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Implementation of Law No. 22 of 2022 on the Right to Health Services for Detainees and Prisoners at Magelang Class IIA Prison

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Abstract

The right of detainees and prisoners to health services is guaranteed by Law No. 22 of 2022 on Corrections, yet prisons struggle to fulfil it where inmate numbers far exceed capacity. Magelang Class IIA Prison, with a capacity of 221, has held more than twice that number in every year from 2018 to 2022. This study examines how the right is implemented at the prison, how far the services meet the applicable standards, and which obstacles prevent full compliance. It is empirical legal research with a legal-sociology approach, based on observation and unstructured interviews at the prison in October 2022 to January 2023, supported by analysis of statutes, regulations and the Nelson Mandela Rules. The prison provides promotive, preventive, curative and rehabilitative services, a polyclinic, referral and cooperation agreements, and was named a pilot prison for health services. It meets the minimum staffing and referral rules and the admission-screening standard, but has no psychologist, psychiatrist or nutritionist, only about IDR 20,000 per inmate per month for health, too few isolation rooms and weak hygiene awareness. The right is therefore not yet fully fulfilled. Staffing norms, a per-inmate health budget and a plan to reduce overcapacity require national decisions, while hygiene supervision and medicine control can be improved by the prison itself.

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Keywords

Prisons; Health; Detainees; Overcapacity; Corrections; Magelang

Introduction

The 1945 Constitution protects the right to health services. Article 28H(1) provides that everyone has the right to live in physical and spiritual well-being, to have a home and a good and healthy environment, and to receive health services,[1] and Article 34(3) makes the state responsible for providing decent health and public facilities.[2] 'Everyone' includes detainees and prisoners, although the state may restrict citizens' rights by law. Detainees and prisoners are citizens whose liberty is restricted for breaking the law, but loss of liberty does not remove all other rights.[3] Because the public readily criticises this group, the fulfilment of the rights of correctional inmates (WBP) requires particular care.

Law No. 22 of 2022 on Corrections replaced Law No. 12 of 1995[4] and is the legal basis for enforcing the rights of detainees and prisoners. Article 7 lists the rights of prisoners and Article 9 those of detainees, and both include decent health services and food that meets nutritional needs.[5][6] The rights are worked out in more detail in Government Regulation No. 32 of 1999 (as amended by No. 28 of 2006 and No. 99 of 2012) for prisoners,[7] and in Government Regulation No. 58 of 1999 for detainees.[8] Under these regulations every prison must have a polyclinic with at least one doctor and one other health worker, health checks must be carried out at least once a month and recorded, infectious or dangerous disease must be treated in isolation, and patients who need further care are referred to a government hospital with the permission of the head of the prison (and, for detainees, of the detaining agency). These regulations were made under the 1995 Law, not the 2022 Law. The 2022 Law has transitional provisions under which existing implementing regulations are understood to remain in force, so far as they do not conflict with the new Law, until they are replaced; this article therefore treats them as the operative rules while noting that a new government regulation under the 2022 Law would supersede them. The literature on penitentiary law supplies the general background to these rights.[9]

Despite these norms, prisons face obstacles. Skin diseases remain common, inmates with mental disorders and elderly inmates need special attention, and prisons

[1] Constitution of the Republic of Indonesia 1945, art 28H(1).
[2] *Ibid*, art 34(3).
[3] Bahder Johan Nasution, *Negara Hukum dan Hak Asasi Manusia* (Bandung: Mandar Maju, 2011).
[4] Law No 12 of 1995 on Corrections (Indonesia) (repealed).
[5] Law No 22 of 2022 on Corrections (Indonesia), art 7.
[6] *Ibid*, art 9.
[7] Government Regulation No 32 of 1999 on the Requirements and Procedures for the Implementation of the Rights of Correctional Inmates (Indonesia).
[8] Government Regulation No 58 of 1999 on the Requirements and Procedures for the Implementation of the Authority, Duties and Responsibility for the Care of Detainees (Indonesia).
[9] Marlina, *Hukum Penitensier* (Bandung: Refika Aditama, 2011).

generally suffer from overcapacity. Magelang Class IIA Prison has a capacity of 221 but housed more than twice that number in every year from 2018 to 2022 (Table 1), with an occupancy rate between about 230 and 281 per cent. Overcapacity is associated with the rapid spread of infectious disease, leaves little room for isolation and stretches a health team that is small even without it. International literature on HIV in prisons shows that prisons concentrate infectious disease and that the state bears human-rights obligations to provide prevention and care within them.[10]

Table 1. Inmates of Magelang Class IIA Prison, 2018–2022

Year	Capacity	Detainees	Prisoners	Total (as reported)	Occupancy (%)
2018	221	106	514	622*	281
2019	221	86	517	603	273
2020	221	65	442	507	229
2021	221	71	476	547	248
2022	221	59	449	508	230

Source: Database Pemasyarakatan, Registration Office, Magelang Class IIA Prison, as reported to the authors. Occupancy is the reported total divided by capacity, calculated by the authors. *For 2018 the detainee and prisoner figures sum to 620, not 622; the reported total is shown and the discrepancy should be checked against the prison register. The date within each year to which the annual figures refer was not recorded.

Earlier Indonesian studies have examined health services in overcrowded prisons. A study of Class IIA Ambarawa Prison found that care was provided by a single nurse with no doctor on site and limited facilities, using interviews with eight informants, observation and document review.[11] A study of Class IIA Sidoarjo Prison found that food and health services did not meet the national nutritional adequacy standards or the ministry's food guidelines, and that the prison tried to stretch its budget over a larger population.[12] Neither study concerns Magelang Class IIA Prison, and neither assesses implementation against the 2022 Law and the Nelson Mandela Rules together. This study adds a finding-by-finding assessment of a prison that has been named a pilot for health services, and separates the obstacles that the prison can remove from those that need national decisions.

Three questions follow. How is the right to health services of detainees and prisoners under Law No. 22 of 2022 implemented at Magelang Class IIA Prison? How far do the services comply with the applicable standards, namely the statute,

[10] Leonard S Rubenstein et al, "HIV, prisoners, and human rights" (2016) 388:10050 *The Lancet* 1202, DOI: <10.1016/S0140-6736(16)30663-8>.

[11] Aditya Rafif Widyardi & Rachmayanthy Rachmayanthy, "Implementation of Health Services to Prisoners in Overcrowded Conditions at Class IIA Ambarawa Prison" (2025) 18:1 *Journal of Management: Small and Medium Enterprises (SMEs)* 441.

[12] Elyna Amelia Dewi & Pudji Astuti, "Pemenuhan Hak-Hak Narapidana di Lembaga Pemasyarakatan Kelas II A Sidoarjo yang Mengalami Over Capacity (Kelebihan Kapasitas) Berkaitan dengan Hak Mendapatkan Makanan dan Kesehatan" (2019) 6:1 *Novum: Jurnal Hukum*.

government regulations, the 2011 ministerial guideline and the Nelson Mandela Rules? What obstacles prevent full compliance, and who can remove them? The purpose is to answer these questions and to give concrete recommendations.

Research Method

This is empirical legal research with a legal-sociology approach, used to see how the right to health services is actually delivered in the prison, with the prison's polyclinic as the focus. The legal materials are the 1945 Constitution, Law No. 22 of 2022, the government regulations on the rights of prisoners and detainees, the 2011 ministerial guideline on prison health services, the ministerial regulation on inmates' food, the 2021 Director General decision on pilot prisons, and the Nelson Mandela Rules, together with books and journal articles. The field data come from direct observation and unstructured interviews with prison officials and health staff and from prison records, gathered on 20 October 2022, in December 2022 and on 5 January 2023. The data were reduced, presented and analysed descriptively and qualitatively. Each element of the services was then compared with the standard that governs it, and a finding of compliance, partial compliance or non-compliance was recorded. The study relies on the prison's own account and statistics; it does not include inmates' views or data on disease incidence before and after overcrowding, and these limits are taken into account in the findings.

Results and Discussion

Implementation of Health Services

The prison's polyclinic has moved to a larger room with one examination room, one dispensary and one inpatient room, although the inpatient room is new and still unused. A health post and a hospital lie next to the prison (Kerkopan Community Health Centre to the west and a private hospital opposite), so that emergency and further care can be given quickly by referral. The prison was named one of 40 pilot prisons for health services nationwide (two in the Central Java regional office, the other being Semarang Class I Prison) by Director General of Corrections Decision No. PAS-36.OT.01.03 of 2021, on grounds that include facilities, staff, easy referral and cross-sector cooperation.[13]

[13] Decision of the Director General of Corrections No PAS-36.OT.01.03 of 2021 (Indonesia) (pilot prisons for health services).

Services follow the guidelines of Ministry of Law and Human Rights Regulation No. M.HH.02.UM.06.04 of 2011 on health service guidelines and cover four types.[14] Promotive services consist of health education and training of inmate health cadres. Preventive services consist of screening of new inmates, a 14-day quarantine in three rooms (introduced for Covid-19), special rooms for inmates with mental disorders (two rooms), elderly inmates (one room) and the sick or those with infectious disease (two rooms), Covid-19 vaccination including boosters in cooperation with the police health unit, a military hospital and the health centre, environmental monitoring, health visits to cells three times a week and an annual chest examination with the City Health Office (recorded in the field notes as a CT scan, which was not independently verified). After the examination of 16 March 2022, four inmates were suspected of tuberculosis, were isolated for six months and were reported cured. Recreational activities (twice-daily time outside cells, weekly fitness sessions, art and skills programmes under a cooperation agreement with the job-training centre) are also treated by the prison as preventive.

These practices can be set beside the Nelson Mandela Rules, which require that prisoners enjoy the same standard of health care as is available in the community,[15] that a medical examination follow admission,[16] that those needing specialised treatment be transferred to specialised institutions or civil hospitals,[17] and that food, hygiene and sanitation be regularly inspected and advised on by a physician or a competent public health body.[18] Admission screening with quarantine, referral to the neighbouring health centre and hospital, and environmental monitoring correspond to these rules. The preventive programme is therefore consistent with the international standard in form; whether the care is equivalent to community care depends on staffing and funds, discussed below.

Curative services consist of daily basic treatment at the polyclinic from 09.00 to 11.00, recorded in a health card and the corrections database, with doctors and nurses on call outside working hours. Table 2 shows the cases treated each month: skin disease is by far the most common (426, 335 and 434 cases in October, November and December and 183 in the first two weeks of January), followed by respiratory infection (64, 145, 46 and 26) and the 'other' category. These counts are

[14] Minister of Law and Human Rights Regulation No M.HH.02.UM.06.04 of 2011 on Health Service Guidelines in Prisons and Detention Centres (Indonesia).
[15] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), GA Res 70/175, UNGAOR, 70th Sess, UN Doc A/RES/70/175 (2015), rule 24(1).
[16] *Ibid*, rule 30.
[17] *Ibid*, rule 27(1).
[18] *Ibid*, rule 35(1).

of cases treated, not of persons, and they are put as an association with overcrowding, not as proof of cause (see below). Inmates needing observation are placed in a cell near the guard commander because the new inpatient room is not yet in use. Referral to hospitals follows different routes for detainees and prisoners and for emergency and non-emergency cases, and inmates with mental disorders see a psychiatrist at a mental hospital every month. Rehabilitative services include social rehabilitation for 100 and medical rehabilitation for 20 prisoners who abused drugs in 2022, with 70 and 20 places planned for 2023 in cooperation with the district narcotics agencies.

Table 2. Cases treated at the prison polyclinic, October 2022 – mid-January 2023 (selected categories)

Category	Oct	Nov	Dec	Jan (1–14)
Skin disease	426	335	434	183
Respiratory infection (ISPA)	64	145	46	26
Mental disorder	18	55	32	17
Nervous system	14	4	6	3
Digestive	11	8	13	6
Eye	3	3	4	2
Heart	5	0	0	0
Other	160	130	153	53

Source: Keswat database, Magelang Class IIA Prison, as reported to the authors. Categories with no cases in this period (hepatitis, STIs, TB, malaria, dengue, kidney disease, cancer) are omitted. The absence of TB cases is consistent with the text: the four suspected cases were identified and treated in March 2022, before the period of the table, and were reported cured.

Skin disease is not necessarily infectious, and the table does not separate scabies from other conditions. The high number of skin cases is a signal that deserves investigation, not a demonstration that overcrowding causes infectious disease.

Food is a further component of the right. The prison follows Ministry of Law and Human Rights Regulation No. 40 of 2017, which sets 2,345 kcal for adult men and 1,995 kcal for adult women.[19] Food is bought from a third-party winner of a tender, with a ten-day menu cycle, at a budget of IDR 19,000 per inmate per day, with extra food for the sick, pregnant and nursing women and the elderly, an extra IDR 5,000 per day during Ramadan, and food brought by families. Because there is no nutritionist, the nutritional adequacy of meals cannot be assessed, and the Nelson Mandela Rules' requirement that food be of adequate nutritional value cannot be shown to be met.[20]

[19] Minister of Law and Human Rights Regulation No 40 of 2017 (Indonesia) (food standards for inmates).
[20] Nelson Mandela Rules, *supra* note 15, rule 22(1).

Obstacles

Five obstacles stand in the way of full fulfilment. First, health staff: the prison has two doctors and one nurse. This meets the minimum in the 1999 regulations (one doctor and one other health worker) but not the 2011 ministerial guideline, which calls for at least two doctors, two nurses, a midwife, a laboratory analyst, a pharmacy assistant, a nutritionist, a sanitarian and a psychologist (Table 3).[21] Neither instrument sets a ratio of inmates to doctors. The prison has no psychiatrist although nine prisoners have a mental disorder, and it reduces the gap through cooperation agreements with the City Health Office and hospitals, which bring in specialists such as a dermatologist and a psychiatrist.

Table 3. Health staff required by the 2011 guideline compared with staff at the prison

Staff	Minimum under 2011 guideline	At the prison (as reported)
Medical doctor	2	2
Nurse	2	1
Midwife	1	–
Laboratory analyst	1	–
Pharmacy assistant	1	–
Nutritionist	1	–
Sanitarian	1	–
Psychologist	1	–

Source: compiled by the authors from Ministry Regulation No. M.HH.02.UM.06.04 of 2011 and field data. The posts shown as '–' were not reported as filled at the prison; whether any are covered by other units was not established.

Second, budget. Health spending is about IDR 20,000 per inmate per month, covering inpatient care, medical supplies and medicine, of which inpatient care is IDR 5,000 per inmate per month, with a total inpatient budget of IDR 34,620,000 that also covers outpatient care in hospitals. There is no separate line for palliative disease, tuberculosis or mental illness. The prison is trying to obtain a polyclinic licence so that it can become a first-level health facility and enrol inmates in the social health insurance scheme (BPJS). Third, overcapacity limits isolation rooms: only seriously ill inmates are isolated, while inmates with mild infectious disease such as scabies stay in ordinary cells, and only ten were in special care. Fourth, drug misuse: medicine is hoarded and taken in excess, so health staff require inmates to take medicine on the spot. Fifth, low awareness of personal and environmental hygiene, which persists despite warnings and education, with too few guards to supervise. General crime and narcotics cases account for most inmates, with 510 inmates on 5 January 2023 (68 detainees and 442 prisoners; 483 men and 27 women; 124 repeat offenders).

[21] Ministerial Regulation of 2011, *supra* note 14.

Assessment against the Applicable Standards

Fulfilment of the right can be judged only against a standard. Table 4 sets each element of the services against the instrument that governs it and records a finding. Where the prison's practice is reported without evidence of quality, the finding is 'not verified' and not 'complies'.

Table 4. Compliance of health services at Magelang Class IIA Prison with the applicable standards

Element	Standard	Finding at the prison	Assessment
Polyclinic with a doctor and another health worker	Govt Reg 32/1999	Polyclinic with two doctors and one nurse	Complies
Recorded health checks	Govt Reg 32/1999	Cell visits three times a week; health card and database	Complies (on reported practice)
Isolation of infectious disease	Govt Reg 32/1999	Only seriously ill inmates isolated; mild cases such as scabies stay in cells	Partly complies
Referral for further care	Govt Reg 32/1999; Mandela Rule 27	Neighbouring health centre and hospital; monthly psychiatrist visits	Complies
Staffing	2011 guideline	Two doctors, one nurse; six other posts not filled	Does not comply
Interdisciplinary team with psychology and psychiatry	Mandela Rule 25(2)	No psychologist; psychiatrist only by referral	Does not comply
Medical examination on admission	Mandela Rule 30	Screening and 14-day quarantine	Complies
Food and nutritional adequacy	Ministerial Reg 40/2017; Mandela Rule 22	Energy standard followed; no nutritionist to assess	Not verified
Inspection of hygiene and sanitation	Mandela Rule 35	Environmental monitoring; no sanitarian	Partly complies
Care equivalent to the community	Mandela Rule 24(1)	About IDR 20,000 per inmate per month; no BPJS enrolment yet	Not shown

Source: compiled by the authors from the instruments named and the field data.

The table gives a mixed picture. The formal requirements of the 1999 regulations are met, and so are admission screening and referral. The shortfalls cluster where care depends on specialist staff, space and money: the full staffing complement, psychological and psychiatric expertise, isolation of mild infectious cases and a nutritional assessment of food. The finding that the right is not yet fully fulfilled is therefore supported by the evidence.

That finding should prevail over the pilot-prison designation. The designation rests on inputs, namely facilities, staff, easy referral and cooperation, and recognises that the prison does more with limited means than many others. It does not show that the services reach the standard, and it cannot cancel the gaps in Table 4. The designation explains how the prison manages; the compliance findings show where the right remains unfulfilled. The causal claim that overcapacity produces infectious disease also needs care. The study has case counts for four months but no incidence data from before the overcrowding, so the supportable statement is that overcapacity is associated with, and plausibly aggravates, the spread of disease, by limiting isolation and stretching staff; the Rules recognise this concern by requiring

the physician to report to the director when conditions of imprisonment adversely affect health.[22]

The obstacles differ in who can remove them (Table 5). The prison can improve hygiene supervision, control the use of medicine, put the inpatient room into use, finish the polyclinic licence and widen cooperation agreements. It cannot by itself change the staffing standard, the budget per inmate, the enrolment of inmates in social health insurance or the number of people sent to it; these need decisions of the Directorate General of Corrections, the Ministry and the legislature.

Table 5. Obstacles classified by who can remove them

Obstacle	Removable by the prison	Needs a national decision
Health staff	Cooperation agreements for specialists; use of inmate health cadres	Staffing standard and posts for nutritionist, psychologist and others
Budget	Polyclinic licence to qualify for insurance enrolment	Per-inmate health budget; separate lines for chronic and mental illness
Isolation rooms	Put the inpatient room into use; reorganise rooms	Reduction of overcapacity
Misuse of medicine	Observed intake; stricter control	–
Hygiene awareness	Education and supervision by guards	Number of guards

Source: analysis by the authors.

Legal Consequences and Remedies

Failure to fulfil the right has consequences at three levels. For the inmate, untreated illness is an injury to health and, if it results from a failure to provide required care, a breach of the state's duty under the Constitution and the Corrections Law. For the prison, the Nelson Mandela Rules expect inmates to be able to make requests and complaints to the director and to higher authorities.[23] In practice this means a complaint to the head of the prison or the regional office of the ministry, and beyond them to external bodies such as the Ombudsman or the National Human Rights Commission. The field data do not show that any inmate has complained about health services, and this study did not examine a case of complaint or claim for redress. This study also has not identified a specific remedy, such as compensation, that the Corrections Law attaches to a failure to provide health services. The right is thus well declared but its enforcement is weak. Written complaint procedures for health services, with reasons given and records kept, would be the minimum step to make the right enforceable.

Comparison with Earlier Research

The findings agree with earlier research in the main. At Ambarawa Class IIA Prison, another prison in Central Java, health care rested on a single nurse with no doctor

[22] Nelson Mandela Rules, *supra* note 15, rule 33.
[23] *Ibid*, rules 56–57.

and limited facilities.[24] Magelang is better staffed, with two doctors and one nurse and a larger polyclinic, but it shares the pattern that staff and facilities do not grow with the number of inmates. The Sidoarjo study found that food and health services did not meet the national nutritional standards in an overcrowded prison;[25] in Magelang the energy standard is followed but, without a nutritionist, adequacy cannot be shown, so the same gap in verification appears. The international literature on prison health treats the prison as a setting in which infectious disease concentrates,[26] which fits the importance of screening, quarantine and isolation at Magelang. The difference of this study is that it tests each element against named standards and separates the obstacles by who can remove them, which shows that part of the shortfall lies within the prison's control and part does not.

Conclusion

Implementation of Law No. 22 of 2022 on the right to health services for detainees and prisoners at Magelang Class IIA Prison is not yet fully achieved. The prison meets the formal requirements of the 1999 regulations and the Nelson Mandela Rules on admission screening and referral, and it offers promotive, preventive, curative and rehabilitative services. It does not meet the 2011 staffing guideline or the Rules' requirement of psychological and psychiatric expertise; the adequacy of food cannot be shown without a nutritionist; isolation space is too small; and funds of about IDR 20,000 per inmate per month do not demonstrate care equivalent to that in the community. Overcapacity of more than twice the prison's capacity is associated with, and likely aggravates, the spread of disease. The pilot-prison designation shows effort and does not cancel these gaps. Four recommendations follow. The Directorate General of Corrections should set staffing norms, including a nutritionist, psychologist and sanitarian, and a per-inmate health budget with separate lines for chronic and mental illness. The regional office should review placement so that overcapacity at Magelang is reduced. The prison should supervise hygiene, control medicine, put the inpatient room into use, complete its polyclinic licence and introduce a written complaint procedure for health services. The City Health Office and hospitals should widen cooperation to cover specialist visits and nutrition assessment. Improvement can be judged by the filling of posts against the 2011 guideline, the occupancy rate, the share of infectious cases isolated and the health spending per inmate. The study has limits: it rests on the prison's

[24] Widyardi & Rachmayanthy, *supra* note 11.
[25] Dewi & Astuti, *supra* note 12.
[26] Rubenstein et al, *supra* note 10.

own account and one set of statistics for four months, without inmates' views or incidence data, and the number of informants and the chest-examination method were not independently verified. Research with inmates' views and incidence data over time would test the findings further.

Ethics and Data Availability

This study was empirical legal research and collected information from prison officials and health staff in their official capacity, who were informed of the purpose of the research and took part voluntarily. No personal health data of inmates were collected and no individual is named; informants are referred to by role only. The study therefore did not involve human participants as research subjects or personal data in a way that required ethical approval. The statutes, regulations and published sources are publicly available. The prison statistics and field notes are held by the authors and can be made available on reasonable request, subject to the permission of the prison.

Use of Generative AI

Generative AI was used only to improve the language of this article (grammar, clarity and style). The authors reviewed the output and are responsible for the content of the article.

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