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**OPEN-ENDED INTERGOVERNMENTAL EXPERT GROUP
ON THE STANDARD MINIMUM RULES FOR THE
TREATMENT OF PRISONERS**

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**GOOD GOVERNANCE FOR PRISON HEALTH IN THE
21st CENTURY
A POLICY BRIEF ON THE ORGANIZATION OF PRISON
HEALTH¹**

Prepared by

WHO EUROPE²

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Good governance for prison health in the 21st century

A policy brief on the organization of prison health





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ABSTRACT

Against the background of concern about ministerial responsibility for the health of prisoners in Europe, the members of the WHO European Network on Prison and Health asked the WHO Regional Office for Europe to provide a document on the governance of prison health. A special Expert Group for the Stewardship of Prison Health and members of the WHO European Network on Prison and Health have contributed to this document. The Expert Group concluded, with regard to institutional arrangements for prison health, that: (i) managing and coordinating all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility, and (ii) health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions. The Expert Group considers that such governance of prison health is in accordance with and supportive of the new European policy for health, Health 2020, and will lead to better health and well-being of prisoners as part of better public health.

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Abbreviations

CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
ECHR	European Court of Human Rights
NHS	National Health Service (United Kingdom)
TB	tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS

Preface

Currently, either the justice ministry or the interior ministry is responsible for prison health in the vast majority of Member States of the WHO European Region. Although a body of international rules for prison health has been developed and widely adopted in recent decades, the right to health of prisoners is frequently disregarded.

In recent years, several Member States have transferred the responsibility for prison health to their health ministries. They had concluded that clearly dividing roles between the ministry in charge of prisons and the health ministry would be the most effective and efficient arrangement to achieve sustainable high standards in both prison security and prison health. Given these changes, many Member States in the WHO European Network on Prison and Health requested WHO to draft a document on the governance of prison health, especially on which government department should be responsible for prison health. The scope and purpose as well as the methods, content, conclusions and positions of this document have been developed by an Expert Group on the Stewardship of Prison Health, discussed within the WHO European Network on Prison and Health and adopted by the Steering Group of the Health in Prisons Programme of the WHO Regional Office for Europe.

This document prominently refers to the recommendations and positions regarding prison health of the Council of Europe. In addition to the 47 Member States that are also members of the Council of Europe, the WHO European Region includes the following six Member States: Israel, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. Because the recommendations and positions of the Council of Europe regarding prison health are based on overarching legal and ethical principles, the conclusions of this document are equally relevant not only to the WHO European Member States that belong to the Council of Europe but to all Member States in the European Region.

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Executive summary

Currently, either the justice ministry or the interior ministry is responsible for prison health in the vast majority of Member States of the WHO European Region. The right to health of prisoners is frequently disregarded. For this document, relevant studies on the health of prisoners as well as sources of international law relating to the legal and ethical requirements of prison health have been analysed. The analysis leads to the following findings.

- Prisoners share the same right to health and well-being as any other person.
- Prisoners mostly come from socially disadvantaged segments of the community and carry a higher burden of communicable and noncommunicable diseases compared with people in the general population.
- Prisons are settings with high risks of disease. Because their inhabitants continuously exchange with outside communities, they present a complex and difficult challenge for public health, especially with regard to the tackling of communicable diseases such as human immunodeficiency virus or tuberculosis.
- States have a special, sovereign duty of care for prisoners. They are accountable for all avoidable health impairments to prisoners caused by inadequate health care measures or inadequate prison conditions with regard to hygiene, catering, space, heating, lighting, ventilation, physical activity and social contacts.
- Prison health services should be at least of equivalent professional, ethical and technical standards to those applying to public health services in the community.
- Prison health services should be provided exclusively to care for prisoners and must never be involved in the punishment of prisoners.
- Prison health services should be fully independent of prison administrations and yet liaise effectively with them.
- Prison health services should be integrated into national health policies and systems, including the training and professional development of health care staff.

Despite these requirements, an analysis of European instruments of human rights shows that the following poor practices frequently occur across Europe.

- The right to health of prisoners is frequently disregarded.
- Many states insufficiently meet their special duty of care for prisoners.

- Prisoners are frequently subjected to avoidable health risks: for example, through lack of access to screening or immunization programmes or active case-finding programmes.
- Health personnel often do not act independently of prison authorities but are involved in conflicts of loyalty between providing health care for prisoners and the efforts of authorities to discipline and punish prisoners.
- The public health challenges of prisons are not adequately met. The opportunity and obligation to offer this most vulnerable of populations with great health needs good access to health care in their own right, while also tackling the wider public health needs in general, are often not taken advantage of. For example, this is the case when prisoners are not included in public health programmes such as active case-finding, screening and immunization.

Given these findings, and in accordance with and in support of the new European policy for health, Health 2020, as well as the recommendations of the Council of Europe on prison health, the Expert Group concluded, with regard to the institutional arrangements for prison health, that:

- the management and coordination of all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility;
- health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions.

A whole-of-government approach to prison health in the longer term will have beneficial effects such as:

- lower health risks and improved health protection in prisons;
- improved health of prisoners;
- improved performance of national health systems;
- improved health of deprived communities;
- improved public health of the whole community;
- improved integration of prisoners into society on release;
- lower rates of reoffending and reincarceration and reduction of the size of the prison population; and
- increased governmental credibility based on increased efforts to protect human rights and reduce health inequalities.

1. Prison¹ health is public health

1.1 Imprisonment in the WHO European Region

There is no official data collection on imprisonment that covers all 53 Member States in the WHO European Region. An official database only exists for the 47 Member States that are also members of the Council of Europe. Hence, the data presented here stem from different sources. They are to be interpreted with caution, providing an approximate but as accurate as possible picture of the situation of imprisonment in the WHO European Region.

On any given day in 2012, an estimated two million men, women and children were imprisoned in places of detention throughout the WHO European Member States (1). Considering the high turnover in the prison population, an estimated six million people are incarcerated at some point during a given year (2). In most of the 47 member states of the Council of Europe, the prison population has increased during the past decade (3). The prison population rate in these states varies between nearly 600 inmates per 100 000 inhabitants (0.6%) to less than 10 inmates per 100 000 inhabitants (0.01%), with an average of about 150 prisoners per 100 000 inhabitants (0.15%) (3). Most prisoners are from poor communities and vulnerable social groups (4). In the 47 WHO Member States that also belong to the Council of Europe, about 21% of prisoners are foreign nationals. The rates of imprisoned foreign nationals show a remarkable east–west gradient, from a top rate higher than 90% to Member States with no imprisoned foreigners (3). Based on the total of new entries to penal institutions and on an average of nearly 10 months of imprisonment (3), it may be assumed that at least 3 million person-years are spent in the prisons of the 47 WHO European Member States belonging to the Council of Europe per year. On average, the respective countries spent more than €500 million for imprisonment in 2010 (3). Nevertheless, almost no data are available that show the money allocated to prisoners' health.

1.2 High risks of disease in prisons

Even though the prison population is absent from most national health statistics (see section 3), many studies have shown that the rates of HIV infection, hepatitis B and C and tuberculosis (TB) among prisoners in all countries are significantly

¹ In this document, the terms "prison" and "prisoner" refer to their scope and application in the European Prison Rules.

higher than those in the general population (2). The TB rate in prisons in the Region in 2002 was 84 times higher than in the general population (5). In 2010, 3 WHO European Member States reported TB cases in prisons exceeding 10% of the countrywide total of new cases, and the TB relative risk in prisons was up to 145 times higher than in the general population (6). Transmission in prisons is well documented for TB (7) and, according to WHO and the European Centre for Disease Prevention and Control, must be associated with "... poor control measures and/or the concentration of vulnerable sub-groups of populations (such as immigrants from high TB-incidence countries)" (6). Transmission in prison is also documented for HIV (8); there is some evidence that high-risk behaviour, such as injecting drug use, occurs in European prisons (9–11). However, such risks can be tackled: Spain has been able to reduce HIV transmission in prisons from 0.7% in 2001 to 0 people newly infected in 2010 (12) as a result of the country's strong harm reduction policies that also include prisons.

Furthermore, mental health problems and disorders are more prevalent in prisons than outside, and prisoners have higher risks of cardiovascular disease and some types of cancer (13). Suicide rates per 10 000 prisoners range from 0 (0%) to almost 30 (0.3%), with an average of about 6 (0.06%) in the 47 WHO European Member States that belong to the Council of Europe (3).

The health risks mentioned are frequently aggravated by unhealthy conditions of imprisonment such as lack of space, fresh air and light, lack of clean sanitary facilities or means for personal hygiene, inadequate nutrition and violence. A major aggravating factor that currently occurs in more than 20 Member States is overcrowding (3). In addition, many Member States face shortages of qualified health care personnel in prisons, and prison health services are often inferior to the public health services provided to the general population.

The following quote from a legal study of prison health brings the problem of prisoners' health sharply into focus: prisoners are "... incarcerated in overcrowded, unsanitary, stressful and violent conditions, alongside others who share the same increased health vulnerabilities. As a result, the prison environment is one marked by disease transmission, environmentally exacerbated health decline and death, and heightened risks of mental illness." (14).

1.3 Prison health is public health

Prisons are closely linked to communities. Prisoners go on leave, receive visitors and sometimes attend outside work placements or health care facilities. The vast majority of prisoners will eventually leave prison and reintegrate into society. Prison personnel constantly oscillate between prisons and their communities. Thus, prisons also affect public health in the wider community. Even though reporting of health-related data from prisons is rather poor, evidence indicates that outbreaks of TB in prisons have caused increased TB in local communities (15). According to WHO and the European Centre for Disease Prevention and Control, in countries with high TB incidence and large prison populations prisons significantly contribute to the regional TB burden (6). Considering the global epidemic of HIV, the first epidemic outbreak of HIV in Thailand, according to the United Nations Office on Drugs and Crime, "... likely began among injecting drug users in the Bangkok prison system in 1988" (16). In the recent past, Latvian prisons were documented as posing a threat to public health because of a high prevalence of HIV and TB in the absence of adequate prevention and treatment (17,18). Prison settings thus present a challenge to public health. According to a recent scientific review of how prisons affect public health, prisoners whose physical and mental illnesses are not adequately dealt with during incarceration may "... act as reservoirs of infection and chronic disease, increasing the public health burden of poor communities" (13). Consequently, "tackling the mental and physical illness of prisoners will improve public health" (13). This can be demonstrated: for example, in England prison-based hepatitis B vaccination programmes have contributed significantly to the rise in the uptake of hepatitis B vaccination among people who inject drugs in the community (19).

2. Legal cornerstones of prison health

2.1 Prisoners' right to health

Imprisonment is never only about safety, security and discipline but, as the Council of Europe laid down in its 2006 Prison Rules, is always also about "... ensuring prison conditions which do not infringe human dignity and which offer meaningful occupational activities and treatment programmes to inmates, thus preparing them for their reintegration into society" (20). Therefore, one of the most important principles that guide the deprivation of liberty is that prisoners remain bearers of

all human rights insofar as they are not lawfully restricted or limited to an extent demonstrably necessitated by the fact of incarceration (20,21). This also applies to their right to health, which is established on various foundations of fundamental human rights (22). Most important is Article 12 of the International Covenant on Economic, Social and Cultural Rights (23). In its General Comment No. 14 to give guidance to states, the United Nations Committee on Economic, Social and Cultural Rights laid out the scope and content of the right to health. With regard to its scope, the Committee states that "... the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health" (24). According to the Committee, the necessary public health and health care facilities, goods and services have to meet the following qualities (24):

- *availability*: facilities, services and goods have to be available in sufficient quantity, including the underlying determinants of health, such as safe and potable drinking-water as well as adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel and essential drugs;
- *accessibility*: facilities, services and goods and health-related information have to be physically and economically accessible (affordable) without discrimination, especially to vulnerable or marginalized populations;
- *acceptability*: facilities, services and goods must respect medical ethics, respect confidentiality and improve the health status of those concerned;
- *quality*: facilities, services and goods must be scientifically and medically appropriate and of good quality which, according to the Committee, requires (among other things) skilled health care staff, scientifically approved and unexpired drugs and equipment, safe and potable water and adequate sanitation.

With respect to prisoners, the following statements of the Committee are especially important. The first two refer to states' parties' obligations as to the right to health. They maintain that "States are under the obligation to *respect* the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees ..., to preventive, curative and palliative health services" (24), and that "States parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable ... to realize that right themselves by the means at their disposal" (24). A third

statement explicitly includes in the right to health the “right to be free from torture” (24). The most important statements regarding prisoners are to be found in what the Committee calls the “core obligations” of states. They constitute an individual legal entitlement (22) and obligate states as follows (24):

[Article 43]:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

...

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

...

(f) To adopt and implement a national public health strategy and plan of action, ... [which] shall give particular attention to all vulnerable or marginalized groups.

[Article 44]:

...

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

...

(e) To provide appropriate training for health personnel, including education on health and human rights.

In reference to Article 12 of the International Covenant on Economic, Social and Cultural Rights, the right to health of prisoners during the past decades has been enshrined in various international human rights norms, guidelines and standards on which this document is based. A comprehensive study of the right to health of prisoners has analysed how international case law is gradually transforming these into accepted legal norms. The study concludes “... that, far from articulating non-binding standards, in many cases these guidelines have become accepted minimum legal requirements for governments to meet” (25). Regarding the European Prison Rules, which represent a source of major importance to this document, the Council of Europe states that they “... should be implemented in ‘national law’ ...” and be a reference document to assist the European bodies that monitor human rights and prisons (26).

2.2 States’ special duty of care

Prisoners have no alternative but to rely on the authorities to protect and promote their health. To safeguard the right to health of prisoners, international

law subordinates to the state a legally enforceable duty of care. A state can be made accountable for failure to prevent all forms of avoidable health impairment or damage to the well-being of its prisoners (22). If the health of any prisoner is harmed, a government trying to escape from its legal accountability must prove that state bodies did not cause the harm directly and (cumulatively) that it has taken all reasonable measures of safeguarding and prevention. Failing to do so would represent a violation of human rights (22). The European Prison Rules also reflect this special duty of care of the state: "Prison authorities shall safeguard the health of all prisoners in their care" (20). The official comment on the European Prison Rules deduces the state's special duty of care from the right to health as enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (26):

Alongside this fundamental right, which applies to all persons, prisoners have additional safeguards as a result of their status. When a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary. Prison administrations have a responsibility not simply to ensure effective access for prisoners to medical care but also to establish conditions that promote the well-being of both prisoners and prison staff. ... This applies to all aspects of prison life, but especially to healthcare.

Two fundamental consequences of this are that all imprisoned people must be offered a proper medical examination as promptly as possible after admission and that prisoners are entitled to care and treatment free of charge (27).

The European Prison Rules and the Standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) refer to the specific elements and standards of the state's duty of care. With regard to the conditions of imprisonment relevant for health and prison health services, they require the following:

- conditions of imprisonment that include:
 - accommodation that offers enough space, light and fresh air;
 - good hygiene and clean sanitary facilities;
 - clothing and heating suitable for the climate;
 - adequate nutrition adapted to individual needs (20);

- prison health services that include;
 - access to a doctor at any time of detention without undue delay;
 - equivalence of care (see below);
 - the patient's consent and confidentiality;
 - preventive health care;
 - humanitarian assistance to vulnerable prisoners;
 - professional independence (see below);
 - professional competence (28,29).

Representatives of about 40 Member States reaffirmed these elements and standards at a meeting of the WHO European Network for Prison and Health in Abano Terme, Italy in 2011.

Both instruments of the Council of Europe mentioned have made it clear that the state's duty of care applies even in times of fiscal austerity. Basic Principle 4 of the European Prison Rules states that "prison conditions that infringe prisoners' human rights are not justified by lack of resources". The CPT further elaborates on this, as follows (28):

The CPT is aware that in periods of economic difficulties – such as those encountered today in many countries visited by the CPT – sacrifices have to be made, including in penitentiary establishments. However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life-threatening diseases.

The Human Rights Committee supports this view in its Communication No. 763/1997 (30):

... the essential fact remains that the State party by arresting and detaining individuals takes the responsibility to care for their life. It is up to the State party by organizing its detention facilities to know about the state of health of the detainees as far as may be reasonably expected. Lack of financial means cannot reduce this responsibility.

The Expert Group therefore concludes the following:

- if conditions of imprisonment and prison health services do not correspond to the standards mentioned above, a state should either set priorities for resources that favour better prison health or consider alternatives to imprisonment;
- otherwise, a state not only risks violating human rights but also endangering the health of people in its care.

2.3 The mission of prison health staff and the need for independence

The relationship between health care providers and patients is a crucial factor for the success of any health system. According to the CPT, a trustful doctor–patient relationship “is a major factor in safeguarding the health and well-being of prisoners” (31). The states’ special duty of care for prisoners has three fundamental implications for the role, mission, duty and alignment of prison health personnel.

The first is a single duty of care. All relevant prison rules state that the sole mission of health personnel in prisons is to care for and advocate the health and well-being of prisoners. This includes making arrangements for continuity of care after release, inspecting and reporting to prison directors about the conditions of imprisonment relevant to health, and identifying and reporting any sign of ill treatment of prisoners to the relevant authorities (20).

The second is the highest claims to professional ethics. The relationship between health personnel and patients in prisons is not based on free will. The patient cannot choose the doctor, nor can the doctor choose the patient. This places the highest demands on the professional ethics of prison health personnel. Thus, most international prison rules contain provisions on medical ethics relating to prison health personnel (32). Most prison rules reflect the ethical dilemma of dual loyalty, which may represent a particularly characteristic challenge for prison health staff (33,34), and which the CPT describes as follows: “The health-care staff in any prison is potentially a staff at risk. Their duty to care for their patients (sick prisoners) may often enter into conflict with considerations of prison management and security. This can give rise to difficult ethical questions and choices” (35). To avoid any such conflict, Principle 3 of the United Nations resolution on the principles of medical ethics relevant to health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment states that “it is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional

relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health” (36).

Third, professional independence is essential. An organizational prerequisite for the undivided loyalty of prison health staff to their patients is full professional independence. Thus, for example, the Committee of Ministers of the Council of Europe states in paragraph 20 of its Recommendation No. R(98)7 Concerning the Ethical and Organisational Aspects of Health Care in Prison: “Clinical decisions and any other assessments regarding the health of detained persons should be governed only by medical criteria. Health care personnel should operate with complete independence within the bounds of their qualifications and competence” (29). The CPT adds: “In order to guarantee their independence in health-care matters, the CPT considers it important that such personnel should be aligned as closely as possible with the mainstream of health-care provision in the community at large” (28).

The foregoing considerations lead the Expert Group to the following conclusions:

- health personnel in prisons should act in their professional capacity completely independent of prison authorities and in the closest possible alignment with public health services, while remaining in effective liaison with prison staff to enable health care to be delivered efficiently;
- such an understanding of their role implies the necessity for all people working in prisons to be trained in and respect human rights and medical ethics (37,38).

2.4 Principle of equivalence and integration

Based on the above requirements for prison health – prisoners retain their right to health, states have a legally enforceable duty of care for the health of prisoners, the single mission of health personnel in prisons is to care for their patients’ health, and health personnel should operate with complete independence from prison authorities – there follow two interrelated further principles of prison health that are widely represented in international prison rules:

- the principle of equivalence
- the principle of integration.

Since the latter is an institutional consequence of the former, and since the two cannot be clearly separated in legal texts, it is suggested to refer to them as one single principle of equivalence and integration.

Regarding *equivalence*, Principle 9 of the United Nations Basic Principles for the Treatment of Prisoners states that “prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation” (21).

At the European level, this provision was incorporated verbatim in the European Prison Rules (20) and further elaborated by the Committee of Ministers of the Council of Europe in paragraphs 10–12 of its 1997 Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison (29) by additionally introducing the notion of integration:

10. Health policy in custody should be integrated into, and compatible with, national health policy. A prison health care service should be able to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public. ...

11. The prison health care service should have a sufficient number of qualified medical, nursing and technical staff, as well as appropriate premises, installations and equipment of a quality comparable, if not identical, to those which exist in the outside environment.

12. The role of the ministry responsible for health should be strengthened in the domain of quality assessment of hygiene, health care and organisation of health services in custody, in accordance with national legislation. A clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries, which should co-operate in implementing an integrated health policy in prison.

Regarding the principles of equivalence and integration and, therefore, implicitly regarding all previously discussed requirements and principles of a legally compliant prison health service, the Committee of Ministers of the Council of Europe in its official commentary to the revised and updated European Prison Rules in 2006 concluded that “... the most effective way of implementing rule 40 [on the organization of prison health care] is that the national health authority should also be responsible for providing health care in prison, as is the case in a number of European countries” (26). According to the Committee of Ministers, this would benefit prisoners and staff alike: “This will not only allow for continuity of treatment but will also enable prisoners and staff to benefit from wider developments in

treatments, in professional standards and in training" (26). Further, the CPT opts for the health authorities being responsible for prison health care. *Paragraph 52 of the 15th General Report on the CPT's activities* states (see Reference 39): "The CPT shares the view that the most effective way of ensuring that such links [between health care in prisons and health care in the community] exist is for the provision of health care in prisons to be contracted to the general health-care system" (39). In its 2009 report to the United Kingdom, the CPT justified and further substantiated this position: "The complexities of the health of the prisoner population and the ethics of health care delivery in a custodial setting require a discrete, independent service. The transfer of health care to the NHS [National Health Service] can be seen as recognition of this fact" (40).

From a public health perspective, the principle of integration was postulated by the Council of Europe in Recommendation Rec(2001)12 of the Committee of Ministers to Member States on the Adaptation of Health Care Services to the Demand for Health Care and Health Care Services of People in Marginal Situations (41). Among other things, this referred to Recommendation No. R(98)7 concerning the ethical and organizational aspects of health care in prison: "To be efficient, any health policy, especially if oriented towards the needs of persons living in marginal situations, should be based on an integrated approach ... member states, working in a long-term perspective, should endeavour to meet the needs of persons living in marginal situations within the existing health system" (41). In their 2003 Oslo Declaration on Health, Dignity and Human Rights, the European health ministers stressed the leading role of health ministries in providing appropriate health care for vulnerable and socially excluded groups (42).

The position of the Council of Europe was recalled by the delegates present at the joint WHO/Russian Federation International Meeting on Prison Health and Public Health in the Moscow Declaration of 2003, stating "... that penitentiary health must be an integral part of the ... health system of any country". The Moscow Declaration was based on and in accordance with most relevant international law referring to the right to health of prisoners. It was sent to the governments of all European countries (43).

At the global level, official documents by WHO, the United Nations Office on Drugs and Crime and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have further developed and set out this position (16,44,45), most recently in their 2013

publication *HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*: "In the longer term, transferring the control of health in closed settings to public health authorities will have a positive impact on both prison and public health in general..." (46). The authors stress the need to ensure continuity of care of as one of the starting-points for considering such a transfer:

In order to ensure that the benefits of treatment (such as antiretroviral therapy, tuberculosis treatment, viral hepatitis treatment or opioid substitution therapy) started before or during imprisonment are not lost, as well as to prevent the development of resistance to medications, provision must be made to allow people to continue these treatments without interruption, at all stages of detention: while the person is in police and pretrial detention, in prison, during institutional transfers and after release.

3. Persistent shortcomings of prison health

Either the justice ministry or the interior ministry is responsible for all aspects of prisons, including prison health, in most countries worldwide and in the vast majority of the 53 Member States of the WHO European Region. Any assessment and evaluation of prison health conditions and services will, therefore, struggle with a basic and characteristic shortcoming of prison systems without the close involvement of national health authorities in prison health: the almost universal absence of the prison population from national health statistics and the widespread absence of health data from prison statistics (47).

In the absence of reliable and continuous baseline data on prisoners' health, any attempt to assess the performance of prisons in coping with the health needs of prisoners in the WHO European Region must consider the findings of the two main instruments of the Council of Europe to protect prisoners and their rights:

- the reports of the CPT (48); and
- the growing body of case law of the European Court of Human Rights (ECHR) concerning prison health (49).

The ECHR judges individual complaints brought by prisoners or by their legal representatives mainly on the basis of Articles 2 (Right to life – “Everyone’s right to life shall be protected by law”) and 3 (Prohibition of torture – “No one shall be subjected to torture or to inhuman or degrading treatment or punishment”) of the European Convention on Human Rights (50). In its judgements, ECHR also regularly refers to the recommendations of the Council of Europe repeatedly cited in this document and to the standards set by the CPT (see section 2.2). That is how the latter are strengthened by international case law. Even though the ECHR always deals with individual complaints, many of its judgements reflect on the overall health conditions in a given prison or prison system.

The CPT, another integrated part of the Council of Europe’s system for the protection of human rights, visits places of detention to assess how people deprived of liberty are treated and reports its findings to the states. The CPT thereby always evaluates the conditions of imprisonment relevant to health and the performance of prison health services. The CPT justifies its caring for prison health by referring to Article 3 of the European Convention on Human Rights (Prohibition of torture, see above) and by arguing that “an inadequate level of health care can lead rapidly to situations falling within the scope of the term ‘inhuman and degrading treatment’” (28). In its reports to the states, the CPT refers to the recommendations of the Council of Europe relating to prisons to an even greater extent than to the ECHR. Even though the CPT always deals with specific institutions at a certain time, many of its findings reflect on health conditions in the wider prison system.

The case law summarized by the CPT, and the ECHR reports provide evidence of continual and widespread disregard of the legal cornerstones and standards of prison health described in this document (see section 2). The reports and the case law illustrate multiple shortcomings on substantive, procedural and structural levels, such as:

- lack of an in-house health service in many prisons, and work carried out by too few or insufficiently qualified staff in many prison health services (51–54);
- screening by duty prison staff of prisoners’ requests for access to the medical staff (55);
- carrying out by prisoners working in the health care unit, some as orderlies, of medical tasks such as measuring temperature, blood pressure and pulse (55,56);

- carrying out by non-medical staff in custodial functions of work for which they are not qualified, such as distributing prescribed medicines (57);
- failure to give prison health staff any specific training for carrying out health care duties in prisons, and thus isolating them from mainstream health care practice (58);
- failure to offer access at the right time to a general practitioner or to specialized care (59–61);
- failure to offer and carry out any medical entry examinations or failure to offer and carry out medical entry examinations within a reasonable time (31,51,54,59,62,63);
- failure to draw up and keep uniform, consistent and substantial medical records (54,64,65) or to make records accessible to independent supervision (66);
- failure to treat medical data confidentially (51,67–69);
- failure to monitor and effectively address the problem of hepatitis C among prisoners (58);
- failure to provide a prisoner with a minimum scope of medical supervision and assistance regarding treatment of his HIV infection at the right time (70,71);
- failure to protect the life of a prisoner with deteriorating health caused by HIV, who died shortly after release, by not providing him with adequate medical assistance during imprisonment (72);
- failure to provide comprehensive medical supervision and treatment to prisoners infected with TB and HIV, failure to provide physical conditions adapted for their recovery, and promotion of the dissemination of TB within prison by failure to segregate healthy inmates from those suffering from TB (73,74), thus promoting multidrug-resistant forms of the disease;
- failure to provide and carry out a comprehensive drug policy for prisoners that combines medical detoxification, psychological support, life skills, rehabilitation, substitution programmes and prevention (54,56,60);
- failure to effectively enable and organize continuity of care for prisoners on transfer (75);
- involvement of doctors and other health staff in body searches for security reasons (51);
- shackling of prisoners for medical examination (51,75);
- involvement of doctors and other health personnel in the punishment of prisoners, such as solitary confinement (31,40,54,76,77); and
- failure by doctors and other health personnel to record and report cases of ill-treatment to competent authorities (51,54).

Besides these examples that directly refer to prison health services, the CPT and the ECHR have repeatedly criticized material prison conditions detrimental to health, such as overcrowding, poor ventilation, lighting and heating, and poor hygiene and sanitary conditions (54,65,78–80). In addition, the CPT has found allegations and cases of ill-treatment of prisoners by prison officers and cases where prisoners have not been effectively protected from violence between prisoners (60,81). Both findings are contrary to states' special duty of care for prisoners.

Despite these shortcomings, and against the recommendations of the Council of Europe, health ministries are hardly or not at all involved in prison health in most Member States. However, in some cases, the CPT has explicitly called for health ministries to become more strongly involved or even called for health authorities to assume responsibility for prison health (54,55,82,83).

4. Good governance for prison health in the 21st century

The foregoing considerations lead the Expert Group to the following conclusions.

- Prisoners have the same rights to health and well-being as any other people.
- Prisoners mostly come from socially disadvantaged segments of the community and carry a higher burden of communicable and noncommunicable diseases than the general population.
- Prisons are settings with high risks of disease. Because there is a constant interchange between their inhabitants and communities outside, they present a complex and difficult challenge for public health, especially with regard to the tackling of communicable diseases such as HIV or TB.
- States have a special, sovereign duty of care for prisoners. They are accountable for all avoidable health impairments to prisoners caused by inadequate health care measures or inadequate prison conditions with regard to hygiene, catering, space, heating, lighting, ventilation, physical activity and social contacts.
- Prison health services should be at least of equivalent professional, ethical and technical standards to those applying to public health services in the community.
- Prison health services should be provided exclusively to care for prisoners and must never be involved in the punishment of prisoners.

- Prison health services should be fully independent of prison administrations and yet liaise effectively with them.
- Prison health services should be integrated into national health policies and systems, including as regards the training and professional development of health care staff.

However, although a body of international rules for prison health has been developed and widely adopted in recent decades, an analysis of European instruments of human rights shows that the following poor practices frequently occur across Europe.

- The right to health of prisoners is frequently disregarded.
- Many states do not meet their special duty of care for prisoners adequately.
- Prisoners are frequently subjected to avoidable health risks, for example, through lack of access to screening or immunization programmes or active case-finding programmes.
- Health personnel often do not act independently of prison authorities but are involved in conflicts of loyalty between providing health care for prisoners and participating in the efforts of authorities to discipline and punish prisoners.
- The public health challenges of prisons are not being adequately met. The chance and obligation to offer this most vulnerable of populations with great health needs good access to health care in their own right, while also tackling the wider public health needs in general, are often not taken advantage of. According to the CPT (28), this applies especially to transmissible diseases:

The spread of transmissible diseases and, in particular, of tuberculosis, hepatitis and HIV/AIDS has become a major public health concern in a number of European countries. Although affecting the population at large, these diseases have emerged as a dramatic problem in certain prison systems. In this connection the CPT has, on a number of occasions, been obliged to express serious concerns about the inadequacy of the measures taken to tackle this problem. Further, material conditions under which prisoners are held have often been found to be such that they can only favour the spread of these diseases.

The present document reaffirms the human rights approach to prison health that the WHO Regional Office for Europe has promoted for more than a decade. With regard to the position of the Regional Office relating to what it considers good governance for prison health, reference must be made to the new common

European policy framework for health, Health 2020 (84), which was adopted by the 53 European Member States at the sixty-second session of the WHO Regional Committee for Europe in Malta in September 2012. Health 2020 aims at reducing health inequalities by improving the governance of health and by giving priority to reducing the burden of disease and strengthening health systems and the resilience of communities. Thus, it reinforces and optimizes the implementation of all strategies and frameworks that guide the work of WHO in the European Region. Health 2020 is based on the values enshrined in the WHO Constitution: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” (85). In Health 2020, Member States recall that the right to health is a basic human right under international law. They state that “...it is time to renew European health policy and to address the human right to health in the context of what is known and what can be achieved in promoting and maintaining health. These benefits should be available for everyone as far as possible. Achieving them will require new and radically different leadership and governance for health” (84). Health 2020 emphasizes the benefits of linking WHO with “evolving types of partnerships for health” such as prison settings (84).

Given the foregoing conclusions, and in accordance with and in support of the new European policy for health, Health 2020, as well as the WHO *Roadmap to prevent and combat drug-resistant tuberculosis 2011–2015* (86), the *European Action Plan for HIV/AIDS 2012–2015* (87) and the comprehensive mental health action plan 2013–2020 adopted by the Sixty-sixth World Health Assembly on 27 May 2013 (88), and in consideration of the Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (89) and the 2005 resolution on prevention of injuries in the WHO European Region (90) and in accordance with and in support of the recommendations and standards of the Council of Europe relating to prison health, the Expert Group concluded, with regard to the institutional arrangements for prison health, that:

- the management and coordination of all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility;
- health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions.

In recent years, several Member States in the WHO European Region have transferred the responsibility for prison health to their health ministries. These

are, in order of the time since this transfer took place: Norway, France and the United Kingdom. Italy, some Swiss cantons and two autonomous regions of Spain have implemented a similar reform. Currently, several other entities are considering or have begun a similar reform, including Finland, Kazakhstan, Kosovo² and the Republic of Moldova.

This process is likely to continue throughout the Region. Yet obtaining evidence that it results in better prison health is not an easy task. The reasons for this are the widespread lack of baseline health data in prison systems where health service provision is not the responsibility of health ministries, and the fact that the transfer processes are usually system-wide so that randomized controlled trials are not possible. Positive health outcomes were, however, reported at an international conference in London in 2004 by representatives of several Member States that had undertaken this transfer or were about to undertake it. Their unanimous conclusion was that *(91)*:

... the gains [of transfer] can be great. Evaluations that have been carried out indicate that the standard of care provided to prisoners has improved in all four countries. National health policy has greater awareness of the specific health needs of prisoners. Recruitment and quality of staffing has improved. Links with the community have been strengthened.

Individual European Member States have further reported benefits such as improved resources and funding for key prison health issues, and the inclusion of prisoners in major public health initiatives *(92)*. Most recent evidence from the Region confirms that the performance of prison health services may considerably improve following transfer to health ministries, and that such transfers can favour the development of prison health indicators, service performance assessments and integration of prison health data into national health statistics *(93)*.

The Expert Group is aware that transferring prison health care to the jurisdiction of health ministries and thus integrating prison health into national health systems will be a long process. It is aware that success, and not putting prisoners at increased health risks, require that governments give this process the highest political commitment, communicate fully across all levels of management

² In accordance with United Nations Security Council resolution 1244 (1999).

and personnel, and carefully plan and execute the practical steps, including all necessary budgetary implications and transfers of funding.

There are strong indications that such a whole-of-government approach to prison health in the longer term will have beneficial effects, including:

- lower health risks and improved health protection in prisons;
- improved health of prisoners;
- improved performance of national health systems;
- improved health of deprived communities;
- improved public health of the whole community;
- improved integration of prisoners into society on release;
- lower rates of reoffending and reincarceration and reduction of the size of the prison population; and
- greater governmental credibility based on increased efforts to protect human rights and reduce health inequalities.

Three principles of international law are always indispensable safeguards for the correct treatment of prisoners according to the principles and standards summarized in this document, regardless of which ministry is responsible for prison health (94).

1. International regulations and recommendations on prison health and medical ethics should be integrated into national law.
2. Prisoners should have the opportunity to submit requests and complaints to prison authorities and the right to appeal to an independent authority without facing any negative consequences.
3. Government agencies should regularly inspect prisons to assess whether they are being administered in accordance with the requirements of national and international law, and independent bodies that are legally entitled to visit prisons and whose findings should be published should monitor prison conditions and the treatment of prisoners.

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