل على العلاج النفسي؟

□ نعم ما هذا العلاج: .....

□ لا؟

□ لا؟؟

20. هل تعرف إذا كان أي شخص في زنزانتك يعاني من مرض السل و/ أو هو مصاب بفيروس التهاب الكبد الوبائي/ ا ؟؟؟

□ نعم مرض السل

□ نعم فيروس التهاب الكبد الوبائي "ج" □ لا؟ زد

□ نعم كلاهما مرض السل وفيروس التهاب الكبد الوبائي "ج" □ لا؟ زد

21. هل يوجد أي مجتمعات في زنزانتك؟

□ نعم

□ لا؟

21) أ(إذا أجبت بنعم/ هل تحصل على العلاج النفسي؟

□ نعم ما هذا العلاج: .....

□ لا؟

□ لا؟؟

22. يبين المكان في هذا السجن، حيث يُقدم العلاج أو المعالجات من أي نوع من الاضطرابات التالية:

22) أ(مرض السل

□ نعم

□ لا؟

□ لا أعرف

أي تعليقات أخرى تريد أن تضيفها:

22ب(في رواسن قص المناعة البشرية/ ا ؟؟
□ نعم
□ ؟
□ لا أتذكر

يرجى وصف كيف تحمي نفسك:

22ج(موضوعات أخرى
□ أخرى (يرجى التحديد) ....
□ لا أتذكر

22د(من الذي عادة ما يقدم هذه المعلومات أو التعليمات؟
يرجى التحديد(....................................
□ لا أتذكر تلقي أي معلومات أو تعليمات بشأن أي من ؟مور المذكورة ؟؟ه، أو في ما يتعلق بأي موضوعات أخرى تتعلق بالصحة.

23. هل يمكنك الحصول على خدمات العلاج بالعقاقير ؟؟ا في هذا السجن؟
□ نعم
□ ؟
□ أ؟؟

23)أ(إذا أجبت نعم يرجى تحديد العلاج ؟ المتاح.
ال ؟؟؟؟؟؟...

23)ب(إذا أجبت نعم من الذي يوفر طاقم ا ؟؟ان
□ السجن
□ العيادة
□ أخرى يرجى التحديد(.....................
□ أ؟؟

24. ماذا تفعل للحفاظ على صحتك؟

25. هل أنت راضٍ عن خدمات الرعاية الصحية المقدمة في:

25)أ(هذا السجن (على مقياس من 1إلى 10(؟
□راضٍ) 7- 10)
□متوسط)4- 6)
□غير راضٍ) 1- 3(يرجى تحديد السبب.....

25)ب(المرفق الصحي/ المستشفى الذي تم إحالتك إليه (على مقياس من 1إلى 10(؟
□راضٍ) 7- 10)
□متوسط)4- 6)
□غير راضٍ) 1- 3(يرجى تحديد السبب.....

26. هل أنت راضٍ عن خدمات الغذاء والطعام في هذا السجن (على مقياس من 1إلى 10(؟
□راضٍ) 7- 10)
□متوسط)4- 6)
□غير راضٍ) 1- 3(يرجى تحديد السبب.....

27. هل شعرت بأي تحسن أو تدهور في الحصول على الرعاية الصحية أو جودتها خلال السنة؟
□نعم
□؟
□ ؟؟|

28. هل لديك أي اقتراحات لتحسين نظام الرعاية الصحية في هذا السجن؟

Appendix 6.3: Self-administered questionnaire for female detainees- English version

Health security, food security and adequacy of diet

From the human, social and health perspectives

Self-administered questionnaire for the prisoner

Age:

Categories: □ Male

□ Female

□ Lebanese

□ Non-Lebanese Please specify nationality:

Status: □ Awaiting trial/Under trial

□ Sentenced/Convicted

Length of stay in the selected prison:

□ More than 2 weeks but less than a month

□ More than a month but less than one year

□ More than one year

Do you have health insurance? □ Yes □ No If yes, what type?.....

1. **Did you have any sicknesses/diseases when you entered this prison, any preexisting conditions?**

□ Yes

□ No

□ Do not remember

1a. If yes, specify what kind of disease or illness

Description of disease or illness:

1b. If you were being treated, was the treatment continued in prison?

□ Yes

□ No

□ Do not remember

1c. Where did you get this treatment?

□ Prison

□Family

□Other(specify) …….

□Do not know

2. **Were you given a medical examination when you first arrived at or entered this prison?**

□ Yes

□ Questions/Medical interview

□ Physical examination

□ No

□ Do not remember

2.a If you answered Yes:

Specify by whom: …….

□ Doctor

□ Nurse

□ Security officer

□ Other

Specify when: How many days after arrival:……

3. **Upon arrival, were you told how the prison healthcare system worked and how to get access to healthcare?**

□ Yes

□ Oral

□ Written

□ No

□ Do not remember

3a. If you answered yes, specify who gave you this information

Who…….

□ Do not know

4. **Have you sought medical care/assistance since your arrival in this prison?**

□ Yes

□ No

□ Do not remember

4a. If yes, please specify for what disease and when (take the last episode of disease)

Description of disease or illness:
When last time…….
What disease…….
□ Do not remember

5. **What did you have to do to see the doctor/nurse? Whom did you contact first, second…?Please describe the process**

Description of the process of gaining access to healthcare:
……..
…….
□ **Do not remember**

6. **Have you ever had to pay (in cash or kind or in the form of services) for access to the prison clinic or for a medical consultation or procedure?**

□ Yes

- □ Access to clinic
- □ Medical consultation or procedure

□ No

□ Do not remember

6a. If yes, specify to whom and how much.

To whom……..
How much……..
□ Do not remember

7. **How long did it take to see the doctor after your last request for medical care/assistance?**

□Same day
□ 2-5 days
□ More than 5 days
□ Did not see a doctor or nurse
□ Do not remember

8. **Have you ever been refused permission to go to prison clinic?**

□Yes
□No
□Do not remember

8a. If yes, who turned down your request? Who……
□ Do not know

9. **Where do you usually see the doctor/nurse for a consultation? (Select the most common option)**

□Prison clinic
□ Inside the cell
□ Prison yard
□ Other (specify)……
□ Do not remember

10. **What did the doctor/nurse do during your last consultation? (Select all options that apply)**

□Questions/medical interview

□ Physical examination

□ Only took vital signs(pulse, blood pressure, temperature)

□ Took samples (e.g. blood,urine,stool,sputum) for laboratory tests

□ Other (specify)…….

□ Do not remember

11. Is anybody other than the doctor/nurse usually present during a consultation?

(Select the most common option)

□Yes
□No
□Do not remember

11a.If yes, specify who. (Select all options that apply)

□ Security officer

□ Other detainees

□ Other (specify)…….

□ Do not remember

12. How long does a consultation normally last?

□ Less than 10 minutes

□ 10 to 20 minutes

□ More than 20 minutes

□ Do not remember

13. If you needed medicines, who usually provided them after a consultation or when they were prescribed?

(Select all options that apply)

□Prison clinic

□ Family

□ Other(specify)……..

□ Do not know

13a. Specify who provided the medicines

□ Doctor/nurse

□ Security officer

□ Detainee

□ Other(specify)……..

□ Do not remember

14. How long did it take for you to receive your medicines after the last consultation or the last time they were prescribed?

□ Immediately

□Same day

□ 2-5 days

□ More than 5 days

□ Did not receive any medicines

□ Do not remember

15. What happened if your health problem(s) persisted after treatment or after a consultation? What did you usually do?

Describe the process.

Description of the process □ Do not remember

16. Have you, or has anyone in your cell, ever had a health emergency?

□Yes

□Never had or witnessed an emergency

□Do not remember

□ Do not remember

16 a. If yes, describe what happened

17. Have you ever had to be referred to a hospital /specialist?

□ Yes
□ No
□ Do not know

17 a. If yes, describe the process and how long you had to wait.

Description of the process:

Waiting time:

□ Do not remember

17b. If you needed medicines after being referred to a hospital / specialist, who provided them after the consultation or after they were prescribed? (Select all options that apply.)

□Hospital

□Prison clinic

□Family

□Other(specify) …….

□Do not know

18. Do you know or have you heard of detainees at this prison who are / were addicted to drugs or alcohol?

□ Yes
□ No

18a. If yes, did they get medical support?

□Yes What support (specify).....

□ No

□ Do not know

19. Do you know or have you heard of detainees in this prison who are / were mentally ill?

□ Yes
□ No

19a. If yes, did they get medical support?

□Yes What support (specify).....

□ No

□ Do not know

20. Do you know whether anyone in your cell is suffering from Tuberculosis(TB) and / or living with HIV /AIDS?

□ Yes TB
□ Yes HIV / AIDS
□ No TB or HIV / AIDS

21. Are there any detainees with disabilities in your cell?

□ Yes
□ No

21a. If yes, did they get medical support?

□Yes What support (specify).....

□ No

□ Do not know

22. While at this prison, have you been given information about or instruction of any kind with regard to:

22a. Tuberculosis

□Yes

□ No

□ Do not remember

Describe how you would protect yourself:

22b. HIV/AIDS

□Yes

□ No

□ Do not remember

Describe how you would protect yourself:

22c. Other topics

□ Other (specify)……..

□ Do not remember

22d. Who usually provided such information or instruction?

Specify: …….
□Do not remember receiving any information about or instruction in any of the matters listed above, or with regard to any other health-related subjects

23. Do you have access to dental care at this prison?

□Yes

□ No

□ Do not know

23a. If yes, specify what treatment is available

Treatment: ……..

23b. If yes, who provides dentures.

□Prison clinic

□Family

□Other(specify) …….

□Do not know

24. What do you do to preserve your health?

25. Are you satisfied with the health-care services provided at?

25a. This prison (on a scale of 1 to 10)?

□Satisfied (7-10)
□Average (4-6)
□Not satisfied (1-3), specify reason.....

25b. The referral health facility / hospital (on a scale of 1 to 10)?

□Satisfied (7-10)
□Average (4-6)
□Not satisfied (1-3), specify reason.....

26. Are you satisfied with the food and nutrition services provided at the prison?

□Satisfied (7-10)
□Average (4-6)
□Not satisfied (1-3), specify reason.....

27. Have you experienced any improvement or worsening of access to / quality of health care during the year?

□Yes
□ No
□ Do not know

28. Do you have access to gynaecological care?

□Yes
□ No
□ Do not know

29. What medical support did you receive during your pregnancy and after giving birth?

30. Do you have access to everything you need to take care of your child (clothes, hygiene items,
nutritional support, including replacement feeding / powdered milk, etc.)?

□Yes
□ No

30a. If yes,who provides it?

□Prison

□Family

□Other(specify) …….

□Do not know

31. Do you and / or your child have access to vaccination?

□Yes
□ No
□ Do not know

32. Do you have any suggestions for improving the health-care system in this prison?

Appendix 6.4: Self-administered questionnaire for female detainees- Arabic version

الصحي والغذائي و ؟؟؟ النظام الغذائي المتبع في السجن
السجون المختلفة من المرافق □ ؟؟ النية ؟ تجهيزات المرافق الصحية

استمارة تتبع من قبل الباحث على النزلاء (

العمر:.....

الفئات:

□ ذكر

□ أنثى

□ مواطن يمني

□ مواطن غير يمني حدد الجنسية: .....

الوضع القانوني:

□ في انتظار المحاكمة / يقبع في السجن المحكوم عليه

□ صدر الحكم عليه/ عليها

مدة البقاء في السجن تاريخ الدخول:

□ أكثر من سنة ولكن أقل من شهر

□ سنة واحدة من شهر

□ أكثر من سنة

هل لديك أي تصنيف صحي

□ نعم

□ لا

إذا كانت الإجابة نعم، ما نوعه؟.....

1. **هل كان لديك أي أمراض عند دخولك هذا السجن، أو أي حالة إصابة حقيقية؟**

□ نعم

□ لا

□ لا أعلم

1)أ(إذا أجبت بنعم ، حدد نوع المرض.

وصف المرض:

1)ب(إذا كانت إجابتك على ج؟، هل كان لديك مرافق في السجن؟

□ نعم
□ ؟
□ لا أتذكر

1)ج(من أين حصلت على هذا الدواء؟ ج؟
□ السجن
□ العيادة
□ مصدر آخر يرجى التحديد.....
□ ؟؟؟

2. هل تم فحصك طبيا من قبل الممرض أو الطبيب عند دخولك السجن لأول مرة؟
□ نعم
□ نعم/ لكن ليس بشكل روتيني
□ لا
□ ؟
□ لا أتذكر

2)أ(إذا أجبت بنعم ، حدد من أجرى الفحص)طبيب ، ممرض ، مسؤول أمن أو غير ذلك (و متى)بالنسبة لأول دخول لك إلى السجن(
من أجرى الفحص ..... متى .....
□ ؟؟؟

3. عند وصولك، هل تم إخبارك بالخدمات الصحية المتاحة في السجن وكيفية الحصول على الرعاية الصحية؟
□ نعم
□ نعم، شفهيًا
□ نعم، كتابة
□ ؟
□ لا أتذكر

3)أ(إذا أجبت بنعم، من قدم لك هذه المعلومات؟
من:.....
□ ؟؟؟

4. هل سمح لك بالحصول على الرعاية/الأدوية من طبيبك الخاص عند وصولك إلى هذا السجن؟
□ نعم
□ لا
□ لا أتذكر

4)أ(إذا أجبت بنعم، وكان لديك مرض، متى كان ذلك (التاريخ)

الوقائع الجارية.)

وصف المرض:

متى كانت آخر مرة ..... ما المرض.....

□ ؟ أعرف

5. ما الذي كان يجب عليك فعله في زيارة الطبيب/ المستشفى آخر مرة ظهرت فيها أولًا .. يرجى وصف الواقعة الجارية.

يرجى وصف الواقعة على النحو الصحيح :

□ ؟ تأكد

6. هل سبق لك أن دفعت (نقدًا أو شيكًا أو في شكل خدمات) من أجل الوصول إلى العيادة المسجل أو الحصول على استشارة طبية أو إجراء طبي؟

□ نعم

□ الوصول إلى العيادة

□ الحصول على استشارة طبية أو إجراء طبي

□ ؟

□ تأكد

6)أ(إذا أجبت بنعم، يرجى تحديد المبلغ الذي دفعته في كل مناسبة.

المبلغ: .....كم:.....

□ تأكد

7. كم من الوقت غرق الأمر لزيارة الطبيب بعد آخر طلب قدمته للحصول على الرعاية/ المساعدة الطبية؟

□ في اليوم نفسه

□ 2-5 أيام

□ أكثر من 5 أيام

□ لم أتمكن من زيارة الطبيب أو المرض

□ تأكد

8. هل سبق أن رفض طبك الحصول على إذن للتوجه إلى العيادة المسجل؟

□ نعم

□ ؟

□ تأكد

8)أ(إذا أجبت بنعم ، من الذي رفض طلبك؟
من: .....

□ أعرف

9. أين تزور الطبيب/ الممرض عادة للحصول على استشارة؟ يرجى تحديد الخيار الأكثر شيوعًا.)

□ عيادة السجن
□ داخل الزنزانة
□ فناء السجن
□ أخرى يرجى التحديد.....
□ لا أذكر

10. ما الذي فعله الطبيب/ الممرض في آخر استشارة لك؟ يرجى تحديد جميع الخيارات التي تنطبق(

□ أعطاني/ وصف لي الأدوية
□ فحص بدني
□ قياس المؤشرات الحيوية)النبض، وضغط الدم، ودرجة الحرارة(
□ أخذ عينات من الدم، والبول ، والبراز، والحلق)من أجل الفحص المختبري(
□ أخرى يرجى التحديد.....
□ لا أذكر

11. هل كان أي شخص آخر غير الطبيب/ الممرض عادة ما يكون موجودًا في أثناء الاستشارة؟(يرجى تحديد الخيار الأكثر شيوعًا.)

□ نعم
□ ؟
□ لا أذكر

11)أ(إذا أجبت بنعم يرجى تحديد هذا الشخص. يرجى تحديد جميع الخيارات التي تنطبق(

□ مسؤول أمن
□ محتجز آخر)محتجزون آخرون(
□ أخرى يرجى التحديد.....
□ لا أذكر

12 كم استغرق الوقت؟ ؟؟؟ عادة؟

□ أقل من 10 دقائق
□ بين 10 و 20 دقيقة
□ أكثر من 20 دقيقة
□ لا أذكر

13. إذا كنت بحاجة إلى أدوية فمن الذي عادة ما يوفرها بعد استشارة أو عندما يتم وصفها؟(يرجى تحديد جميع الخيارات التي تنطبق)

□ عيادة السجن

□ العلاجة
□ أخرى يرجى التحديد.....
□ لا أعلم

13)أ(إذا تم تشخيص إصابتك بالسكتة الدماغية، فمن الذي قام بتشخيص حالتك؟

□ طبيب/ ممرض
□ ممرض؟ □ من؟
□ مشرج
□ أخرى يرجى التحديد.....
□ لا أعلم

14. كم استغرق الوقت منذ ظهور الأعراض الأولى للسكتة الدماغية التي تعرضت لها حتى وصولك إلى المستشفى؟

□ خلال ساعة
□ 2-5 أيام
□ أكثر من 5 أيام
□ لم أصل إلى أي مستشفى
□ لا أعلم

15. هل كان هذا الحدث الذي تعرضت له هو أول سكتة دماغية تصاب بها؟ إذا كان لا، فكم عدد السكتات الدماغية التي تعرضت لها؟

وصف الحالة □ لا أعلم

16. هل سبق وأن تعرضت أنت، أو أي شخص في عائلتك، لحالة طوارئ صحية؟

□ نعم
□ لا
□ لا أعلم

16)أ(إذا أجبت بنعم، يرجى وصف ما حدث.

الوصف □ لا أعلم

17. هل سبق إحالتك إلى مستشفى/ أخصائي؟

□ نعم
□ ؟
□ ؟□؟

17)أ(إذا أجبت بنعم يرجى وصف الحالة والمدة التي انتظرتها.

وصف الحالة

؟□ن؟ظار.....

□ ؟ئك؟

17)أ(إذا لم تتم إحالتك إلى مستشفى أخصائي، من الذي كان يفترض أن يقوم بإحالتك؟ ؟؟؟ بعد أن وصفه؟)يرجى تحديد جميع الخيارات التي تنطبق.)

□ المستشفى
□ إدارة السجن
□ العيادة
□ أخرى يرجى التحديد.....
□ ؟ئك؟

18)أ(هل تعتقد بوجود مختصين في هذا السجن ممن هم/ كانوا مدمني مخدرات أو كحوليات أوسمعت عنهم؟

□ نعم
□ ؟

18)أ(إذا أجبت بنعم فهل يعمل الموظفون/ الموظفات على دعمك؟

□ نعم ما هذا الدعم:.....
□ ؟
□ ؟؟|

19)أ(هل تعتقد بوجود مختصين في هذا السجن ممن هم/ كانوا مرضى نفسيين أوسمعت عنهم؟

□ نعم
□ ؟

19)أ(إذا أجبت بنعم فهل يعمل الموظفون/ الموظفات على دعمك؟

□ نعم ما هذا الدعم :.....

□ ؟
□ ؟؟أ

20. هل تعرف ما إذا كان أي شخص في منزلك يعاني من مرض السل و/ أو مصاباً بفيروس نقص المناعة البشرية/ الإيدز؟؟؟

□ نعم
□ نعم، فيروس نقص المناعة البشرية/ الإيدز
□ نعم، مرض السل
□ لا أعرف

21. هل يوجد أي شخص في منزلك يتناول أدوية لعلاج السل؟

□ نعم
□ ؟

21أ) إذا أجبت بنعم، هل يتلقى المصاب/ المصابون الدعم؟ ما هذا الدعم:

□ نعم ما هذا الدعم: .....
□ ؟
□ لا؟؟أ

22. يبين ما إذا كنت في هذا السجن، قد تلقيت أو تتلقى أي نوع من العلاجات التالية:

22أ) مرض السل

□ نعم
□ ؟
□ لا أذكر

أي تعليقات أخرى تريد إضافتها:

22ب) فيروس نقص المناعة البشرية/ الإيدز؟؟

□ نعم
□ ؟

□ لا أذكر

يرجى وصف كيفية حمايتك نفسك:

22)ج(موضوعات أخرى
□أخرى يرجى التحديد) .....
□ لا أذكر

22)د(من الذي عادة ما يقدم هذه المعلومات أو التعليمات؟
يرجى التحديد(.....
□ لا أذكر في أي وقت أو في أي مكان أتوقع أن أي من ؟؟ه،وأفضل مكورة ؟مور لا أي موضوعات أخرى تتعلق بالصحة.

23)ل(يمكن الحصول على خدمات الإقراض ؟؟ان هذا السجن؟
□نعم
□ ؟
□ لا ؟؟

23)أ(إذا أجبت بنعم يرجى تحديد العلاج؟ حالات.
؟؟؟؟؟؟؟؟؟.....ل

23)ب(إذا أجبت بنعم من الذي يوفر أو يقدم ؟؟ان
□ السجن
□العيادة
□أخرى يرجى التحديد(.....
□ لا ؟؟

24. ما الذي نفعله للحفاظ على صحتك؟

25. هل أنت راضٍ عن خدمات الرعاية الصحية المقدمة في:

25)أ(هذا السجن في مقياس من 1إلى 10(؟

□راضٍ) 7- 10)
متوسط)4- 6)
□غير راضٍ) 1- 3(يرجى تحديد السبب.....

25)ب(لرفق الصحي/ لمشتفى الذي تم تحويلك إليه حالياً)على مقياس من 1إلى 10(؟
□راضٍ) 7- 10)
متوسط)4- 6)
□غير راضٍ) 1- 3(يرجى تحديد السبب.....

26. هل أنت راضٍ عن خدمات الغذاء والطعام في هذا السجن)على مقياس من 1إلى 10(؟
□راضٍ) 7- 10)
متوسط)4- 6)
□غير راضٍ) 1- 3(يرجى تحديد السبب.....

27. هل ترغب بأي تحسينات أو تطوير في الحصول على الرعاية الصحية أو جودتها في السجن؟
□نعم
□ ؟
□ ؟؟|

28. هل يمكنك الحصول على الرعاية أمراض النساء؟
□نعم
□ ؟
□ ؟؟|

29. ما الدعم الطبي الذي تحتاجه ؟ إلخ وبعد ذلك ؟؟؟

30. هل يمكنك الحصول على احتياجاتك الخاصة للرعاية الطبية، ومتطلبات النظافة، والدعم الغذائي بما في ذلك الوجبات الخاصة.. إلخ؟
□نعم
□ ؟

30)أ(إذا أجبت بنعم من فضلك قدم التفاصيل؟
□ السجن
□ العيادة
□أخرى يرجى التحديد(.....

□ ؟؟؟

31. هل يمكنك أنت ولو أطفالك الحصول على الطعام؟

□ نعم

□ ؟

□ ؟؟؟

32. هل لديك أي اقتراحات لتحسين نظام الرعاية الصحية في هذا السجن؟

Appendix 7: Link sheet for data collection in RCP

اسم الباحث: رويدة	الباحث المسؤول عن جمع البيانات:

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Appendix 8.1: Officer information sheet for checklist

جامعة إيست لندن
مجموعة دوك كيدز، لندن W16 2RD

نزاهة البحث

تلتزم جامعة إيست لندن بأعلى معايير النزاهة في جميع جوانب البحث وممارساته. وتتوقع من جميع الباحثين الالتزام بهذه المعايير.

تلتزم جامعة إيست لندن بحماية حقوق الإنسان والحرية الأكاديمية، وعلى هذا النحو فإن من المتطلبات الأساسية لأي دراسة تجريها الجامعة أن تحصل على موافقة أخلاقية من لجنة البحث المختصة قبل بدء البحث مع المشاركين البشريين أو بياناتهم الشخصية.

الباحثون الرئيسيون

الدكتورة جوليا وميس، محاضرة أولى في القانون الجنائي، جامعة إيست لندن
EB.1.107 دور كيدز
هاتف: [redacted] بريد إلكتروني: g.wemyss@uel.ac.uk

الدكتور رامي بشروش، محاضر أول في القانون الجنائي، جامعة إيست لندن
KD.1.15. دور كيدز.
هاتف: [redacted] بريد إلكتروني: r.Bashroush@uel.ac.uk

الدكتورة أوراس أسماء، محاضرة أولى في القانون الجنائي/ جامعة إيست لندن
EB.1.11 دور كيدز
هاتف: [redacted] بريد إلكتروني: a.lounasmaa@uel.ac.uk

الباحث الرئيسي

السيد يوسف خريف/ مرشح لدرجة الدكتوراه في القانون الجنائي، جامعة إيست لندن
بريد إلكتروني: u2009750@uel.ac.uk

الموافقة على المشاركة في دراسة بحثية

يهدف هذا النموذج إلى الحصول على موافقتك على المشاركة في البحث الموصوف أدناه. يرجى قراءة المعلومات التالية بعناية قبل اتخاذ قرارك بشأن ما إذا كنت ترغب في المشاركة أم لا. إذا قررت المشاركة، فسيُطلب منك توقيع هذا النموذج.

عنوان المشروع

التحقيق في الأطفال الذين يُزعم أنهم ضحايا للاستغلال الجنسي من قبل عصابات الاستغلال الجنسي للأطفال.

الموضوع

ستشارك في دراسة بحثية تهدف إلى فهم وجهات نظر الأطفال الذين يُزعم أنهم ضحايا للاستغلال الجنسي من قبل عصابات الاستغلال الجنسي للأطفال.

اهداف الدراسة هي كالتالي:

- تقييم أمن صحة و غذاء السجناء و عمة النظام الغذائي.
- التركيز على المواطنين المهمشين اجتماعيا مثل السجينات الإناث و/أو السجناء الذين ينتمون إلى مجموعات أقلية عرقية.
- استهداف استراتيجيات تطبيق التدخلات الغذائية والرعاية الصحية بما يتطابق مع المعايير الدولية لضمان و/أو إدارة سوء التغذية ؟؟ راض بين السجناء وتوفير قواعد الحد الأدنى لحقوق الإنسان بغض النظر عن الجنس، العرق، الدين أو الجنسية.
- الدعوة إلى سياسة مرسومة بخرف تعزيز وممارسات صحية وغذائية ملف العمل ومتابعة السجناء ضمن نظام إدارة متابعة السجناء.

تحتوي ؟ بكم ارة على أسئلة تتعلق بالنظام الصحي في السجون بنظام العلاج ومات الصحي تقديم العناية الصحية الموارد البشرية الخدمة الصحي المقدمة للسجناء، ا ؟ دوية والعلاج ؟ بكمة ال ؟ بكم ارات لتحسين النظام.

سرية المعلومات

سنحفظ سرية المعلومات التي ستزودون بها بشكل تام. لن يتمكن أي شخص آخر من الوصول إلى ؟ بكم ارات ؟ هذه ؟ بكم ارات ستستخدم لأغراض البحث. لن نذكر أسماء المشاركين في البحث. سيتم وضع ا بكم ارات في صندوق مقفل في أحد مكاتب الباحثين الرئيسيين في بريطانيا. سيتم إضافة المعلومات التي تزودنا بها إلى جهاز كمبيوتر محمول (لابتوب) يحتفظ به بكلمة مرور قوية وشفرة.

المشاركة

إذا وافقت على المشاركة في هذه الدراسة، سيتم تزويدك ب ؟ بكم ارة لتأكيد موافقتك.

الانسحاب

رجاء إخطارنا على الفور إذا كنت لا تريد المشاركة في هذه الدراسة هي طوعية تمامًا لكل شخص ؟؟ ؟ اب من الدراسة في أي وقت تشاء دون الحاجة إلى تقديم أي تبرير أو تعرض ؟ ي جزاء عليك بدون أن يترتب عليك أي التزام بإعطاء أسبابك. لن يؤثر قرارك بعدم المشاركة على علاقتك مع أي من أعضاء مجموعة السجن التي تنتمي إليها. ؟ حراس السجن لن يكون على علم بأي طريقة يمكن من خلالها ربط مشاركتك في الدراسة بأي حال، ستستمر في تلقي أي مساعدة تحتاجها من الموظفين المعروفين ؟؟ من الصحة وتوفير الحق في الوصول إلى السجناء وضع الصحي.

لجنة الأخلاقيات البحثية الجامعية

إذا كان لديك أي شكاوى أو استفسارات تتعلق بطريقة إجراء هذا المشروع البحثي، فيرجى الاتصال بالباحث الرئيسي المذكور أعلاه، أو الاتصال بالمشرف، مجموعة السجون، جامعة إيست لندن، مجمع الأعمال، شارع رومفورد، لندن E16 2RD

(هاتف: 0044 20 8223 6683 بريد إلكتروني: researchethics@uel.ac.uk

تحتفظ بسجل عن البحث لمدة 10 سنوات بعد الانتهاء من البحث. يرجى الاطلاع على ورقة المعلومات في أعلى هذه الورقة.

Appendix 8.2: Officer information sheet for interviews

جماعة إيمت لندن

مجمّع دوك ستريت، لندن W16 2RD

نزاهة البحث

تلتزم جامعة إيسيكس بدعم أعلى معايير النزاهة والأخلاقيات في جميع جوانب البحث ومراعاة أفضل الممارسات المهنية والقانونية والتنظيمية المناسبة.

تلتزم جامعة إيسيكس بالحفاظ على الحرية الأكاديمية وعلى هذا النحو فإن من المتطلبات الأساسية أن يكون المشاركون في البحث على دراية بطبيعة ومدى ومخاطر أي بحث قبل الموافقة على المشاركة فيه، وأن يكونوا قادرين على ممارسة حقوقهم القانونية فيما يتعلق بالخصوصية وحماية البيانات وحرية التعبير.

البيانات الشخصية

الدكتورة جيسيكا ويمس، محاضرة أولى في القانون الجنائي، جامعة إيسيكس، تلتسفورد، إسيكس، CM1 1SQ
EB.1.107 مبنى
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الدكتور رامي بشروش، محاضر أول في القانون الجنائي، جامعة إيسيكس، تلتسفورد، إسيكس، CM1 1SQ
مبنى KD.1.15.
هاتف: [redacted] بريد إلكتروني: r.Bashroush@uel.ac.uk

الدكتورة أولا لونا سماء، محاضرة في القانون الجنائي، جامعة إيسيكس، تلتسفورد، إسيكس، CM1 1SQ
مبنى EB.1.11
هاتف: [redacted] بريد إلكتروني: a.lounasmaa@uel.ac.uk

التواصل مع الباحث

إذا كان لديك أي أسئلة أخرى بخصوص مشاركتك في هذا البحث، فيرجى الاتصال بالباحث الرئيسي، جامعة إيسيكس، تلتسفورد، إسيكس، CM1 1SQ
بريد إلكتروني: u2009750@uel.ac.uk

الموافقة على المشاركة في الدراسة البحثية

يهدف هذا النموذج إلى التأكد من أنك على علم بالمعلومات التي تحتاج إلى أخذها بعين الاعتبار قبل الموافقة على المشاركة في هذا البحث. يرجى قراءة المعلومات التالية بعناية وطرح أي أسئلة قد تكون لديك قبل الموافقة على المشاركة.

عنوان المشروع

الصحي والرفاهية النفسية للسجناء: النظام العقابي الإنجليزي في سياق الأزمات الوطنية والعالمية

الموضوع

ستشارك في هذه الدراسة البحثية التي تهدف إلى فهم وجهات نظر السجناء حول الصحي والرفاهية النفسية في السجون الإنجليزية، وكيف تأثرت بالأزمات الوطنية والعالمية الأخيرة، مثل جائحة كورونا.

أهداف الدراسة هي كالتالي:

- تقييم أمن صحة و غذا المس اجين و ؟ عمة النظام الغذائي.
- ال تركي ز على المواطنين المهمشين اجتماعيا بشال لل سجينات ا كاث وا ؟ين/والس جناء الذين ينتمون إلى مجموعات أقل عرقية.
- استهداف استراتيجيات تطبيق التد ؟تال غذائية والرعاية الصحية قبما يتطابق مع المعايير الدولية لضمان عدم إساءة استخدام الأغذية ؟؟ راض بين المسا جين الذين تنتهك حقوقهم الإنسانية أثناء غضب النظر عن الجنس، العرق، النوع الاجتماعي أو الجنسية.
- الدعوة إلى سياسة/ممارسة تعترف بحق المرضى في الحصول على الأغذية والرعاية الصحية المناسبة ثقافيًا داخل نظام إدارة المخاطر للمسا جين.

تتضمن الأسئلة البحثية المقترحة على النظام الصحي في السجون نظام الرعاية الصحية المقدم للمسا جين، الأدوية والعلاج ؟ا ؟ب ؟ة التي تحسن النظام.

سرية المعلومات

سنحفظ سرية المعلومات التي تزودنا بها بشكل تام. لن يتم مشاركة أي معلومات تحدد هويتك مع أي شخص خارج فريق البحث. ؟ يتم الحصول على أجوبتك سوى أغراض البحث التي تم شرحها لك في هذه ؟ورقة المعلومات. ؟ اهداف البحث. لن نبلغ عن أي شيء يمكن أن يحدد هويتك في أي نشر نتائج البحث.

القانون

إذا وافقت على المشاركة في هذه الدراسة، سيتم الاحتفاظ بتراضيا على تطبيق MS TEAMS بناءً على موعد مسبق.

الانسحاب من الدراسة

رجاء اخذ العلم ان مشاركتك في هذه الدراسة هي طوعية بشكل كامل ولك حرية ؟؟؟اب من الدراسة في أي وقت بدون الحاجة إلى تقديم أي تبرير أو تعرض ؟ي جزاء بدون أي التزام باعطاء ا ؟باب. لن يؤثر قرارك بعدم المشاركة على علاقتك مع أي من أعضاء فريق البحث في جامعة ؟ؤسسة لندن البريطانية بأي طريقة ممكنة. على أي حال، سنستخدم المعلومات التي قدمتها في وضع المسودة النهائية لتقريرنا ؟؟؟ من المعروف أن تؤثر على الحق في الانسحاب من البحث بعد جمع البيانات.

لجنة الأخلاقيات البحثية الجامعية

إذا كان لديك أي شكاوى بخصوص الطريقة التي تمت بها دراستك، الرجاء الاتصال بالمشرف المسؤول عن الدراسة، مجموعة البحث، جامعة لندن، مجمع الشرق، EB 1.43، شارع الملكة، لندن، E16 2RD

البريد الإلكتروني: researchethics@uel.ac.uk هاتف: [redacted]

تتجسد أهداف البحث الرئيسية في الحصول على البيانات اللازمة للبحث العلمي وتحليلها بهدف الوصول إلى النتائج والتوصيات الخاصة بموضوع البحث.

Appendix 9.1: Officer consent form-Arabic version

جامعة إدنبرة

نموذج الموافقة على المشاركة في البحث الخاص بمشاركة ضباط الشرطة

ا؟من لص حي ول غ ف ئ ي و ؟؟ م ق ل ن ظ م ا ل غ ف ئ ي ل م س ا ج ي ن ف ي ا ل س ج و ن ا ل ب ل ا ت ي ة م ن ل ق ر ا ب ا ت ا ! ك ا ن ي ة و ا ج ت م ا ع ي ة و ل ص ح ي ة ل ل ث و ر ة ج و ر ج ي ن ا ي س ي ا ل ث و ر ة ي ع ا ش ر و ش ، ل ل ث و ر ة ا و ر ا ل ف ا س م ا ء ل س ي د ي ا ي س ي ف خ ر ي

ل ل ر ج ا ء و ض ع إ ش ا ر ة ف ي ل ل ك ا ن ا ل م ن ا س ب:

	ن ع م	؟
ل ق د ق ر أ ت ُ ف ه م ت ُ ل م ع ل و م ا ت ل ل و ا ر د ة ف ي م ت ن د ل م ع ل و م ا ت ل خ ا ص ة ب ل د ر ا س ة ل ح ا ل ي ة. ل ق ت ش ر ح ي ط ب ي ع ة و أ ه د ا ف ل د ر ا س ة ل ح ا ل ي ة و أ ع ط ي ت ل ف ر ص ة ل ط ر ح ا ل أ س ئ ل ة و ط ر ح ا ل م ل ا ح ظ ا ت ع ن م ت ن د ل م ع ل و م ا ت ف ه م ت ج ي د ً ا ل م ا د ة ل م ق ت ر ح ة و ا ل ط ر ق ل ت ي س ت خ د م ب ع ش ر ح ه ا ل ي ف ص ؟.			
أ د ر ك ا ن ل خ ر ا ط ي ف ي ه ذ ه ل د ر ا س ة ت ه ا ل ع ل و م ا ت ل م ح ة ف ي ه ذ ا ل ب ح ث س ي ق ت ش ك ل ت ل م. ل ن ي ت ك ن م ن ل ح ص و ل ع ل ى ه ذ ه ل ع ل و م ا ت س ى ل ب ا ح ث و ن ل خ ر ط و ف ي ه ذ ه ل د ر ا س ة.)ل ر ج ا ء ق ر ا ء ة ل ب ي ا ن ا ت (			
أ ف ه م أ ن ل م ق ص ود ب ل م ل ح ظ ة ع ل ى غ ا ي ة ل س ي ت خ ض ع ل ل ش ر و ط ل ت ا ل ي ة: س ي ت م ل م ل ح ظ ة ع ل ى س ر ي ة ل م ش ا ر ك و ل ن ي ت ع ر ض ل أ ي ش ي ء.			
س ي ت م ا س ت خ د ا م ق ت ب ا س ا ت م ج و ل ة ل م و ق ف ي ل ل ش و ر ا ت.			
و س ا ئ ل ن ش ر ن ت ا ئ ج ل ب ح ث ي ه ي ل ت ا ل ي ة: أ ط ر و ح ة، ق ا ل م ُ ر ا ج ع ا ت ر ا ف ي ن ش ر ة ف ي ق ر ا ر ي ة ف ن ي ة ر ي د ا خ ل ي، م ق ا ل ت ر، أ و ل م ج م و ع ا ت م ع ي ن ة ف ي ل م ت ع ل ق ة ب م و ض و ع ل س ج و ن.			
ل ح ص و ل ع ل ى ف ق ة ل م ش ا ر ك ي ك ? ؟ ب ي ا ن ا ت ف ي د ر ا س ا ت أ خ ر ى ت ق و ب ط ر ي ق ل ب ح ث.			
ت ش ر ح ل ي م ا ل ذ ي س ي ح ص ل ب م ج ر د ا ن ت ه ا ء ل ب ح ث.			
ف ه م أ ن م ش ا ر ك ت ي ف ي ه ذ ه ل د ّ ر ا س ة ط و ع ّ ي ة ت م ا م ً ا ي ل ح ق ف ي ا ! ك س ح ا ب م ن ل د ر ا س ة ف ي أ ي و ق ت ك ا ن د و ن ل ت س ب ب س ل ب ي ا ت ت ج ا ه ن ي س ي و ب د و ن ا ن ا ج ر ع ل ى إ ع ط ا ء أ ي ب ر ر ا ت و ف ه م أ ن ي م ك ن ن س ح ب ي ا ن ا ت ل خ ا ص ة ب ي ح ت ى م ر ح ل ة ت ح ل ي ل ل ب ي ا ن ا ت و ل ب ع د ه ذ ه ل م ر ح ل ة ؟ ل ك ن ي م ن ل م م ك ن س ح ب ل م ش ا ر ك ة.			
أ و ا ف ق ط و ع ً ا ع ل ى ل م ش ا ر ك ة ف ي ه ذ ه ل د ّ ر ا س ة ل ت ي ت م ش ر ح ف ص ي ل ه ي ب ق ة و ل س م ح ل ك ب ا س ت خ د ا م ل ت ق ا ط ب س ا ئ ل ن ش ر ن ك ص ل ق ب ل ب ح ث.			

ا س م ل م ش ا ر ك ة ل م ش ا ر ك) ؟؟؟ (ل ك ي ر ة (:

.....

ت و ق ي ع ل م ش ا ر ك ة ل م ش ا ر ك:.....

ل ت ا ر ي خ: .....

Appendix 9.2: Officer consent form-English version

ج ا م ع ة إ س ت ل ن د ن

ل م و ف ق ة ع ل ى ل م ش ا ر ك ة ف ي ب ر ن ا م ج ي ش م ا س ت خ د ا م و ك ا ل ي ن ب ش ر ي ي ن

ا؟من لص حي ول غ ئ ي و ؟؟م ق ل ن ظ م ال غ ئ ي ل م س اج ي ن ف ي ال س ج ون ال ب ل ي ة من ل ق ر اب ات ا ؟ ك ن ي ة و اج ت م ع ي ة ل ص ح ي ة
ل ل ث ور ة ج ي ور ج ن ا ي ي س س ل ل ث ور ة ي ي ع اش روش ، ل ل ث ور ة اور ل ن ف اس م اء ل س ي د ق ي اس ي ف خ ر ي

ل ل ر ج اء و ض ع إ ش ار ة ف ي ل ل خ ان ل ن ف اس ب:

	ن ع م	؟
ل ق د ق ر أ ت ُ ف ه م ت ُ ل م ع ل و م ات ل ل و ار د ة ف ي م ت ن د ل م ع ل و م ات ل خ ا ص ة ب ل د ر ا س ة ل ب ح ث ي ة ل ق د ت م ت ش ر ح ي ط ب ي ع ة و أ ه د اف ل د ر ا س ة ل ب ح ث ي ة و أ ع ط ي ل ف ر ص ة ل ق ا ش ف ي ل و ط ر ح ا ب ر ط ة ع ن م ت ن د ل م ع ل و م ات ف ه م ت ج ي د اً أ ل م ا د ة ل م ق ت ر ح ة و ا ب ل ي ل ت ي س ت ت م ج م ع ه ا ي ف ص ؟.			
أ د ر ك ا ن ل خ ر ا ط ي ف ي ه ذ ه ل د ر ا س ة ت و ا ل ع ل و م ات ل م ح ق ف ي ه ذ ا ل ب ح ث س ق ى س ي ق ش ك ل ت ل م. ل ن ي ت م ن ل ح ص و ل ع ى ه ذ ه ل ع ل و م ات س ى ل ب ا ح ث ون ل خ ر ط و ف ي ه ذ ه ل د ر ا س ة.)ل ر ج ا ع ق ر ا ء ة ا ب ك ي(			
أ ف ل ه م أ ل م ل خ ظ ة ع ى غ اي ة ل س ي ت خ ض ع ل ق ي ي د ل ت ا ل ي ة: س ي ت م ل م ل خ ظ ع ى س ي ق ل م ش ار ك ول ن ي ت ف ض ح أ ي ش ي ء.			
س ي ت م ا س ت خ د ام ق ت ب ا س ات م ج ول ة ل ه ق ف ي ل ل ش ور ات.			
س ط ر ل ش ر ت ط ا ج ل ل ب ح ث ي ل ت ا ل ي: أ ط ر و ح ة، ق ال ُ ر ا ج ع ا ك ر ا ف ي ش ر ة ف ي ق ي ة ق ي ي د ا ل خ ي، م ق م ر، أ و ل م ج م و ع ات م ع ن ة ف ي ل م ت ع ل ك ون م ع ي ق ب ض و ع ل س ج ون.			
ل ل ح ص ول ع ى ف ق ة ل ش ار ك ي ك ؟ ؟ ب ي ا ف ي د ر ا س ات أ خ ر ى ق و ب ط ر ي ق ل ب ح ث.			
ت ش ر ح ل ي م ا ل ذ ي س ي ح ص ل ب م ج ر د ا ن ت ه اء ل ب ح ث.			
ف ل ه م أ ن ش ار ك ت ي ه ذ ه ل د ّ ر ل ة ط و ع ّ ق ت م ام ً أ ي ل ح ق ف ي ا ؟ ك س ح اب م ن ل د ر ل ة ف ي أ ي و ق ت ك ا ن د ون ل ت س ب ب س ل ي ا ت ت ج ا ف ن س ي و ب د ون ا ن ا ج ر ع ى إ ع ط اء أ ي ب ر ر ات و ف ه م أ ل ه ي م ك ن س ح ؟ ب ي ا ت ل خ ا ص ة ب ي ح ل ة ت ح ا ل ي ل ا ت و ل ب ع ه ذ ه ل م ر ح ل ة ؟ ك ون م ن ل م ك ن س ح ب ل ش ار ك ة.			
أ و ا ف ق ط و ع اً ع ى ل ش ار ك ة ف ي ه ذ ه ل د ّ ر ل ة ل ت ي ت ش ر ح ف ا ص ي ل ه ي ب ق ة و ل س م ح ل ك ب ا ت خ د ام ل ت ا ج ب س ائ ل ش ر ن ا ت ل ب ح ث.			

ا س م ل م ش ار ك ة ل م ش ار ك ة) ؟؟؟| ل ك ي ة(:

.....

ت و ق ي ع ل م ش ار ك ة ل م ش ار ك ة:.....

ل ت ا ي خ: .....

Appendix 10: Confidentiality agreement

Confidentiality Agreement

Project title - **Health security, food security and adequacy of diet in Lebanese prisons from the human, social and health perspectives**

I, (name) , ,have been chosen to assist and help in the recruitment of participants, distribution of forms(consent forms, information sheets, questionnaires) and safe handling and transfer of filled forms.

I agree to -

1. Keep all the research information shared with me confidential by not disclosing, discussing or sharing the information in any form or format (e.g., documents) with anyone other than the *Researcher(s)*.

2. Keep all research information in any form or format (e.g., documents) secure while it is in my possession.

3. Return all research information in any form or format (e.g., documents) to the *Researcher(s)* when I have completed the research tasks.

4. After consulting with the *Researcher(s),* erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher(s)* (e.g., scratch documents, schedule of participation of prisoners, information stored on computer hard drive).

5. Keep the information filled by participants confidential by making sure envelopes that contains the set of signed consent form and filled questionnaire are sealed.

(Print Name)	(Signature)	(Date)

Researcher(s)

(Print Name) (Signature) (Date)

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by Research Ethics Committee at University of East London.

For questions regarding participant rights and ethical conduct of research, contact Catherine Hitchens, Research Integrity and Ethics Manager, Graduate School, EB 1.43

University of East London, Docklands Campus, London E16 2RD

(Telephone: [redacted], Email: researchethics@uel.ac.uk)

Appendix 11: Arabic information sheet (for the prisoner)

جامعة إيست لندن
مجمّع دوك كي دز، لندن W16 2RD

نزاهة البحث

تلتزم الجامعة بمسؤوليتها في تعزيز ودعم أعلى معايير الدقة والنزاهة في جميع جوانب البحث ومراعاة ؟؟ا؟ و؟الأطر القانونية والمهنية المناسبة.

تلتزم الجامعة بالحفاظ على الكرامة والحقوق والسـ ؟والرفاهية، وعلى هذا النحو فإن من المتطلبات ؟؟زامية للجامعة أن يتم منح الموافقة ا؟ ؟؟الموسيقي من لجنة ؟ثقيات البحث، قبل بدء البحث مع المشاركين البشريين أو بيانات البشرية.

الباحثين الرئيسيين

الدكتورة جورجينا ويميس، محاضرة أولى كلية القانون والعلوم ا؟جتماعية، جامعة إيست لندن

غرفة EB.1.107

هاتف: [redacted] بريد إلكتروني: g.wemyss@uel.ac.uk

الدكتور رامي باشروش، محاضر أول قسم الهندسة والكمبيوتر جامعة إيست لندن

غرفة KD.1.15.

هاتف: [redacted] بريد إلكتروني: r.Bashroush@uel.ac.uk

الدكتورة أورا لوناسماء، محاضرة كلية العلوم ا؟جتماعية/ جامعة إيست لندن

غرفة EB.1.11

هاتف: [redacted] بريد إلكتروني: a.lounasmaa@uel.ac.uk

التلميذ الباحث

السيدة ياسمين فخري/مرشحة لدرجة الدكتوراه كلية العلوم ا؟جتماعية جامعة إيست لندن

بريد الكتروني: u2009750@uel.ac.uk

الموافقة على المشاركة في دراسة بحثية

يهدف هذا الكتاب إلى تزويدك بالمعلومات التي تحتاجون إلى أخذها با؟عتبار عند تقرير ما إذا كنتم ستشاركون بهذه الدر ؟؟؟

عنوان المشروع

ا ؟الأمن الصحي والغذائي و ؟؟النظام الغذائي للمساجين في السجون اللبنانية من المقاربات الإنسانية ا؟جتماعية الصحية.

الموضوع

ستشكل هذه الدراسة والبحث على الصعيد الوطني موجّها غذائيا وصحيا عن المساجين في لبنان. ستقيّم ا؟من الصحي والغذائي للسجناء ول ؟ ءمة الغذائية النظام المقدم للسجناء.

اهداف الدراسة هي التالية:

- تقييم أمن صحة و غذاء المساجين و ؟ ءمة النظام الغذائي.

- التركيز على المواطنين المهمشين اجتماعيا مثل السجناء السابقين/والسجناء الحاليين وأسرهم.
- استهداف استراتيجيات التطبيق التي تتوافق مع المعايير الدولية لضمان إدارة سوء التغذية وفقا لمعايير حقوق الإنسان الدولية المعترف بها على نطاق واسع، بغض النظر عن السجن، العرق، الجنس، الجنسية.
- الدعوة إلى سياسة/ممارسة تعترف وتعالج سوء التغذية في المؤسسات العقابية كجزء من نظام إدارة مخاطر السجناء.

تتكون الأسئلة العامة التي يمكن طرحها على المشاركين المحتملين في البحث من:

سرية المعلومات

سنحافظ على سرية المعلومات التي تزودنا بها بشكل تام. لن يتمكن أحد من معرفة ما إذا كنت قد شاركت في البحث أم لا. سنحافظ على سرية هويتك ما لم تخبرنا أنك تريد منا عدم القيام بذلك. لن نكشف عن أي شيء قد تخبرنا به إلى أي شخص آخر، ما لم نعتقد أنك أو شخص آخر في خطر أو أن القانون يجبرنا على القيام بذلك. سنناقش **حدود السرية** معك في بداية المقابلة. سيتم تخزين البيانات الإلكترونية المخزنة على جهاز كمبيوتر محمول محمي بكلمة مرور وتشفير.

الموافقة

قبل بدء المقابلة، سيُطلب منك التوقيع على نموذج الموافقة المستنيرة الذي يؤكد أنك وافقت على المشاركة في الدراسة.

الانسحاب

يمكنك الانسحاب من المشاركة في هذه الدراسة في أي وقت دون إبداء أي سبب. لن يؤثر قرارك بعدم المشاركة أو الانسحاب على أي خدمات تتلقاها أو قد تتلقاها في المستقبل. لن يُطلب منك تقديم أي سبب لرغبتك في الانسحاب. بعد المقابلة، لديك أسبوعان للانسحاب من الدراسة دون إبداء أي سبب. بعد هذا الوقت، قد لا يكون من الممكن إزالة بياناتك من الدراسة.

لجنة أخلاقيات البحث الجامعي

إذا كان لديك أي شكاوى بشأن طريقة إجراء البحث، فيرجى الاتصال بالمشرف الرئيسي الخاص بك، الدكتورة [redacted]، مدرسة الدراسات العليا والبحوث، جامعة إيست لندن، مجمع الشرق، شارع رومفورد، لندن E16 2RD

البريد الإلكتروني: researchethics@uel.ac.uk الهاتف: [redacted]

شكرا لك على الوقت الذي خصصته لقراءة هذه الورقة.

Appendix 12: English information sheet (for the prisoner)

University of East London
Docklands Campus, London E16 2RD

Research Integrity
The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.

The University is committed to preserving your dignity, rights, safety and wellbeing and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences.

The Principal Investigator/Director of Studies

Dr Aura Lounasmaa, Lecturer, School of Social sciences, University of East London EB.1.11,Docklands

Telephone: [redacted] , Email:a.lounasmaa@uel.ac.uk

Dr Rabih Bashroush, Senior Lecturer, Department of engineering and computing, University of East London

KD.1.15,Docklands

Telephone: [redacted], Email:r.Bashroush@uel.ac.uk

Dr Georgina Wemyss, Senior Lecturer,School of Law and social sciences, University of East London

EB.1.107,Docklands

Telephone: [redacted], Email:g.wemyss@uel.ac.uk

Student researcher

Yasmine Fakhry, PhD candidate, School of Social sciences, University of East London

4-6 University Way London E16 2RD

Email: u2009750@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title

Health security, food security and adequacy of diet of prisoners in Lebanese prisons

From the human, social and health perspectives

Project Description

The study will be the first detailed nationwide nutrition-oriented research towards prisoners in Lebanon. It will assess the nutrition status of prisoners and nutrition adequacy of the diet offered at Lebanese prisons.

The objectives of the study are the following:

- Assess nutritional status, adequacy of diet and food security of prisoners.
- Emphasize on socially disadvantaged populations like females and refugees/ethnic minority groups prisoners.
- Aim towards applying nutrition and healthcare intervention strategies in accordance with international standards to prevent and/or manage malnutrition and diseases within prisons and

meet the standard minimum rules of human rights regardless of gender, ethnicity, religion and nationality.

- Advocate a policy/decree to add health and nutrition information to every prisoner's data file within prisoner file management system.

The questionnaire include general questions related to you ,your health status and the health services provided by the prison.

There are no major risks resulting from your participation in this study. Some of the questions we will ask may bother you and you can choose not to answer or withdraw from the study if you wish.

Confidentiality of the Data

The data you provide will be kept strictly confidential. Your name will not be documented on the questionnaire. Only the members of the research group will have access to the questionnaires that will only be used for research purposes. Your name will not be reported when disseminating research findings.Procedures have been placed to prevent the re-identification and crossing matching of your filled questionnaire with your consent form that includes your name. The filled questionnaires will be locked in a cabinet at one of the researchers' office in Lebanon. Electronic versions of the data will also be stored on laptop, which is password locked and encrypted.

Location

If you accept to participate in this study, you will be provided with a questionnaire to fill it at a private place allocated for the research within the prison campus.

Disclaimer

Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. Please note that your data can be withdrawn up to the point of data analysis – after this point it may not be possible.

University Research Ethics Sub-Committee

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Hitchens, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: [redacted], Email: researchethics@uel.ac.uk)

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet.

Appendix 13: Arabic consent form (for the prisoner)

جامعة إدنبرة
الموافقة على المشاركة في بحث استخدام الشباب السجناء

من القائمين على البحث والغرض منه ؟؟ من قانون الطب النفسي للسجون الجنائية من الدراسات الإكلينيكية والاجتماعية والجنائية
الدكتورة جيورجينا إيفيس، الدكتورة أورلا فيتزباتريك ، الدكتور ريتشارد كروس ، السيد فيصل خري

الرجاء وضع إشارة في الخانة المناسبة:

	نعم	؟
لقد قرأتُ وفهمتُ المعلومات الواردة في مستند المعلومات الخاص بالدراسة البحثية لقد تمت شرح جميع جوانب وأهداف الدراسة البحثية وأعطيت الفرصة لطرح أسئلة عن مستند المعلومات وفهمت جيداً المعلومات المقترحة والإجابات التي تم تقديمها على أسئلتي ؟.		
أدرك أن المشاركة في هذه الدراسة تهدف إلى جمع المعلومات في هذا البحث فقط. لن يتم الحصول على هذه المعلومات لأي أغراض أخرى دون موافقتي الكتابية.		
أفهم أن الملاحظات على جلسة السجن ستخضع للقيود التالية: سيتم الاحتفاظ بالملاحظات على سجن المشارك ولن يتم تضمين أي شيء.		
سيتم استخدام اقتباسات مجهولة المصدر في المنشورات.		
شروط المشاركة في البحث هي التالية: أطروحة، قد أراجع المشاركة في تقرير الدكتوراه، مقترحات، أو المجموعات المركزة في المستقبل وقد تكون مرتبطة بالسجون.		
الحصول على موافقة المشارك [illegible] في دراسات أخرى قد تتطلب البحث.		
تشرح لي ما الذي يحصل بعد انتهاء البحث.		
فهم أن مشاركتي في هذه الدراسة طوعية تماماً أي أنه يحق لي الانسحاب من الدراسة في أي وقت كان دون الحاجة إلى تبرير السبب وبدون أن يؤثر ذلك على أي علاج أتلقاه في السجن. هل تريد أن تسحب [illegible] الخاص بك في مرحلة تحليل البيانات وفهم أنه بعد هذه المرحلة [illegible] من المشاركة.		
أوافق طوعاً على المشاركة في هذه الدراسة البحثية التي تم شرحها لي وأفهم أنه يحق لي سحب استخدام التسجيلات الصوتية للمقابلة قبل نشرها.		

اسم المشارك (المشاركة) [illegible] التاريخ:
.....

توقيع المشارك (المشاركة):.....

التاريخ: .....

Appendix 14: English consent form (for the prisoner)

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.

Health security, food security and adequacy of diet of prisoners in Lebanese prisons

From the human, social and health perspectives

Dr Aura Lounasmaa,Dr Rabih Bashroush,Dr Georgina Wemyss,Mrs Yasmine Fakhry

Please tick as appropriate:

	YES	NO
I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only the researchers involved in the study will have access to the data. *(Please see below)*		
I understand that maintaining strict confidentiality is subject to the following limitations: Participant's confidentiality will be maintained, and no disclosure will happen at any place.		
Anonymized quotes will be used in publications.		
Methods of publication dissemination of research findings are: Dissertation / Thesis, article in peer reviewed journal, internal report and conference presentation.		
Obtain participants' permission to use the data in future research by the research team.		
It has been explained to me what will happen once the programme has been completed.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature(or proof of proper understanding through initials or cross writing)
……..
Date: …….

Appendix 15: Research Ethics Committee Approval

University of East London

Pioneering Futures Since 1898

Dear Yasmine,

Application ID: ETH2324-0260

Original application ID: ETH2122-0089

Project title: "Beyond Cells and Walls: Exploring Human Rights and Social Justice through Health and Nutrition in Lebanese Prisons"

Lead researcher: Mrs Yasmine Fakhry

Your application to Ethics and Integrity Sub-Committee (EISC) was considered on the 12th June 2024.

The decision is: **Approved**

The Committee's response is based on the protocol described in the application form and supporting documentation.

Your project has received ethical approval for 4 years from the approval date.

If you have any questions regarding this application please contact your supervisor or the administrator for the Ethics and Integrity Sub-Committee.

Approval has been given for the submitted application only and the research must be conducted accordingly.

Should you wish to make any changes in connection with this research/consultancy project you must complete 'An application for approval of an amendment to an existing application'.

Approval is given on the understanding that the UEL Code of Practice for Research and the Code of Practice for Research Ethics is adhered to.□□

Any adverse events or reactions that occur in connection with this research/consultancy project should be reported using the University's form for Reporting an Adverse/Serious Adverse Event/Reaction.

The University will periodically audit a random sample of approved applications for ethical approval, to ensure that the projects are conducted in compliance with the consent given by the Ethics and Integrity Sub-Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of the project.

For further guidance and resources please check our Research Ethics Handbook.

Yours sincerely,

Fernanda Da Silva Hendriks

Research Ethics Support Officer

Docklands Campus
University Way
London E16 2RD

Stratford Campus
Water Lane
London E15 4LZ

University Square Stratford
Salway Road
London E15 1NF

[redacted]
srm@uel.ac.uk
uel.ac.uk

Appendix 16: Lebanese Authorities' Approval

المديرية العامة للأمن الداخلي
صادرة

ساعة البث	التاريخ	الرقم	المصدر
	11 /7/ 2019	51622	شعبة العلاقات العامة

من : اللواء المدير العام لقوى الأمن الداخلي

إلى : - العميد قائد الدرك الإقليمي / فرع الخدمة والعمليات/

- العميد رئيس هيئة الأركان / شعبتي:المعلومات- الخدمة والعمليات /لاخذ العلم/

نص البرقية

عطفاً على كتاب الطالبة ياسمين فخري ، المتعلق بطلب الموافقة على اجراء مقابلات مع من يلزم بغية الإستحصال على بيانات ديموغرافية وصحية عن نزلاء السجون اللبنانية لإستثمارها في دراسة تعدها عن الوضع الغذائي لنزلاء السجون بهدف نيل شهادة الدكتوراه .

مع الموافقة على الطلب، لذلك يعهد الى قيادة الدرك الإقليمي تكليف كل من:العقيد رئيس فرع السجون والعقيد قائد سرية السجون المركزية / روميه، والملازم اول كريستوف كرم المشرف على التغذية في السجن المركزي / روميه كل فيما خصه بما يلي:

اولاً: إبلاغ الجهة المستدعية مضمون هذه الموافقة، واجراء مقابلة معها وتزويدها بالمعلومات اللازمة .

ثانياً: إجراء التنسيق اللازم على الرقم: 528388/03 .

ثالثاً: ابلاغ الجهة المستدعية وجوب عرض محتوى الأطروحة علينا قبل الإستثمار .

رابعاً : الإفادة عن التنفيذ فور الإنتهاء.

الناشير: عثمان

التوقيع : اللواء عماد

بثها ..... تلقاها .....

التوقيع ....

.....00000000000

الجمهورية اللبنانية
وزارة الداخلية والبلديات

وثيقة إحالة

موضوع المعاملة : بشأن طلب المساعدة على إنجاز بحث علمي.

رقم التسجيل	جهة الإرسال وأسباب الإحالة	التاريخ والتوقيع
٢٦٥٨٥	**جانب المديرية العامة لقوى الأمن الداخلي**	
	نودعكم ربطاً كتاب المستدعية الآنسة ياسمين وضاح فخري المسجل لدينا تحت	
	رقم ٢٦٥٨٥ تاريخ ٢٠١٩/١٢/١٠ المتعلق بالموضوع المذكور أعلاه،	
	مع الموافقة،	
	للإطلاع وإجراء المقتضى بالتنسيق مع القضاء [redacted]	
	تبلغ نسخة لجانب:	
	– الجهة المستدعية %	
	–المستشار كريم مجدلاني/ للمتابعة والتنسيق %	
	١٢ كانون الأول ٢٠١٩	

المديرية العامة لقوى الأمن الداخلي

هيئة الإركان – شعبة الخدمة والعمليات

رقم ٢٠٤/ ٢٠٢١ ش/

تاريخ ٢٠٢١/ ٣/ ٤

حضرة السيدة ياسمين وضاح فخوري

الموضوع : إجراء بحث عن السجون.

عطفاً على كتابكم الآلي رقم تاريخ ٢٠٢١/٠١/١٥ المتعلق بطلب الاستحصال على البيانات المرتبطة بـ "التوجيه العقابي والأمن العقابي وبإدارة النظام العقابي للسجون" بهدف إجراء دراسة في المجالات الإدارية والاجتماعية والصحية" في إطار متابعة أطروحة الدكتوراه في جامعة University Of East London

وبعد الاطلاع، وبغرض تطوير خاصة في ظل الجهد المشار إليه أعلاه، فإنه لا يمكن مقاومة أي من الطلبين، علماً أنه يمكنكم:

أولاً: الاستحصال على:

١١- البيانات العامة المتعلقة بالسجون (عدد السجناء، الجنس، الجنسية).

١٢- القوانين والتعليمات التي تتناول الأمور الصحية المتعلقة في معالجة السجناء الطبية.

ثانياً: عقد اجتماع مع كل من:

- آمر سجن الأحداث

- المشرف على مطبخ السجن المركزي في رومية.

مع الإشارة إلى أنه يمكن التواصل مع الرائد حسن بركات على البريد الالكتروني: (Hassan.Barakat@isf.gov.lb) لأي إستفسار.

للتفضل بأحد العلم.

[redacted]

FH

المديرية العامة لقوى الأمن الداخلي
وحدة الإدارة المركزية - مصلحة الصحة

[redacted]

الموضوع : ملف معالجة .

نظر و حول

عدد: ٢٠٦/٣٨٦٠٥

إلى الرائد الطبيب رئيس مركز سجن زحلة الطبي

تنفيذاً لامر رئاسة الادارة المركزية الرقمي رقم ٢٠٤/٢٥٦٥ف٨/٣ تاريخ ٢٠٢٢/١٢/٣٠

للاطلاع واجراء المقتضى على ان يتم التنسيق مع الطالبة ياسمين فخري رقم الهاتف ٠٣/٥٢٨٣٨٨ ورؤساء المراكز الطبية المتواجد ضمن نطاقها سجون او مستقرة داخل السجون (رومية وطرابلس) بحال دعت الحاجة ولتكون الاجابات دقيقة وموضوعية وفقاً لواقع الحال وكذلك مع مكتب الادوية واللوازم الطبية، والاعادة

حرر في بيروت في ٢٠٢٣/١/[illegible]
رئيس مصلحة الصحة
[illegible]حادة

[redacted]

المديرية العامة لقوى الأمن الداخلي

برقية مخولة

المصدر	الرقم	التاريخ	ساعة اعطائها
شعبة الخدمة والعمليات	٢٠٤/١٠٩٨ش٢	٢٠٢٢/٤/٣٠	

من: اللواء المدير العام لقوى الأمن الداخلي

الى: العميد رئيس الادارة المركزية وكالة

فوري

نص البرقية

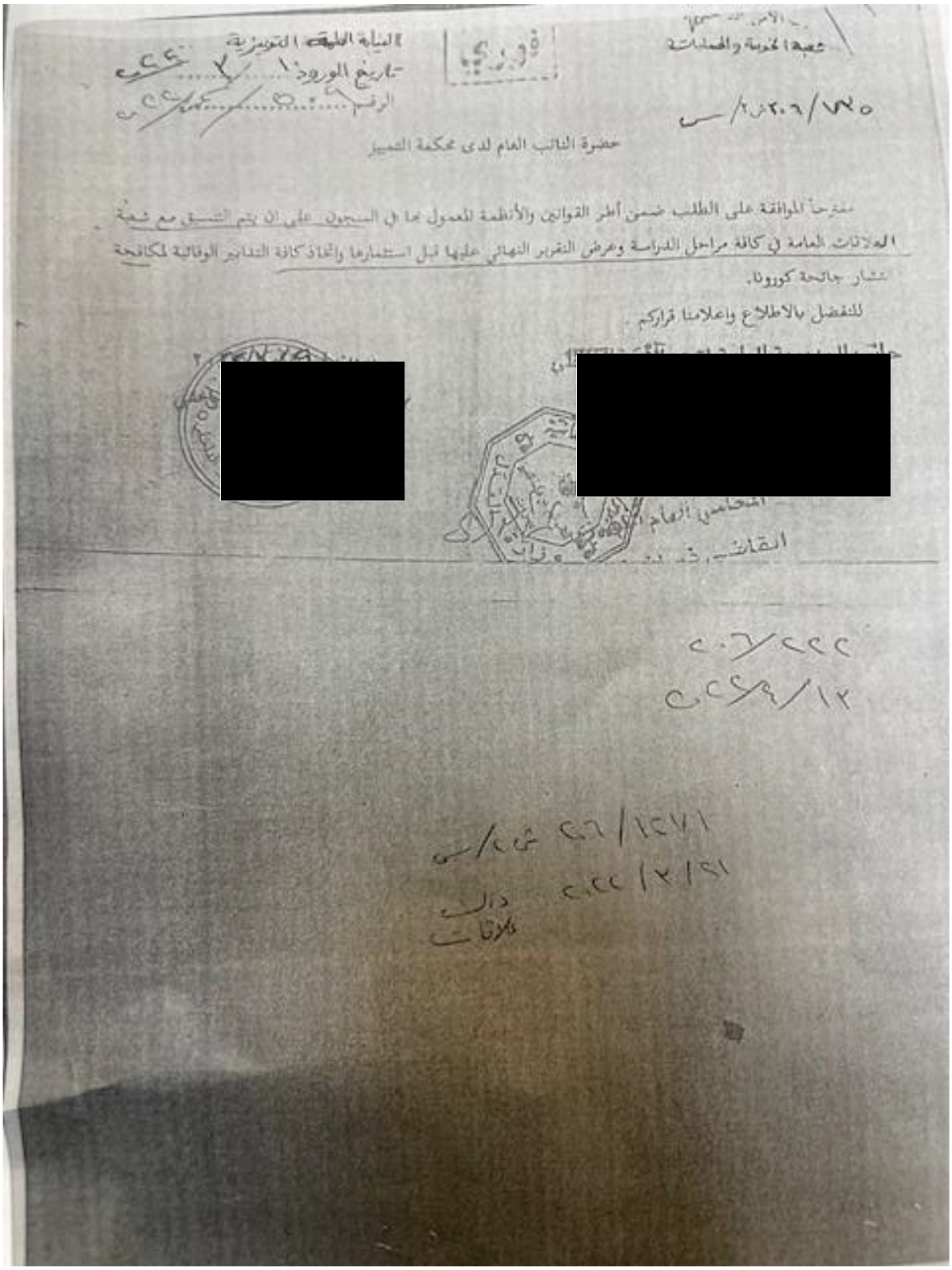
إلحاقاً لأمري الإحالي رقم ٢٠٦/١٢٧١ش٢/س تاريخ ٢٠٢٢/٠٣/٢١ المتضمن موافقة النيابة العامة التمييزية على تعيئة استمارة مرتبطة بدراسة الأمن الصحي والغذائي داخل السجون.

نرفق ربطاً إستمارة للتعبئة من قبل مصلحة الصحة.

للإطلاع وإجراء المقتضى على أن يتم التنسيق مع الطالبة ياسمين فخري على رقم الهاتف ٠٣/٥٢٨٣٨٨. والإفادة في حينه.

[redacted]

الناشير:



المديرية العامة لقوى الامن الداخلي

برقية منقولة

معجل للغاية	X	معجل جدا*		عادي		عدد الصفحات
من : العميد رئيس الادارة المركزية وكالة – فرع الادارة –						ف٨/٣
الى : العميد المهندس رئيس مصلحة الصحة						
النص	الرقم : ٢٠٤/ ٣٥٦٥ ف٨/٣			التاريخ: ٢٠ / ١٢ / ٢٠٢٢		

إنفاذا" لأمر المديرية العامة – شعبة الخدمة والعمليات البرقي رقم ٢٠٤/١٠٩٨ش٢ تاريخ ٢٠٢٢/١٢/٣٠ ، المرفق ربطا".

نرفق إستمارة للتعبئة من قبلكم.

للاطلاع وإجراء المقتضى على أن يتم التنسيق مع الطالبة ياسمين فخري رقم الهاتف ٠٣/٥٢٨٣٨٨ والافادة في حينه.

المديرية العامة لقوى الامن الداخلي
الوحدة : الادارة المركزية
المصلحة : مصلحة الصحة
الوارد في ٢٠ / ١٢ / ٢٠٢٢
السجل تحت عدد ٢٠٢٢/٢٨٦٥

[redacted]

Appendix 17: Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and under which students, researchers tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often emstudent researcherrical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that understudent researchern creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
STUDENT RESEARCHER /Researcher	**Yasmine Waddah Fakhry**
STUDENT RESEARCHER /Researcher ID (e.g. ORCiD)	0000-0001-8917-7862
STUDENT RESEARCHER /Researcher email	U2009750@uel.ac.uk
Research Title	Health security, food security and adequacy of diet in Lebanese prisons From the human, social and health perspectives
Project ID	ETH2122-0089
Research start date and duration	Research Start Date: October 20 2022 Minimum Period is up to 08 Jan 2025 Maximum Period is up to 08 Jan 2027

Research Description	Malnutrition is a global worrying issue contributing to a series of diseases. In fact, this term does not only include undernourishment, yet it also encompasses overnutrition and inadequate vitamins and minerals uptake. According to WHO, malnutrition has a double burden in populations and individuals characterized by the coexistence of undernutrition along with OW, OB or non-communicable diseases related to diet (WHO, 2017). Speaking of numbers in 2014, approximately half a billion adults worldwide were underweight, while 1.9 billion were either OW or OB(Di Cesare et al., 2016). When addressing malnutrition thoughts, it comes to our mind several marginalized and disadvantaged populations, among them is prisoners, refugees and homeless, people in poor health,elderly,etc… Prisoners are typically individuals who are put in prison or jail, deprived of their liberty as a punishment after committing a certain crime.Some prisoners are sentenced for months, years or even for life while other individuals are convicted until trial. In particular, malnutrition is very common in prisons and makes a major risk factor for mortality and morbidity in both developed and underdeveloped countries(Karen M. Davison et al., 2019). Worldwide, more than 11 million individuals are imprisoned either as convicted (pre-trial) or sentenced and the prison population is continuing to grow over the years as compared with the world population(Walmsley, 2018). After reviewing the available literature tackling nutrition in prisons from the perspective of human rights, social and health needs worldwide, the review concludes that there are still uneven methodologies for nutritional assessment of prisoners. On the other hand, literature suggests conflicting results about nutrition status of prisoners as compared between low income countries and rich countries with countries having no studies in regards with this issue, particularly in middle east area and Lebanon specifically. This suggests the need to put ground for a research and have a tested nutrition assessment tool for prisoners and examine the health security,food security and adequacy of diet of this population in Lebanon. The study will provide first detailed nationwide nutrition and health-oriented research towards prisoners in Lebanon. It will deliver evidence-based data to advocate policies and strategies that will prioritize nutrition within standard minimum human rights frame and taking into consideration gender, nationality, medical status, social status, etc… The project will be executed through the following methodologies 1)Virtual interview with Representative of prison authority at ministry of interior and municipalities General Fares Fares (via MS teams) 2)Virtual interview with Senior officer responsible for health services of prisoners General Ibrahim Hanna (ISF) (via MS teams) 3)Checklist to be filled by Physician counseling at Roumieh central prison. 4) Checklist to be filled by Pharmacist at Roumieh central prison. 5) Self-administered questionnaires for a Sample of prisoners in Roumieh central prison and Baabda women prison For the first 2 interviews,me as student researcher will hold the interview online whereas the others will be auto-filled by concerned parties. For the prisoners,a sample of 359 prisoners is needed out of population size of 5415 with 5%margin of error and 95% confidence level. Checklists to be filled with health authorities will be sent via email.

<table>
<tr><td></td><td>For prisoners, self-administered questionnaires will be sent in a closed envelope with information sheet and consent form where the prisoner will return all the documents to the sealable envelope.
Besides,adequacy of diet will be measured through analysing the standard menu served at Roumieh central prison(which hosts 59% of prisoners of Lebanon) and from which 27 other prisons and detention offices receive meals for their detainees. The menu will be analysed through a software for energy, macronutrients and essential vitamins and minerals adequacy.</td></tr>
<tr><td>Funder</td><td>N/A</td></tr>
<tr><td>Grant Reference Number (Post-award)</td><td>N/A</td></tr>
<tr><td>Date of first version (of DMP)</td><td>August 4th, 2020 reference ETH1920-0152</td></tr>
<tr><td>Date of last update (of DMP)</td><td>12/06/2024</td></tr>
<tr><td>Related Policies</td><td>Research Data Management Policy
https://repository.uel.ac.uk/download/e565f51a281eac8a6bb72a0358cc954f4b6932ef93524d39f87df379a8ab3e9a/138022/UEL-Research-Data-Management-Policy-2019.pdf</td></tr>
<tr><td>Does this research follow on from previous research? If so, provide details</td><td>No</td></tr>
<tr><td>Data Collection</td><td></td></tr>
<tr><td>What data will you collect or create?</td><td>
<table>
<tr><th>Types of data to be collected</th><th>File format and size</th></tr>
<tr><td>Data sets related to demographical distribution of prisoners in Lebanese prisons, which are prison name, gender distribution and nationalities’ distribution.</td><td>XLS not exceeding 10 MB</td></tr>
<tr><td>Data sets related to interview notes</td><td>XLS not exceeding 10 MB</td></tr>
<tr><td>Data sets of weekly menu plans of Roumieh central prison</td><td>XLS not exceeding 10 MB</td></tr>
</table>
</td></tr>
</table>

	Data sets related to general information of prisoners.	XLS not exceeding 10 MB

	Types of data to be collected	Source/Process
How will the data be collected or created?	Data sets related to demographical distribution of prisoners in Lebanese prisons, which are prison name, gender distribution and nationalities' distribution.	These data sets are non-personal public data provided by the website of ministry of justice of Lebanon (www.pa.justice.gov.lb).
	Data sets of sample weekly menu plans of Roumieh central prison.	These data sets will be obtained as hard copy from supervisor of central kitchen of Roumieh prison.
	Data sets related to general information of prisoners: Age, gender, nationality, status, length of stay in prison	These data sets will be obtained from self-administered questionnaires filled by prisoners.
	Data sets related to access to health care and services	These data sets will be obtained from self-administered questionnaires filled by prisoners and some ISF officers through checklists. Also through virtual interviews with other ISF officers. Via MS Teams Concerning Checklists for ISF officers, the plan is to send by email to

	<table><tr><td></td><td>be filled and sent back again electronically. (If there is a certain barrier to this, they will be filled on hard paper)</td></tr></table> The project will be executed through the following methodologies 1)Virtual interview with Representative of prison authority at ministry of interior and municipalities General Fares Fares (via MS teams) 2) Virtual interview with Senior officer responsible for health services of prisoners General Ibrahim Hanna (ISF) (via MS teams) 3)Checklist to be filled by Physician counselling at Roumieh central prison. 4) Checklist to be filled by Pharmacist at Roumieh central prison. 5) Self-administered questionnaires for a Sample of prisoners in Roumieh central prison and Baabda women prison For the first 2 interviews, me as student researcher will hold the interview online whereas the others will be auto-filled by concerned parties. For the prisoners, a sample of 359 prisoners is needed out of population size of 5415 with 5%margin of error and 95% confidence level. Checklists to be filled with health authorities will be sent via email. For prisoners, self-administered questionnaire will be sent in a closed envelope with information sheet and consent form where the prisoner will return all the documents to the sealable envelope. Once finalized all the sealed envelopes will be placed in sealed envelopes, which will be handled according to the confidentiality agreement, until I pick up from Beirut branch of prisons. Besides, adequacy of diet will be measured through analysing the standard menu served at Roumieh central prison (which hosts 59% of prisoners of Lebanon) and from which 27 other prisons and detention offices receive meals for their detainees. The menu will be analysed through a software for energy, macronutrients and essential vitamins and minerals adequacy.
Documentation and Metadata	
What documentation and metadata will accompany the data?	Blank consent form Participant information forms Data collection sheets File naming conventions List of variables (for data entry and creation) Field notes taken during the time of data collection Coding system for variables.
Ethics and Intellectual Property	

Identify any ethical issues and how these will be managed	The study involves data collection from prisoners (human participants). Ethical issues taken into consideration for the recruitment of participants are highlighted through an information sheet and consent form, to carefully explain the study's benefits, goals, voluntary participation and right to withdraw from the study. Once the prisoner reads/understands the information sheet and decides to participate, he/she must document his/her approval on the consent form. Designated ISF officers will be helping in recruitment and facilitating the process of administering the questionnaires to participants. Officers will sign the "confidentiality agreement" to make sure participant's' data and information are safely handled. Data will be pseudonymised: Participants will be labelled as P1, P2, P3 etc. So, they will be labelled as such on questionnaire, information sheet and consent form to be able to link them until "due date of documents' destruction" Data will be stored pseudonymised with codes P1, P2, P3 etc. In fact, in order to make the prisoner's participation as anonymous as possible, the following direct identifiers will not be retrieved: name, father name, family name, year of birth, photo or even voice recording. Also, no indirect identifiers could be linked with other information to identify the prisoner. The guidelines of the Helsinki Declaration will direct the study. Indeed, ethical approval will be obtained from the Research ethics committee at the University of East London. Plus, approval for access to prisons and data collection from Lebanese prisons from the Lebanese Ministry of Interior affairs and municipalities has been already acquired. I have not planned to audio record the virtual interviews to avoid handling personal data identified by the voice of the participants. After pilot study, methodology and logistics will be assessed for feasibility, and accordingly if needed I will consider audio recording, which will be amended in the ethics application and DMP as well. Within 4 weeks of data collection, participants willing to withdraw from the study will be able to do (they know this from information sheet) so as I will be able to identify them through the "link sheet". After 4 weeks, I will make sure that data is properly entered and participants withdrew (if any), the link sheet along with filled questionnaires and other hard copy research related documents will be destroyed. The electronic version of link sheet will be stored in the UEL OneDrive separate from the pseudonymised data

Identify any copyright and Intellectual Property Rights issues and how these will be managed	**None**
Storage and Backup	
How will the data be stored and backed up during the research?	Data collected from checklists, questionnaires, menus and virtual interviews will be transferred to excel as coded and data entry will happen after completion of data collection of every prison. Data collected will be stored in password locked files (excel sheets) on UEL OneDrive. Signed consent forms will be stored separate from filled questionnaires in two different drawers in my locked office in Lebanon,and there will be a sheet to link "link sheet" between signed consent forms and filled questionnaires. As soon as practically possible they will be transferred to digital storage and any hard copy data will be destroyed. Completed consent forms and "link sheet" will be stored on OneDrive in a separate folders from the pseudonymised data to protect participant anonymity. The link sheet will then be destroyed after the participant withdrawal period (4 weeks) has pass.
How will you manage access and security?	Files will be password locked individually and OneDrive accessed on password locked and encrypted laptop. Sharing of data within the UEL supervisory team will be done through securelinks on OneDrive. Hard copies of data collection sheets and consent forms will be transferred in a locked suitcase by my car. External collaborators will gain access to appropriate information through secure UEL one drive. No files will be stored on USBs or shared through emails.
Data Sharing	
How will you share the data?	Participants should be aware of this through information sheet and should consent about data sharing. No raw data is suitable sharing on UEL's research repository <u>because raw data alone cannot be understood, used and analyzed unless linked with other determinants of my research itself.</u> What would be absolutely suitable for sharing via the repository is manuscripts, reports, thesis, etc…

Are any restrictions on data sharing required?	There is no restriction due to licensing issues
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Digital transcribed version of questionnaires and checklists is of a great value for long term retention as they might be used for future research. There are no other reasons to keep these data including legal, ethical or contractual reasons.
What is the long-term preservation plan for the data?	Pseudonymised questionnaires and consent forms will be stored on the PI's UEL OneDrive for 5 years and backed up on SharePoint, after which they will be reviewed for further retention or deletion. Consent forms will be retained for one year after the project end to allow the PI to share results with participants as outlined in the Participant Information Sheet.
Responsibilities and Resources	
Who will be responsible for data management?	Myself as STUDENT RESEARCHER.
What resources will you require to deliver your plan?	The following resources will be required, and will be met through personal out of pocket expenses by the STUDENT RESEARCHER: -Travel(transportation) to prisons chosen for the study. -Equipment (Non consumables) like papers and pens -Printing material for data collection sheets, information sheets and consent forms. -Software copyrights (Nutritionist pro and SPSS).
Review	

	Reviewer comment: If any further amendments during the researchdata@uel.ac.uk
Date 12/06/2024	Reviewer name: Joshua Fallon Assistant Librarian (RDM)

Appendix 18: Nutrition policy

في الغذاء

المادة 75 :-) المعدل بموجب المرسوم رقم 13328 تاريخ 9 / 7 / 1963 (:

يحظر استيراد المواد الغذائية وتسويق المواد التي يتم الحصول عليها من تعديل المواد الغذائية بموجب مرسوم يصدر بناء على اقتراح وزير الصحة العامة .

يجب أن تكون المواد الغذائية المستوردة والمسوقة في المغرب مطابقة للمواصفات التي يحددها التشريع الجاري به العمل ، وفق الشروط المنصوص عليها في هذا القانون و في النصوص التشريعية المتخذة لتطبيقه .

يمكن أن تحدد بمرسوم المواد الغذائية التي يمنع استيرادها أو تسويقها أو تصديرها ، وكذا الشروط التي يجب أن تستجيب لها المواد الغذائية المسموح باستيرادها أو تسويقها أو تصديرها .

المادة 76 :- يحظر على كل شخص يمتهن أو يعتزم أن يمتهن تسويق المواد الغذائية أن يخلط أو يسمح بخلط المواد الغذائية المسموح بتسويقها بمواد غذائية أخرى .

المادة 77 :-) المعدل بموجب المرسوم رقم 3101 تاريخ 25 / 1 / 1993 (:

إن مراقبة نوعية المواد الغذائية التي يتم تسويقها تستهدف الطابع الكامل لمكوناتها وتحدد على الخصوص فيما يلي :

1- صنف أول : لبنة أو جبنة : 100 غرام أجبان مرتبة حسب النوع مع كوبشاي .
مربى أو حلوة : 100 غرام مرتبة حسب النوع مع كوبشاي .

2- صنف ثان : جوب 150 غراما وبيا من المواد التالية مجموعة أو مفرقة (حسب الوصفة المختارة ؟)
أرز ، عدس ، حمص فول يابس برغل (.

3- صنف الثالث : لحم بقري طازج : 150 غرام مرتان بالأسبوع
.
لحم دجاج طازج : 200 غرام مرتان بالأسبوع .

4- صنف الرابع : بطاطا : 300 غرام بالأسبوع .
مكرونة : 100 غرام مرة بالأسبوع .

بيض : مرتان في الأسبوع .

خبز عربي : 500 غرام يومياً .

5- صنف الخامس : خضار : 180 غرام يومياً من الأنواع التالية
مجتمعة أو مفترقة :
(بدون أسكدنيا ، فول أخضر ، باذنجان ، سلق ، قرنبيط ، خس ، باذنجان رومي ، كوسا) .

6- صنف السادس : زيتون ، زيت زيتون أو سمن نباتي ، سكر :
15 غراماً يومياً من كل نوع .
طحينة وشاي : 5 غرامات يومياً من كل نوع .

7- صنف السابع : ملح بهار بصل ، بدون دورة ، حامض ،
ثوم ، كزبرة ، حلبة ،
حاجة للطبخة ولوجبة .

8- صنف الثامن : فاكهة : 100 غرام يومياً من الأنواع التالية
مجتمعة أو مفترقة : (تفاح ،
برتقال ، موز ، عنب) .

المادة 78 :- (المعدل بقرار مجلس الوزراء رقم 3101 تاريخ 25 / 1 / 1993) :

يمكن عدم التقيد بالمقادير الواردة في المادة السابقة لحالة مرض ان الكمية اليومية التي يجب أن يتناولها السجين شرط أن يتناول في اليوم مجموع كميات المحددة في اليوم .

يصرف من هذه المواد ثلاث وجبات يومية وفق أحد جدول وجبات أسبوعي ينظمه قائد السجن مرفقاً ويتضمن أصناف الوجبة وكمية المواد المستخدمة فيها .

المادة 79 :-) المعدل بالمرسوم رقم 3433 تاريخ 17 / 11 / 1950 (:

في الأحوال التي لا يقدم فيها المتهم الطعن يتقيد المحكوم عليه بالمواد التالية :

1 / 600 / سجن لمدة لا تجاوز غراماً من الخمر ، 2 / 100 / جلدة غراماً من التمر أو الحشيش أو الأفيون أو الحشيشة ،

3 / 200 / جلدة غراماً من البن أو الفحم أو 50 غراماً من الحشيشة الهندية ، 4 / 30 / ثلاثون غراماً من الزيتون .

المادة 80 :-) المعدل بالمرسوم رقم 14109 تاريخ 25 / 2 / 1970 (:

للنساء الحوامل والمرضعات والمرضى الذين يعالجون في مستشفيات السجون أو مستوصفاتها أن يأخذوا وجبات طعام خاصة وفقاً لتعليمات الطبيب المشرف .

المادة 81 :- للمحكوم عليهم أن يشتروا طعامهم من الخارج بشرط أن لا يتجاوزوا حدود النظام الذي يحدده مدير السجن بما يتفق مع الأحوال في هذه الحالة وأن يخضعوا للمواقيت التي يكون للمحكوم عليه الحق بالحرية التي يقدمها ؟؟ارة .

- إذا أساء المحكوم عليهم استعمال هذا الحق أو ارتكبوا ذنباً يعاقب عليه القانون جاز حرمانهم من الطعام من الخارج على سبيل التأديب لمدة لا تزيد على المحددة في المادة 103 من هذا المرسوم .

Appendix 19: Medical file

Medical file

Name:	Family name:
Fathers name:	Mothers name:
Date of birth:	Place of birth:
Nationality:	Registry number and place:
Marital status: □ Single □Married □Others	Number of children:
Education status: □ Illiterate □Elementary □Intermediate □Secondary □University □Technical	Previous work:
Previous prisons and duration in each prison :	Date of admission to prison:
Type of crime:	Judiciaray status:□Under trial □Convicted
Emergency contact: name,family name,degree of relativity,home address,home phone nb,mobile nb)	Other information

- Eyesight

Date of consultation	Right eye	Left eye	Signature of treating physician	Comments

- Hearing

Date of consultation	Right ear	Left ear	Signature of treating physician	Comments

- Medical history

Status			
Smoker	□ Yes	□No	If Yes-Duration
Alcoholic	□ Yes	□No	If Yes-Duration
Alcohol drinker	□ Yes	□No	If Yes-Duration
Drug user	□ Yes	□No	If Yes-Duration
Previous sexual relations	□ Yes	□No	If Yes-Duration
Previous blood donation	□ Yes	□No	If Yes-In which country?

-Chronic diseases

Disease			
Hypertension	□ Yes	□No	
Diabetes Mellitus	□ Yes	□No	
Hypercholesteremia	□ Yes	□No	
Heart diseases	□ Yes	□No	If yes specify :
Asthma	□ Yes	□No	
Gastric ulcer	□ Yes	□No	
Pulmonary diseases	□ Yes	□No	If yes specify :
Liver diseases	□ Yes	□No	If yes specify :

Kidney diseases	□ Yes	□No	If yes specify :
Urinary tract diseases	□ Yes	□No	If yes specify :
Bone diseases	□ Yes	□No	If yes specify :
Skin diseases	□ Yes	□No	If yes specify :
Psychological disorders	□ Yes	□No	If yes specify :

Allergies

Vaccine	□ Yes	□No
Insect bite	□ Yes	□No
Food	□ Yes	□No
Anesthesia drug	□ Yes	□No
Coackroaches	□ Yes	□No
Others(specify):		

Previous communicable diseases with Date of sickness

……
……
……

Other medical information

Surgical history

Surgery	Hospital	Physician	Year

Family history

……
……

Laboratory tests

Test	Date	Laboratory/Radiology center	Result
IDR			
Rx Thorax			
VDRL			
HBs Ag			
HIV IET2			

Psychological consultations

Treatment and requested test	Next physician visit	Name and signature of treating physician

External consultations

Name of medical center	Consulted physician	Date of consultation	Findings from consultation

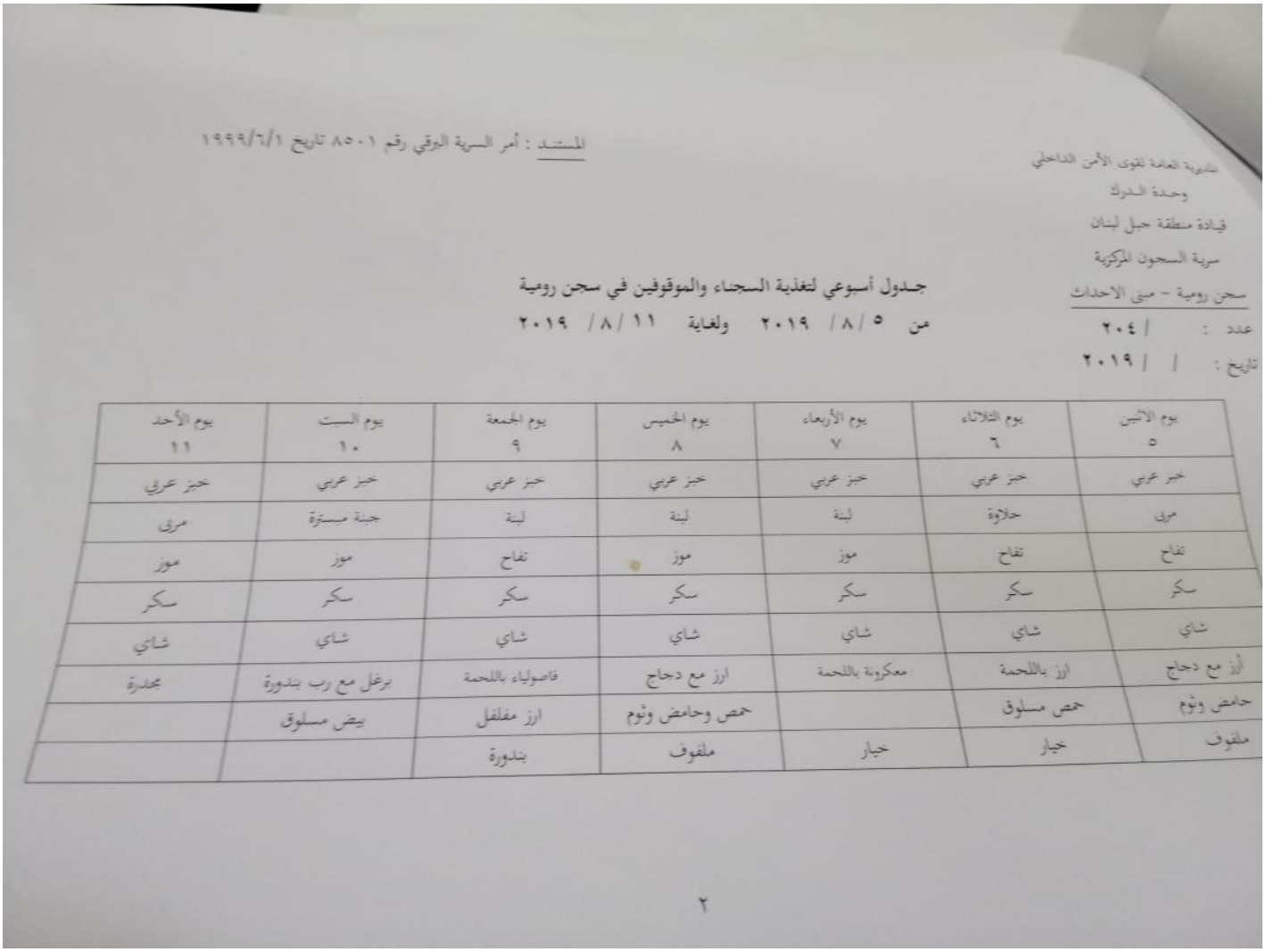
Hospitalizations

Name of Hospital	Date of admission	Date of discharge	Treating physician	Chief complaint/admitting diagnosis

Dentistry and oral diseases

Registry number	Consultation date	Type of treatment

Appendix 20: Menus from RCP – 2019



المديرية العامة لقوى الأمن الداخلي
وحدة الدرك
قيادة منطقة جبل لبنان
سرية السجون المركزية
سجن رومية – مبنى الاحداث
عدد : / ٢٠٤
تاريخ : / / ٢٠١٩

المستند : أمر السرية البرقي رقم ٨٥٠١ تاريخ ١٩٩٩/٦/١

جدول أسبوعي لتغذية السجناء والموقوفين في سجن رومية
من ٥ / ٨ / ٢٠١٩ ولغاية ١١ / ٨ / ٢٠١٩

يوم الاثنين ٥	يوم الثلاثاء ٦	يوم الأربعاء ٧	يوم الخميس ٨	يوم الجمعة ٩	يوم السبت ١٠	يوم الأحد ١١
خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي
مربى	حلاوة	لبنة	لبنة	لبنة	جبنة مبسترة	مربى
تفاح	تفاح	موز	موز	تفاح	موز	موز
سكر	سكر	سكر	سكر	سكر	سكر	سكر
شاي	شاي	شاي	شاي	شاي	شاي	شاي
أرز مع دجاج	ارز باللحمة	معكرونة باللحمة	ارز مع دجاج	فاصولياء باللحمة	برغل مع رب بندورة	مجدرة
حامض وثوم	حمص مسلوق		حمص وحامض وثوم	ارز مفلفل	بيض مسلوق	
ملفوف	خيار	خيار	ملفوف	بندورة		

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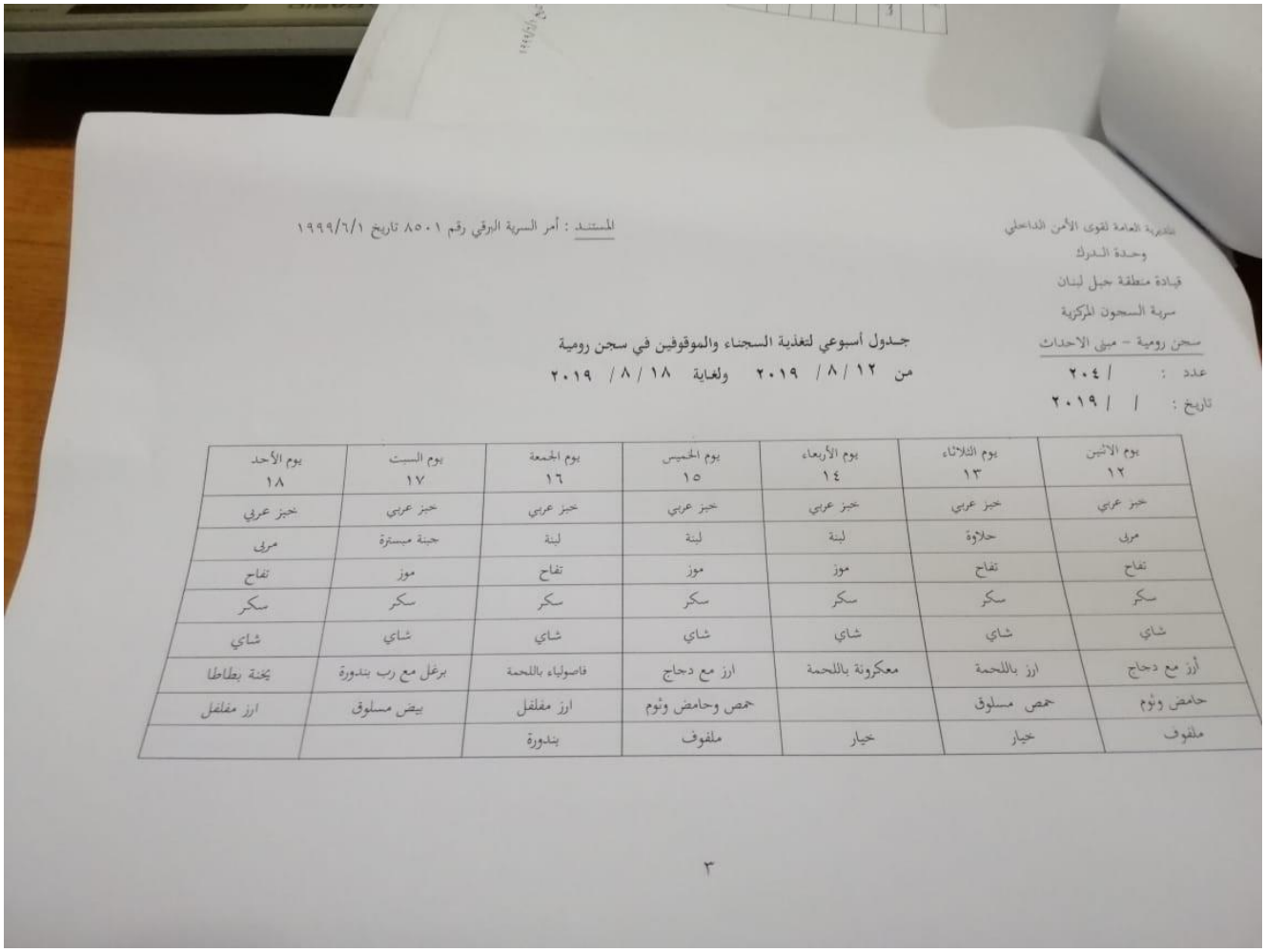

المديرية العامة لقوى الأمن الداخلي
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سرية السجون المركزية
سجن رومية – مبنى الاحداث
عدد : /٢٠٤
تاريخ : / /٢٠١٩

المستند : أمر السرية الورقي رقم ٨٥٠١ تاريخ ١٩٩٩/٦/١

جـدول أسبوعي لتغذية السجناء والموقوفين في سجن رومية
من ١٢/٨/ ٢٠١٩ ولغاية ١٨/٨/ ٢٠١٩

يوم الاثنين ١٢	يوم الثلاثاء ١٣	يوم الأربعاء ١٤	يوم الخميس ١٥	يوم الجمعة ١٦	يوم السبت ١٧	يوم الأحد ١٨
خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي
مربى	حلاوة	لبنة	لبنة	لبنة	جبنة مبسترة	مربى
تفاح	تفاح	موز	موز	تفاح	موز	تفاح
سكر	سكر	سكر	سكر	سكر	سكر	سكر
شاي	شاي	شاي	شاي	شاي	شاي	شاي
أرز مع دجاج	ارز باللحمة	معكرونة باللحمة	ارز مع دجاج	فاصولياء باللحمة	برغل مع رب بندورة	يخنة بطاطا
حامض وثوم	حمص مسلوق		حمص وحامض وثوم	ارز مفلفل	بيض مسلوق	ارز مفلفل
ملفوف	خيار	خيار	ملفوف	بندورة		

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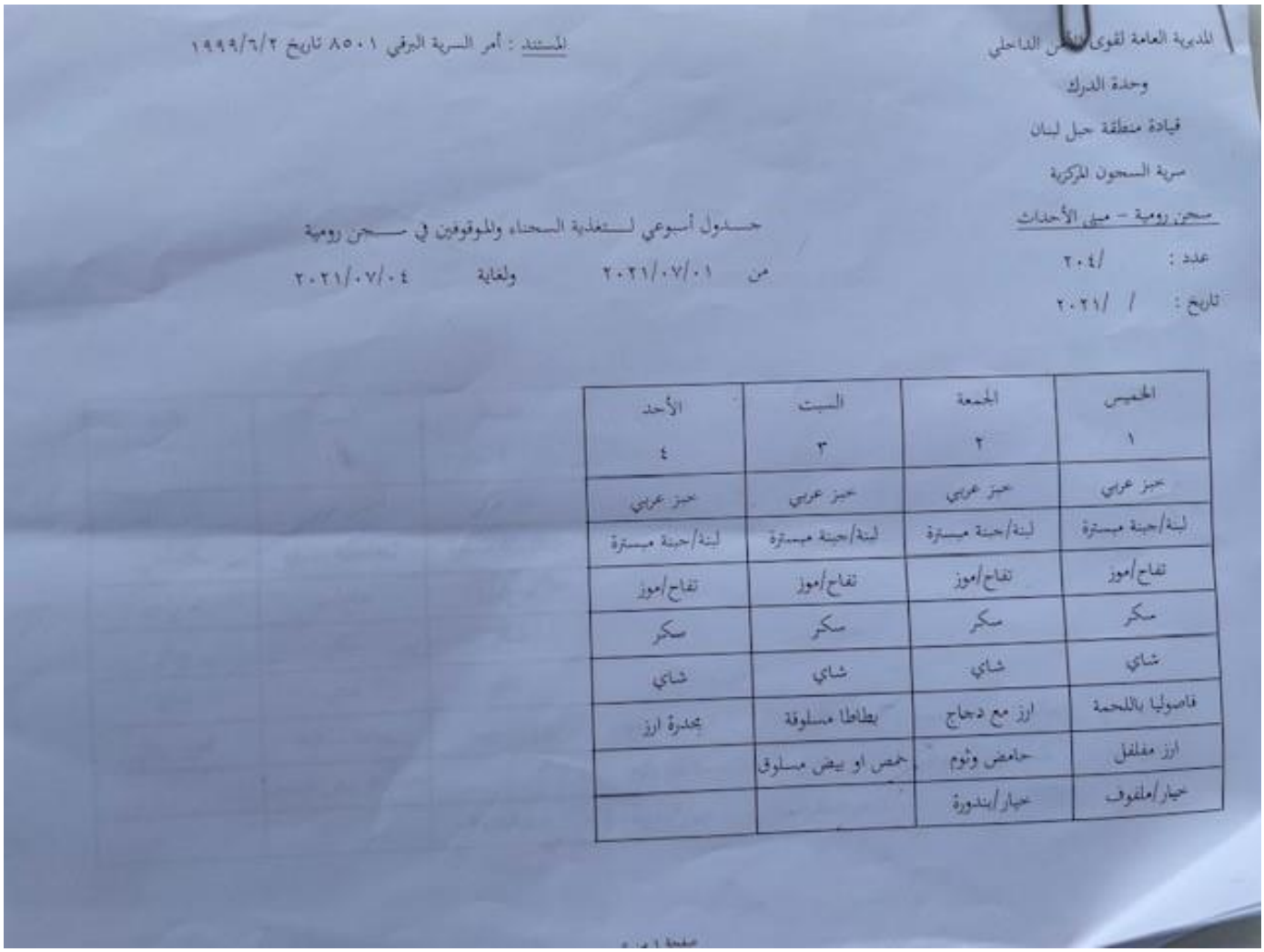
Appendix 21: Menus from RCP – 2021



المديرية العامة لقوى الأمن الداخلي
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سرية السجون المركزية
سجن رومية – مبنى الأحداث
عدد : ٢٠٤/
تاريخ : / /٢٠٢١

المستند : أمر السرية البرقي ٨٥٠١ تاريخ ١٩٩٩/٦/٢

جدول أسبوعي لتغذية السجناء والموقوفين في سجن رومية
من ٢٠٢١/٠٧/٠١ ولغاية ٢٠٢١/٠٧/٠٤

الخميس ١	الجمعة ٢	السبت ٣	الأحد ٤
خبز عربي	خبز عربي	خبز عربي	خبز عربي
لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة
تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز
سكر	سكر	سكر	سكر
شاي	شاي	شاي	شاي
فاصوليا باللحمة	ارز مع دجاج	بطاطا مسلوقة	مجدرة ارز
ارز مفلفل	حامض وثوم	حمص او بيض مسلوق	
خيار/ملفوف	خيار/بندورة		

قوى الأمن الداخلي
وحدة الدرك
قيادة منطقة جبل لبنان
سرية السجون المركزية
سجن رومية – مبنى الأحداث
عدد : /٢٠٤
تاريخ : / /٢٠٢١

المستند : أمر السرية الورقي ٨٥٠١ تاريخ ١٩٩٩/٦/٣

جـــدول أسبوعي لـــتغذية السجناء والموقوفين في ســـجن رومية
من ٢٠٢١/٠٧/٠٥ ولغاية ٢٠٢١/٠٧/١١

الإثنين ٥	الثلاثاء ٦	الأربعاء ٧	الخميس ٨	الجمعة ٩	السبت ١٠	الأحد ١١
خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي
حلاوة/مربى	حلاوة/مربى	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	حلاوة/مربى
تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز
سكر	سكر	سكر	سكر	سكر	سكر	سكر
شاي	شاي	شاي	شاي	شاي	شاي	شاي
ارز مع دجاج	معكرونة مع رب بندورة	برغلا باللحمة	ارز مع دجاج	ارز باللحمة	بطاطا مسلوقة	مجدرة برغل
حامض وثوم	طحينة وزيت زيتون	ارز مفلفل	حامض وثوم		حمص او بيض مسلوق	
حس/ملفوف	خيار/بندورة	حس/ملفوف	خيار/بندورة	خيار/بندورة		

قوى الأمن الداخلي
وحدة الدرك
قيادة منطقة جبل لبنان
سرية السجون المركزية
سجن رومية – مبنى الأحداث
عدد : /٢٠٤
تاريخ : / /٢٠٢١

المستند : أمر السرية الورقي ٨٥٠١ تاريخ ١٩٩٩/٦/٣

جـــدول أسبوعي لـــتغذية السجناء والموقوفين في ســـجن رومية
من ٢٠٢١/٠٧/١٢ ولغاية ٢٠٢١/٠٧/١٨

الإثنين ١٢	الثلاثاء ١٣	الأربعاء ١٤	الخميس ١٥	الجمعة ١٦	السبت ١٧	الأحد ١٨
خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي
حلاوة/مربى	حلاوة/مربى	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	حلاوة/مربى
تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز
سكر	سكر	سكر	سكر	سكر	سكر	سكر
شاي	شاي	شاي	شاي	شاي	شاي	شاي
ارز مع دجاج	معكرونة باللحمة	فاصوليا باللحمة	ارز مع دجاج	برغل مع رب بندورة	بطاطا مسلوقة	مجدرة ارز
حامض وثوم	طحينة وزيت زيتون	ارز مفلفل	حامض وثوم		حمص او بيض مسلوق	
حس/ملفوف	خيار/بندورة	حس/ملفوف	خيار/بندورة	خيار/بندورة		

قوى الأمن الداخلي

وحدة الدرك

قيادة منطقة جبل لبنان

سرية السجون المركزية

سجن رومية – مبنى الأحداث

عدد : /٢٠٤

تاريخ : / /٢٠٢١

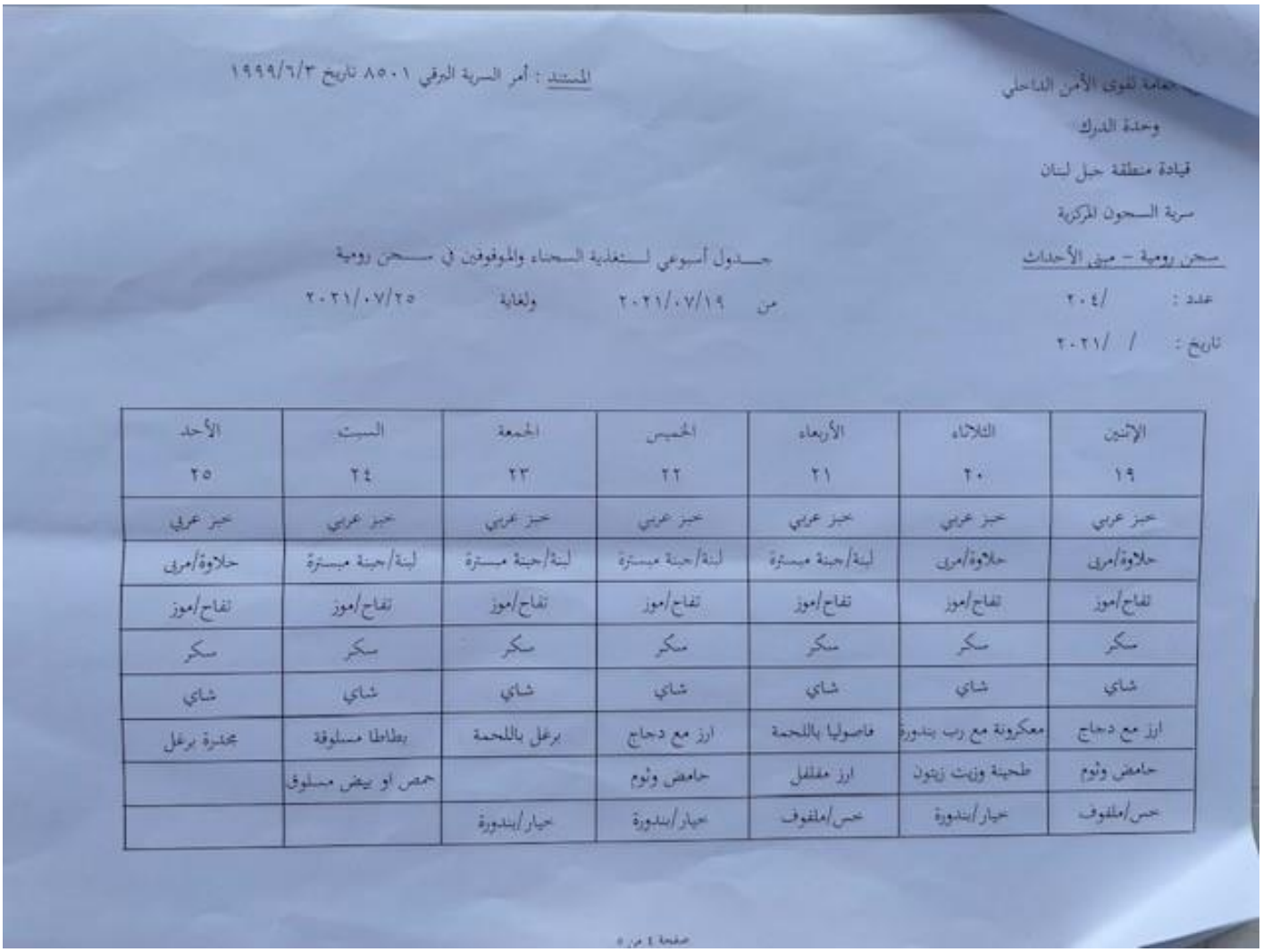
المستند : أمر السرية البرقي ٨٥٠١ تاريخ ١٩٩٩/٦/٣

جدول أسبوعي لتغذية السجناء والموقوفين في سجن رومية

من ٢٠٢١/٠٧/١٩ ولغاية ٢٠٢١/٠٧/٢٥

الإثنين	الثلاثاء	الأربعاء	الخميس	الجمعة	السبت	الأحد
١٩	٢٠	٢١	٢٢	٢٣	٢٤	٢٥
خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي
حلاوة/مربى	حلاوة/مربى	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	حلاوة/مربى
تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز
سكر	سكر	سكر	سكر	سكر	سكر	سكر
شاي	شاي	شاي	شاي	شاي	شاي	شاي
ارز مع دجاج	معكرونة مع رب بندورة	فاصوليا باللحمة	ارز مع دجاج	برغل باللحمة	بطاطا مسلوقة	مجدرة برغل
حامض وثوم	طحينة وزيت زيتون	ارز مفلفل	حامض وثوم		حمص او بيض مسلوق	
حس/ملفوف	خيار/بندورة	حس/ملفوف	خيار/بندورة	خيار/بندورة		

صفحة ١ من ١



قوى الأمن الداخلي

وحدة الدرك

قيادة منطقة جل لسان

سرية السجون المركزية

سجن رومية – مبنى الأحداث

عدد : /٢٠٤

تاريخ : / /٢٠٢١

المستند : أمر السرية الورقي ٨٥٠١ تاريخ ١٩٩٩/٦/٣

جدول أسبوعي لتغذية السجناء والموقوفين في سجن رومية

من ٢٠٢١/٠٧/١٩ ولغاية ٢٠٢١/٠٧/٢٥

الإثنين ١٩	الثلاثاء ٢٠	الأربعاء ٢١	الخميس ٢٢	الجمعة ٢٣	السبت ٢٤	الأحد ٢٥
خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي	خبز عربي
حلاوة/مربى	حلاوة/مربى	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	لبنة/جبنة مبسترة	حلاوة/مربى
تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز	تفاح/موز
سكر	سكر	سكر	سكر	سكر	سكر	سكر
شاي	شاي	شاي	شاي	شاي	شاي	شاي
ارز مع دجاج	معكرونة مع رب بندورة	فاصوليا باللحمة	ارز مع دجاج	برغل باللحمة	بطاطا مسلوقة	مجدرة برغل
حامض وثوم	طحينة وزيت زيتون	ارز مفلفل	حامض وثوم		حمص او بيض مسلوق	
حس/ملفوف	خيار/بندورة	حس/ملفوف	خيار/بندورة	خيار/بندورة		

صفحة ١ من ١

Appendix 22: Health Policy

فـي ?ةارلطبي ـة

لمادة 52 :- يقوم بإدارة الطبية في السجون :

أ- أطباء لديهم خبرة عن مدة لا تقل عن سنة واحدة من وزارة الداخلية بعد اجتيازهم لفحص طبي من رأي وزارة الصحة .

ب- أطباء متفرغون في المستشفيات الملحقة بالسجون وفقاً لما تحدده اللائحة .

ج- أطباء للعيادات في السجون وهي ما يلي :

- يقوم طبيب أسنان من وزارة الداخلية بمعالجة أسنان النزلاء بالسجون بعد موافقة مدير السجن.

لمادة 53 :- (على وفق ما جاء بالمرسوم رقم 6394 تاريخ 6 / 1 / 1967) :

ينبغي على أطباء الفحص والتطعيم في المادة السابقة أن يزوروا السجن ?| مرات على الأقل في الشهر ، وأن يتخذوا جميع التدابير الواقية ?? مراض المعدية وأن يعنوا بأمر المرضى

ويزوروا كلما دعت الحاجة إلى ذلك .

ويسجلوا في سجل خاص ?مور الصحية وخواف المكوث ?| التي يقدمها المتعهدون والتي يتابعها في الحلوت .

- وهي مما أن يدونوا ?حظاتهم في السجل رقم 14 .

لمادة 54 :- في حالة تلبث أشد مريض عن ?طباء قرار ?? حال النزلاء من السجن إلى مستشفى الشرطة الصحية وعن حالة

المسجونين وهي مما أن يتخذوا جميع ا ?? التي يتفقون وقوعها مع بعض الأطباء عدد المصابين وأنواعها وأسبابها . وهذا التقرير يقدم على نسخ تنسخ?? إلى قائمقام السجن الذي يتبعه المستشفى مديرية الشرطة العامة والشرطة إلى وزير الداخلية وإلى وزير الصحة بعد عرضه على الطبيب .

المادة 55 :- يعاون الضابط في مستشفيات السجون عدد ؟؟ من الجنود ؟؟ تحت إشراف أحد الضباط المصريين
وإذا اقتضت الحاجة يعاون مع واحد أو

أكثر من السجانين ذوي الرتب الأدنى في الحالات التي يقع فيها الواجب عليه مع مراعاة ما تقضي به المادة 59 من هذا المرسوم .