Policy dialogue on prison health: analysis and the way forward in the Portuguese context

15–16 February 2023
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Abstract

This report presents the main points debated during the national policy dialogue co-organized by the Portuguese Ministries of Health Justice following the publication of the Status report on prison health in the WHO European Region 2022. This dialogue identified and evaluated the need for improvement of the status of prison health in Portugal, alongside relevant health-care initiatives and responses, to ensure that people deprived of liberty retain both their fundamental rights with regard to health and the ability to participate in decisions that affect them. With support from the WHO Regional Office for Europe, the recently constituted Working Group in charge of drafting the Operational Plan for Health in the Context of Deprivation of Liberty for the period 2023–2030 is entering a critical 4-month period of preparing and presenting concrete proposals for action, and this report provides an overview of the targets to be achieved, the needs thus far identified, and the steps that need to be taken to continue to improve practice and ensure that no one is left behind.

Keywords

PRISONS
PORTUGAL
COMMUNICABLE DISEASES
MENTAL HEALTH
PUBLIC HEALTH
RISK FACTORS
HEALTH INEQUITIES
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## Abbreviations

<table>
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<th>Abbreviation</th>
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<td>CVD</td>
<td>cardiovascular diseases</td>
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| DGRSP        | Direção-Geral de Reinserção e Serviços Prisionais  
[General Directorate of Reintegration and Prison Services] |
| DGS          | Direção-Geral da Saúde  
[General Directorate of Health] |
| ECDC         | European Centre for Disease Prevention and Control |
| INSA         | Instituto Nacional de Saúde Doutor Ricardo Jorge  
[National Institute of Health Doctor Ricardo Jorge] |
| ISPUP        | Instituto de Saúde Pública da Universidade do Porto  
[Institute of Public Health of the University of Porto] |
| NGO          | nongovernmental organization |
| P-NHS        | Portuguese National Health Service |
| PrEP         | pre-exposure prophylaxis |
| RRMD         | redução de riscos e minimização de danos  
[risk reduction and harm minimization] |
| SICAD        | Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências  
[Intervention Service for Addictive Behaviours and Addictions] |
Persons deprived of liberty should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge, without discrimination on the grounds of their legal status.¹

The most important thing inside prison is Health.²

² WHO Regional Office for Europe. The most important thing inside prison is health: Bruno shares his story [video]. YouTube: 18 July 2021 [https://www.youtube.com/watch?v=8E11b-P1E1c].
Opportunities

- The publication of the Status report on prison health in the WHO European Region 2022 (the Report) (1) and the ensuing national meetings marked the beginning of a period of heightened analysis and reflection on the current status of health in Portuguese prisons, and on indicators identified in the report, taking a participatory, interdisciplinary and in-depth approach, which has allowed a diagnosis of needs and identification of priority actions to be implemented.

- Portugal has a legal framework that recognizes health protection as a fundamental right at both the constitutional and ordinary law levels. The country has established a universal, general and progressively free-of-charge National Health Service (P-NHS), and recognizes that people deprived of liberty still have the right to health protection through the Service under the same terms as other users.

- Incarceration can be viewed as an opportunity to improve the health status of people living in prison through access to the health-care continuum in an integrated manner: promotion, prevention, diagnosis, treatment, rehabilitation and palliative care.

- The cooperation of Portuguese prisons with Portuguese National Health Service [Serviço Nacional de Saúde Português (P-NHS)] facilities concerning health issues such as HIV, viral hepatitis and tuberculosis has proven to be a beneficial practice that translates into health gains and can serve as an example in other areas of health provision.

- Science and technology now allow the complete digital management of health information in prison settings, as well as the interoperability and integration of information systems. While the General Data Protection Regulation frames this process and participants’ rights are not obscured, it does not present an impediment to the benefits of better-shared data.

- The WHO Prison Health Framework (2) and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) (3), among other documents, have established a systematic framework for the design, planning, implementation and evaluation of health policies and responses in prisons.

- The WHO Regional Office for Europe is available to continue providing support and to collaborate in the continued monitoring of future developments in Portuguese prison health.

- Institute of Public Health of the University of Porto [Instituto de Saúde Pública da Universidade do Porto (ISPUP)] has achieved official recognition as a WHO collaborating centre, which represents both a testament to the Institute’s contribution towards research and understanding of the social and behavioural determinants of health, and an opportunity to strengthen collaboration between Portugal and WHO, both within the field of prison health and further afield.

Identified needs

- Ensure that health care in prisons is organized similarly to public health-care initiatives and responses, and that people deprived of their liberty retain their fundamental rights, particularly with regard to health and the ability to participate in decisions that affect them.
• Ensure cooperation and continuity of care between prisons and the P-NHS, including the integration of health information systems. This should be undertaken as part of coordination with community outreach organizations concerning areas such as health, social security, education, work and housing in order to both promote health and reduce inequalities and inequities, as well as stigma and discrimination, and in this way to counteract the potential of incarceration worsening health outcomes.

• Ensure access to health promotion and preventative care, in addition to diagnosis, treatment, rehabilitation and palliative care.

• Address issues caused by noncommunicable diseases associated with population ageing. These can be aggravated in prison by premature ageing, primarily observed in those over 50 years of age. Further issues to be addressed include infectious diseases, anticipating future needs, and planning and implementing appropriate responses in a timely manner.

• Fully implement a system for carrying out custodial measures for those not responsible for their crimes so that they are detained in non-custodial institutions.

• Concerning health information management in the prison context:
  › deepen the detail used in recording indicators for future analysis, such as vaccination coverage, use of personal protective equipment and adherence to screening in addition to recording information on the availability and disaggregation of indicators and equal provision for more vulnerable population subgroups, and should include other groups and indicators not yet covered in data recording. This will ensure that data can be gathered from events such as cause of death (e.g. suicide or overdose) alongside the prevalence and modes of transmission of infection currently observed within prison and between all healthcare professionals who work within these systems, not just doctors and nurses;
  › improve data collection processes and make them simpler and more streamlined;
  › ensure that information collected is of high quality, reliable and trustworthy;
  › ensure that digitalization of the health information systems in prisons is treated as diligently as the recent work undertaken within the P-NHS. This is essential to improve diagnosis, referrals and treatment following screening;
  › ensure interoperability and integration between prison health information systems and the P-NHS; and
  › decrease the time that health-care professionals currently have available to dedicate to data processing and health information management.

• Build capacity to allow prison professionals to deliver integrated, quality and person-centred health care.

• Research and generate knowledge about the health of those in prison to enable better-informed and higher-quality decision-making.

Next steps

• Regarding the recently constituted Working Group in charge of drafting the Operational Plan for Health in the Context of Deprivation of Liberty for the period 2023–2030 (the Working Group) [4]:
  › include representatives of all stakeholders within and around the prison system, including the communities of people deprived of their liberty and vulnerable subgroups such as drug users or migrants, as well as prison staff, officers and academic consultants;
begin to consult with relevant national and international entities to gain a wider perspective of the issues;

start working immediately on the preparation and presentation of concrete proposals for action;

identify the necessary means (human, financial and others) to accomplish these proposals within the expected time frame of 4 months; and

in potential collaboration with the WHO Collaborating Centre for the Study of Social and Behavioural Determinants of Noncommunicable Diseases, which is part of the Working Group, monitor the evolution of the work over this 4-month period; namely, collaborating, if requested, on the definition of measurable targets to be achieved and their subsequent monitoring throughout the duration of the Plan.

• Review and improve existing Collaboration Protocols between the Direção-Geral de Reinserção e Serviços Prisionais (DGRSP) [General Directorate of Reintegration and Prison Services] and the Ministry of Health, in the areas of:
  
  › screening and prevention of tuberculosis; and treatment of HIV and viral hepatitis;
  
  › ensuring the prescription and supply of medication directly by prison services, as well as the allocation of specific days for P-NHS doctors to work in prisons;
  
  › extending this good practice transversally to the cooperation between prison health services and the P-NHS, including for noncommunicable diseases; and
  
  › better utilization of tele-health, for a wider and more effective implementation of the Plan.

• Review and update the Procedures Manual for Health Care Provision in Prison, according to the Direção Geral de Saúde (DGS) [General Directorate of Health] Clinical Guidelines, national programmes and international standards recommended by WHO.

• Establish criteria and priorities for implementing and evaluating knowledge-based measures using the available resources to achieve WHO and European Centre for Disease Prevention and Control (ECDC) goals, as well as reinforcing Portugal's commitment to achieving the Sustainable Development Goals, including in the areas of ageing and dementia.

• Implement health promotion and prevention strategies in all areas of prison health in general, and in particular:
  
  › promote healthier environments and behaviours through physical activity, balanced nutrition and smoke-free environments with appropriate support for smoking cessation;
  
  › promote better mental health, including through recognition and timely management of common psychological problems such as anxiety and depression;
  
  › promote health literacy among people in prison;
  
  › implement cognitive stimulation programmes;
  
  › encourage better health protection practices, including safer sex, using products already available in prisons such as condoms, lubricants and pre-exposure prophylaxis (PrEP);
  
  › implementing vaccination programmes against hepatitis B for people who have not yet had the vaccine or who have lost the immunity it confers, such as older people or migrants, as well as against human papilloma virus and meningococcus; and
  
  › implementing needle and syringe exchange programmes and expanding the scope and coverage of evidence-informed treatments, primarily for opioid agonists.
• Improve the response of treatment programmes and integrated response centres to problems due to addictive behaviours and addiction, as well as their interaction.

• At the prison health information management level:
  › in the immediate term and where they still exist on paper, digitize files and their respective data to ensure that prison health care workers have access to the same information systems and computer applications currently available to the P-NHS; namely, the Health Data Platform and SClinic;
  › clarify the objectives of data processing, better identify data that needs to be collected and solve persistent technical challenges;
  › ensure the future of the universal electronic health record system as a cross-cutting and integrative solution for health information and care whether provided in or out of prison; and
  › allocate dedicated professionals to data processing, with specific training for the purpose.

• Promote the involvement of the prison community, including the most vulnerable, in the individual, institutional and political decisions that affect them; namely in the diagnosis of needs, the planning and implementation of health care, and the co-creation of health programmes in prisons. This should include attention to the involvement of prison staff at all levels, including prison officers, in all levels of prison health response.

• Promote the training of all prison staff on digital skills, the various areas of prison health intervention and human rights, with the contribution, in particular, of the Ministry of Science, Technology and Higher Education and respective entities.

• Invest in research, specifically through public funding; particularly research on the implementation of health interventions in prisons (so-called implementation research).

• Implement the investments already planned in the Recovery and Resilience Plan, related to health in prisons, namely:
  › establishing forensic psychiatric inpatient units and the construction of forensic community transition units; and
  › digital transition of the four pillars of health: infrastructure, citizens, professionals and data.

• Implement the multiyear investment plan to improve conditions of detention in the prison system.

• Implement measures to reduce the number of people in prisons and the length of time spent there, based, inter alia, on the experience of managing the COVID-19 pandemic in prisons and other relevant experiences.
Scope and purpose
WHO has been involved in the domain of prison health since the creation of the Health In Prisons Programme by the WHO Regional Office for Europe in 1995. Two of the main working axes are monitoring health in prisons and the development of policies and legal frameworks for health in prisons.

In 2021 the WHO Regional Office for Europe launched through its Regional Committee the WHO Prison Health Framework (2), which was developed aiming to establish and define the main components of prison health systems and consequently standardize and improve the data collection process for characterizing the performance of each of the prison system’s components and their impact on health indicators. During this same year, WHO invited national focal points from its 53 WHO European Region Member States to complete the Health in Prisons European Database survey about health systems and services in prisons, in collaboration with the respective prison authorities. Collected data were then analysed, validated and collated into the Status report on prison health in the WHO European Region 2022 (1). This report, an important landmark, provides essential data for Member States to establish objectives for the performance of prison health systems, considering the trends in the WHO European Region, and to monitor progress throughout time.

On the 15–16 February 2023, WHO organized a two-day event that constituted an excellent opportunity to discuss with Member States, prison health workers, prison administrators, main experts in the field, professional organizations and civil society, the necessary changes in governance of prison health systems, and jointly identify ways forwards to improve the provision of healthcare to people deprived of their liberty in the WHO European Region.

The event included an international meeting, on the morning of the 15 February to launch the report and discuss its main findings and conclusions, with the participation of government representatives, national and international organizations, academia and independent experts. A national debate followed (afternoon of 15 February), that continued the following day, 16 February, with the aim to align prison health and public health policies in Portugal, which included discussions around the barriers and facilitators for implementation, and which favoured the interaction with civil society organizations and professionals working in the field of prison health.

The main objectives of this event were to:

- present and launch the Status report on prison health in the WHO European Region 2022 (1);
- discuss the implications in terms of public policies of some of the main areas identified in the context of the WHO Prison Health Framework (2) and the Status report on prison health in the WHO European Region 2022 (1) that are relevant for Member States to consider in their efforts to improve the provision of health services; and
- discuss barriers and possible solutions that are meaningful to the Portuguese context.

The current report covers only the national debate’s Portuguese policy dialogue, which was exclusively held in Portuguese during the afternoon of 15 February and the full day of 16 February during the national debate [Annex 1].

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3 The report, alongside the individual country profiles, is accessible at https://www.who.int/europe/publications/i/item/9789289058674 or through the WHO Regional Office for Europe webpage devoted to the Health in Prisons Programme at https://www.who.int/europe/health-topics/prisons-and-health. Other national data may be obtained through the Health in Prisons European Database, hosted at the Global Health Observatory. https://www.who.int/data/region/europe/health-in-prisons-european-database-(hiped)

Policy dialogue on prison health: analysis and the way forward in the Portuguese context
Day 1 (afternoon)
Key messages from the Status report on prison health in the WHO European Region 2022 in the Portuguese context

Using evidence generated by the Report to improve access to health-care services in prisons: reflections for the Portuguese context

In the Portuguese context, reflection calls for looking at both figures and context.

The prison statistics presented in the Report (see Annex 2) indicate that there is capacity to reduce inequities in health and above all, provide the health care urgently needed by vulnerable groups.

The information made available allows for better understanding and, additionally, reflection on how to attend to and adapt to:

• the double burdens (social and moral) associated with deprivation of liberty;
• stigmatization, including its extension beyond the time an individual is in prison and how it can follow them for the rest of their life;
• the fact that prisons are progressively becoming places of confinement for vulnerable individuals with mental health disorders who may have been previously confined to psychiatric hospitals. This has followed an intended movement towards openness within the community, which has instead created a need for alternative solutions towards housing these individuals, remaining as yet unrealized;
• the issue of premature ageing of the prison population, where their age-based needs extend beyond those expected by their biological age. This issue is exacerbated by the increasingly high number of people aged over 50 years of age in Portuguese prisons, which is currently around 20%;
• the role of people deprived of liberty in the decision-making processes that affect their lives, considering that the loss of physical freedom does not eradicate their inherent human rights;
• how the transition of people between the communities and prison is managed, especially regarding information and conceptions that people take with them (in particular, health information) and the movement of these concepts back to communities as people are released from custody; and
• absences and unoccupied positions with regard to prison health-care professionals in varied areas.

Prison health is public health: it involves all relevant professionals, not only physicians and nurses but also other professionals including prison officers, nutritionists, psychologists, social workers, epidemiologists and all who are involved in the various components of the organized response to a population and its community health problems. In addition to individual response (5,6), it is also necessary to listen to and involve local communities.

It is equally necessary to consider noncommunicable diseases, which remain underrecognized as a key health issue in prisons, even in comparison with communicable diseases, despite the fact that among those deprived of liberty the risk of health impacts such as cervical cancer (in the case of women), death from various cancers, respiratory diseases (particularly considering the higher
proportion of smokers within prisons), cardiovascular diseases (CVD) and chronic mental health disorders is particularly high [7]. When combined with the higher risk of communicable diseases this translates into a double burden of disease that necessitates special attention.

The United Nations Standard Minimum Rules for the Treatment of Prisoners [Nelson Mandela Rules] [8] defines a set of rules, such as respect for equal rights, which, when considering the nature of human rights and the rights of individuals, must be implemented by all countries. This includes those rights that refer to health and health care, with a view to observing that only one right—freedom—should be curtailed for those under detention.

Health care in prisons has also been considered by a variety of international regulations such as the Nelson Mandela and Bangkok Rules [9], for women deprived of liberty, among others. These regulations consider the ethical nature of dilemmas facing health-care professionals in particular, not least because of their double relationship with people that they have to care for and to whom they are also hierarchically accountable. These regulations attest not only to civilizational gains, but also the inherent difficulty of many of the choices that must be made to respond to health issues.

One of these dilemmas is the guarantee of clinical independence [10], in a context where both ethical issues, organizational problems and structural barriers are faced. These make provision of care, to the extent it is expected, difficult, with respect to health as a human right and not a paid commodity, as it can too-easily become in some Portuguese prisons.

There is very little existent evidence for a health-care-provision governance model that promotes health equity [11]. Prison can be the first moment where an individual will receive appropriate health care; and, considering this, can encounter a response to health problems that have never previously been addressed. Considering the circumstances that people face prison within itself, this situation can equally induce health inequities.

**From an epidemiology perspective, the Report shows that there is ample variation between Member States, which shows there is much room for improvement of the prison health system.**

With regard to the proportion of people in prison per 100,000 inhabitants, Portugal is ranked statistically in an intermediate position among commonly analysed countries. However, the question may be raised whether this value may be too high; during the COVID-19 pandemic, the number of people admitted and held in detention in Portugal during 2020 per 100,000 inhabitants was much lower, which indicates that too many people have suffered in detention too long; and at very least this bears reflection and further examination.

Regarding rehabilitation, education and training programmes exist in all Portuguese prisons, as well as employment opportunities; however the Report does not specify what qualifications can be earned from these.

Mortality due to suicide in the Portuguese prison population is much higher than that observed in the general population. While this has understandable aspects and the data is lacking concerning overdose-attributable mortality, even in the absence of this information it is clear that the situation has considerably improved over since 2010. No deaths were attributed to COVID-19, which is aligned with the fact that most COVID-attributable deaths in Portugal were in those over 75–80 years of age, and this population is low within prisons.
The Report still lacks information on several health issues in Portugal which WHO has identified as most relevant in the prison context, such as oral health, mental health disorders, drug use disorders, diabetes mellitus, hypertension, CVD and cancer. A similar situation is visible in the domain of health-influencing behaviours, which is particularly pertinent considering that in 2005 this information existed for analysis. In some cases, information is collected but is not easily accessible and analysed and therefore cannot be shared. Action is necessary to ensure that data of this nature can be available for the future reports.

With regard to screening for communicable diseases, an opt-out model has been adopted in Portuguese prisons. Considering the ethical issues that exist in prisons, the extent to which those deprived of liberty truly have the capacity to opt out is questionable.

In terms of secondary cancer prevention, colon cancer screening is not offered in Portuguese prisons by the Portuguese National Health Service (P-NHS).

The prevalence of HIV infection in prisons shown in the Report (3.90%) is 10 times higher than the equivalent for the general Portuguese population (0.38%). Additionally, there is no information about the cascade of HIV infection, excepting the proportion of diagnosed people receiving treatment in detention, which is similar to that observed in the community. It would be reasonable to expect that the situation in prisons would be far better, because many of the barriers that exist for the general population are absent in prisons. There are intentions to achieve the 95–95–95 targets4 established for HIV in prisons, which requires knowing the proportion of people who receive treatment and also the proportion of people with suppressed viral load, a figure that is difficult to obtain for the general population.

There is no information on the prevalence of tuberculosis in the Report, although this condition is very common in Portuguese prisons, as it is in the Portuguese population. It is essential to obtain this information, considering that 15.5% of the prison population are migrants, some of whom originate from high-endemic countries.

The prevalence of hepatitis B in the Portuguese prison population (1.6%) is lower than the prevalence observed in the general population 30 years ago, when Portugal was an intermediate-endemic country with 2–3% of the population living with hepatitis B antigen. This indirectly demonstrates the extraordinary impact of the public hepatitis B vaccination policy in Portugal. However, it is important to know the proportion of infection present in people born in Portugal and in those born in other countries where the infection is still prevalent, highly incidental and where there is no vaccination.

The proportion of people infected with hepatitis C undergoing treatment (less than 10%) is still concerning, considering that in 2017 a programme for eliminating hepatitis C was launched, including within prisons. With this said, the prevalence of hepatitis C in 2020 is also approximately the same as it was in 2005. It is necessary to respond to unmet needs such as the availability of sterile needles in prisons. In 2007 the Needle Exchange Programme was aborted because there was no capacity to implement it. More than a decade later, injection-associated infections are still unnecessarily prevalent. To change this paradigm it is necessary to have the courage to understand that there are dependent people who will not adhere to alternative responses and, therefore, to break the cycle of trafficking, it is necessary to provide them with the substance they need, such as

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4 By 2030, that 95% of all people living with HIV will know their HIV status, 95% of those diagnosed will receive sustained antiretroviral therapy and 95% of those receiving therapy will have viral suppression.
providing insulin to a person with diabetes or other chronic medications to people that need them, even if this conflicts with current legislation in Portugal.

In relation to COVID-19, the same frequency of infection was recorded in prisons as in the general population 2020 and, therefore, it can be concluded that prisons performed well in this regard.

Recommendations from the working group created in 2006 with the mission to present proposals to implement a National Action Plan to combat the transmission of communicable diseases in the criminal justice system (12), namely with regard to disease prevention and health promotion, are, 15 years later, still not reflected in the Report. Figures show that, under the current circumstances, there is room for improvement, particularly in the context of the Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD) [Intervention Service for Addictive Behaviours and Addictions].

**In summary**, Portugal is approximately aligned with WHO European Region averages, but it is still desirable for the Region to improve, and for individual Member States to improve as well. Portugal showed capability in taking important steps such as the adoption of the Law decriminalizing drug use (13), but it is now time to continue taking other steps, particularly when considering that the prison landscape has changed throughout the years. Regarding the challenge of missing health information, there is technical capacity to solve it, but so far there has not been capacity to find mechanisms for effective information sharing. Equally, it is not enough to simply collect data – quality data are necessary, as well as an ambition to obtain disaggregated data that may support problem solving. This is an area where WHO can adopt a leading role. It is necessary to transform information into knowledge. Without knowledge, it is not only impossible, but also dangerous to act. It is, therefore, important to invest in methodological thinking and science, including through public financing of research concerning health in prisons. In addition, it is necessary to bring all interested stakeholders into closer discussion to ensure that health is a continuum and to avoid missing opportunities.

**Communicable diseases in prison: recommendations from the national coordinators**

**Viral hepatitis**

Bringing P-NHS hospitals closer to prisons, made possible through the creation of the Referral Network for hospital health care provision in the context of HIV and viral hepatitis infections to prison populations, was a very important step.

It is extremely difficult to collate data on viral hepatitis in prisons, because the two ministries with responsibilities in this area (Justice and Health) do not always communicate with each other. Additionally, these data are particularly sensitive in nature, as illustrated by the General Data Protection Regulation. It is certain that there is willingness to collect data and if data then prove to be incorrect, it is necessary to improve both the process of collection and the data itself. This can be achieved through fully dedicated health-care professionals working on these data, instead of health-care professionals responsible for providing care being also committed to collecting, recording and analysing data.
The databases that exist for hepatitis C were not initially designed to also collect data from prisons, which goes towards explaining the lack of correct information currently contained in the Report. Around 20 years ago, the prevalence of hepatitis C in prisons was around 40% (14), and currently, it is estimated to be around 4% (although the Report points to 8.5%).

Influencing these data is the fact that the analysis of hepatitis C data is complex. First, it is necessary to analyse whether the antibody is positive and, if so, whether the viral load is positive. For example, in the last study conducted in the Lisbon Prison Establishment, more than half of those with a positive antibody no longer exhibited a positive viral load. This fact may explain the difference between the estimated prevalence of hepatitis C in Portugal and the figure reported, even although the survey used, the basis for the report, specifies that chronic hepatitis C corresponds to a positive test in the RNA detection test. In other words, individuals considered to have chronic hepatitis C were those with a positive antibody, regardless of their viral load.

Reducing the burden of hepatitis C is one of the easier tasks faced. The efficacy of treatment for hepatitis C is around 97%, with no side-effects. The test is made upon admission to prisons and is, therefore, very easy to treat. However, many of those admitted have liver cirrhosis and may in the future develop hepatocarcinoma. As such, it should be evaluated whether any person requiring treatment already has cirrhosis. Currently, 40% of those treated in Portugal have advanced fibrosis or cirrhosis.

Hepatitis C cannot be examined in isolation from people and their social and family context. Many come from vulnerable backgrounds and, therefore, a non-punitive approach must be adopted, where restorative health is promoted. The hepatitis B vaccine is currently advised for the whole population up to 60 years of age (as recommended in the United States of America (15) and in some European countries) and other cofactors for hepatitis disease, such as alcohol (a major health problem in prisons), tobacco (more than 80% are heavy smokers), mental health disorders (with a high risk for suicide) and obesity.

Currently in Portugal, hepatic disease is the fourth leading cause of premature death (including cirrhosis and hepatocarcinoma, which have been increasing in recent years) and people deprived of liberty suffer most from this disease. It is, therefore, necessary that both the Ministries of Justice and Health invest in solving the shortage of health-care professionals working in prisons to promote the health of people deprived of liberty.

**HIV infection**

It is important to improve data collection tools in order not only to increase the detail of the various indicators present in the Report, but also to collect other types of information. For example, in addition to the availability of preventive means and health protection materials, it is necessary to evaluate the quantity of materials actually used; because, for example, the number of condoms provided by the National Programme for Sexually Transmitted Diseases and HIV infection is meaningless considering the size of the prison population.

The process of data collection for the Report must be more articulated and participatory, because often the data exists but is not collated and worked on collaboratively. A greater involvement of all stakeholders working in this area will surely improve the data quality.

Regarding the preventive measures defended by the Programme, which are implemented and
disseminated in the community, these should be transposed to the prison context and take into mind its particular characteristics.

Prison can be a privileged context for providing health care at different levels, from prevention to treatment to the provision of other types of care. But it is also a context where communicable diseases may be more prevalent. With regard to sexually transmitted diseases, such as HIV infection and the behaviours associated with their transmission, the ambiguity in the transmission approach (see next point) is a major obstacle to effective prevention and decreasing prevalence in prisons, which remains a priority to be addressed.

The fact that there are behaviours which in theory should not happen in an imprisonment context, such as sexual intercourse and drug use, should not impede planning and implementing of strategies and programmes that evidence shows are cost-effective such as barrier methods, pre-exposure prophylaxis (PrEP) and needle exchange programmes. It is, therefore, necessary to reflect on ways to overcome constraints and barriers that hinder implementation of these programmes. Condoms and lubricants are available in prisons, just as they are in the community, but their utilization must be promoted. On the other hand, in 2007 the attempt to implement a needle exchange programme in two prison establishments was not pursued.

It is important to continue the implementation of collaborative protocols that provide for the travel of P-NHS physicians to visit prisons. These are recognized as good practice and should be improved in order that they may address infections through not only a treatment perspective, but also throughout a fuller continuum of care: from prevention to diagnosis and treatment, including when people are released by connecting them to health care to ensure treatment continuation. Moreover, it is important that screening is completed not only upon admission, but also during any period of incarceration and ahead of release.

**Tuberculosis**

The data presented in the Report are not in accordance with data published by the National Programme for Tuberculosis and, therefore, the different sources of information must be intersected and interpreted to make them as homogeneous and coherent as possible. Around two thirds of people deprived of liberty are indicated in the Report as receiving tuberculosis treatment are not people with active tuberculosis but instead are on preventive treatment. In addition, a significant proportion (up to half) of people with active tuberculosis have the bacilliferous form, i.e. pulmonary tuberculosis, which has a different impact on the strategies that must be adopted in prisons.

In Portugal, around half of cases diagnosed in 2021 were diagnosed in the context of a screening for vulnerable populations and not solely following exposure, including people with comorbidities such as viral hepatitis or HIV infection. In prisons, there is a very significant proportion, almost 30% of people with active tuberculosis and HIV coinfection. This proportion is around 20% in people on preventive treatment. Other risk factors are viral hepatitis coinfection and addictions, with drug use disorders (by injection or other administration routes) being relevant a social determinant. Therefore, there is a clear benefit to developing a common strategy for the three programmes (tuberculosis, viral hepatitis and HIV infection) not only in the area of tuberculosis but also in the other areas. Being a migrant is an oscillating risk factor for tuberculosis in the prison population. While in 2020 almost half of those with active tuberculosis were foreign citizens, in 2021 there was only one foreign citizen with active tuberculosis across all Portuguese prisons.
Screening for infection in asymptomatic vulnerable individuals is the most efficient long-term strategy, as it allows early identification of infection cases and breaks of transmission pathways, with a future impact on new active tuberculosis cases. In immunocompromised individuals with no recent exposure, preventive treatment is shorter, allowing for greater adherence and, consequently, greater efficacy. However, due to the incidence of tuberculosis in Portugal, practice is still very much directed at active tuberculosis cases.

The protocol established between the Direção-Geral de Saúde (DGS) [General Directorate of Health] and the Direção-Geral de Reinserção e Serviços Prisionais (DGRSP) [General Directorate of Reintegration and Prison Services] provides for screening upon admission to prisons, which is targeted towards active tuberculosis diagnosis, because the main premise is symptom screening (along with imagiological investigation), followed by laboratory investigation, if suspected. However, there is a good implementation of health care in prisons with tuberculosis consultations available at Pneumological Diagnostic Centres (public structures for responding to tuberculosis in the community), where pharmacological treatment is provided free of charge. There is also the possibility to liaise with the nearest P-NHS hospitals for further investigation or, if isolation is necessary, referral to the São João de Deus Prison Hospital (the only in the country, located in Caxias). A protocol renewal is underway, which will include a more significant emphasis on tuberculosis screening and preventive treatment of infection.

Noncommunicable diseases in prison: recommendations by the national coordinators

Mental health

There is ambivalence about whether health in prisons should be the responsibility of the Ministry of Justice or the Ministry of Health. Currently, there is a mixed system and the lack of data may also be a result of this ambivalence. There are already protocols established in the area of communicable diseases, but the ministries of health and Justice should jointly develop general health care planning and then each programme may be adapted to the prison context.

Suicide has always been a complex problem in the prison context. Despite the existence of an Integrated Programme for Suicide Prevention, which is implemented in all prison establishments in Portugal and a growing number of mental health professionals, in particular at the São João de Deus Prison Hospital, better coordination is needed between the P-NHS and prison services is needed to be able to respond more comprehensively in this area.

A collaboration between the Ministry of Health’s National Coordination of Mental Health Policies and prison services has focused somewhat on primary prevention, but mainly on the reintegration of unimputable people and in secondary prevention. For many years, such work has been developed in proximity with the prison services, with three units which are currently being requalified, providing for unimputable offenders, and now through additional transitional units [release houses] that are being created operating closer to the community, in order to double the level of care and response provided to this population by 2025.
Oncological diseases

The Report mentions the absence of colorectal cancer screening in Portuguese prisons, which is unexpected considering it is the cheapest and easiest to implement of all cancer screening programmes. The National Programme for Oncological Diseases is conducting further work to understand if indeed this screening is unavailable, or if it the problem is more related to the collection and transmission of data. On the other hand, it would also be useful to also know the adherence rate to screening programmes in prisons. Greater understanding of the status of colorectal cancer screening and adherence rate to breast and cervical cancer screening in prisons will be useful in the context of the Europe’s Beating Cancer Plan, which is part of the wider National Strategy against Cancer 2021–2030 extending to all other forms, such as oral cancer.

In addition to the availability of screening programmes, it is very important to ensure cases are referred and that the response provided by the P-NHS comes in a timely manner, which would be expedited if all prisons used electronic health records (as has already been implemented in the P-NHS) and if there was communication between the information systems of all health-care providers, including those within the P-NHS, which is not always the case.

In Portugal, there are 10 radiotherapy centres and 36 centres for oncological and surgical care in the various P-NHS hospitals. Electronic communication between these centres is very important and is a problem that must be overcome, both for good of the prison and general populations and to improve data collection and integration with the National Cancer Registry. For this to happen, investment in technological and human resources is required.

Regarding oncological health-care professional, the ratio of specialists in Portugal is currently close to that recommended by the European Union. The challenge in this area is, above all, to ensure physicists provide quality control for screening mammographs, new emerging screenings (such as low-dose computed axial tomography scans) and multiparametric magnetic resonance imaging.

Cerebral-cardiovascular diseases

Based on the written contribution of Carlos Aguiar, representative of the National Programme for Cerebral-cardiovascular Diseases.

Most CVDs are caused by atherosclerosis. Atherosclerotic CVDs are preventable: around 80% of myocardial infarction and cerebrovascular accident cases are due to risk factors that can be corrected or eliminated; for example, high blood pressure, dyslipidemia, tobacco smoking, diabetes mellitus, physical inactivity, obesity (particularly abdominal), dietary errors and biopsychosocial stress.

Cardiovascular risk is increased in people with HIV infection, chronic kidney disease, cancer, chronic obstructive pulmonary disease, autoimmune disease, periodontal disease, obstructive sleep apnoea or mental health disorders and atrial fibrillation. A prison term may raise cardiovascular risk (e.g. through mental health disorders, tobacco smoking, unhealthy diet, physical inactivity, weight gain, impaired ability to monitor risk factors and risk of communicable diseases). However, the prevalence and standards of care offered to people with hypertension or diabetes mellitus and also data on obesity, smoking and physical activity levels of those living in Portuguese prisons are unknown, even although these data are collected upon admission to prison.
In people with one or more risk factors or with family history of CVD at premature age or aged 40 or over (over 50 years or postmenopausal in women), it is important to evaluate and monitor the risk for atherosclerotic CVD and adjust preventive therapeutic interventions to the level of cardiovascular risk.

Atherosclerotic CVDs are treatable. Many of the drugs and medical devices prescribed for these conditions reduce morbidity and/or mortality, as well as improving quality of life and alleviating symptoms. Life expectancy lost due to CVD diagnosis is, today, largely recoverable by the recommended therapeutic measures.

In people with coronary disease and/or heart failure, the influenza vaccination is associated with a lower incidence of serious complications from the infection and a reduction in cardiovascular morbi-mortality. The pneumococcal vaccination is recommended for people with heart failure. The anti-COVID-19 vaccination is recommended for people with CVD.

The resources needed for the prevention and control of cerebro-cardiovascular diseases in people deprived of liberty in Portugal are as follows:

- health-care professionals: physicians (trained in general and family medicine is sufficient for most situations; followed by neurologists or cardiologists, who may be required in selected cases);
- nurses, who play a crucial role in health education and in literacy about diseases and treatment;
- the capacity to rapidly detect emergent situations: adequate conditions for cardiorespiratory resuscitation; electrocardiograms for diagnosis of acute ST-elevation myocardial infarction;
- protocols with hospital institutions for emergency care: equivalent to acute myocardial infarction and stroke fast-tracks;
- access to appropriate follow-up of diseases and their risk factors;
- access to medication and to monitoring of risk factors (blood pressure, glycaemia, etc.); and
- transition care (ensuring continuity of care following release).

In order to prioritize implementation measures and to periodically monitor their progress, it will be important to start auditing the measures that are already in place in Portuguese prison establishments, since the Report did not cover all these aspects.

System barriers and facilitators to effective implementation: information systems

A conceptual model for health information management of people in contact with the criminal justice sector

The Report provides both incentive and opportunity to extensively and contextually characterize the information to be processed, to more fully understand what information is important and should be prioritized, and to try to homogenize data. The digitalization of health in prisons must be authorized and implemented, and efforts made to define the scope and objectives for data collection by those with the responsibility to prioritize, thus avoiding a situation where if everything is important and/or urgent, then no priorities are set. In the context of finite resources, before initiating data collection it is important to reflect on objectives, identifying clearly what knowledge
and insight is required and which data will meet these objectives, as well as to prioritize, otherwise no solution can be implemented.

Equally, the entire system must be digitally enabled. Portugal has shown great advancement in this area, including in the health sector, over the 10–15 years since 2010. While information systems themselves are often blamed for problems of data collection, storing, processing and analysis, it is equally necessary that users are capable of working effectively with systems and that systems are adapted to their working methods. It is insufficient to have the latest software version, a training manual or some training lessons; the study of interoperationalization with the user is essential as input for the refinement and modelling of information systems. At the same time, capacity-building must be multidisciplinary and specialized. Data collection and analysis must involve fully dedicated professionals, with specific training. These do not have to necessarily be health-care professionals, except in the case of sensitive health data, nor it is necessary to have any health training. What is necessary, is to have education about the process of giving consent, otherwise consent is unlikely to be informed.

There are no scientific or technological barriers to solving the data collection and management problem. The challenges are largely technical in terms of design, method and management, and it is necessary to make solutions uncomplicated by design and avoid overcomplexity. It is also necessary to leverage technology that is already commoditized – mobile, wireless and ubiquitous technology.

Personal data, and in particular health data, are sensitive and particularly private information that must be treated as such. Although the prison context establishes some rights (outlined by Law No. 59/2019 of 8 August 2019 that approved rules for managing personal data), these are generalized in their integration and external follow-up. Data protection should not be used as an excuse for inaction; proportionality is the key to data processing and to deciding what can and cannot be accomplished. From a technical point of view, everything must be secure by design, promoting trust – and data management must be auditable and traceable.

Current challenges in health information management within prisons

The prison population is ageing, which implies that health information systems must be in place at two crucial stages – upon admission and release from prison. Currently, communication is conducted through other means at these stages (telephone and letter) to obtain or transmit people’s health information. It would be more efficient and easier to use a common information system inside and outside prisons, in order to maintain continuity of care and optimize the scarce time of health professionals.

It is a fallacy to say that such integration is not possible due to concerns about disclosing whether a person has been incarcerated. For example, when prescriptions are issued for medication, the place of issue is already visible. When it is necessary to contact an individual’s attendant physician in the community, perhaps to obtain information about medication that was prescribed prior to admission to prison, prison health professionals have to identify themselves as such.

While implementation proceeds on universal electronic health records, it is vital to quickly implement an alternative solution such as access to the information systems currently available through the P-NHS (Plataforma de Dados de Saúde and SClínico) for prison health-care professionals.
Perspectives of future developments: integrating prison health into public health

The Report identifies gaps in terms of data collection and digitization. There is a lack of information for providing health care and for ensuring continuity of care between communities and prison, as well as for public health surveillance and planning, which may also reflect a governance problem. From an information perspective, it is necessary to assess what currently exists and what is planned, and to envisage the integration of prison health services in the context of the national information ecosystem. The health information ecosystem in Portugal has a high digital maturity, with a set of information systems that collect population health data from birth to death.

The Recovery and Resilience Plan (16) broadly outlines the future path of digital health in Portugal, based on four pillars – infrastructure, citizens, professionals and data – highlighting its bearing on the integration of prison health services with the P-NHS information system on:

- the existence of an omnichannel platform [SNS24] to ensure simplicity and equity in access to the P-NHS;
- the strengthening the security of information collected and stored at each user’s contact with the P-NHS;
- the development of a data lake, which allows information to be available for reutilization, both at a primary and secondary level; and
- the integration of information systems, in a cross-sectional way, covering all levels of care, which is intended to respond to many of the current challenges and barriers, namely those identified in the context of prison health (for example, lack of funding and resources for the development and implementation of information systems in prisons; outdated technologies and inadequate infrastructure; and lack of standardization between different prisons).

Information must travel with individuals at each point of contact with the health system, in order to ensure integration and continuity of care. To this end, there must be a universal electronic health record: a health record that contains an individual’s health information that is accessible at any point of health-care provision, whether public or private, through all the various applications that health-care professionals and people can use.

A universal electronic health record may benefit prison health care in terms of the quality of care (the information follows the person whether they are in prison or in the community), development of tele-health services, in cost reduction (by avoiding duplication of tests and procedures) and in coordination between prison and community health care. At the same time, the standardization of data collection, storing and communication, inherent to the concept of a universal electronic health record, will enhance the ability to reutilize information for secondary purposes, such as for health monitoring and planning.

The universal electronic health record is based on a set of interoperability components (legal, regulatory and technical) including the definition of protocols and standards for data communication (whether from a security or semantic point of view, the centralization of information in a single database, authorized access for health professionals, unique identification of each person and the availability of specifications that will allow any programming application interface to access the information contained in the record.
The creation of a universal electronic health record is part of an active effort to leverage the global digital health agenda, for primary and secondary use, to ensure data portability and access and availability at any point of health-care provision, and additionally to support personalized medicine. In the context of the European health data space, in May 2022 the European Commission published the legislative proposal for the regulation of the European Health Data Area [17], which aims to overcome the current challenges in the use of health data. Also in the scope of the X-e-health project (Exchanging electronic Health Records in a common framework) [18], funded by the European Union and coordinated by the Shared Services of the Ministry of Health, technical guidelines have been published to define a common framework for communication between electronic health records.

It is important to define a clear and strict timeline for the implementation of a universal electronic health record system.

**Final reflections on ways forwards from theory to practice and policy implementation**

The situation in Portugal has vulnerability characteristics shared with other WHO European Region Member States, but there are specific aspects that must be considered when evaluating needs. Continuing to assess evidence is vital and, therefore, work to gather evidence and data at both the national and international levels is extremely important and must continue.

Evidence is still scarce and must grow, and quality remains limited. However, it is equally necessary to assess a point of balance between scientific excellence and the need for basic data, even if they are not perfect, in order to even begin to inform policy.

It is also important to abandon a moralistic and idealistic approach in favour of expediency in facing existing social and health problems.

At the coordination and integration level, the following priorities are affirmed:

- data cross-checking for higher quality;
- digitization, always based on data protection;
- in terms of interventions, health promotion and interventions focused on social determinants;
- investment in research, monitoring, education and training; and
- the involvement of people working in prisons (health-care professionals and others) and of people deprived of their liberty.

**Ways forward: responses from the health sector**

People deprived of their liberty remain users of the P-NHS and as such must have access to all the service the P-NHS offer, leaving no one behind and adopting a whole-prison approach.

Individual or group support should be operationalized to give people a better future and better health, in particular with regard to behavioural risk prevention in general, treatment for alcohol and substance use disorders, monitoring of mental health, and providing support to individuals, families and communities.
The following principles should be reflected in health management, including in health promotion and disease prevention:

- health gains, translated through indicators
- de facto guaranteeing of the exercise of human rights
- equity promotion.

These issues, as well as others listed in the Report and discussed during this policy dialogue, should be the object of further study by the Government-appointed Working Group (by joint order of the Ministries of Health, Justice and Science, Technology and Higher Education) that will be in charge of preparing the Operational Plan for Health in the Context of Deprivation of Liberty for the period 2023–2030, which aims to strengthen access to health care, identify remaining barriers and address the gaps in prevention, access, retention and continuity of care (4). In particular, the following issues should be considered:

- information and knowledge (epidemiological surveillance, validity and comparability of data, analysis and information sharing);
- people (prison population and its characteristics, health needs and heterogeneity);
- health and disease (activities and interventions may share commonalities across different programmes, with gains from these synergies, including at the prevention level);
- occupational health (space management, risk management, violence prevention);
- literacy (literacy promotion among people deprived of their liberty on not just health but other areas such as environmental or financial literacy) including human rights literacy among health professionals and others;
- reintegration (availability of means; integration of responses to ensure continuity of care; awareness of communities, families and health services); and
- dialogue and partnerships between all sectors including health, justice, academia, social security and community.

The WHO Prison Health Framework (2) presents a model for organizing prison health systems, highlighting the main pillars of this model: inputs, outputs and outcomes, which must be used to develop and adjust the necessary interventions to improve their performance and achieve a greater impact.

Ways forward: responses from the justice sector

The rehabilitation of the prison population involves health interventions, and improving the health of people deprived of liberty can contribute to their rehabilitation and reintegration.

A P-NHS user number is assigned to any person entering the criminal justice system who does not yet have one, in order to guarantee free access to the health care provided within the scope of the P-NHS.

Each prison establishment develops a health promotion and disease prevention plan appropriate to its population, which must be submitted for the approval of the General Director of Reinsertion and Prison Services.

The provision and implementation of health care in prison establishments includes specialized
interventions (drug-free units in five prisons, pharmacological programmes in conjunction with P-NHS services and specific rehabilitation programmes); staff and part-time subcontracted human resources including physicians (general and family medicine and psychiatry in all prisons, plus a hospital with other specialties), nurses, psychologists, pharmacists, diagnostic and therapeutic technicians and nutritionists; health services in all prisons; and two mental health clinics (in the prison hospital and in a prison establishment in northern Portugal).

In 2008 a Manual of Procedures for the Provision of Health Care in Prison was developed, which itemizes the various health interventions so that they may be standardized across all prisons. This will be revised by the DGRSP to reflect changing needs and initiatives.

The São João de Deus Prison Hospital covers 48 prisons and has 160 beds, which is insufficient for the needs of a population of around 12 800 people. It provides external consultations and teleconsultations, has inpatient hospitalization (although if necessary, it can use P-NHS facilities in severe cases requiring specific care) and oversees the distribution of medicines to other prisons.

Prison services are integrated in three DGS Programmes (HIV infection, viral hepatitis and tuberculosis) and are committed to conduct screening for HIV, viral hepatitis and tuberculosis infections, and to guaranteeing access to treatment and its continuity for the entire prison population.

The prison population is vulnerable, with higher rates of disease, and it is often in prison that diagnoses is established or that individuals receive regular health monitoring for the first time, in terms of health literacy promotion, disease prevention, health promotion, treatment, rehabilitation and palliative care.

Currently, provisions already exist to bring the level of health care for people deprived of their liberty closer to the level offered to the general population, namely:

- legislation that establishes that people deprived of liberty have rights as full users of the P-NHS;
- protocols with P-NHS hospitals for treatment of communicable diseases and telephone consultations (since 2017);
- arrangements with the Instituto Nacional Doutor Ricardo Jorge [INSA] [National Institute of Health Doctor Ricardo Jorge] for conducting laboratory analysis (since 2017; covering the northern region and some establishments in the south and currently being expanded to the central region);
- discussion with the Division for Intervention in Addictive and Dependent Behaviours concerning drug addiction, although this has suffered difficulties in achieving a suitable resolution, both from the Division and from the prison health services;
- inpatient admission of unimputable people is being provided for by the P-NHS; however, this is still insufficient for requirements and an increase in the number of vacancies in mental health units for carrying out internment measures not integrated in the prison system (19) is expected soon;
- dentist offices in 20 prison establishments, where people with oral health problems can be referred; however, the services available are still rudimentary: basic treatment and tooth extraction, with difficulty in acquiring prostheses such as dentures or crowns;
- the recently established protocol with the Portuguese League Against Cancer, for oral cancer screening, which has already been implemented in two prison establishments and as a result, the League is seeking to establish a partnership with another institution for the acquisition of prostheses; and
- liaison with community institutions, namely nongovernmental organizations (NGOs) and other bodies that aim to support people when their prison sentence ends.
With regard to the future, it is necessary to:

- evaluate the implementation of existing protocols (HIV infection, viral hepatitis and tuberculosis) and consequently introduce improvements and expand to other areas, including noncommunicable diseases, as became evident as a result of this meeting;
- make procedures uniform across prisons, according to DGS norms and regulations;
- review and update procedures, namely the Manual of Procedures for the Provision of Health Care in Prisons;
- dematerialize health information from prisons, integrating it with the P-NHS computer system, with a view to creating a single clinical process; and
- improve the response from integrated response centres to problems of addictive and dependent behaviours.

**Final comments**

**Final comments from the WHO Regional Office for Europe**

WHO is available to collaborate and move the agenda forward to produce the necessary evidence needed to inform future steps.

The information system is extremely significant and the indicators are fundamental; however, there are challenges encountered in reporting data on the current situation. The WHO Prison Health Framework (2) forms the basis for assessing health in prisons and analysing the different pillars of the prison health system, and the indicators represent the minimum set of information needed to inform necessary measures in terms of public policies in order to improve the health status of people living in prison. The Framework also makes it possible to benchmark the performance of different Member States in each of these pillars. In the case of SARS-CoV-2 and Mpox infections, Member States were able to report weekly to WHO on a minimum dataset of indicators and, therefore, WHO believes that Member States are capable of more; plainly, reporting all indicators related to health in prisons.

The involvement of the Ministries of Health, Justice and Science, Technology and Higher Education shows that the political will to examine health in prisons exists, and points to opportunities for improving responses, either through the improvement of the prison information system and its integration into the context of the P-NHS, or through the analysis and revision of governance and planning structures and processes to ensure more efficient cooperation between existing structures and plans. It also shows that for effective coordination in the field of prison health it is necessary to ensure that all stakeholders are involved, invested and work together to improve the health of the prison population. This was evidenced during the COVID-19 pandemic, where without coordination it would not have been possible to respond to communicable disease outbreaks in prisons. Therefore, it is necessary to improve governance and dialogue between the various entities.

Multidisciplinarity of human resources is necessary and includes all of those who, at a given time, are part of the needed response, inside and outside of prisons, where discussion and integration with community health care is fundamental, particularly upon admission and release.
Final comments about the future of prison health in Portugal

The Report and the survey used as the basis for data collection are essential to fully understand the reality of the situation, to evaluate interventions, to identify work that remains to be done and to decide on the best interventions for the future.

The challenge of presenting the Report in Portugal was embraced by the Ministries of Health, Justice and Science, Technology and Higher Education and encouraged the various stakeholders to analyse the document and the reality, and to recognize not only existing gaps and weaknesses, but also the extensive potential to jointly explore ways to improve information sharing and the process of data collection and validation and, above all, to reflect on destinations and goals for each of the areas captured by the main indicators.

The Report reinforces a holistic view about health, based on human rights and the reduction of inequalities, which includes aspects of system organization, monitoring, prevention, health promotion, well-being, rehabilitation, access, acceptability and quality. In this way the Report de facto serves as an orientation guide for the path for the future, with the following priorities:

- improving information systems and resolving inconsistencies, analysing technical limitations and identifying the necessary data and the best way they can be obtained, in order to guarantee that when data are needed, there is proper support and the necessary interoperability;
- improving communication and articulation between the various areas, entities and programmes, including within the scope of the recently appointed Working Group;
- implementing a set of measures, those attributed the highest priority and the most capable of changing what is currently below expectations and those most likely to result in positive impacts on the lives and future of people deprived of liberty, with a visible impact on the next WHO report;5
- seizing the opportunity, while people are deprived of their liberty, for engaging disease prevention and health promotion, and thereby contributing to reducing inequities and guaranteeing full reintegration;
- reinforcing the collaboration between prison services and the P-NHS, involving all stakeholders, including people living in prison, who are the most interested parties and can be health-promoting agents; and
- ensuring that prison admission, stay and release are not moments of discontinuity of care, so as not to aggravate existing inequalities or increase the health-risk for people in contact with the criminal justice system.

There is much to be done in the area of health, both in the community and in prisons. Many people deprived of their liberty come from a context of vulnerability and inequality, so it is necessary to truly realize the potential that exists in prisons in terms of rehabilitation and reduction of inequities. The above-mentioned dialogue between the Ministries of Health, Justice and Science, Technology and Higher Education illustrates the existing commitment. The fields of Social Security, Labour, Housing and others are also fundamental contributors and must also be called upon to participate.

5 Note: reports are published every three years; the most recent data collected concern 2020, and therefore the next wave of data collection will be in 2023.
Day 2
The process that culminated with the publication of the Status report on prison health in the WHO European Region: 2022 was gradual and time-consuming, but important in creating a uniform framework for monitoring the performance of prison health systems and the health of people deprived of liberty, based on standardized indicators. Difficulties were faced in obtaining all requested information from each country, including Portugal, which further highlights the need for developing health information systems in prisons. Such an information system is not simply a set of data, but also a source for health intelligence to allow decision-making based on cultivated information and knowledge, in order to formulate policies and improve the system.

The Report provides a very important picture of the state of health in prisons in the WHO European Region and of the current challenges and ongoing development in the 36 Member States in which the survey was conducted. This overview enables reflection on the past, present and future of health in prisons, accompanied by strongly identifying the need for methodology to obtain better data, to make data easier to collect and share, and for better decisions and management in regard to the health of people deprived of liberty. This model must apply at all stages, from the time of entry into prison, throughout any prison stay and extend to the community after release, ensuring that people not only enjoy full reintegration to health-care systems but that the continuity of their data is maintained. This is fundamental to the quality of health-care continuity.

These reflections will be of the greatest importance in realizing a blueprint for the implementation of new actions aimed at improving health in prisons. Among these actions, the sharing of information between prisons and the P-NHS is a high priority and will represent a huge step forward in terms of progress once realized. It is, therefore, critical that the recommendations made are pragmatic, targeted towards practice and as simple as possible to implement, and that they continue to consider and facilitate ease of collaboration between multiple sectors, such as Health, Justice, Science, Technology and Higher Education.

Portugal has a legal framework, both at the constitutional and ordinary law levels, which recognizes the right to health protection as a fundamental right, establishes a universal and general P-NHS that tends to be free of charge and recognizes that people deprived of liberty have, for all intents and purposes, the same right to health protection through the P-NHS as any other user. When a person is deprived of freedom, although it represents a particularly negative life moment generally, it can often be the first time when an individual is seen by a health professional. This provides an opportunity for individuals to maintain and even increase their health capital and reduce their risk of exposure, so that the journey through prison is not a factor exacerbating pre-existing inequalities and disadvantages.

On the basis of the above provisions and to implement the right to health protection of people deprived of liberty, the Ministries of Health and Justice have instigated closer collaboration in order to improve health care in prisons and to better include prison health in national health policies. Among the results of this collaboration, the following are of note:

- the mechanism of referral of people deprived of liberty with HIV infection and viral hepatitis to P-NHS hospitals;
- the management of the COVID-19 pandemic, with its established goal of saving lives and protecting those most vulnerable, resulting in no lives lost in Portuguese prisons due to the pandemic;
• the installation of a helpdesk system in all prisons and educational centres in 2022, which now allows access to telephone consultations with any P-NHS establishment;

• the ongoing work being carried out to integrate prison health records with P-NHS records and enable community health professionals, prisons and health units to more easily access users’ health information;

• the extension of the collaboration to those unimputable due to mental illness, to whom by judicial decision a measure of security of hospitalization in a mental health institution is applicable, preferably in an P-NHS unit for the unimputable (and in this way reserving the psychiatric units of prison services for people who require greater security). For this purpose, a significant investment was made to renew and expand the capabilities of the P-NHS units for the unimputable, in order to allow a progressive transfer of people previously admitted to the prison system’s psychiatric units;

• the promotion of mental health care in the prison context, through measures such as the recent legislative amendment to allow the installation of telephone lines in all prison cells, with the exception of maximum-security establishments. Pilot experiments have shown that this can lower stress levels and bring people deprived of freedom closer to their loved ones, with clear benefits to their well-being;

• the recent adoption of a manual with new procedures to welcome trans people into the prison system in order to ensure their safety and well-being;

• the ongoing preparation of a multi-annual investment plan to improve prison conditions, which plays a decisive role in the physical, mental health and welfare of people deprived of liberty; and

• the creation of the Working Group in charge of drafting the Operational Plan for Health in the Context of Deprivation of Liberty for the period 2023–2030, which includes representatives of the Ministries and Secretariats of State, in addition to the Directorates-General and the various institutions involved in these areas. The Group should present their conclusions within late 2023, following which work can begin to implement the necessary identified measures (4).

Regarding the involvement of the Ministry of Science, Technology and Higher Education in the prison context, its contribution affirms its main missions and its meaning and relevance in social terms.

• The first mission is to transform people. The work that has been done with prisons, particularly from the Open University, which today translates into more than 100 people deprived of liberty now studying higher education, is the realization of this ability to transform these people, contribute to their accomplishments and facilitate their reintegration to society when applicable. Better-qualified people will feel more like welcome contributors to society, compared with the current situation where participation and acceptance were experienced in a more limited way.

• The second mission is to deepen knowledge, often from research, mobilizing the knowledge that exists in different areas of the university and research teams, to approach deeper and clearer understanding of the current situation and reality, make more informed decisions and formulate public policies based on this knowledge. In relation to health, this mission is particularly important for the Science, Technology and Higher Education team. As one of the priority objectives, to affirm the transversality of the contribution that Science, Technology and Higher Education can make to all areas, health stands out as an obvious priority area, particularly in the fields of advanced training and research. In the prison context specifically, the contribution to the training of prison professionals is highlighted (a relevant and more significant challenge than simply increasing their numbers), as are the contributions to improving research, generating knowledge and informing decision-making about the best
measures to implement within the newly created Working Group. Heightened collaboration between governmental areas reduces the fragmentation that often characterizes public intervention and further qualifies the contribution that science and knowledge can make in this field.

- The third mission is that of service to the community, accomplished through the contribution to strengthening democratic citizenship and humanist formation. This is one of the areas that is most at risk during the present time of simplistic, superficial views that are often uninformed and preoccupied with exacerbating fears and conflicts and, therefore, where academia, higher education and the scientific community can make a particularly important contribution to go beyond these visions and look at people deprived of liberty from a human rights perspective.

The assignment to Instituto de Saúde Pública da Universidade do Porto (ISPUP) [Institute of Public Health of the University of Porto] of the role of WHO Collaborating Centre for the Study of Social and Behavioural Determinants of Noncommunicable Diseases is an important recognition of its contribution to WHO’s European and global programmes in these areas and its remarkable work in the field of public health.

**Effective interventions for preventing communicable diseases in prisons**

The problem of health and human rights in the prison system has been an issue in the last 40 years of work of community-based organizations, so it is sometimes difficult to overcome scepticism in the face of various failed attempts that have already attempted to improve the situation, indicators and quality of life of people within the prison system in a consistent manner.

When considering health in prisons, one must not only think of people deprived of liberty, but also of the entire prison health system, including health indicators for guards and health professionals working in prisons.

In 2010 in a study carried out in prisons in Lisbon, there was an observed epidemic of anabolic steroid use among prison staff and people deprived of liberty. For the prevention of transmission of disease, it does not matter what is injected, what matters is the safety of what is used, and all actors should be involved in responding to health challenges and promoting human rights in prisons.

Enlightened political leaders are also needed, who consider the knowledge base from academia, international organizations (WHO, European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction) and from community-based organizations themselves. It has, however, proved difficult to mobilize these stakeholders, which has resulted in failed attempts to advance, even using the best and most recent knowledge. This was the case with the proposals presented by the Working Group for the Implementation of the National Action Plan to Combat the Propagation of Infectious–contagious Diseases in Prison, which resulted in very little changes in practice.

In addition to the recognition of human rights, it is necessary to establish criteria and priorities on paper that implement and evaluate knowledge-based measures from available resources in order to achieve the goals of WHO, ECDC and the Sustainable Development Goals, to which Portugal and most Member States are committed. In this sense, the new Working Group in
charge of drafting the Operational Plan for Health in the Context of Deprivation of Liberty for the period 2023–2030 now set up by the Government must deliver not only proposals but also the means of implementation, including considering budget, because without adequate funding and direction, proposals are nothing more than intentions.

Some relevant epidemiological data on infectious diseases (HIV infection, viral hepatitis, etc.) are missing from the report, which makes it difficult to diagnose the current position. Other data need to be revisited because they do not seem consistent, particularly regarding hepatitis C, where it is necessary to distinguish between people who have antibodies and people who have the disease (i.e. a positive viral load) and, therefore, must be treated. In the Report, individuals with positive antibodies appear to have been considered as having chronic hepatitis C, regardless of the viral load value, despite the questionnaire specifying that chronic hepatitis C as defined should correspond to positive RNA. Conversely, it is essential that data are obtained and analysed in a timely and accurate manner, and academia and civil society must also be involved in this work.

Regarding hepatitis C, access to treatment must be implemented as a public health programme and not as a pilot project. Portugal has made a pioneering effort to ensure access for all people to treatment for hepatitis C at affordable prices, and in prison it is easier for people both to have access to treatment and to be effectively treated. However, if the medication was available in prisons (and not only in P-NHS hospitals), it could be dispensed immediately at the time of diagnosis instead of requiring a later consultation as is currently the case. Problematically, no doctor within the prison health services, except for the Porto prison establishment, can ask for viral load from people with a positive hepatitis C antibody, as this can only be requested by a P-NHS hospital doctor. It would be simpler and more useful if prison doctors could immediately request such an analysis from INSA (within the framework of the DGRSP analysis protocol). The current hepatitis C treatment protocol is so simple that any properly trained doctor can perform it, so it should also be possible for doctors in prisons to prescribe treatment.

With regard to HIV, the Report states that 3.9% of people deprived of liberty have HIV infection. It is important to know the prevalence of infectious diseases within prisons but also to have information, which does not exist in the report, about transmission within prisons (what infections are transmitted and what forms of transmission) and about risk behaviours (such as use of injectable drugs, sex among men or sharing razor blades). Regarding prevention, PrEP and post-exposure prophylaxis should exist and be used in the context of prisons, given the prevalence of HIV infection. Treatment should also be considered as prevention, because a treated person does not transmit the infection. In the report, there is information on the proportion of people with HIV infection that are treated (87.3%), but it is important to also know the adherence to and continuity of treatment over time, as well as the proportion of people who have suppressed viral load. Prevention of new infections also implies health education, promotion of healthy environments and involvement of facilitators/peers. The 15.5% of migrants who exist in prisons should be the subject of particular attention due to possible communication barriers, different risk behaviours and ways of acquiring the infection. Genomic data allow us to identify HIV transmission chains and understand, for example, whether people have acquired infection in prison or not and what clinical and sociobehavioural determinants are associated with transmission.

The National Vaccination Program should be 100% complied with in prisons as all the requirements are in place. This is an opportunity to overcome any personal or institutional resistances that
may exist at local level, as there are conditions to comply with the Program in all prisons. People who are not vaccinated against hepatitis B are usually older (who have not been covered by the Program or who have lost immunity from vaccination) or migrants. Upon entry into Portuguese prisons, all people eligible for vaccination gain access to the Program. However, there is a large disparity between the prisons in the northern and southern regions, because in the south there are more migrants from Portuguese-speaking African countries, which puts greater pressure on prison establishments in this region in relation to vaccination against hepatitis B.

Treatment programmes with opioid agonists are available in a minority of prisons and there are barriers to the distribution of prevention products in a prison context. The Report may be an opportunity to finally implement the programmes that institutions involved in dependency interventions in prisons have been advocating for and seeking to implement: that is, both health prevention and promotion programmes and Risk Reduction and Harm Minimization (RRMD) programmes that are of the utmost importance and cannot be postponed further. There already exists an example in the Guarda prison establishment (20), which exhibits both good practices and also the necessary legal framework. At present, it is necessary to urgently implement a comprehensive RRMD programme in the prison context at national level, based upon knowledge and with appropriate funding, involving the prison professionals and NGOs already working in this area and taking into account the complexity of the social system in prisons in order to overcome existing resistances, particularly regarding the availability of needles (which are also already used for administering insulin).

Regarding information systems, the current lack of integration generates a lot of additional bureaucratic work for doctors and other health professionals, which in turn inspires little motivation to collect the data needed to develop a knowledge base. There are no scientific and technological barriers, nor are the General Data Protection Regulations an impediment; therefore, this integration can and should happen: the digitization of health information in prisons and its integration with P-NHS information must be a priority.

In relation to P-NHS doctors who also perform functions in prisons, they should be allocated specific days for this purpose, rather than it being supplementary work to P-NHS hospitals, because in prison patients are more receptive and professionals more motivated.

Solutions for violence, self-harm and suicide

The Report does not identify the causes of death of people deprived of liberty, but it is known that mortality risk is greater in people who have gone through the prison system. The comparison of general mortality with mortality in prisons can be misleading, because there was no standardization for age in the Report and the average age of people deprived of liberty is lower than the general average age. Suicide is also much higher in prisons than in the general population, including in Portugal. However, since there is great diversity among prison establishments, namely at the level of their (over)capacity, the risk of occurrence of phenomena such as suicide may also be different from prison to prison.

It is estimated that 15% of the Portuguese population outside prison has an undiagnosed mental illness. This lack of diagnosis is primarily because there is still a lot of stigma associated with mental illness. It is known that the prison population has a higher prevalence of mental
illness than the general population. The mental disorder most associated with suicide is major depressive disorder.

The prevention of suicide in prison requires interdisciplinary teamwork involving all prison professionals, not just those in health care.

The Integrated Suicide Prevention Programme, which is implemented in all prisons in Portugal, provides for observation on admission with the completion of a surveillance checklist, which is then followed with observation by technicians from the rehabilitation office and periodic meetings attended by prison management staff, doctors and other professionals (including prison guards), with the aim of early detection of signs, symptoms and risk factors for self-injurious and suicidal behaviours. All signposted situations must be guided and monitored.

According to the Manual of Procedures for the Provision of Health Care in Prisons, upon admission to prison people should be appraised both in the first 24 hours and the following 72 hours by a doctor but if required, some people should be immediately assessed and a detailed check of clinical history should be made to assess the risk of suicide.

The availability of nursing professionals 24 hours a day and protocolized guidelines allow for very effective interventions in the case of admission of a person who presents signs and symptoms of self-injurious ideation or suicide, namely, the possibility of pharmacological intervention even before a doctor’s assessment.

There should also be guidance covering several formal moments of observation at key times of stress commonly experienced by people deprived of liberty: release on temporary licence, any return following this, and the point of full release, with formal reporting made to the relevant health centre and, if there is known additional pathology, referral to appropriate support structures, with adequate advance planning.

The prison environment can influence suicidal behaviour, in particular through adaptation to context (deprivation of liberty, absence of family support systems, and adjustment to new schedules and rules), through the authoritarian nature of the environment (and thus, authority must be exercised constructively), discrimination, sexual abuse, violence and lack of control over the future. Given these factors, preventive measures must be considered covering all stages of the process.

Other factors associated with the risk of suicide are, in particular, mental pathology (major depressive disorder), dependence on alcohol or other drugs, reluctance to accept help, loss or separation from personal support networks, loss of health, feelings of shame, humiliation and guilt, fears associated with stereotypes, re-offending during prison stays, a lack of criminal background, high social status, the need for or dependence upon medication (which must be relieved), self-mutilation (which tends to be repeated), ingestion of foreign bodies and family and personal history. Regarding the length of imprisonment, the few women who committed suicide in the prison establishment of Santa Cruz do Bispo had been in prison for a long time. However, this does not mean that these data can be extrapolated to all female prisons.

In women’s prisons there is a very important protective factor, the presence of children.

Whenever there is a suicide in prison, it should be guarded as much as possible and not spoken about, including by the media, due to the extensive effect of the so-called “domino effect”.

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6 Introduced by Law no. 115/2009, of 12 October, judicial leave (commonly referred to as “release on temporary licence”) were created with the aim of maintaining and promoting family and social ties and preparing the prisoner for life in freedom. For its implementation there are established criteria that are based on the remaining penalty time.
It is also necessary to note and clarify some other aspects related to suicide:

- all suffering of the individual must be validated and legitimized and the fact that a person speaks of suicide should not be devalued;
- people do not always intend to die; there is usually an ambivalent desire in relation to suicide and what people actually want is change or to be noticed;
- suicide attempts are usually repeated; and
- asking about suicidal intentions does not precipitate suicide, on the contrary, it can avoid it; therefore, there should be no hesitancy in directly questioning people.

Since it became possible to hire licensed professionals all prisons had a psychiatrist available according to information available in 2019; however, the reality varies between prison establishments due to the fact that two institutions have a greater number of psychiatrists employed, which artificially inflates the average numbers: the Psychiatric Clinic of the Santa Cruz do Bispo Prison Establishment and the São João de Deus Prison Hospital.

Peer participation is not common in the prison system, although it did feature in the Integrated Responses Program in the Guarda prison establishment (20). It can still play an important role in health promotion and prevention, so peers and their associates, as well as the community of people deprived of liberty themselves, should be involved where possible in cocreating necessary solutions.

When people enter prison, they are entering a system where they are given a number and are deprived of some humanity; an institution that observes time uniquely alongside a completely different values system manifested as power relations. This culture shock is compounded by the fact that in Portugal, the length of sentences is much higher than the European average (21,22) and imprisonment periods are increasing; and, therefore, peer support is fundamental in helping those entering prisons to adapt to the context through welcome.

On the other hand, there is no prison establishment where a programme of integrated responses, such as that of the Guarda Prison Establishment, cannot be implemented, but this cannot depend on the goodwill of prison directors and people involved, but rather must be an organized, financed and sustainable public health programme, with the possibility of adaptation according to the needs and conditions of each prison establishment.

The previous needle exchange pilot project in prisons was unsuccessful, because it happened at an inappropriate time and was poorly explained and misunderstood. When discussing such a possibility again, professionals have continued to misunderstand the justifications; however, this does not mean that there is no longer a requirement for such a programme.

The management of the COVID-19 pandemic within prisons has shown that it is possible to set up an effective exit policy, which shows that many people who are in prison could have alternative measures.

To respond to suicide rates among prison guards (whose rate is more than double the population in general), the Prison Guards Union trains its associates and other prison guards in awareness of signalling measures showing suicidal ideation, and skills for prevention. With regard to imputable people and those at risk of suicide, prison guards are not sufficiently capable of dealing with such situations. Guards must themselves have psychological backup in order to assist them in managing complicated situations.
Training of all other health professionals should be simultaneously ongoing to ensure the effective handling of suicides and other emergency situations.

Clinical emergency teams in prison must include health professionals and prison guards, who must in turn provide support to prison personnel following traumatic events. The northern region will soon put forward a pilot project intended to respond to and support this exact need.

Similarly, all prisons have an automatic defibrillator on the premises, but not all have personnel trained and qualified for use of such devices. Initial training in defibrillator use was given to some prison professionals but did not cover them all, nor were any new training actions provided.

In relation to imputable people, the communitization of mental illness has meant that, in other countries, people who were institutionalized in psychiatric hospitals without protection mechanisms have become prisoners; in other words, confinement that was previously solely psychiatric became imprisonment; this is a situation that must be anticipated and prevented in the future organization of Portuguese mental health care.

Managing noncommunicable diseases in an ageing population

More than one quarter of the population in Portuguese prisons are over 50 years old, and this statistic is poised to increase: not only due to general ageing of the population, but also as a result of legislative changes, such as criminalization of domestic violence that is now resulting in older people being incarcerated for the first time; a result of which is a prison population that now includes people aged from 70 to 90 years of age.

In recent years, despite improvements in prisons (including health), overcrowding is still an issue in many prisons, and people deprived of liberty can spend a large part of each day inactive. Current expenditure by prison establishments on cooked meals raises doubts as to whether the budget is sufficient to ensure an adequate supply of food, especially when considering necessary adaptations to accommodate the nutritional needs of women. This issue presents clear and immediate health implications. Compounding this issue, in addition the budget allocation in 2021 for research, prisoners and reinsertion services was reduced by around 15%, or approximately €60 million (23).

The characterization of people deprived of liberty is very scarce in the Report, but making such characterizations alongside listening to and involving people deprived of liberty in decision-making are important concepts to enable the implementation of effective plans for healthier lives, encompassing physical exercise, adequate nutrition, smoking cessation, etc. Because vulnerability factors can influence adherence or non-adherence to certain behaviours, there can be no single solutions in terms of plans or measures; and increased active participation of people deprived of liberty in their co-construction is fundamental to achieving adequate and effective solutions from theory through to practice, especially with regard to citizen participation. For the same reason, the newly created Working Group (4) should include all stakeholders who are part of the prison system, including people deprived of liberty and prison guards.

In prisons, it is necessary to intervene in health promotion and prevention and this cannot be done only when a health issue is already in place. Interventions must also meet the needs of
older populations, and additionally must include professionals in interdisciplinary teams (e.g. physiotherapists, sociocultural animators). Regarding the practice of physical activity, the Report states that all prisons have structures for this purpose. However, in practice, the prevalence of sedentary behaviours is very high in prison establishments, particularly among older people, where the existence of other comorbidities such as problems of functionality and autonomy, sarcopenia, CVDs require an adaptation of common methods of activity and physical exercise provision.

It is not possible to implement practices which promote physical activity without understanding the current situation more fully; and especially understanding and empathizing with reasons for physical inactivity in prisons. It is, therefore, necessary to both monitor activity levels and implement appropriate strategies to promote physical activity and exercise, including ensuring the awareness of healthy lifestyles and their requirements. WHO recommends at least 150 minutes of moderate-intensity physical activity per week. This can be done daily along with the promotion of other healthy behaviours or structured specific physical exercise programmes, which can vary across prisons. Equally, it is clear that it is not only health professionals who must be aware of the benefits of the promotion of physical activity, but also the entire prison establishment, with the involvement of all.

Sport has always been offered as an activity in prisons, but perhaps more directed to younger populations; for example, team sports (football, volleyball, handball) and gyms. In recent times, as prison populations have been observed to age, sporting activities as a function of health care must include people undergoing haemodialysis, those in wheelchairs, tracheotomy patients and people affected by cancer. It is these people who most need interventions to promote physical activity as a health benefit. While the COVID-19 pandemic suspended previous perspectives of intervention in this area, it will be necessary to examine needs and respond to them much more fully and inclusively. In the design of physical activity promotion programmes, gender, age and clinical and functional conditions must be considered, starting from existing good practices and adapting them to the context of Portuguese prisons. For example, in Spain the Real Madrid Foundation provides a programme (24) that promotes physical exercise through football in 22 prisons. Other prisons offer the cultivation of vegetable gardens; this is also physical activity. Physical education professionals are also needed in prisons to cultivate these initiatives and programmes and develop them to be more inclusive.

Regarding smoking, it is perhaps unsurprising that within prisons, 6–8 in 10 people have a smoking habit in prison. These are people who have been deprived of their freedom, and endure the associated psychological suffering, so it can be argued that health risks from smoking are the least of their current problems at that very moment: to be blunt, it is not an issue they should be expected to consider. It is advisable to employ a more inclusive and generous thought process when examining the habits of any incarcerated person concerning the concept of well-being, and remembering that this includes psychological well-being.

Evidence concerning smoking cessation interventions that work in prison certainly exists; for example, pharmacological interventions associated with cognitive–behavioural therapy and support groups, and initiatives based on such evidence should be available to both people deprived of liberty and prison guards. After leaving prison, articulation with primary health care is important to ensure the maintenance of smoking cessation. However, despite being a concern for health professionals in prisons, smoking cessation has been overlooked in favour of other interventions.
At present, there is an overwhelming urgency with regard to bringing noncommunicable diseases under control within the ageing prison population. In addition to simple overcrowding in some prison establishments, there are an increasing number of extremely vulnerable people entering prisons such as people from homeless situations, without documents or with mental health problems. In a scenario where human and financial resources are constrained and in which the provision of care adds an overload of bureaucratic work due to lack or inadequacy of information systems, not all necessary interventions to deal with noncommunicable diseases are carried out; in particular, smoking cessation interventions and regular consultations on hypertension and diabetes. In the case of people who need continuous monitoring for glycaemia, they have to go to an endocrinologist in a P-NHS establishment because in prison there is no possibility to do so.

In Portugal, in terms of cancer prevention, three population-based surveys (breast, cervix and colorectal) are carried out in the community, as recommended as effective by WHO (25). There is good implementation and high adherence to breast cancer and uterine cancer screening at national level, but coverage and adherence to colorectal cancer screening needs to be improved almost everywhere, with the exception of the northern region. The Portuguese League Against Cancer operates in complementarity with the P-NHS in the areas of primary prevention and screening (including oral cancer), with teams that can visit prison health services to intervene by establishing appropriate protocols. A protocol has already been drafted with the League for the screening of oral cancer, and in the case of suspected lesions, biopsies will now be performed for immediate referral.

The future in terms of ageing populations also involves increasing prevalence of dementia and the fact that the prison population has multiple conditions associated with cognitive disorders; for example, vascular, pharmacological, etc. In order to deal with these situations in prisons with dignity, it is already a priority to plan and implement solutions towards preventing cognitive decline and to care for people with dementia, including social articulation and the inclusion of social workers.

The continuity of health care upon release from prison is also problematic. Many people with chronic conditions such as HIV, diabetes or mental illness do not attend community consultations. While the reasons for this vary, there are no mechanisms in place to follow up these situations in the community, and going forward these must be generated.

The ageing of the prison population is a reality in all prisons in Portugal as well as in other countries, necessitates change to existing clinical, nutritional and physical activity paradigms. Alternative solutions might be changes regarding the permanence of people in prisons from a certain age (as in several European countries, where people over 80 years of age are released from prisons) or under certain health conditions. This is a political and social choice balancing risks such as sentence evasion against the promotion of human rights-based policies.

It is important to resolve the paradoxical situation (defended by the WHO and other institutions) where there is an integrated view of RRMD as it relates to use of illicit substances, but a more prohibitionist view in relation to alcohol, tobacco and other legal substances. Alongside the provision of interventions to stop drinking, smoking etc., the alienable rights of people to make their own choices must be maintained balanced with not harming others. The vision on how to deal intelligently with the phenomenon of illicit drug use should also be adopted in relation to legal substances, and tolerance must be learned in terms of coexisting with use of such substances.
Main research and education priorities in prison health

Research is crucial to understand both the meanings and implications of collected data and numbers, and to gain insight into the possibility and ease of health interventions; thus, knowledge generated must be relevant and easily understood by decision-makers. Without this, decisions cannot be properly informed, nor can research provide value to the prison system itself. Studies must generate knowledge to both support clinical practice on the one hand and to illustrate and quantify the need for more resources and organizational changes in the provision of care within prisons.

There remains few studies focused on problems within the context of prisons, and those that exist are narrowly focused on sociological or psychological perspectives. This further highlights the need to make greater investment in the area of prison research in Portugal.

In addition to researchers’ visions of prison research, it is important to include the vision of professionals from other fields as well as the community of people deprived of liberty. In other European countries, it is communities themselves that demand research and knowledge production concerning the problems that affect them; rather than demand being driven by governments or universities. This change in approach must be opened up to people deprived of liberty who are available to participate in research projects.

In prison, even basic existence is marred by overcrowding, inadequate food and nutrition, reduced physical activity or circumstances involving abuse, corruption or dereliction. Therefore, the conditions that cause illness must be investigated and considered alongside alternatives to prison institutionalization and the necessary legal changes that must accompany such changes in approach and policy.

Another priority area of research is exploratory study of the needs and expectations of people deprived of liberty from their own perspectives, as well as ways of understanding how whether, given informed consent, they would act in the same way outside prison.

It is also important to conduct research on ageing in prison and its associated health, social and economic consequences. Other priority areas of research are mental health and other noncommunicable diseases and their impact on burden of disease and quality of life, as well as the provision of health care in prisons compared with that in the community (including primary and secondary prevention) and the reintegration of people with specific health situations such as cancer and barriers in the continuum of care.

Investment in health literacy must also be made, empowering people to choose and promote healthier lifestyles and to better know how to recognize signs and symptoms independently.

Education for sexual and reproductive health is also essential even in a prison context. This must be carried out without prejudice and at a time when a relationship of trust has been built between health professionals and people deprived of freedom; at the admission stage, people tend to be silent or reluctant to discuss such matters. It is also important to address homosexuality, including improving the literacy of the entire prison population on gender issues.

At the turn of the century, the primary health concerns in prisons were HIV infection, viral hepatitis and similar situations. At present day many more must be given consideration, including diseases of ageing: cancer, stroke and dementia, which are all becoming be increasingly prevalent.
With regard to cancer, the most effective current methods of education are known and in place, including several instruments that better enable health education. For example, a very simple, free and useful prevention tool, the European Code against Cancer, which may be suitable for both health education, research and other diseases associated with ageing.

In terms of formal education, the Judicial Centre, a partner of the DGRSP, collaborates in training of people deprived of liberty and liaises with the Institute of Employment and Vocational Training on employability issues. There are also some prison establishments that have companies operating within them that give jobs to people deprived of liberty. Some prisoners accept training within prison establishments, but more research needs to be undertaken to understand why uptake is not greater.

**Final comments**

For the first time, an attempt has been made to bring the fields of science, technology and higher education into a closer working relationship with those of health and justice. This is an important milestone, given its potential to transform, educate and serve the community and the fact that Portugal has not historically been a particularly science-friendly country.

Prison health is public health, so systems must be organized around public health responses. Public health encompasses a response component. However, in prisons and in the community, people are often overwhelmed by urgency, to the detriment of reflection and long-term planning. In this sense, it is necessary to think about future alternatives in parallel with current actions to ensure completeness and consistency. For example, this meeting did not discuss the fact that people deprived of liberty in Portuguese prisons do not have access to the meningococcal vaccine.

There must also be intelligence in action and the ability to make recommendations that lead to concrete actions.

There is also a need for interoperability between information systems. This is already technologically possible and the technical barriers that persist must be overcome. It is also essential to understand fully what information is required and necessary, and information must be standardized by age, gender and comorbidities.

Additionally data provided to WHO should not be appropriated purely to make Member States appear successful. For example, when the Report states that Portugal has a national tobacco-free policy applicable to all Portuguese prisons, without further comment this does not reflect actuality, where the legislation exists but is not always enforced fully, similarly to the community.

Prison deaths are another deeply concerning issue, especially as it is possible to prevent and reduce these deaths.

Simply allocating budget to prison health serves little purpose without detailed knowledge of what, where and how to invest. Prisons and the outside community have both seen major changes, so it is necessary to ascertain what issues are seeing satisfactory solutions, and identify those that still need to be solved. To this end, a budget for research is an initial necessity in order to lay the foundations of a knowledge base about prison health, and to consider how to act within the current political and institutional framework from a scientific outlook.

Listening to and engaging with people must be an ongoing process, because people are not immutable, they have varying needs and represent diverse communities.
Societies are measured by how they treat the most unprotected, the vulnerable and the voiceless. Those who are in prison lose freedom but they do not lose other rights, so it must and can be ensured that people deprived of liberty have access to the same health care as those in the community (reducing risks and minimizing data, screening, medication, etc.) and to monitor circumstances to make it possible wherever this is not yet the case.

WHO has expressed thanks for and satisfaction with the launch of the Report in Portugal and for the opportunity to conduct an in-depth discussion in partnership with the support of the different Ministries and ISPUP (now a WHO collaborating centre), and with the participation of the various stakeholders involved in the prison context.

This open discussion was essential to enable all stakeholders to recognize that gaps in published information can be improved through greater interministerial and intersectoral collaboration. Further work being developed by ISPUP, with the collaboration of DGS and DGRPS, will give rise to a new, updated blueprint for Portugal.

The Status report on prison health in the WHO European Region 2022, and the efforts made by Member States to collect data for it, have contributed to giving visibility to the problems within an area of action (prison health) where too often only the tip of the iceberg is seen. Not only is more applied research needed, but also better-quality information and a systematic and comprehensive analytical framework to produce concrete recommendations for practice, a challenge also for the Working Group in charge of drafting the Operational Plan for Health in the Context of Deprivation of Liberty for the period 2023–2030.

At the meeting (organized in partnership by the WHO, the various ministries and ISPUP with the involvement of the various actors involved in the prison context), there was an in-depth discussion and important reflection on the future of health in prisons in Portugal, which is beneficial for both WHO European Regional initiatives and the newly established Working Group, legally established after this meeting, stressing the importance of dialogue, experience sharing and a playbook of good practices that will also underpin national discussions.

There is a need to change the paradigm in the way health is addressed in prisons to converge towards a public health approach; in this way moving from a rationale compartmentalised by pathology and interventions to reduce illness and disease, to a public health philosophy based on risk reduction, the promotion of health, and the prevention and mitigation of harm, with interventions based on epidemiological characterization of circumstances and ongoing evaluation of the effectiveness of interventions.

Issues related to continuity of care occurring on entry and exit from prison require better liaison between prison health care and the P-NHS for the provision of integrated health care. At this level, information systems are key, as well as the organization of health-care provision and ensuring that the same health care is provided in prisons as in communities, with an emphasis on primary care and reoriented towards health promotion and prevention criteria.

However, coordination and liaison should not just be between prison health services and the P-NHS. It is also necessary to ensure coordination and liaison with social security and neighbourhood social and health responses. As the population ages, the prevalence of chronic diseases such as dementia and issues such as disability after leaving prison increase; more methods of response, not limited to medical response, will be needed for full reintegration in the future.


15. Who should be vaccinated against hepatitis B. Atlanta (GA): US Centers for Disease Control and Prevention; 2022 [https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm#C1, accessed 27 June 2023].


Annex 1.

Programme of the national debate

Wednesday 15 February 2023

14:30–14:50  Key messages from the WHO Status Report for Portugal

Henrique de Barros  Head of ISPUP, WHO Collaborating Centre

Using evidence from the WHO status report to improve access to health services in prison: reflections for the Portuguese context

14:50–15:30  Round table discussion 1: preventing infectious diseases in prisons – can national programmes be transposed to prison populations? What are the necessary adaptations? Recommendations from the national coordinators

Moderator:

Raquel Duarte  Assistant Professor, Faculty of Medicine, Head of the Research Group of Infectious Diseases, ISPUP

**Viral hepatitis, HIV, tuberculosis**

Joana Bettencourt  Senior Officer National Programme for STIs and HIV, Directorate-General of Health

Isabel Carvalho  Director of the National Programme for Tuberculosis, Directorate-General of Health

Rui Tato Marinho  Director of National Program for Viral Hepatitis, Directorate-General of Health

Wrap-up

15:30–16:10  Round table discussion 2: preventing noncommunicable diseases in prisons – can national programmes be transposed to prison populations? What are the necessary adaptations? Recommendations from the national coordinators

Moderator:

Carla Lopes  Associate Professor of Epidemiology and Coordinator of the PhD programme in Public Health, Faculty of Medicine, U.Porto | Researcher at the Laboratory for Integrative and Translational Research in Population Health (ITR), Institute of Public Health (ISPUP)

**Mental health, oncologic diseases, cerebro-cardiovascular diseases**

Miguel Xavier  National Coordinator for Mental Health Policies, Ministry of Health

Henrique Barreto  Representative of the National Programme for Mental Health Policies, Ministry of Health

Eduardo Netto  Adjunct of the Director of the National Programme for Oncological Diseases, Directorate-General of Health

Carlos Aguiar  Representative of the National Programme for Cerebro-Cardiovascular Diseases, Directorate-General of Health

Wrap-up

16:10–16:20  Active break
16:20–16:50 Barriers and facilitators at the system level to effective implementation: focusing on health information systems in prison

**Conceptual model for managing health information of people in contact with the criminal justice sector**

Moderator and speaker:

*Rui Oliveira*
Associate Professor, Informatics Department of University of Minho, and Board of Directors of the Institute for Systems and Computer Engineering, Technology and Science (INESC TEC)

**Current challenges in managing health information in prisons**

*Rui Morgado*
Coordinating Physician of Porto Prison Establishment, Directorate-General for Reinsertion and Prisional Services, Ministry of Justice, Portugal

**Perspectives of future developments integrating prison health into public health**

*Cátia Pinto*
International Relations Coordinator, Shared Services of the Ministry of Health

Wrap-up

16:50–17:25 Final reflections on ways forwards to move from theory to practice and policy implementation

Moderator:

*Linda Montanari*
Principal Scientist, Health and Social Responses, European Monitoring Centre for Drugs and Drug Addiction, Portugal

**Ways forward from the health sector**

*Rui Portugal*
General-Health Sub-Director, Directorate-General for Health, Portugal

**Ways forward from the justice sector**

*Mafalda Vieira de Castro*
Team Lead, Competence Centre for Management of Health Care, Directorate-General for Reinsertion and Prisional Services, Ministry of Justice, Portugal

17:25–17:40 Closing remarks from WHO Regional Office for Europe

*Carina Ferreira-Borges*
Regional Advisor, Alcohol, Illicit Drugs and Prison Health Programme, WHO Regional Office for Europe

**Closing remarks on the future of prison health in Portugal**

*Margarida Tavares*
Secretary of State of Health Promotion, Ministry of Health, Portugal

Thursday 16 February 2023

**09:00–09:15 Welcome and opening remarks**

*Daniel Lopez-Acuña*
Adjunct Professor, Andalucian School of Public Health, Former WHO Director

*Margarida Tavares*
Secretary of State of Health Promotion, Ministry of Health, Portugal

*Jorge Albino Costa*
Deputy Minister, Ministry of Justice

*Pedro Nuno Teixeira*
State Secretary for Higher Education, Ministry of Science, Technology and Higher Education
### Deep dive discussion 1: effective interventions to prevent infectious diseases in prisons

**Introduction from the chairs**

- Luís Mendão, Portuguese Activists Group on Treatments
- Graça Vilar, Service for Intervention in Addictive Behaviour and in Dependences, SICAD
- Jorge Tavares, Nurse, Manager of the Drug Free Unit at Porto Prison Establishment
- Rui Gaspar, Gastroenterologist and Hepatologist, São João Hospital
- Ana Abecasis, Assistant Professor of the Unit for Global Public Health, Institute of Hygiene and Tropical Medicine
- Rui Miguel Domingues Benedito, Representative of the National Union of Prison Guard Corps

### Coffee-break

10:45–11:00

### Deep dive discussion 2: addressing violence, self-harm and suicide

**Introduction from the chairs**

- Rui Coimbra, Board, Associação Casorganizados
- Amélia Bentes, Psychiatrist, Prison Establishment of Santa Cruz do Bispo
- Paulo Moimenta de Carvalho, Director, Prison Establishment of Judiciary Prison of Porto
- Claudia Martins, Physician, Female Prison Establishment of Santa Cruz do Bispo
- José Rocha, Head Nurse, Female Prison Establishment of Santa Cruz do Bispo
- Carlos Sousa, Criminologist, Representative of the National Union of Prison Guard Corps

### Lunch

12:30–14:00

### Deep dive discussion 3: tackling noncommunicable diseases in an ageing population

**Introduction from the chairs**

- Ana Henriques, Doctor in Public Health, ISPUP
- Joana Carvalho, Researcher at Centro de Investigação em Actividade Física, Saúde e Lazer (CIAFEL) and Vice-Dean of Porto University
- Rui Morgado, Clinical Director, Coordinating Physician of Porto Prison Establishment
- Teresa Leão, Public Health Specialist, Associate Professor, ISPUP
- Mário Santos, Nurse Specialist in Mental and Psychiatric Health and in Diabetes
- José Júlio Carvalho, Director of Prison Establishment of Porto
- Diogo Cabrita, President of the Board of Portuguese Association for Former Inmates
- Nelson Afonso Teixeira Sousa, Representative of the National Union of Prison Guard Corps

### Deep dive discussion 4: main research priorities in prison health

**Introduction from the chairs**

- Mariana Abreu, Physician, Porto Prison Establishment
- Carla Pipa Ferreira, Nurse, Center of Competences for Health Care Management
- Diogo Cabrita, President of the Board of Portuguese Association for Former Inmates
- Rui Medeiros, President of the European Association of Cancer Leagues; Vice Director, Research Center of the Portuguese Oncology Institute of Porto
- Vítor Veloso, President of Liga Portuguesa Contra o Cancro NRNorte

### Closing remarks

- Henrique de Barros, Head of ISPUP, WHO Collaborating Centre
- Daniel Lopez-Acuña, Adjunct Professor, Andalucian School of Public Health, Former WHO Director
Annex 2.

Prison health profile for Portugal
Portugal

Population, 2020: 10 295 909
High
Income group
US$ 22 194
Gross national income per capita

A: PENAL STATISTICS

OFFICIAL PRISON CAPACITY:

12 600

NUMBER OF PEOPLE IN PRISON:

11 412

NUMBER NEWLY ADMITTED IN THE PREVIOUS YEAR:

4357

Fig. A1. Incarceration rate per 100 000 inhabitants in Europe
Portugal  

A: PENAL STATISTICS  

OFFICIAL PRISON CAPACITY: 12,600  

NUMBER OF PEOPLE IN PRISON: 11,412  

NUMBER NEWLY ADMITTED IN THE PREVIOUS YEAR: 4,357  

OCCUPANCY LEVEL (%):  

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>INCARCERATION RATE Per 100,000 of national population</td>
<td>114.0</td>
<td>90.6</td>
</tr>
<tr>
<td>139.0</td>
<td>110.8</td>
<td></td>
</tr>
</tbody>
</table>

Population, 2020: 10,295,909  

B: PRISON HEALTH SYSTEMS  

HEALTH SYSTEM FINANCING  

Agency or agencies responsible for delivering prison health care: Both Ministry of Health and Ministry of Justice/Ministry of Interior, with 16.7% of Member States reporting Ministry of Health only (or health authorities) (n = 36).  

Agency or agencies responsible for financing prison health care: Both Ministry of Health and Ministry of Justice/Ministry of Interior. Half of Member States (50%, out of n = 36) are financed by Ministry of Justice only.  

To what extent is health care of people in prison covered by any health insurance systems: Fully covered by health insurance. Health care fully covered by health insurance was reported by 41.7% of Member States (n = 36).  

HEALTH SYSTEM PERFORMANCE  

AVAILABILITY  

Total number of health-care staff (physicians, nurses, nursing assistants, etc., including external service providers) in prisons on full-time equivalents (FTEs) and ratio (per 1000 incarcerated people) for a known year:  

Fig. A2. Health-care staff available in prison  

<table>
<thead>
<tr>
<th>Health-care staff</th>
<th>FTE</th>
<th>Ratio per 1000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total staff</td>
<td>382</td>
<td>33.5</td>
</tr>
<tr>
<td>Nurses</td>
<td>318</td>
<td>7.1</td>
</tr>
<tr>
<td>Physicians</td>
<td>33</td>
<td>5.3</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>19</td>
<td>0.1</td>
</tr>
<tr>
<td>Dentists</td>
<td>12</td>
<td>1.1</td>
</tr>
</tbody>
</table>

ACCEPTABILITY

Proportion of prison established with vaccines available:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Offered at</th>
<th>% Member States with “All prisons”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, tetanus and pertussis (DTP)</td>
<td>All prisons</td>
<td>72.2</td>
</tr>
<tr>
<td>Human papilloma virus</td>
<td>A minority of prisons</td>
<td>52.9</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>No prisons</td>
<td>55.9</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>All prisons</td>
<td>69.4</td>
</tr>
<tr>
<td>Seasonal flu</td>
<td>All prisons</td>
<td>83.3</td>
</tr>
<tr>
<td>Measles, mumps and rubella (MMR)</td>
<td>All prisons</td>
<td>61.8</td>
</tr>
<tr>
<td>Meningococcal vaccination</td>
<td>No prisons</td>
<td>52.9</td>
</tr>
<tr>
<td>Pneumococcal vaccination</td>
<td>All prisons</td>
<td>57.6</td>
</tr>
<tr>
<td>COVID-19</td>
<td>All prisons</td>
<td>91.4</td>
</tr>
</tbody>
</table>

Proportion of prison establishments where people in prison have access to HIV prophylaxis:

- Post Exposure: No prisons
- Pre-exposure: All prisons

<table>
<thead>
<tr>
<th>% Member States with &quot;All prisons&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Exposure</td>
</tr>
<tr>
<td>Pre-exposure</td>
</tr>
</tbody>
</table>

QUALITY OF CARE

Assessments performed in prisons on the availability of essential medicines

- Yes: 88.9%

Standardized process for reporting medication errors in prisons

- No: 41.7%

Standardized process for reporting adverse drug events in prisons

- Yes: 55.6%
HEALTH INFORMATION

Inform public health authorities about diseases amongst prisoners:
Yes, for infectious diseases (IDs) only. Public health authorities being informed for both IDs and for noncommunicable diseases (NCDs) was reported by 45.5% of Member States (n =33).

Keep clinical health records of people in prison:
Yes, we keep paper-based clinical health-records. Electronic clinical health records in all prisons were reported by 22.2% of Member States (n =36).

<table>
<thead>
<tr>
<th>Information registered in clinical records:</th>
<th>Yes/No</th>
<th>% Member States with “Yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening tests performed</td>
<td>YES</td>
<td>91.7</td>
</tr>
<tr>
<td>Screening tests results</td>
<td>YES</td>
<td>94.4</td>
</tr>
<tr>
<td>Vaccination</td>
<td>YES</td>
<td>97.2</td>
</tr>
<tr>
<td>Health behaviours</td>
<td>YES</td>
<td>97.2</td>
</tr>
<tr>
<td>Diagnoses established</td>
<td>YES</td>
<td>97.2</td>
</tr>
<tr>
<td>Visits to external care providers</td>
<td>YES</td>
<td>94.4</td>
</tr>
<tr>
<td>Treatment and medications</td>
<td>YES</td>
<td>97.2</td>
</tr>
</tbody>
</table>

C: HEALTH SERVICES

PREVENTIVE SERVICES

DISEASE PREVENTION

History of tuberculosis (TB) and current signs and symptoms assessed on or close to reception for all people in prison:
Yes, a clinical evaluation of signs and symptoms is made, including evaluation of previous history. Half of Member States report “Yes, clinical assessment and diagnostic tests are made and when the test is positive, additional assessment for MDR-TB is ensured” (50%, out of n =36).
### Cancer screening offered to prisoners:

<table>
<thead>
<tr>
<th>Screening</th>
<th>Cervical</th>
<th>Colon</th>
<th>Breast</th>
</tr>
</thead>
<tbody>
<tr>
<td>No prisons</td>
<td>No prisons</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| % Member States with “Yes” | 66.7 | 58.3 | 66.7 |

### Health Protection

**Products offered free of charge:**

<table>
<thead>
<tr>
<th>Product</th>
<th>Soap</th>
<th>Condoms</th>
<th>Lubricants</th>
<th>Needles and syringes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered at</td>
<td>All prisons</td>
<td>All prisons</td>
<td>No prisons</td>
<td>No prisons</td>
</tr>
<tr>
<td>% Member States with “All prisons”</td>
<td>97.2</td>
<td>47.1</td>
<td>12.1</td>
<td>8.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product</th>
<th>Disinfectants</th>
<th>Dental dams</th>
<th>Tampons/ sanitary towels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered at</td>
<td>No prison</td>
<td>No prison</td>
<td>All prisons</td>
</tr>
<tr>
<td>% Member States with “All prisons”</td>
<td>30.6</td>
<td>28.6</td>
<td>72.2</td>
</tr>
</tbody>
</table>

### Health Promotion

**Smoke free policy implemented in the country applicable to prisons:** Yes, nationwide. Most Member States report “Yes, nationwide” (72.2%, out of n = 36).
Cancer screening offered to prisoners:
Colon
Cervical
Breast
66.7 58.3 66.7% Member States with “Yes”

HEALTH PROTECTION
Products offered free of charge:
Soap
All prisons
97.2
Condoms
All prisons
47.1
Lubricants
No prisons
12.1
Needles and syringes
No prisons
8.3
Disinfectants
No prison
30.6
Dental dams
No prison
28.6
Tampons/sanitary towels
All prisons
72.2

HEALTH PROMOTION
Smoke free policy implemented in the country applicable to prisons: Yes, nationwide.
Most Member States report “Yes, nationwide” (72.2%, out of \( n =36 \)).

Screening for infectious diseases:
Yes, on an opt-out basis
HIV
Hepatitis B Virus (HBV)
Yes, on an opt-out basis
Hepatitis C Virus (HCV)
Yes, on an opt-out basis
Sexually Transmitted Infections (STIs)
Yes, risk-based screening

Proportion of people diagnosed that received\(^a\) or completed\(^b\) treatment over the last 12 months:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Year of Diagnosis</th>
<th>( n ) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB</td>
<td></td>
<td>76 (-)(^c)</td>
</tr>
<tr>
<td>Multidrug-resistant Tuberculosis (MDR-TB)</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td>386 (87.3)</td>
</tr>
<tr>
<td>HCV</td>
<td></td>
<td>81 (8.4)</td>
</tr>
<tr>
<td>HCB</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>STIs</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>Oral health</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>Mental health disorders</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td></td>
<td>MISSING</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>MISSING</td>
</tr>
</tbody>
</table>

Notes:
\(^a\) Percentage is calculated by dividing the number of individuals receiving treatment in 2020 by the total number of individuals with diagnosis on record, using the same reference year.
\(^b\) Percentage is calculated by dividing the number of individuals completing treatment in 2020 by the total number of individuals with access to treatment, using the same reference year.
\(^c\) Percentage not reported as number of individuals receiving treatment might be higher than individuals diagnosed.

Clarification: Health data is recorded in a physical clinical process, thus not available for extraction and analysis.
ARRANGEMENTS FOR SECONDARY AND TERTIARY CARE

Arrangements/protocols established for transferring people in prison to specialized institutions to treat:

- Mental health disorders: In all prisons (86.1% Member States with "All prisons")
- Cancer: In all prisons (83.3% Member States with "All prisons")

REHABILITATION

Access to:

- Education and training programmes: In all prisons (75.0% Member States with "All prisons")
- Employment opportunities: In all prisons (88.9% Member States with "All prisons")

CONTINUITY OF CARE

Support service to register people released from prison with a general practitioner (GP)/community health service:

No. Having this support service was reported by 47.2% of Member States (n = 36).

HEALTH AND WELL-BEING

Assessments of perceived well-being (or life satisfaction):

Yes, on an ad hoc basis. Assessments conducted regularly were reported by 19.4% of Member States (n = 7).

Access to mental health counsellors:

In all prisons. Having mental health counsellors in all prisons was reported by 72.2% of Member States (n = 36).

MORTALITY

<table>
<thead>
<tr>
<th></th>
<th>Total mortality</th>
<th>Mortality rates per 100 000 incarcerated people</th>
<th>Mortality rates per 100 000 people (general pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total deaths</td>
<td>72</td>
<td>630.9</td>
<td>1427.8 (4)†</td>
</tr>
<tr>
<td>Suicide</td>
<td>21</td>
<td>184.0</td>
<td>27.9 (4)†</td>
</tr>
<tr>
<td>Drug overdose</td>
<td>MISSING</td>
<td>MISSING</td>
<td>0.9 (4)†</td>
</tr>
<tr>
<td>COVID-19</td>
<td>0</td>
<td>0.0</td>
<td>67.9 (5)†</td>
</tr>
</tbody>
</table>

Notes: † As the female prison population is 7.0%, the general population data is given only for males over 20 years.
* Given for both sexes, as disaggregated data was not available in open source.

D: HEALTH OUTCOMES

People are allowed to continue their family relationships by web communication:

No. Most Member States report “Yes, with time restrictions” (38.9%, out of n = 36).
MORBIDITY

Number and proportion* of unique individuals living in prison diagnosed with:

<table>
<thead>
<tr>
<th>Condition</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Active TB diagnosis</td>
<td>MISSING</td>
</tr>
<tr>
<td><strong>MDR-TB</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Active MDR-TB diagnosis</td>
<td>MISS</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>442 (3.9)</td>
</tr>
<tr>
<td>Active HIV diagnosis</td>
<td></td>
</tr>
<tr>
<td><strong>HCV</strong></td>
<td>965 (8.5)</td>
</tr>
<tr>
<td>Chronic HCV infection (HCV RNA positive)</td>
<td></td>
</tr>
<tr>
<td><strong>HCB</strong></td>
<td>182 (1.6)</td>
</tr>
<tr>
<td>Chronic HBV (HBsAg)</td>
<td></td>
</tr>
<tr>
<td><strong>STIs</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>STI diagnosis (last 12-month)</td>
<td></td>
</tr>
<tr>
<td><strong>COVID-19</strong></td>
<td>520 (4.6)</td>
</tr>
<tr>
<td>SARS-Co-V2 infection laboratory confirmed</td>
<td></td>
</tr>
<tr>
<td><strong>Oral health</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Individuals keeping 21 or more natural teeth</td>
<td></td>
</tr>
<tr>
<td><strong>Mental health disorders</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Mental disorder diagnosis on record</td>
<td></td>
</tr>
<tr>
<td>Psychotic disorder diagnosis on record</td>
<td></td>
</tr>
<tr>
<td>Recorded suicide attempt events (last 12-month)</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Use Disorders</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Active drug use disorder (last 12-month)</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes Mellitus</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Diagnosis on record</td>
<td></td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Diagnosis on record</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular Disease</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Diagnosis on record</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>MISSING</td>
</tr>
<tr>
<td>Diagnosis on record</td>
<td></td>
</tr>
</tbody>
</table>

Notes: *Percentage is calculated by considering the number of people with a diagnosis on record in 2020 divided by the total number of people in prison in the same country where data has been provided for the same reference year.

Clarification: Health data is recorded in a physical clinical process, thus not available for extraction and analysis.
**E: PRISON ENVIRONMENT**

<table>
<thead>
<tr>
<th>Offered at</th>
<th>Most prisons</th>
<th>All prisons</th>
<th>All prisons</th>
<th>All prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Member States with “All prisons”</td>
<td>69.4</td>
<td>94.4</td>
<td>91.7</td>
<td>88.9</td>
</tr>
</tbody>
</table>

**F: HEALTH BEHAVIOURS**

<table>
<thead>
<tr>
<th></th>
<th>Both sexes, n (%)</th>
<th>Male, n (%)</th>
<th>Female, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body mass index (BMI) ≥ 25</td>
<td>MISSING</td>
<td>MISSING</td>
<td>MISSING</td>
</tr>
<tr>
<td>BMI≥ 30</td>
<td>MISSING</td>
<td>MISSING</td>
<td>MISSING</td>
</tr>
<tr>
<td>Currently use tobacco products</td>
<td>MISSING</td>
<td>MISSING</td>
<td>MISSING</td>
</tr>
<tr>
<td>Drink/have drank alcohol (last 12 months)</td>
<td>MISSING</td>
<td>MISSING</td>
<td>MISSING</td>
</tr>
<tr>
<td>Use/have used drugs (last 12 months)</td>
<td>MISSING</td>
<td>MISSING</td>
<td>MISSING</td>
</tr>
<tr>
<td>Inject/have injected drugs (last 12 months)</td>
<td>MISSING</td>
<td>MISSING</td>
<td>MISSING</td>
</tr>
<tr>
<td>Regularly exercise for a minimum of 150 minutes/week</td>
<td>MISSING</td>
<td>MISSING</td>
<td>MISSING</td>
</tr>
</tbody>
</table>

*Clarification: Health data is recorded in a physical clinical process, thus not available for extraction and analysis.*
G: ADHERENCE TO THE PRINCIPLE OF EQUIVALENCE AND OTHER INTERNATIONAL STANDARDS

Decisions taken by health staff can be overruled or ignored by non-health prison staff: **No.** Most Member States report “No” (77.8%, out of \( n = 36 \)).

National health-care complaints system, available to prisoners: **Yes.** Most Member States report “Yes” (72.2%, out of \( n = 36 \)). Number of complaints received: 0.

H: REDUCING HEALTH INEQUALITIES AND ADDRESSING THE NEEDS OF SPECIAL POPULATIONS

Health related information products for people in prison in multiple languages: **In a minority of prisons.** Most Member States report “In all prisons” (52.8%, out of \( n = 36 \)).

### Option to be attended by female health-care staff

- **No**: 75.0
- **Yes**: 25.0

### Pregnancy test on admission to prison

- **No**: 38.9
- **Yes**: 61.1

### Possibility of prenatal care or termination, in case of a positive result

- **No**: 0.0
- **Yes**: 100.0

Number of women who gave birth whilst in prison in the last 12 months: \( n = 4 \) (0.5% of all women living in prison).
The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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