World Health Organization

REGIONAL OFFICE FOR Europe

# Status report on prison health in the WHO European Region

World Health Organization

REGIONAL OFFICE FOR Europe

# Status report on prison health in the WHO European Region

**ABSTRACT**

This report presents an analysis of data collected on the health status of people in prison and prison health systems for 39 countries in the WHO European Region. The Health in Prisons European Database (HIPED) survey collected data from Member States between 2016 and 2017 to enable monitoring and surveillance of health in prisons. The aim of this report is to provide an indication of the current status of prison health in the European Region and highlight areas of prison health policy that should better be aligned to WHO guidance. The report presents data and recommendations under the following headings: prison population statistics, prison health-care systems, prison environment, risk factors for ill health, disease screening on admission, prevention of infection, treatment and mortality. These data, alongside WHO guidance on health in prison, will help to inform and influence policy-makers to improve the health outcomes of people in prison.

**Keywords**
PRISONS
HUMAN RIGHTS
HEALTH EQUITY
HEALTH POLICY
HEALTHCARE DISPARITIES
PUBLIC HEALTH SURVEILLANCE

**ISBN 9 789289 054584**

Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (http://www.euro.who.int/pubrequest).



**Suggested citation.** Status report on prison health in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2019.
Licence: CC BY-NC-SA 3.0 IGO.

**Cataloguing-in-Publication (CIP) data.** CIP data are available at http://apps.who.int/iris.



Design: Damian Mullan, So it begins …, United Kingdom (Scotland).

Cover photo: WHO.

# CONTENTS

## ACKNOWLEDGEMENTS

This publication was prepared by the Health in Prisons Programme (HIPP) based at the WHO European Office for the Prevention and Control of Noncommunicable Diseases, Division of Noncommunicable Diseases and Promoting Health through the Life-course of the WHO Regional Office for Europe. The report draws from the Health in Prisons European Database (HIPED), which was launched in January 2018. The database provides an overview of health in prisons according to important public health indicators and includes data collected through the national questionnaire for the minimum public health dataset for prisons in the WHO European Region in 2016/2017.

WHO would like to thank Dr Lars Møller, former Programme Manager, Health in Prisons Programme and Alcohol and Illicit Drugs, WHO Regional Office for Europe, and Dr Éamonn O'Moore and Ms Sunita Stürup-Toft from the United Kingdom Collaborating Centre for WHO Health in Prisons Programme at Public Health England, for overseeing the development of the WHO Minimum Public Health Dataset for Prison Health survey. WHO would also like to thank Dr Lisa Schölin, former consultant, WHO Regional Office for Europe, for her contributions to the data collection and validation for the HIPED survey results.

The first draft of the report was prepared by Ms Emilia Janca, intern, WHO Regional Office for Europe, and Research Officer, Justice Health Unit, Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne, Australia. WHO would like to thank the following peer reviewers for their contributions to the first draft: Ms Sunita Stürup-Toft, the United Kingdom Collaborating Centre for WHO Health in Prisons Programme, Public Health England; Ms Linda Montanari, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA); Dr Emily Wang, Yale University School of Medicine, United States of America; Ms Kate McLeod, University of British Colombia, Canada; and Dr Kathryn Snow, Ms Louise Southalan, Ms Claire Keen and Ms Melissa Willoughby, Justice Health Unit, Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne, Australia.

The final version was prepared by Ms Audrey Lazaris, consultant, WHO Regional Office for Europe, and Dr Carina Ferreira-Borges, Programme Manager, Health in Prisons Programme and Alcohol and Illicit Drugs, Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe. The authors would also like to thank Dr Bente Mikkelsen, Director of the Division of Noncommunicable Diseases and Promoting Health through the Life-course of the WHO Regional Office for Europe, and Dr João Breda, Head, WHO European Office for the Prevention and Control of Noncommunicable Diseases, for their overall leadership and support for the development of this report.

WHO would like to thank: Professor Stuart Kinner and Ms Emilia Janca, Justice Health Unit, Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne, Australia; Dr Éamonn O'Moore and Ms Sunita Stürup-Toft, the United Kingdom Collaborating Centre for WHO Health in Prisons Programme, Public Health England; Professor Daniel Lopez Acuña, Andalusian School of Public Health, Spain; and Dr Ruth Gray, South Eastern Health and Social Care Trust, Northern Ireland, United Kingdom, for their peer review of the final draft.

This publication was developed with financial assistance from the Finnish Ministry of Social Affairs and Health.

## ABBREVIATIONS

| | |
|---|---|
| BBV | bloodborne virus |
| HIPED | Health in Prisons European Database |
| HIPP | (WHO) Health in Prisons Programme |
| NCDs | noncommunicable diseases |
| NGO | nongovernmental organization |
| OST | opioid substitution therapy |
| SDGs | (United Nations) Sustainable Development Goals |
| STI | sexually transmitted infection |
| TB | tuberculosis |

# FOREWORD

*It is said that no one truly knows a nation until one has been inside its jails.*
*A nation should not be judged by how it treats its highest citizens, but its lowest ones.*
**Nelson Mandela**

*Over the past 25 years, the WHO Health in Prisons Programme (HIPP) has advocated for improved health outcomes and equivalence of care for people deprived of their liberty, as health care should be of the same standard inside or outside prison. Individuals in prisons and other places of detention are a key population that must not be "left behind" in the pursuit of the United Nations Sustainable Development Goals and as part of the WHO initiatives of universal health coverage and improved health and well-being for all.*

*For the majority of people in prisons, their custody experience is often for a short but disruptive period of time, and many find themselves caught in a cycle of disadvantage, crime and imprisonment. In most countries, very few people serve life sentences, so people in prison must be prepared for release back to the community, which includes addressing their health conditions. The deprivation of liberty is itself the punishment for crime; respect for human dignity and fundamental human rights must be observed at all times during imprisonment.*

*During the time of incarceration, prisons become a "home" and "community" for the people living and working in these environments. It is through this lens that WHO continues to advocate with Member States and support them to ensure that this key population is not overlooked in public health agendas. Time spent in prison can be used by health services to address health issues that may not have been treated in the community due to a variety of barriers to access to health services and health inequities. Prison therefore must be seen as a health-promoting setting in which health interventions can address existing health conditions and contribute to positive lifestyle changes. Time in prison can also be used to improve skills that can help people find a job after release.*

*It is not, however, easy to provide health care in prisons, which by their nature are designed for safe custody and are operated with strict security regimes. Moreover, the prison service is often the least known and understood of all public services, despite its importance for keeping society safe.*

*The groundbreaking work on health in prisons by the WHO Regional Office for Europe has demonstrated that improving the health of people in prison and integrating prison health into the overall public health agenda is an essential step towards improved well-being in general and reducing health inequities. Compared to individuals in the community, people in prison are characterized by a high prevalence of co-occurring health problems, often caused by significant social, environmental and economic determinants of health that occur throughout the life-course, both before and after incarceration. Governments are expected to give a degree of priority to health in prisons to meet their duty of care for those deprived of their liberty, as mandated by the United Nations Nelson Mandela and Bangkok Rules.*

*The health of people in prison is of great importance for the WHO European Region and, indeed, globally, as it is estimated that 11 million people are held in custody across the globe at any one time and more than 30 million people worldwide are thought to move between their communities and prisons annually. Yet people in prison generally are not included in public health data collections, so the true health needs of this key population are not highlighted to the same degree as populations within the community.*

*The* Status report on prison health in the WHO European Region *is an innovative initiative that illustrates the complex nature of health in prisons and represents a milestone achievement for the WHO HIPP. For the first time, WHO has been able to report on the health of individuals in custody, ensuring that the health status of this population is no longer missing from public health data. This work is essential to inform the implementation and evaluation of evidence-based prison health policies in the Region and ensure continued efforts to integrate prison health policy into the broader health promotion and public health agendas.*

*It is through continuous monitoring and evaluation of the health status of people in prison and the health services delivered in places of detention that Member States can ensure that policies and practices for prison health services appropriately address the health needs of this population.*

**Dr Piroska Östlin**
WHO Regional Director for Europe a.i.

# PREFACE

*It is estimated that 6 million people are incarcerated every year in the WHO European Region. The prevalence of many health conditions is much greater among people in prison, who very often represent those "left behind", compared with individuals in the community. Prison and other places of detention can provide an opportunity to deliver preventive and risk-reduction interventions and treatments to a population that previously may have had limited or no access to health care and healthy living. A large proportion of people in prison return to the community every year, so it is a public health imperative that management and treatment for health conditions, particularly (but not exclusively) infectious diseases, are provided in the prison environment to prevent transmission within the community upon release. Prisons represent one of the settings for health promotion to ensure health and well-being and to achieve the United Nations Sustainable Development Goals.*

*Many Member States of the WHO European Region are striving to improve the health of people in prison, but others do not manage completely to protect the health of those in detention. The WHO European health policy framework, Health 2020, and WHO's 13th General Programme of Work aim to improve public health and reduce health inequalities, and highlight human rights and equity as being key to good governance for health. These principles must also apply to people deprived of their liberty.*

*To improve the health of those in prison, it is essential to have a complete understanding of the complexities of the health status of this population and the services that exist to care for them. By addressing the health needs of individuals during their time in prison, it is possible also to have a positive impact on the health of their families and wider communities upon release from prison. Treatment of communicable diseases in prison contributes to reduced transmission in the community, and promotion of healthy lifestyles targeting noncommunicable disease risk factors can lead to sustained healthy behaviours that continue after release.*

*The* Status report on prison health in the WHO European Region *is the first report on prison health by WHO worldwide. It reveals that the general state of monitoring and surveillance systems for health in prisons in European Member States is poor. Most countries were not able to provide valid responses for many of the database indicators. Without this information, policy-makers will not be able to develop evidence-based policies that effectively target the needs of the prison population. This report therefore recommends that Member States should improve their national data-collection systems to ensure that the health status of people in prison is fully understood and services that improve the health outcomes of this population are delivered.*

*In line with what is generally known about the health of people in prison, data from the Health in Prisons European Database (HIPED) paint a picture of an extremely vulnerable population that suffers from poor health and engages in risky health behaviours, leading to noncommunicable and communicable diseases and mental health conditions. Prevalence of indicators such as tobacco-smoking, injection drug use and bloodborne viruses is shown to be much higher than generally is seen in the community. Furthermore, a large proportion of deaths in custody were found to be from suicide, which emphasizes the urgent need for Member States to safeguard the lives of individuals in their care by ensuring that prison health systems have appropriate screening and treatment for mental health disorders and suicide risk both on reception to prison and throughout an individual's stay in custody.*

*It is hoped that the data and recommendations in this report will support Member States to improve their surveillance systems to allow better monitoring of the health status of people in prison, while providing insights into preventive activities and care. Through evidence-based policies, the WHO European Region can strive significantly to reduce health inequities and achieve equivalent health outcomes for this key population, ensuring no one is left behind.*

**Dr Bente Mikkelsen**
Director of the Division of Noncommunicable Diseases and Promoting Health through the Life-course
WHO Regional Office for Europe

**Dr João Breda**
Head of the WHO European Office for the Prevention and Control of Noncommunicable Diseases
WHO Regional Office for Europe

# EXECUTIVE SUMMARY

## BACKGROUND

On any given day, more than 1.5 million people in the WHO European Region are incarcerated *(1)*. The health profile of people in prison is one of complex, co-occurring physical and mental health conditions *(2)*, and the poor health status of this population is typically set against a backdrop of entrenched and intergenerational social disadvantage. Risk factors for poor health overlap with risk factors for incarceration *(3)*, such as substance use, unstable housing and low educational attainment *(4)*. Incarceration and the process of transitioning back into the community following release also impact on health, and continuity of care between health services in prisons and the community is often lacking.

The field of prison health covers both the health status of individuals in prison and the organization of prison health systems and services. Prison health must be recognized as a broader public health issue, as most people who are incarcerated will return to the community, usually after a relatively short prison sentence. Many people return to prison due to reoffending, and this cycle between prison and community can lead to disjointed and ineffective health care. The benefits of health services delivered (and the consequences of inadequate health-service delivery) in prison are often only realized after individuals return to their communities. Lack of adequate health care in prisons and detention centres frequently requires community health services and hospitals to intervene, at considerable cost, when an individual's physical or mental health problems become acute following release from prison. In the initial period following release from custody, individuals have an increased risk of suicide, self-harm and drug overdose, meaning continuity of care during this transition is essential. This has significant public health implications and can constrain a country's capacity to address health inequalities systematically.

The prison population, with its disproportionate disease burden, is one that cannot be forgotten in WHO's pursuit of the United Nations Sustainable Development Goals (SDGs). To achieve universal health coverage and better health and well-being for all, and as part of the WHO 13th General Programme of Work, it is vital that prisons are seen as a setting for health promotion and an opportunity to change lifestyles to ensure that "no one is left behind".

The importance of prison health being part of public health has been articulated in various international statements, including the WHO Trenčín Statement *(5)*, the WHO Moscow Declaration on Prison Health as Part of Public Health *(6)*, the WHO conclusions of the international meeting on prisons and health (Lisbon, 2017) *(7)* and the Helsinki Conclusions (2019) *(5,7)*. This link between prison health and public health means that prison health-care governance and continuity of care between prisons and the community are of crucial importance.

Good prison health-system governance has important implications in addressing health inequity, improving the health of broader communities and improving health care in prisons. Despite the importance of effective health services and systems in prisons to addressing health issues and inequalities, in most countries, very little is known about these systems. Mapping existing prison health systems in Europe, including the level of provision, implementation and quality of health care, is the main aim of the Health in Prisons European Database (HIPED). This is a critical first step for:

- providing the basis for the development of evidence-informed policies for prison health systems and services in Europe, including the relationship with broader policies relating to health inequalities and universal health coverage;
- capacity-building for collaborations relating to prison health systems; and
- identifying target areas for strengthening of health information systems and prison health services, which has implications for strengthening continuity of information flow with community health information systems and contributing to continuity of care.

Established in 1995, the WHO Regional Office for Europe Health in Prisons Programme (HIPP) is committed to addressing the health needs of people in prisons. Given that people in prison typically are excluded from population health data collections, WHO HIPP has recognized the need for comparable data on the health of people in prison, and on prison health governance, systems and administration. The availability of these data is an essential component in the monitoring of prison health-system performance, and ultimately can be used to improve health services in prisons and reduce health inequalities.

To bridge the gap between evidence and policy, WHO HIPP led the development between 2014 and 2016 of the WHO Minimum Public Health Dataset for Prison Health survey on the health of people in prison and the health systems and services that exist to serve this population. The data collected from the survey comprise the Health in Prisons European Database (HIPED), which represents one of the first attempts to provide comparable data on prison health systems in the WHO European Region and lays a foundation for future work to generate comprehensive and comparable data on prison health in Europe and globally.

## METHODOLOGY

A preliminary pilot survey was completed by the United Kingdom and Portugal in 2016 to assess and refine the survey instrument. Following this pilot, in 2016 and 2017, national focal points from the 53 Member States of the WHO European Region were invited to complete the WHO Minimum Public Health Dataset for Prison Health survey on prison health systems and services in consultation with their prison health authorities.

Data for the 39 countries that completed the survey data-collection process were launched online in January 2018 via the Global Health Observatory *(8).*

This report presents aggregate data for key indicators of the eight domains of the HIPED:

- prison population statistics
- prison health systems
- prison environment
- risk factors for ill health
- disease screening
- disease prevention
- disease treatment
- mortality.

# KEY FINDINGS

## PRISON POPULATION

- Few Member States were able to provide data on different population cohorts within prison:
  - only 16 Member States were able to report on the percentage of people in prison over the age of 55 years;
  - only eight were able to report on the percentage of people in prison from an ethnic or racial minority; and
  - nine were unable to report on the number of women in their prison system.

## PRISON HEALTH-CARE SYSTEMS AND GOVERNANCE

- The Ministry of Justice was the authority most frequently holding responsibility for health-care service authority, administration of the health-care service budget and health-care service funding.
- Fewer than 50% of countries reported the Ministry of Health or other health-care authorities as being responsible for the assessment of prison health systems.
- Fewer than 60% of countries reported the Ministry of Health or other public health authorities as being responsible for the inspection of hygiene, nutrition and living conditions.
- Eighteen Member States reported that people in prison must cover some of their own health-care expenses.
- While most countries reported links between prison and community health-care systems, information about the nature of these links is limited.

## PRISON ENVIRONMENT

- Most countries reported that smoke-free cells were available in prisons.
- Just over half of the countries reported that drug-free units were available in prisons.
- The vast majority of countries reported that the production of meals in prisons occurs in centralized kitchens, with few countries reporting that self-cook kitchen areas were available.

## DISEASE SCREENING AND TREATMENT

- Most countries reported having implemented WHO guidelines regarding mental health screening, substance use treatment and non-mandatory screening for bloodborne viruses (BBVs) and sexually transmitted infections (STIs).
- Some countries, however, reported that key screening processes or substance use treatments were unavailable, or that mandatory screening practices were in place for BBVs and STIs.
- Fourteen per cent of Member States reported that they do not screen for severe mental health disorders on or close to reception.
- Forty-one per cent reported that they do not screen for harmful use of alcohol on or close to reception: of the Member States that do screen, only 47% use a validated screening tool.
- Thirty-one per cent do not screen for oral health issues on reception to prison.

## RISK FACTORS FOR ILL HEALTH

- Data on prevalence of diseases and risk factors generally were missing:
  - only five Member States were able to report on the prevalence of injection drug use among people in prison;

- the number of Member States able to report on the prevalence for noncommunicable disease risk factors was extremely low – only one country reported on the prevalence of obesity, three on overweight, five on tobacco-smoking and eight on high blood pressure; and
- only 10 countries provided prevalence data on tuberculosis in prison, 11 on HIV, 11 on hepatitis C and eight on hepatitis B.

### PREVENTION

- Resources for the prevention of infectious diseases are not universally available across European prison health systems, and a number of countries reported that such resources are entirely unavailable.
- Only six countries reported that needle or syringe exchange programmes were available in some or all prisons.
- A full vaccination course for hepatitis B is not available in prisons in 31% of Member States.

### TREATMENT

- Most countries reported that access to mental health support delivered by health staff in prisons existed, but just over half stated that national guidelines exist for the treatment of severe mental health disorders in prisons.
- Fewer than half of countries reported that national guidelines exist for the prevention of drug-related deaths in prison, and 19% of Member States currently do not offer opioid substitution therapy in prison.

### MORTALITY

- Of the reported numbers of deaths in custody, 13.5% were from suicide, and the suicide rate was 6.5 per 10 000 incarcerated people.
- The mortality rate for men in prison was higher than that for women.

## LIMITATIONS

There were substantial limitations in the availability of the data across many indicators, notably for the prevalence of health risk factors and substance use on admission to prison, for which up to 97% of countries (n = 38) reported that they had no national data for indicators, or did not respond or provide a valid response (meaning their data were missing). This may be because some countries do not collect these data at national level or perhaps due to inconsistencies between the HIPED indicators and the countries' data-collection processes and systems.

Comparisons of conditions and risk factors between the incarcerated population and the community at large cannot easily be made with these data. Age-, sex- and social-class-adjusted rates would be necessary to enable sound conclusions to be drawn.

## CONCLUSIONS

The HIPED represents a milestone, as it is one of the few data-collection initiatives designed to gather comprehensive and comparable data on prison health systems from a region across key domains of prison health-care governance systems and health-care services. While there are limitations to the HIPED data, the collection of these data is an important prerequisite to developing evidence-based policy for prison health systems and services in the European Region and a promising step in informing future work to collect data on prison health in the European Region and internationally. The HIPED is a necessary tool for WHO and Member States to ensure that "we leave no one behind," including those in prison, in the pursuit of the SDGs.

This report summarizes key findings from the HIPED and provides recommendations for Member States to encourage alignment to WHO guidelines and to improve data-collection and reporting ultimately to inform the improvement of prison health systems. The recommendations are compiled in Chapter 6.

## REFERENCES

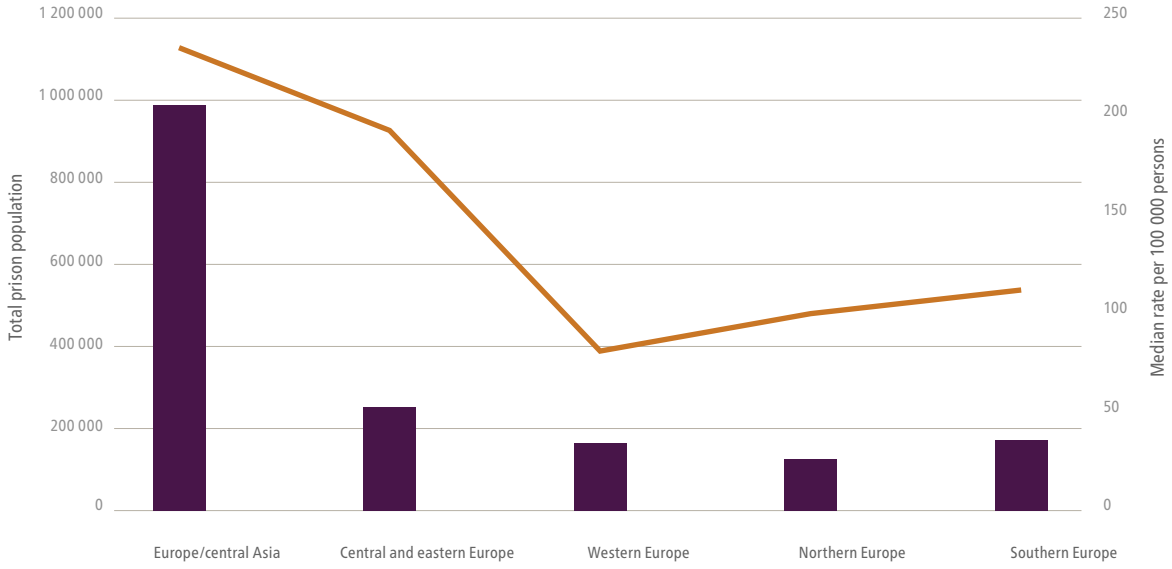

1. Walmsley R. World prison population list, 12th edition. London: Institute for Crime & Justice Policy Research; 2018.
2. Fazel S, Baillargeon J. The health of prisoners. Lancet 2011;377(9769):956–65. doi:10.1016/S0140-6736(10)61053-7.
3. Marmot M. Inclusion health: addressing the causes of the causes. Lancet 2018;391(10117):186–8. doi:10.1016/S0140-6736(17)32848-9.
4. Kinner SA, Young JT. Understanding and improving the health of people who experience incarceration: an overview and synthesis. Epidemiol Rev. 2018;40(1):4–11. doi:10.1093/epirev/mxx018.
5. Trenčin Statement on Prisons and Mental Health. Copenhagen: WHO Regional Office for Europe; 2008 (https://apps.who.int/iris/handle/10665/108575?search-result=true&query=5.%09Trencin+statement+on+prisons+and+mental+health&scope=&rpp=10&sort_by=score&order=desc).
6. Moscow Declaration on Prison Health as Part of Public Health. Copenhagen: WHO Regional Office for Europe; 2003 (http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health).
7. Conclusions of the WHO international meeting on prisons and health Lisbon 2017. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2018/conclusions-of-the-who-international-meeting-on-prisons-and-health-2018).
8. Health in Prisons European Database (HIPED). In: World Health Organization [website]. Geneva: World Health Organization; 2016 (http://apps.who.int/gho/data/node.prisons).

# 1. INTRODUCTION

## 1.1 THE EUROPEAN PRISON POPULATION

Incarceration across the WHO European Region is best understood as part of a more complex global picture. The global prison population exceeds 10.7 million people and is growing at a rate faster than population growth *(1)*. On any given day, more than 1.5 million people in the WHO European Region are incarcerated *(1)*. Countries in the WHO European Region account for approximately 15% of the global prison population, and the incarceration rate across the Region (187 per 100 000) is around 1.3 times greater than the global average (145 per 100 000) *(1)*. The European Region is the only region that has seen a fall in the number of incarcerated people since 2000, with a decrease of 22% *(1)*. This reflects large decreases in eastern European and central Asian countries. In contrast, the number of people incarcerated has increased 6% in western Europe, 12% in northern Europe and 27% in southern Europe *(2)*. Incarceration rates and the static prison population sizes of regions within Europe are summarized in Fig. 1.

**Fig. 1. Incarceration rates and prison population sizes in Europe[a], 2018**




[a] The regions of Europe are as follows. Europe/central Asia: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkey, Turkmenistan and Uzbekistan. Central and eastern Europe: Belarus, Bulgaria, Czechia, Hungary, Republic of Moldova, Poland, Romania, Slovakia and Ukraine. Western Europe: Austria, Belgium, France, Germany, Liechtenstein, Luxembourg, Monaco, Netherlands and Switzerland. Northern Europe: Denmark, Estonia, Finland, Iceland, Ireland, Latvia, Lithuania, Norway, Sweden and United Kingdom. Southern Europe: Albania, Andorra, Bosnia and Herzegovina, Croatia, Cyprus, Greece, Italy, North Macedonia, Malta, Montenegro, Portugal, San Marino, Serbia, Slovenia and Spain: also Kosovo (all references to Kosovo in this document should be understood to be in the context of United Nations Security Council resolution 1244 (1999)). *Source*: based on data from Walmsley *(1)*.

No reliable global or regional estimates of annual prison throughput exist, but the United Nations estimated in 2008 that more than 30 million adults pass through prisons globally each year *(3)*. In many countries in the European Region and internationally, most prison sentences are relatively short and a large number of people in custody are unsentenced (in pre-trial detention) *(4)*, such that the annual prison throughput is larger than the daily number of people who are incarcerated *(4)*.

Consistent with global trends, the number of prison entries in many European countries is substantially greater than the total daily number of people in prisons *(4)*. The lack of routine reporting on annual dynamic prison populations can be said to perpetuate the misconception that prison populations are small and static, and hides the fact that the vast majority of people in prison return to the community, usually after a relatively short period of time in custody.

## 1.2 THE HEALTH PROFILE OF PEOPLE IN EUROPEAN PRISONS

There is overwhelming evidence that people involved in the criminal justice system disproportionately experience complex, co-occurring health problems. These include mental illness *(5)*, substance dependence *(6,7)*, cognitive disability *(8)*, HIV/AIDS, hepatitis A, B and C, tuberculosis (TB) and related communicable infections *(9)*, and noncommunicable diseases (NCDs) *(10)*. The epidemiology, prevention and treatment of NCDs in prisons has largely been neglected; most evidence about the health of people involved in the criminal justice system in Europe typically concerns communicable diseases, highlighting considerable regional differences between western Europe compared with eastern Europe and central Asia in the prevention and treatment of infectious diseases *(9)*.

The mortality rate for people released from prison far exceeds that of the general population, particularly in the month following release, and primarily due to preventable causes such as suicide, injury and drug overdose *(11,12)*. Mortality rates following release from prison are more than twice as high in some eastern European countries than in western, with some European countries reporting mortality rates of up to 500 deaths per 100 000 people *(13)*.

The poor health experienced by people with histories of criminal justice involvement is associated with their exposure to health risk behaviours and environments. Common risk factors for communicable diseases that are greatly overrepresented in this population include injection drug use, unprotected sexual activity, unsterile piercing and unsterile tattooing *(7,14)*. Similarly, risk factors for NCDs, including high rates of smoking, poor diet and insufficient physical activity, are overrepresented in prison populations *(10,15)*. Relapse to health-risk behaviours, such as substance use and harmful use of alcohol, is common following release from prison and can contribute to the poor health outcomes and high mortality rates in this population *(13)*.

People with histories of criminal justice involvement typically experience and are exposed to a range of poor social, economic and environmental determinants of health that are linked to low socioeconomic status and social exclusion *(16)*. Women in prison suffer disproportionately from a range of physical and mental disorders. They comprise a rapidly increasing proportion of the prison population and have markedly high levels of exposure to a range of poor social determinants of health, including domestic violence, sexual abuse, trauma, adverse childhood experiences, homelessness, substance use and mental health disorders *(17,18)*. People from ethnic and minority groups and young and older people also have specific health and social care needs that require tailored support in prison *(19,20)*.

## 1.3 PRISON HEALTH AS A PART OF PUBLIC HEALTH

While the health of incarcerated people is important in its own right, prison health is also a concern for broader society, as prisons are linked closely to communities. The majority of people in prison return to the community, and many people move repeatedly between both settings *(21)*.

Addressing the health of people in prison not only improves the well-being of individuals, but also has impacts on families and wider communities *(22)*. As articulated in the WHO Trenčín Statement *(23)*, the WHO Moscow Declaration on Prison Health as Part of Public Health *(24)*, the WHO good governance

for prison health policy brief *(25)* and the conclusions of the WHO international meeting on prisons and health in Lisbon in 2017 *(26)*, the health of people in prison is a critical part of broader public health. Addressing the health of people in prisons is closely aligned with the global United Nations Sustainable Development Goals (SDGs) and the WHO 13th General Programme of Work *(27)* to ensure no one is left behind.

In some cases, the health risks and problems experienced by people in prison may be worsened during incarceration by unhealthy conditions of imprisonment, such as overcrowding, lack of fresh air and natural light, clean sanitary facilities or means for personal hygiene, inadequate nutrition and exposure to violence *(15)*. In other cases, however, incarceration can provide low-threshold access to health services for people who often face substantial barriers to accessing health care in the community *(21)*. As such, prisons can be a setting for health promotion and an environment in which to provide equitable health care to people experiencing significant barriers to access. Prison can also provide important aspects of a settings-based approach to health promotion, health education and disease prevention.

It is important that people involved in the criminal justice system receive health care without interruption at all stages of detention, including in police and pre-trial detention, in prison, during institutional transfers and following release from prison *(25)*.

## 1.4 WHAT IS UNDERSTOOD BY PRISON HEALTH SYSTEMS

According to WHO, health systems consist of all organizations, people and actions whose primary intent is to promote, restore or maintain health *(28)*. The WHO definition of prison health systems includes six key building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance *(28)*. Prison health systems have several core components, reflecting the functions of health systems more generally, including: prison health-care governance arrangements; the screening, treatment and prevention of both communicable and noncommunicable diseases; rehabilitation; health promotion; and health information.

Guidelines for appropriate and effective prison health services are discussed in more detail in the WHO prisons and health guidance document *(15)*. Key principles include: screening and treatment for mental health disorders, substance use disorders, oral health disease and TB; the availability of non-mandatory testing for bloodborne viruses (BBVs) and sexually transmitted infections (STIs), with appropriate pre- and post-test counselling; the provision of materials that reduce the risk of communicable diseases (such as condoms, lubricants and disinfectants); and the implementation of harm-reduction programmes, including needle and syringe exchange programmes.

Effective health services and systems in prisons are central to addressing health issues and inequalities, yet in most countries very little is known about them. Improving prison and detention health services depends on effective collection and use of information to inform policy, resource allocation and expenditure, and to enable evaluation of services and interventions. The available data on the health of people in prisons and correctional health services in prisons are scarce and subject to large methodological differences, highlighting the need for standardized survey instruments for prison health systems.

To address these issues and bridge the evidence gap, a number of surveys have been conducted in the past two decades to collect data about prison health systems, services and environments across European countries. Past data-collection efforts include surveys on prison population demographics and the prison health system workforce *(4)*, mental health systems *(29,30)*, TB control *(31)*, and the prevalence of BBVs, substance harm-reduction and treatment systems *(32).* Regional survey efforts have generally found high prevalence of illness and variations in services, but only limited conclusions about prison health systems and services at regional level can be drawn due to shortcomings in sampling and limited data collection on a broad range of health conditions and risk factors.

Evidence on the organization of, and screening, treatment and prevention in, European prison health systems is subject to considerable limitations. There appears to be considerable diversity across Europe in how these different health-system elements operate in prison settings, but few conclusions can be drawn about them. Most of the information collected focuses on communicable diseases and is subject to issues regarding comparability. There is a significant dearth of knowledge about NCDs, excluding mental health and substance use; very little is known about the epidemiology of these issues in this population across Europe, let alone the systems and services that exist to respond to them *(33).*

Significant amounts of data on health in prisons are substantially out of date, which is important to recognize given recent and ongoing changes in governance and organization of health systems across the European Region. Additionally, most of the available evidence is generated from high-income countries, with the paucity of information about low- and middle- income countries being widely noted *(19).*

### 1.4.1 THE INTERFACE OF PRISON HEALTH SYSTEMS WITH LARGER PUBLIC HEALTH SYSTEMS

The WHO *Good governance for prison health in the 21st century policy brief (25)* recommends that prison health services be independent of prison administration, integrated into national health policies and systems, and not involved in punishment. The conclusions of the WHO Health in Prisons Programme (HIPP) international meeting on prison health held in Lisbon in 2017 *(26)* highlighted that treatment and prevention programmes restricted to prison settings are unlikely to have sustained benefits for people experiencing imprisonment, underscoring the need to improve continuity of care between prison public health interventions and community health interventions to achieve better health outcomes *(26).*

The connection between prison health services and general public health administration varies substantially across the European Region *(34).* In some European countries, there is little or no cooperation between the administrations of prisons and health authorities. In other countries, health authorities are requested at a minimum to conduct the inspection and supervision of hygiene or the licensing and accreditation of health-care facilities and health-care personnel in prisons *(35).*

Ministries of justice are responsible for the health services provided to people in prison in most European countries, but in some, prison health care has partially been integrated within the national health system, as recommended by WHO guidelines. A number of other countries have commenced the transfer of prison health-care responsibility and administration to the national health system and Ministry of Health. European countries that have implemented a complete transition to ministries of health include Finland, France, Norway, Slovenia, Italy and the United Kingdom; regions of countries that have completed the transition include the Swiss cantons of Geneva, Vaud, Valais and Neuchatel, and Catalonia in Spain *(15,35).*

## 1.5 THE IMPORTANCE OF MAPPING THE EXISTING PRISON HEALTH SYSTEMS IN EUROPE FOR IMPROVING POLICY AND PRACTICE FOR PRISON HEALTH

More information is needed to have a complete picture of existing European prison health systems and how they compare with each other. Past surveys have noted issues regarding standardization of data collection across countries, limitations in knowledge on availability and coverage of health-care services, and differences in the interpretation of questions across countries. More information also is needed about prison health data-collection processes and any challenges faced by Member States in collecting these data.

Assessment and evaluation of prison health conditions and services are also lacking because of the absence of the prison population from many national health statistics and the widespread absence of health data collected as part of prison statistics *(25).* This is a basic and common shortcoming of prison health systems' dialogue with national health authorities. In the absence of reliable and continuous baseline data on the health of people in prison and existing health services and systems, efforts to assess the performance of prisons in addressing the health needs of people incarcerated in the WHO European Region are limited.

### 1.5.1 THE HEALTH IN PRISONS EUROPEAN DATABASE AS A TOOL FOR MAPPING PRISON HEALTH SYSTEMS

The Health in Prisons European Database (HIPED) attempts to complete a comparable, regional data collection of prison health systems and services.

Funded by the Finnish Ministry of Social Affairs and Health, the WHO Regional Office for Europe HIPP commenced work on the HIPED between 2014 and 2016 to develop the WHO Minimum Public Health Dataset for Prison Health survey on prison health systems and services. Partners involved in this process included the HIPP Steering Group, which comprises the United Kingdom Collaborating Centre for the WHO HIPP (supported and hosted by Public Health England), the European Monitoring Centre for Drugs and Drug Addiction, the United Nations Office on Drugs and Crime, AFEW International, the European

Federation for Prison Health, the International Committee of the Red Cross, Penal Reform International, representatives from the Netherlands, Slovenia, Spain and Switzerland, the European Centre for Disease Prevention and Control, and the Pompidou Group of the Council of Europe.

The questionnaire and data-collection process for the national questionnaire for the Minimum Public Health Dataset for Prisons in the WHO European Region was discussed with Member States during the WHO HIPP annual meeting on prison health held in Kyrgyzstan in late October 2015.

During 2016 and 2017, the WHO Regional Office for Europe invited national focal points from the 53 Member States of the WHO European Region to complete the survey in consultation with their prison health authorities. Data for the 39 countries that completed the survey data-collection process were launched online in January 2018 via the Global Health Observatory *(36).*

The aim of this work was to fill critical gaps in what is known about health systems and services for people in prison and to expand the evidence base in this important and under-researched area. The purpose of the survey was to establish a body of knowledge and evidence on prison and detention health systems comparable across countries in the European Region through collection, analysis and sharing of data.

This report summarizes key findings from the HIPED and provides recommendations for Member States to encourage alignment to WHO guidelines and to improve data collection and reporting ultimately to inform the improvement of prison health systems. The intention is to demonstrate the feasibility of the process, set a benchmark for future data collection and reporting processes, and inform future iterations of the survey to enable progressive improvement in the quality of the data. It also represents a key step in developing a comparable and sustainable monitoring and surveillance system of health in prisons.

# 2. METHODS

The HIPED comprises data that were collected as part of a regional cross-sectional survey of 39 European countries between 2016 and 2017. This report summarizes key indicators included in the WHO Minimum Public Health Dataset for Prison Health survey. The data for all indicators are available in the HIPED, which is subject to continuous updating to ensure that the data presented are as accurate as possible.

## 2.1 HIPED INDICATORS

The HIPED comprises 90 indicators across eight domains. A summary of domains and indicators is presented in Table 1, and a complete list of the indicators is available in Annex 1.

**Table 1. Domains and indicators in the HIPED**

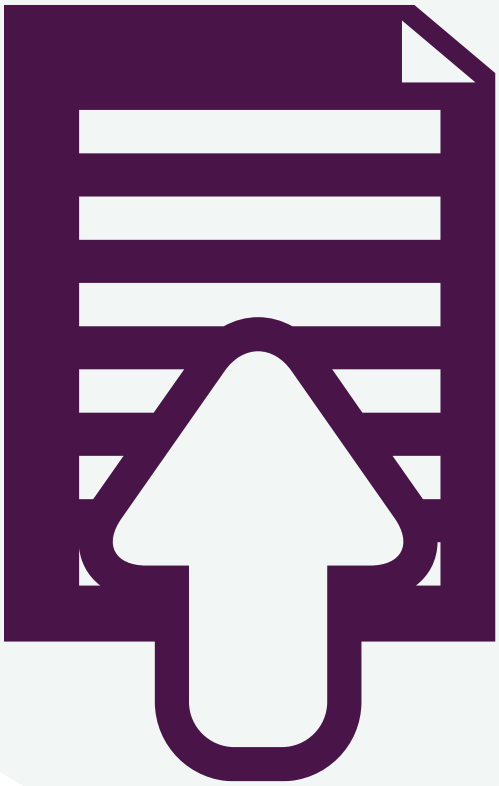
| Domain | Indicators |
|---|---|
| 1. Population demographics | *Seven indicators*<br>Example: total number of incarcerated people, total capacity of prisons, number of people belonging to subgroups (female, youth, senior and ethnic/minority individuals) |
| 2. Prison health systems | *Twenty-one indicators*<br>Example: prison health-care authorities, the obligation of people who are incarcerated to cover health-care costs, prison and health workforce statistics |
| 3. Prison environment | *Three indicators*<br>Example: availability of smoke-free cells and availability of different food systems |
| 4. Risk factors for diseases | *Twelve indicators*<br>Example: prevalence of smoking and obesity, testing protocols |
| 5. Disease screening | *Forty-three indicators*<br>Example: screening, proportion of individuals tested for HIV, availability of mental health disorder screening |
| 6. Prevention of communicable diseases | *Sixteen indicators*<br>Example: availability of disease-prevention programmes, such as needle exchange, availability of drug-free units |
| 7. Treatment of communicable and noncommunicable diseases | *Eight indicators*<br>Example: number of people receiving opioid substitution therapy (OST), number of people receiving HIV and hepatitis C treatment, availability of mental health support |
| 8. Mortality | *Five indicators*<br>Example: total number of deaths, number of deaths of people under 18 years of age, number of deaths by suicide |

## 2.2 DATA COLLECTION, VALIDATION AND CLEANING

### 2.2.1 DATA COLLECTION

Letters of invitation were sent to WHO focal points in the Ministry of Health of 53 Member States during 2016, with responses received from 41. Where prison health services are not under the authority of the Ministry of Health, invitations were forwarded to the responsible ministry (such as justice or interior). A complete list of the participating Member States is available in Annex 2.

Overall, 39 countries completed the entire survey data-collection process, giving an overall response rate of 77%. The response rate means that the data are not generalizable across the entire European Region, as outcomes from this report may be skewed towards the countries that responded.



Between October 2016 and August 2017, the national focal point nominated by the relevant ministry from each participating Member State submitted the survey to the WHO Regional Office for Europe, liaising with other national experts, agencies or ministries as required. The survey was conducted using Qualtrics® Survey Software. Given the multisectoral consultation often involved in this process, a number of focal points completed the questionnaire electronically, exported into Microsoft® Word, or completed printed copies of the survey. Reflecting what is known about prison health governance arrangements, most key survey contacts were from ministries of justice, corrections, home affairs or subsidiary organizations (n = 21). While a number of countries provided some information about different experts and sectors consulted for the survey data collection, the processes regarding data collection from information sources at national level for the purposes of this survey were not well established.

### 2.2.2 DATA CLEANING AND VALIDATION

The first phase of data validation occurred between May 2017 and September 2017 and the second in February 2018, following the initial production of the prison country profile fact sheets *(37)*. In both phases, focal points were contacted to provide clarification regarding missing or inconsistent data. Data cleaning began in August 2017 and the data have since been subject to ongoing data-cleaning and validation processes. Data validation has been conducted in cooperation with the national focal points. Out-of-range values were identified and were dealt with on a case-by-case basis when time and

resources permitted. Where it was not possible to address discrepancies in the data individually, they were resolved through logic checks. In the rare instances where these issues could not be resolved, the conservative approach of not reporting data for that indicator was adopted.

## 2.3 DATA PRESENTED IN THE REPORT

The response "No national data" refers to responses for which Member States indicated that they do not have data for the indicator of interest or in the format required by the HIPED. “No national data” is also used in instances where Member States with a federal structure indicated that they do not have data available for all jurisdictions. "Missing" refers to data that were not provided and for which no explanation was given, or to data that were identified as out-of-range and that could not be resolved through logic checks. "Not applicable" refers to responses that did not apply to Member States based on a previous response.

A number of countries, including those that reported "No national data" where data were not available in the HIPED format, provided more detailed information for indicators in comment variables online in the HIPED.

### 2.3.1 CALCULATIONS

The incarceration rates per 100 000 people for each year (2014, 2015 and 2016) were calculated using the total daily number of incarcerated people collected by this survey and total population data obtained from the World Bank Open Dataset *(38)*.

The percentages of people who are unsentenced, female, under 18 years of age or over 55 years of age were calculated using the total daily number of each subgroup and the total daily number of incarcerated people. Similarly, occupancy levels were calculated using the total daily number of incarcerated people and the total daily capacity as the numerator and denominator respectively.

Ratios of prison staff and health-care staff per 1000 people incarcerated were calculated using the average daily number of total staff and the total daily number of people incarcerated from the same calendar year. The mortality rate per 10 000 people in prison was calculated using death data and total daily number figures from the same calendar years. Similarly, the percentage of deaths from suicide was calculated using suicide death data and total death data from the same calendar years. Across these indicators, where countries did not provide data for both the indicator and total daily number for the same calendar year, their data were excluded from these calculations.

### 2.3.2 METHODOLOGICAL CONSIDERATIONS

A number of participating Member States are federations, which in some cases led to the reporting of data at subnational level. Solutions to this were determined on a case-by-case basis. Where possible, the way in which subnational data were presented was determined in collaboration with national focal points. Where this was not possible, responses were coded as “No national data”. In the instances where data submitted present results of a research study or a survey using a representative sample, this has been noted as “No national data”, with the information available in the HIPED.

# 3. FINDINGS

The findings presented here are limited to the countries that provided data for each indicator. Data might be unavailable for countries because they reported that no national data were available, or because no valid response was provided. Details of missing data are provided in Annex 3. The countries reporting available data for prevalence indicators are outlined in Annex 4 and a list of countries providing responses in this report, including data for calculations, is available in Annex 5.

For some indicators regarding prevalence of testing or illnesses, the reference group used for prevalence estimates varied between countries; these are summarized in Annex 4. For example, some included all people who are incarcerated, and some included sentenced people only. Some countries also specified different groups to which these data referred. As a result, these factors may affect the prevalence estimates provided.

## 3.1 PRISON POPULATION

### 3.1.1 RATES OF INCARCERATION

The incarceration rate per 100 000 people between 2014 and 2016 across Member States (n = 32) declined slightly, from 183 in 2014, to 175 in 2015, and 166 in 2016. Of the 30 countries that provided sufficient data to calculate overcrowding in 2016, nine (23%) reported capacity levels over 100%. The range of capacity levels was 44–114%, with a mean of 90%.

**WHO guidance**

WHO recommends that overcrowding should be avoided in prisons, as it can lead to the accelerated spread of communicable disease such as HIV and TB, restricts the opportunity for physical activity and negatively impacts on mental health *(15)*.

### 3.1.2 POPULATION GROUPS

Twenty-two per cent of the prison population are unsentenced/on remand (n = 26 countries) (Fig. 2) and 6% of the prison population are female (n = 30 countries) (Fig. 3).

**Fig. 2. Sentence status**

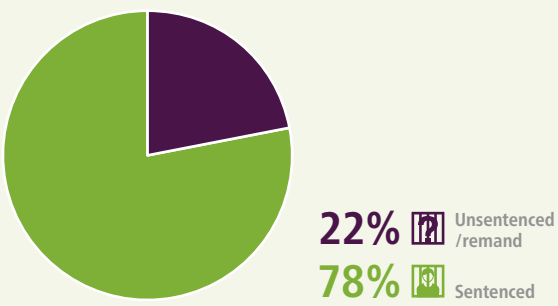
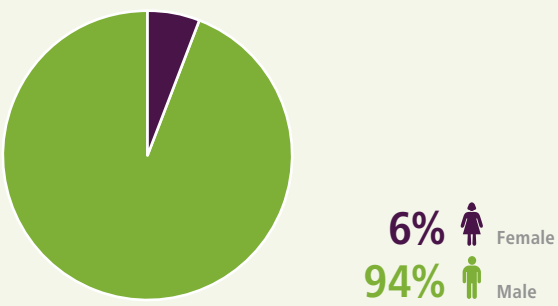



**Fig. 3. Gender distribution**



## WHO guidance

WHO recommends that health services must recognize women's gender-specific needs and gender-sensitive training for the health-care needs of women in prison should be widely available in all prison systems *(15)*.

One per cent of the prison population is under the age of 18 (n = 29 countries) (Fig. 4), and 5% are over the age of 55 (n = 16) (Fig. 5).

**Fig. 4. Children and adolescents**

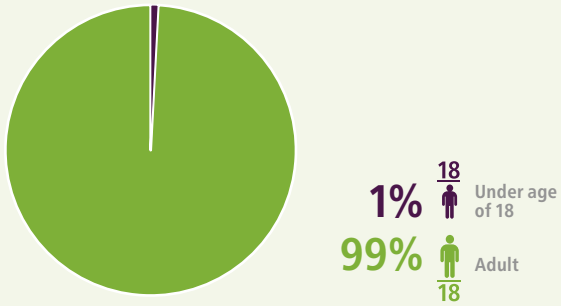
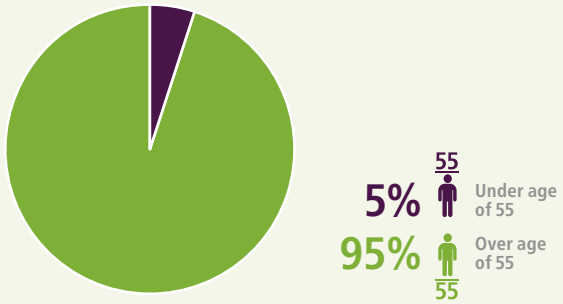



**Fig. 5. Over 55 years of age**




## WHO guidance

Treatments and interventions for children and adolescents must respond to the different manifestations of poor mental health displayed by this group compared to adults *(15)*.

## WHO guidance

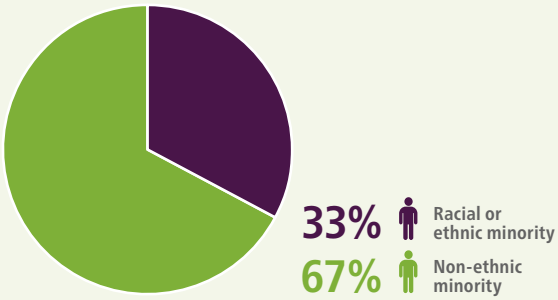
Older people in prison may typically have chronic and multiple health problems, including heart and lung problems, diabetes, hypertension, cancer, Alzheimer's disease, Parkinson's disease, ulcers, poor hearing and eyesight, memory loss and a range of physical disabilities. As a result, older people are likely to require a number of health-care services, including medical, nutritional and psychological treatment. The health care of older people in prison therefore necessitates the engagement of a multidisciplinary team of specialist staff *(15)*.

Thirty-three per cent of the population are of a racial or ethnic minority (n = 8) (Fig. 6).

## WHO guidance

The specific needs of ethnic minorities must be taken into account during treatment and development of care plans, including some awareness of the differences in traditions, religion and language *(15)*.

Fig. 6. Racial or ethinic minority




### 3.1.3 DISCUSSION AND RECOMMENDATIONS

Overall, these data appear to be consistent with what is currently known about the European prison population. The total proportion of women reported in the survey was 6.3%, similar to a recent regional estimate of 6.1% *(39).* The percentage of countries that reported overcrowding (23%) was like a survey of 47 Member States conducted by the Council of Europe, which reported that 29% of countries experienced overcrowding *(4).*

Fewer than half of countries (41%) were able to provide any information about people over the age of 55, and just one fifth (21%) were able to provide any information about people from ethnic or minority backgrounds. As such, there are substantial limitations in how these data can be interpreted.

**Report recommendations – prison population**

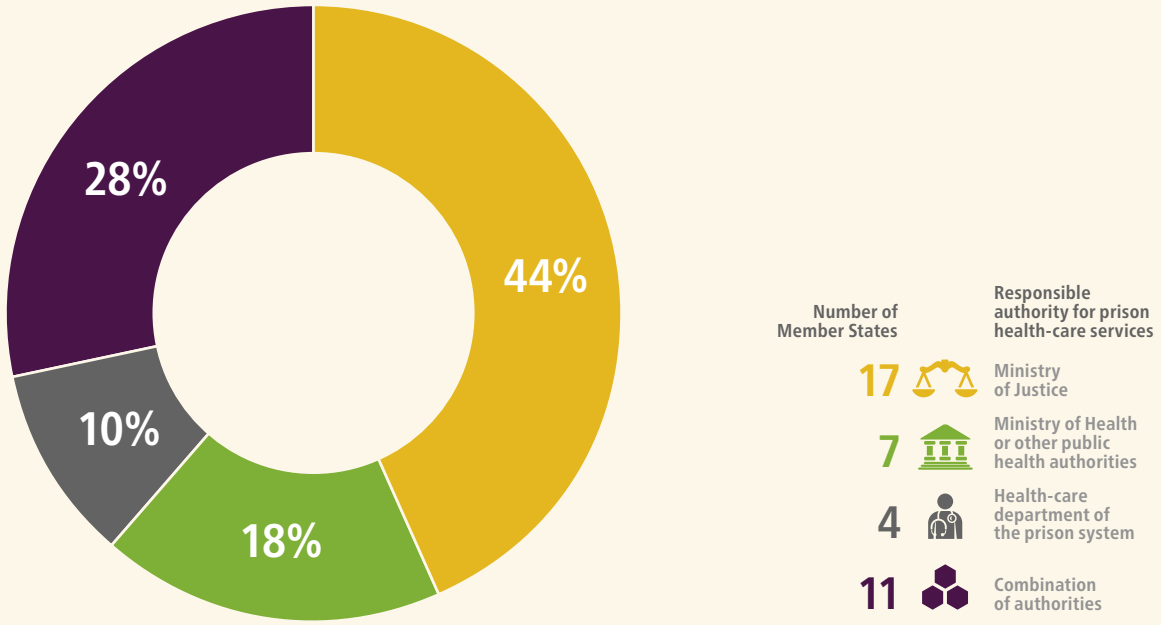
**Recommendation 1.** Member States should ensure that data are collected on the number of people entering and leaving prison, and demographics of people in prison. Health services in prisons must reflect the specific health needs of the population, based on formal health needs assessments.

## 3.2 PRISON HEALTH-CARE SYSTEMS

### 3.2.1 PRISON HEALTH-CARE SERVICE AUTHORITIES

The responsible authorities for prison health-care services as indicated by countries are presented in Fig. 7. Most countries (n = 28) reported a single responsible authority for prison health-care services, while 11 (28%) reported that a combination of authorities are responsible for prison health care, meaning that more than one authority (two government ministries, for example) had a role in organizing prison health care . The Ministry of Justice is the most common sole authority of prison health services (44%), followed by the Ministry of Health (18%) and the health-care department of the prison system (10%). A summary of the authorities reported by each country is available in Annex 5.

Fig. 7. Responsible authorities for prison health-care services




## WHO guidance

The role of the ministry responsible for health should be strengthened in the domain of quality assessment of hygiene, health care and organization of health services in custody, in accordance with national legislation. A clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries, which should cooperate in implementing an integrated health policy in prison *(25)*.

Regardless of which ministry is responsible for prison health, authorities must ensure that *(25)*:

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

### 3.2.1.1 Role of Ministry of Health and other public health authorities

Of the 37 countries providing data, 44% reported that the Ministry of Health or other public health authorities are responsible for the assessment of prison health-care services, 60% that they are responsible for the inspection of hygiene, nutrition and living conditions, and 44% that they are responsible for the prevention of infectious diseases.

### 3.2.2 ADMINISTRATION OF THE BUDGET FOR PRISON HEALTH-CARE SERVICES

The most commonly reported authority responsible for the administration of the prison health-care budget of the 38 countries that reported data was the Ministry of Justice (42%). Ten countries (26%) reported a combination of authorities as responsible, followed by the Ministry of Health or other public health authorities (18%), and the health-care department of the prison system (11%). Countries reporting other arrangements described these as the Department of Corrective Services, Ministry of Home Affairs and Security, prison hospitals, health insurance companies and independent prison budgets.

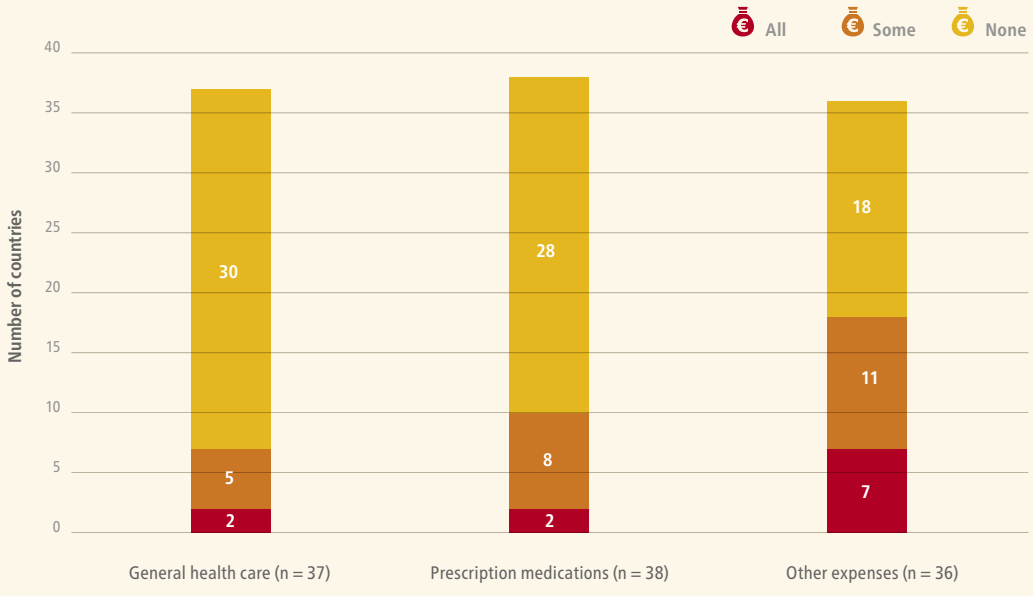
### 3.2.3 FUNDING SOURCE OF HEALTH SERVICES IN PRISONS

The most common responsible authorities for health-care services funding were the Ministry of Justice and the government budget. Twenty-two countries reported a single source of funding, and 13 reported multiple sources of funding. The most commonly reported sole funding source of health services in prisons was the government budget (30%), followed by the Ministry of Justice (22%).

#### 3.2.3.1 Health-care expenses

The obligation of people who are incarcerated to cover health-care expenses is summarized in Fig. 8. A minority of countries reported that people who are incarcerated are obliged to pay at least some general health-care costs (n = 7) and prescription medication costs (n = 10). Half of the responding countries reported that people who are incarcerated are obliged to cover at least some other health-care expenses (n = 18); a number of countries that provided comments described these other costs as being for dental care and prosthetics (n = 5). In addition, countries reported that other additional expenses included health care requested by the patient, not the treating doctor, for people with health insurance, and for people who had self-injured.

**Fig. 8. Obligation of people who are incarcerated to cover health expenses**



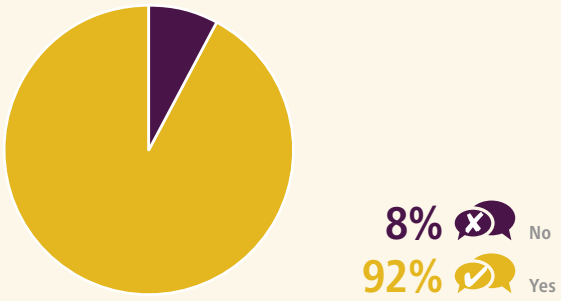
**WHO guidance**

Member States are recommended to ensure that all necessary health care for those deprived of their liberty is provided to everyone free of charge *(15)*.

### 3.2.4 AVAILABILITY OF A NATIONAL HEALTH-CARE COMPLAINTS SYSTEM

Most countries (n = 36) reported data on the availability of national health-care complaints systems in prisons. Of these, 92% indicated that such systems were available to all people in prison (sentenced and unsentenced) (Fig. 9).

**Fig. 9. Availability of national health-care complaints system for people in prison (n = 36)**




**WHO guidance**

A comments and complaints system should be in place for patients to correct apparent faults in the service and to learn from the patient's experience *(15)*.

### 3.2.5 LINKS BETWEEN PRISON HEALTH SYSTEMS AND COMMUNITY HEALTH SYSTEMS FOR HEALTH CARE

Thirty-three (92%) of 36 countries providing data reported that links existed between prison health care and community health-care systems. Descriptions of the links between prison and community health-care systems varied between countries. For example:

- one country described how formal communication procedures exist to ensure safe and efficient continuity of treatment for those requiring treatment for drug dependence, hepatitis C, HIV and mental health issues, and that a number of in-reach service providers also work in the community;
- five countries described links between prison health-care providers and community health care as existing only for HIV treatment; and
- one country reported that linkages between prison health-care service providers and community health care rely on the initiative of either prison health staff or health staff working in the community, in the case that community health-care providers are aware that a patient is sent to prison.

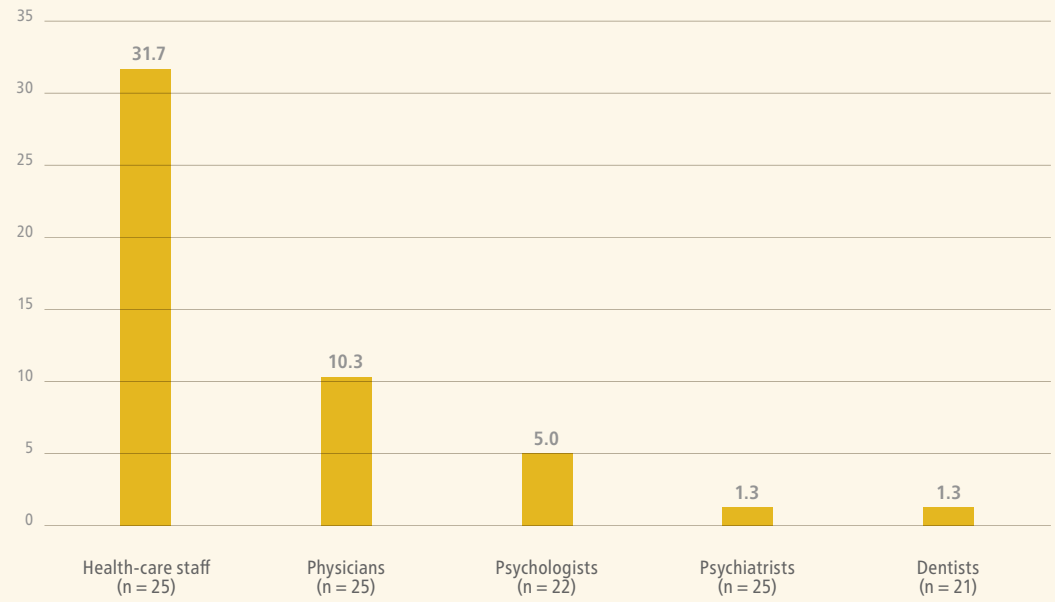
**WHO guidance**

A whole-of-government approach for prison health should be implemented, taking account of the need for integration between prison health and wider public health and social care systems *(26)*.

### 3.2.6 PRISON STAFF AND HEALTH-CARE STAFF

On average, there are 209.6 prison staff and 31.7 health-care staff per 1000 people in prison. The ratio of different categories of health-care staff per 1000 incarcerated people is reported in Fig. 10.

**Fig. 10. Ratio of health-care staff in prisons per 1000 incarcerated people (2014–2016)**




### 3.2.7 DISCUSSION AND RECOMMENDATIONS

Despite WHO recommendations, the Ministry of Justice was the most common authority across all indicators regarding health-care responsibilities. The Ministry of Justice was also most likely to be the sole health-care service authority and the sole body responsible for the administration of the prison health-care budget. The lack of involvement of the Ministry of Health and other public health authorities in essential components of public health governance raises questions about the interface between prison health systems and larger public health systems in these countries, and what specific arrangements are in place across countries in which the Ministry of Health does not serve this role. While a combination of authorities might reflect subnational governance arrangements, more information is required to determine the nature of prison health-care governance where more than one authority is involved.

Several countries reported costs to people incarcerated for dental care, administrative costs, costs for health care on request of the patient, for patients with health insurance and for the purchase of vitamins. Concerningly, one country reported that people are required to cover costs in the case of self-injury, raising ethical issues, particularly given the elevated risk of self-harm and suicide in this population *(13)*. The obligation of people who are incarcerated to cover health expenses for general health care, dental care, prescription medications and other expenses in some prison administrations may raise concerns about health-care equivalence and equity in European prison health-care systems.

**Report recommendations – prison health systems**

**Recommendation 2.** Regardless of which ministry has the authority for prison health care, the responsibility for quality assessment of hygiene, health care and organization of health services in custody should sit with the ministry responsible for health. Health services must adhere to international human right laws, ensure the clinical independence of health-care staff and provide services that are of an equivalent standard to those in the community.

**Recommendation 3.** Member States that do not completely cover all necessary health-care-related expenses in prison should extend health-care coverage to all people for all necessary health services to ensure that universal health coverage includes people in prison.

**Recommendation 4.** All Member States should ensure that formal arrangements are in place to enable integration of prison health services with the wider public health system to achieve continuity of care for individuals released from custody and continuity of universal health coverage for this key population.

## 3.3 PRISON ENVIRONMENT

Prisons should be treated as a setting for health promotion and incarceration as a time during which individuals can address existing health conditions and improve lifestyle factors that may be contributing to their NCD burden. The availability of a health-promoting environment, such as smoke-free cells, drug-free units and self-cook kitchen areas, is an important component of addressing NCD risk factors. A tobacco-free environment encourages individuals to quit smoking tobacco (with appropriate nicotine-replacement therapy), while drug-free units encourage abstinence from illicit drug use and offer the opportunity to seek medical and psychological treatment. Self-cook kitchen areas promote better nutrition compared with traditional mass-produced prison meals and also contribute to individual autonomy and the development of skills in preparation for release from prison.

### 3.3.1 SMOKE-FREE CELLS

Of the 32 countries that provided data, 78% reported that smoke-free cells were available in prisons (Fig. 11). Of these, 88% of countries reported that they are available in all prisons.

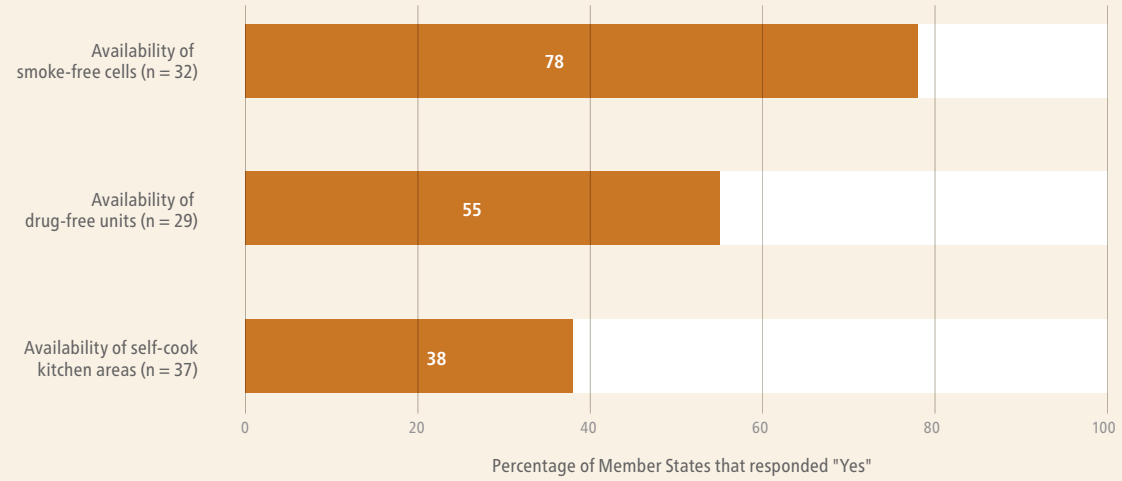
**WHO guidance**

The WHO Framework Convention on Tobacco Control guidelines on implementing Article 8 states that *(40)*:

> careful consideration should be given to workplaces that are also individuals' homes or dwelling places, for example, prisons, mental health institutions or nursing homes. These places also constitute workplaces for others, who should be protected from exposure to tobacco smoke.

WHO does not endorse the use of electronic nicotine delivery systems (e-cigarettes and vapes) in the pursuit of smoke-free prison environments.

**Fig. 11. Prison environment and NCD risk factors**

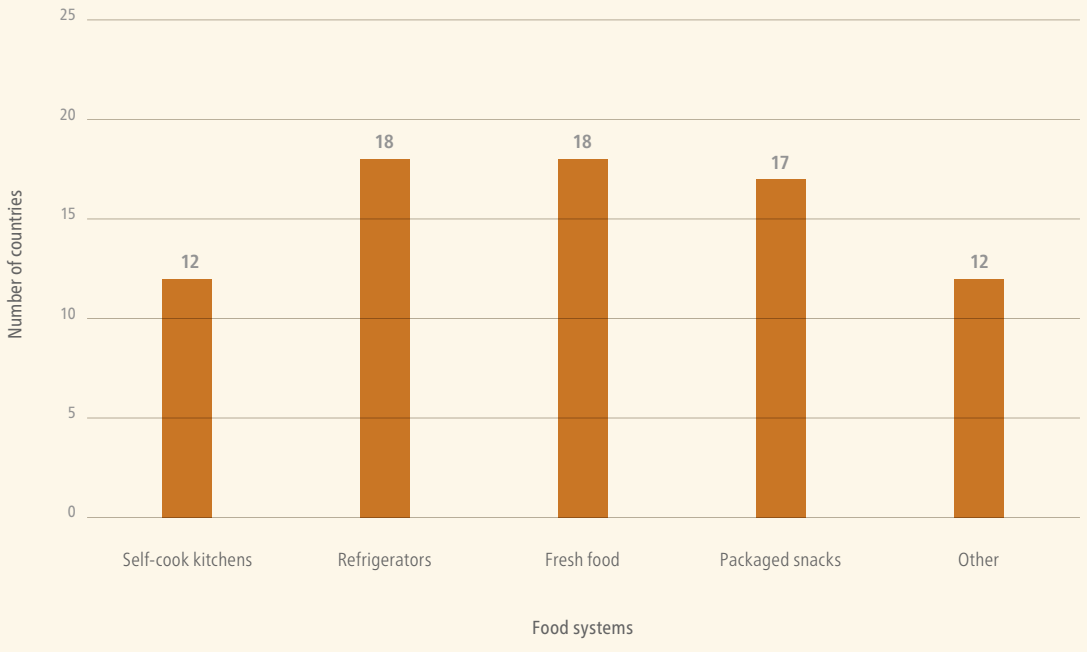



### 3.3.2 PRISON FOOD SYSTEMS

Of the 37 countries with national data available, 97% reported that the production of meals in prisons occurs in centralized kitchens. Thirty-eight per cent of countries reported that self-cook kitchen areas are available. Two countries reported that meals were not produced in centralized kitchens, with other food options or arrangements in place: one articulated that the other arrangement was the State providing food for people who are incarcerated, and the other that other options included all kinds of food available to people, including fresh and frozen food, dairy products, bread and other dry food.

In addition to centralized kitchens, alternative arrangements in place for food systems are shown in Fig. 12. "Other" alternative arrangements include the provision of food by relatives and visitors

**Fig. 12. Alternative food systems available**



(n = 4 countries), the existence of stores where people can buy both cooked food and food to prepare themselves (n = 3), the availability of a fridge in every cell (n = 1) and systems in place to order food (n = 1).

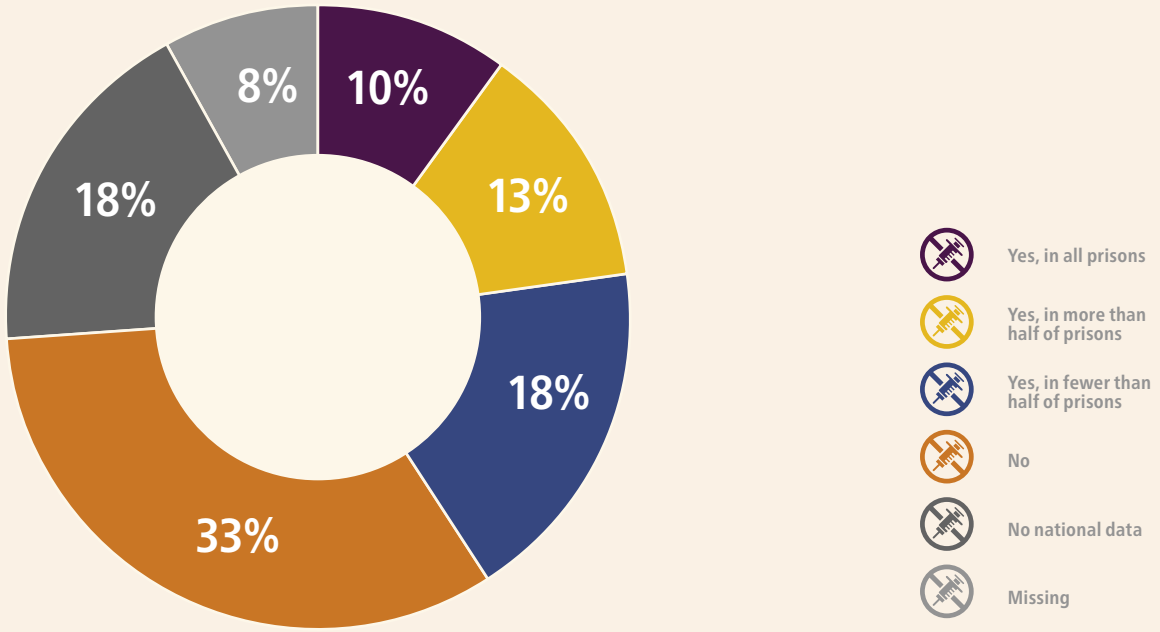
**WHO guidance**

Prison administrations need to ensure that people in prison have access to a nutritionally adequate and balanced diet. The prison environment can contribute to the development of healthy eating patterns when appropriate alternative food systems are available. Cookery programmes and the opportunity to cook for oneself in prisons should be available *(42)*.

### 3.3.3 DRUG-FREE UNITS

Twenty-nine countries had national data available and provided a valid response regarding the availability of drug-free units in prisons. Among these countries, slightly more than half (55%) reported that drug-free units are available in prisons (Fig. 13).

**Fig. 13. Availability of drug-free units in prison (n = 39)**




**WHO guidance**

Drug-free units aim to allow people in prison to keep a distance from the prison drug scene and to provide a space to work on dependence-related problems. The focus in these units is on drug-free living. Individuals staying in these units sometimes enjoy a regime with more favours and privileges, such as additional leave, education or work outside, excursions and more frequent contact with their families. The purpose of staying in a drug-free unit is that the individual will remain drug-free or at least become motivated to continue treatment after release *(15)*.

### 3.3.4 DISCUSSION AND RECOMMENDATIONS

Consistent with the WHO guidance and recent changes in legislation in European prisons regarding smoke-free prison policies, most countries reported that smoke-free cells were available in prisons. Partial or full smoking bans have been introduced in at least 12 European countries *(42)*, with smoke-free prison cells an important step in this process of changing to entirely smoke-free prisons *(15)*. It is not possible to determine from the data which Member States have an entirely smoke-free prison estate, however, and no conclusions can be drawn from this survey about what supports are in place to support smoking abstinence in European prison populations.

Most countries reported that meals are prepared in centralized kitchens. Just 50% of countries reported that refrigerators and fresh food are available in prisons, and fewer than half that self-cook kitchens (33%) and packaged snacks (47%) are available in prisons. The lack of fresh food and limited food options are of concern, given the high prevalence of NCDs in this population. Information about the meals produced in centralized kitchens, the role of people in prison in the preparation of their food and the dietary choices of people in prison is necessary to gain a more comprehensive understanding of the utility of meal production in centralized kitchens and to make an informed assessment about the available dietary options in European prisons.

**Report recommendations – prison environment**

**Recommendation 5.** Member States should follow the WHO Framework Convention on Tobacco Control by giving consideration to the establishment of a smoke-free prison estate and ensure that appropriate support is provided to individuals to quit tobacco-smoking, including nicotine replacement therapy and counselling.

**Recommendation 6.** Fresh and nutritious food options should be provided in place of nutrient-poor meals in prisons to prevent NCDs and contribute to promoting healthy lifestyles and establishing a health-promoting environment.

**Recommendation 7.** The implementation or expansion of drug-free units in prisons is one mechanism by which prisons can become health-promoting environments.

## 3.4 RISK FACTORS FOR ILL HEALTH

### 3.4.1 IDENTIFICATION OF RISK FACTORS ON RECEPTION TO PRISON

Few countries were able to provide national data on the indicators of risk factors on reception to prison, so given the extent of missing data and the wide variation in prevalence where reported, the prevalence range across the available data has been reported (Table 2). A full list of countries that provided data contributing to the reported prevalence ranges is available in Annex 4 and a summary of the reference groups in Annex 5.

### 3.4.2 SCREENING FOR MENTAL HEALTH DISORDERS AND SUBSTANCE USE DISORDERS

Screening for mental health disorders and substance use disorders in prison should be made available on entry to prison to detect immediate risks, such as suicide risk and alcohol or drug withdrawal.

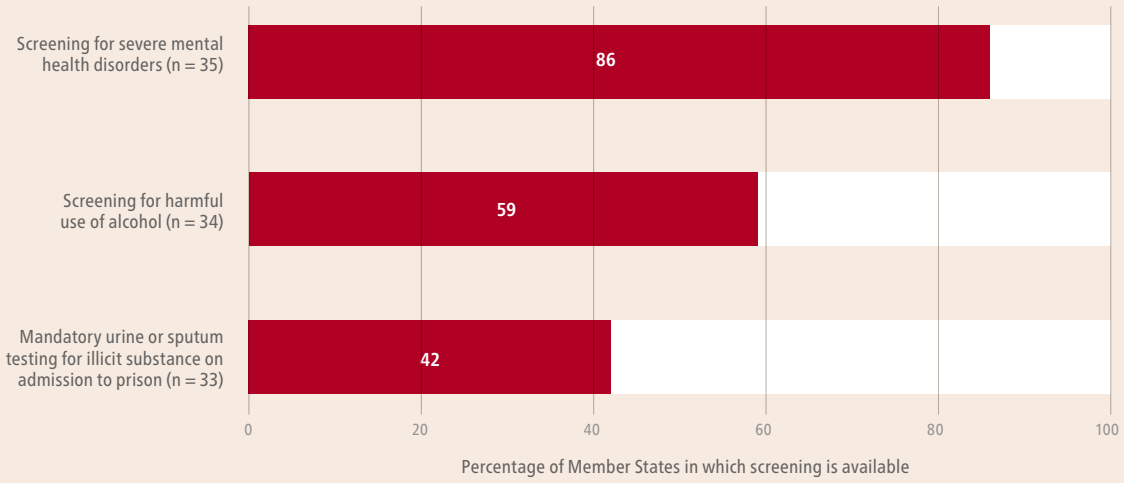
**Table 2. Risk factor prevalence range in prisons in Europe**

| Risk factor (number of Member States that reported data) | Prevalence range in prisons in Europe (percentage) |
|---|---|
| **Tobacco smoking (n = 5)** | 60–88.8 |
| **High blood pressure (n = 8)** | 1.3–9 |
| **Overweight (BMI[a] > 25) (n = 3)** | 0.05–4 |
| **Obesity (n = 1)** | NA[b] |
| **Current injection drug use (n = 5)[c]** | 4.5–25.8 |
| **Ever injection drug use (n = 5)[c]** | 0.72–44 |

[a] BMI: body mass index. [b] NA: not available. [c] Different Member States provided data on current and ever injecting drug use, so the prevalence ranges do not correspond.

The HIPED data show that most Members States currently are conducting assessments for mental health disorders and the harmful use of alcohol on reception to prison. Of the 35 countries that presented data, 86% reported that screening for severe mental health disorders was available; of the 34 countries that provided data on screening for the harmful use of alcohol, 59% reported that it was available (Fig. 14). While these screening processes are a step towards an integrated approach to NCD management, Member States will need to implement screening tools that capture all NCDs, such as cardiovascular disease, respiratory disease, diabetes and cancer, and their associated risk factors – tobacco-smoking, harmful alcohol use, nutrition and physical activity – successfully to manage the whole spectrum of NCDs.

**Fig. 14. Availability of screening for mental health disorders and substance use disorders**



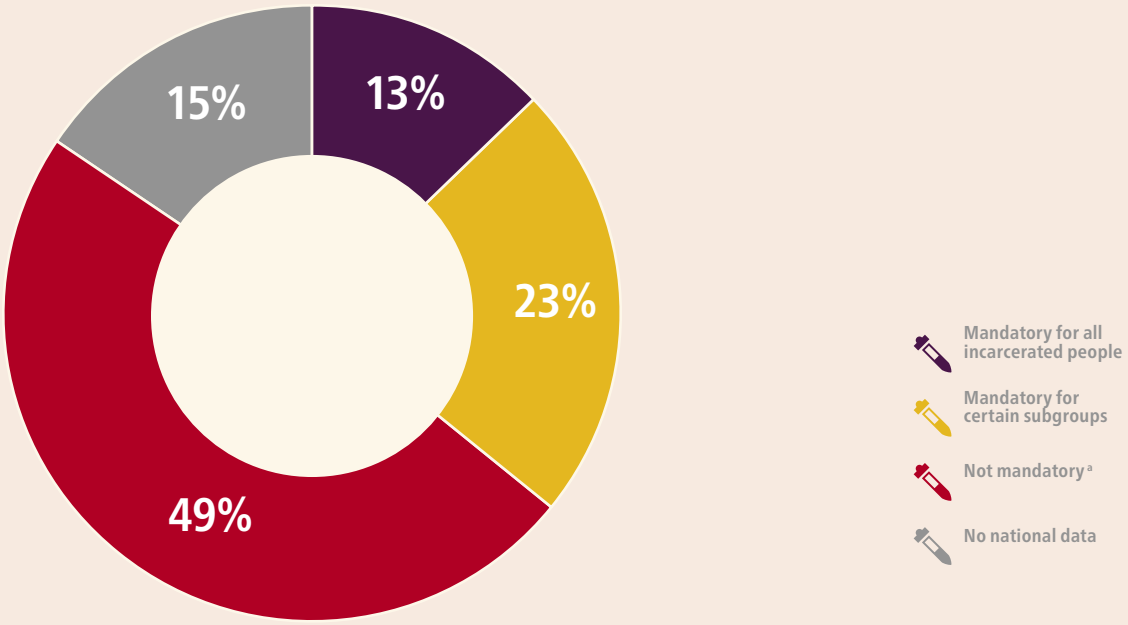
**WHO guidance**

All individuals should undergo health screening on entry to prison to screen for immediate risks for both physical and mental health conditions, including suicide, drug or alcohol withdrawal, and medications reconciliation. This initial reception screen should prioritize minimizing risks for individuals arriving at prison. A second follow-up assessment should be carried out within the first few days in prison to capture complex and longer-term conditions *(15)*.

### 3.4.3 SCREENING FOR SUBSTANCE USE ON RECEPTION TO PRISON

Urine or sputum testing requirements in prisons are presented in Fig. 15. The subgroups for whom testing is mandatory included people with histories of drug use, people suspected of drug use and people receiving opioid maintenance therapy.

**Fig. 15. Urine or sputum testing in prisons (n = 39)**




[a] Includes if testing is unavailable.

Of the 19 countries reporting that testing is not mandatory, 67% indicated that testing is available in prisons, 11% that it is not available, and 22% that other arrangements are in place (which include testing being used in some settings to confirm OST, and that it is used under the suspicion of substance use). Few countries were able to provide national data on the prevalence of screening for illicit substance use and the prevalence of injecting drug use identified on reception to prison.

The reported prevalence of current injection drug use based on responses from five Member States ranged from 5–26%, while the reported prevalence of lifetime injection drug use, also based on data from five (different) Member States, ranged from 0.72– 44%.

**WHO guidance**

Urine and sputum testing should not be used as a form of control over patients to monitor for illicit drug use *(15)*.

### 3.4.4 SCREENING FOR HARMFUL ALCOHOL USE

Of the 34 countries that provided data on the availability of screening for harmful alcohol use, 59% reported that it was implemented in prisons. Screening was implemented in all prisons in 80% of these countries.

A validated screening tool was used to screen for harmful alcohol use in 47% of countries that provided data.

**WHO guidance**

The prison setting is an opportunity to detect, intervene or direct into treatment individuals who have alcohol problems which may or may not be linked directly to their offences and who are often hard to reach *(15)*.

The routine taking of a clinical history can be augmented through the use of a validated alcohol screening tool *(15)*.

### 3.4.5 SCREENING FOR SEVERE MENTAL HEALTH DISORDERS

Of the 35 countries that provided data on screening for severe mental health disorders on admission to prison, 86% reported that it was available. Three of the countries reporting that screening was available explained that mental health screening is conducted by general practitioners and nursing staff.

#### 3.4.5.1 Diversion to mental health treatment

Of the 29 countries that provided information about the availability of diversion to mental health treatment as a result of mental health screening, 84% reported that at least some level of diversion to mental health treatment was available. Two countries provided explanations about pathways to diversion, specifically that diversion existed as a result of a court decision and psychiatrist's opinion.

**WHO guidance**

Individuals should be screened for signs of poor mental health and immediate risks on arrival at prison. A more detailed assessment should be conducted within the first few days of custody to determine the history of mental illness and current mental health status, as well as to screen for traits of personality disorder, substance misuse issues, learning disability or difficulty, autistic spectrum disorder, head injury and other factors that contribute to vulnerability (such as a long sentence or a violent offence).

Treatment for mental health disorders should include basic interventions, such as psychological support through counselling from a psychologist, nurse or stable peer, and psychotropic medications such as antipsychotics, as well as motivating patients for treatment and medication during and after prison and stabilizing substance misuse problems. It will also be necessary to have a crisis facility within or outside the national prison system for a limited number of people in prison with severe psychiatric disorders *(15)*.

### 3.4.6 DISCUSSION AND RECOMMENDATIONS

The survey yielded little data on the prevalence of health risk factors on reception to prison. Given the high prevalence of NCDs in prison populations *(15)*, the dearth of data in the European Region on NCD risk factors is a cause for concern. Complete and comparable information about the risk factors that exist is required to address the health needs of people in prison.

The prevalence of current and lifetime injection drug use on admission are fairly consistent with other available data, with one recent estimate of the prevalence of lifetime injection drug use in European prisons published by the European Monitoring Centre for Drugs and Addiction ranging between 5% and 38% *(7)*. Given that only a minority of countries provided data on injection drug use, however, the prevalence ranges reported in Table 2 are merely a snapshot of the available countries and are not generalizable to the other responding countries or the broader European Region.

While urine tests are a vital part of the initial medical assessment of patients for confirmation of opiate use, as presented in Fig. 15, WHO recommends that they not be used as a form of control over patients to monitor for illicit drug use *(15)*. Of the 33 countries that provided a response on the availability of urine and sputum screening for substance use on admission, 14 (42.4%) reported that testing is mandatory for either all people in prisons or certain subgroups. Overall, 31% of countries (n = 12) reported that testing is not mandatory but is available, or that other alternatives are in place. Two countries (5.2%), however, reported that urine or sputum testing is unavailable. The available evidence about referral to treatment is limited.

Given the high prevalence of alcohol use disorders in prison populations *(6)*, appropriate screening for alcohol use on admission to prison is an essential component of prison health-care assessment to detect, intervene or divert people into treatment.

Many countries indicated that screening for mental health disorders on admission is widely available, and that some level of diversion to mental health treatment exists, consistent with previous findings from other surveys at European regional level *(29)*. Given that some countries reported mental health screening as being unavailable or not available in all prisons, it is apparent that WHO guidelines for mental health screening and diversion to mental health are not universally being met across the European Region.

Some countries reported that screening was conducted by general practitioners and nursing staff, and some also reported diversion as of the result of a court decision and psychiatrist's opinion. There nevertheless is no comprehensive evidence across countries about who is conducting screening, what tools are used and what the pathways into diversion treatment are.

**Report recommendations – screening for NCDs**

**Recommendation 8.** On arrival at prison, all individuals should be screened as soon as practicable (using validated screening tools) for immediate risks, including signs of poor mental health, self-harm and suicide, substance use disorder and medicines reconciliation.

**Recommendation 9.** Within the first week of custody, all individuals should undergo a thorough health assessment to screen for all physical and mental health needs. Individuals requiring treatment should be referred to appropriate health-care services.

**Report recommendations – screening for NCDs contd**

**Recommendation 10.** Member States should implement validated screening tools that capture information on NCDs, including cardiovascular disease, respiratory disease, diabetes and cancer, and their associated risk factors – tobacco-smoking, harmful alcohol use, nutrition and physical activity.

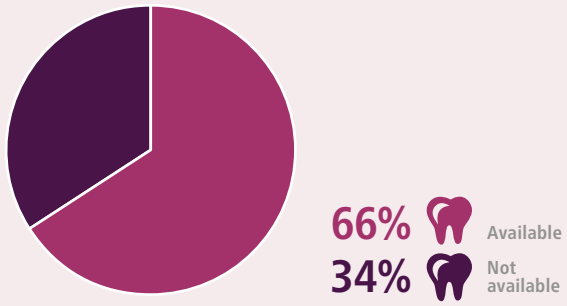
**Recommendation 11.** Data from health screening in prison should be captured and reported at national level to monitor: prevalence rates of diseases and risk factors; changes in health status; improvements in health outcomes in the prison population; and prison health systems' progress in addressing the health needs of the population.

## 3.5 DISEASE SCREENING ON ADMISSION

### 3.5.1 SCREENING FOR ORAL HEALTH

Of the 35 countries indicating that information on oral health screening was available, 66% reported that screening for oral health problems was available on reception (Fig. 16).

**Fig. 16. Availability of oral health screening on reception to prison (n = 35)**




**WHO guidance**

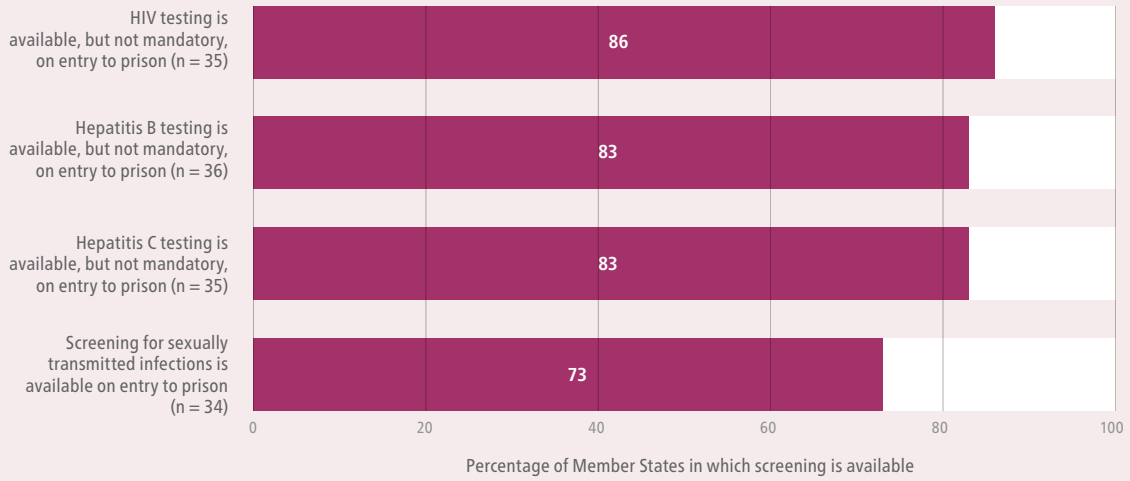
Oral health should be included in induction programmes and health triage systems in prisons *(15).*

A comprehensive dental health-care service should be in place to provide an appropriate range of treatments based on patients' clinical needs *(15).*

### 3.5.2 SCREENING FOR COMMUNICABLE DISEASES

Thirty-five Member States provided data on screening for HIV, 86% of which reported that HIV testing is available but not mandatory. Of the 36 Member States that provided data on screening for hepatitis B, 83% reported testing is available but not mandatory. Eighty-three per cent of the 35 Member States that provided data on screening for hepatitis C reported that testing is available but not mandatory. Of the 34 Member States that provided data on screening for STIs, 73% reported that screening for STIs is available on entry to prison (Fig. 17).

**Fig. 17. Screening for communicable diseases**




**WHO guidance**

Pre- and post-test counselling for BBV screening should be available in prisons *(15).*

### 3.5.3 PREVALENCE OF COMMUNICABLE DISEASES

Table 3 shows the prevalence of communicable diseases in prisons in Europe.

### 3.5.4 STIs

Thirty-four countries had national data on the availability of STI screening, 73% of which reported that screening for STIs was available. Fewer countries provided data on the prevalence of syphilis and chlamydia in males and females on reception. The prevalence ranges across the countries providing data are reported in Table 3.

**WHO guidance**

Voluntary screening for STIs such as chlamydia, gonorrhoea and syphilis should be available to people in prison *(15).*

### 3.5.5 HIV

Thirty-eight countries provided information about the availability of HIV testing on reception to prison. Three (8%) reported that no national data were available. Of the remaining 35 countries that indicated national data were available and provided a response, 11% reported that testing is mandatory for all people who are incarcerated, one country that it is mandatory for certain subgroups, and 86% that testing is not mandatory. Of the 30 countries in which HIV testing is not mandatory, 47% reported that HIV testing is available and 53% that it is offered routinely to all people who are incarcerated on an opt-out basis.

Data for the percentage of HIV screening and prevalence of HIV on reception are available in Table 3.

**Table 3. Prevalence of communicable diseases in prisons in Europe**

| Communicable disease | Prevalence in prisons in Europe (number of Member States that reported data) |
|---|---|
| **HIV** | Males: 0.03–5.4% (n = 11)[a]<br>Females: 0–4.7% (n = 9)[b] |
| **Hepatitis B**[c] | Percentage positive HBsAg[d]: 0–30% (n = 8)<br>Percentage positive Anti-HB[e]: 0–25% (n = 6) |
| **Hepatitis C** | Percentage positive Anti-HCV[f]: 8.1–91% (n = 11)[g]<br>Percentage positive HCV RNA[h]: 5.2–82% (n = 8)[i] |
| **Chlamydia**[j] | Males: 0–24% (n = 6)<br>Females: 0–30.7% (n = 5) |
| **Syphilis**[j] | Males: 0–1.8% (n = 10)<br>Females: 0–0.76% (n = 12) |
| **TB**[k] | Cases detected of new/relapse TB: 0–25% (n = 10) |

[a] Reported year range 2012–2017. [b] Reported year range 2014–2017. [c] Data were provided for the most recent year available. The reported year was either missing or ranged between 2015 and 2017. [d] HBsAg: hepatitis B virus surface antigen. [e] Anti-HB: hepatitis B virus surface antibody. [f] Anti-HCV: hepatitis C virus antibody test. [g] The reported years were 2006, 2015 and 2016. [h] HCV RNA: a test to measure the level of the hepatitis C virus in the bloodstream. [i] The reported years ranged between 2015 and 2017. [j] Reported years were either missing, 2006, 2015 or 2016, or 2015–2017. [k] Reported year was either missing, 2010 or 2014–2016.

**WHO guidance**

Member States should encourage use of the United Nations comprehensive package of services to address HIV and viral hepatitis B and C. Prison systems must ensure all people in prison have easy access to client-initiated testing and counselling programmes on request and at any time during their imprisonment, and testing should never be mandatory. *(26).*

### 3.5.6 HEPATITIS B

Thirty-six countries indicated that national data were available and provided a valid response, 83% of which reported that testing is not mandatory. Of the 30 countries in which hepatitis B testing is not mandatory, 52% reported that hepatitis B testing was available, 38% that it was offered routinely to people who are incarcerated on an opt-out basis, one that testing was not available, two that other arrangements were in place, and data was missing for one country. Of the two countries with other hepatitis B testing arrangements, one reported that it is offered by a nongovernmental organization (NGO) and the other that testing is conducted only on the basis of clinical suspicion.

The prevalence of positive tests for hepatitis B is summarized in Table 3.

**WHO guidance**

All people in prison, and prison staff, should be vaccinated against hepatitis B. Any individual entering prisons who has not been vaccinated should be offered the hepatitis B vaccination *(15).*

### 3.5.7 HEPATITIS C

Thirty-five countries indicated that national data were available, 83% of which reported that testing is not mandatory.

Of these countries, 48% reported that hepatitis C testing was available, 41% that it was offered routinely to people who are incarcerated on an opt-out basis, one that testing was not available, and two that other arrangements were in place (one country reported that it is offered by a NGO and the other that testing is conducted only on the basis of clinical suspicion).

The prevalence of positive tests for hepatitis C is summarized in Table 3.

**WHO guidance**

There is currently no vaccine to prevent hepatitis C infection, so it is essential to screen for the hepatitis C virus on entry to prison and to prevent transmission within prison *(15).*

### 3.5.8 TB

The prevalence of testing and detection of new or relapse TB is summarized in Table 3.

The range of people tested for TB varied from 0–100%: this might indicate that testing is unavailable in some countries and mandatory in others, or that it may be affected by variations in the reference population, but there is insufficient information from which to draw conclusions.

**WHO guidance**

TB infection control is a combination of measures aimed at minimizing the risk of TB transmission. The basis of such infection control is early and rapid identification of individuals with suspected and known TB and effective treatment of disease *(15).*

### 3.5.9 DISCUSSION AND RECOMMENDATIONS

WHO recommends that prisons should offer a comprehensive dental health-care service and provide an appropriate range of treatments based on patients' clinical needs. Oral health should also be included in prison induction programmes and health triage systems *(43).* While the available data suggest that oral health screening is available in 66% of prison health administrations and that oral health screening is available in all prisons in 76% of these administrations, it appears not to be universal in European prison administrations. Conclusions about the provision and accessibility of prison dental health services cannot be drawn from the data, but a number of countries that reported the obligation of people in prison to cover other health-care costs (other than general health care or prescription medications) described these costs as being for general dental care and more complex components of dental care, including prosthetics, raising questions about the accessibility of these services in European prison health services.

Consistent with WHO recommendations for non-mandatory HIV and hepatitis testing, the majority of countries reported that non-mandatory testing was available on reception for HIV, hepatitis B and hepatitis C. A minority of countries, however, reported mandatory HIV or hepatitis testing for all incarcerated people, or certain subgroups. These practices do not align with WHO's position on non-

mandatory testing based on the ethical principles of informed consent. One country does not offer any testing for hepatitis B or C, which could contribute to an increased risk of transmitting these infections among other people incarcerated in the prison system and worsening of chronic conditions associated with viral hepatitis.

WHO recommends voluntary screening for other STIs, including chlamydia, gonorrhoea and syphilis, should be offered to all people in prison who exhibit high-risk health behaviours *(15)*. Approximately three quarters (73%) of countries that provided a response about the availability of STI screening in prisons reported that it was available in some or all prisons.

Given that people in prison are at higher risk of these infections, the lack of universal STI screening across the European Region has implications for health outcomes in this population.

Conclusions about the availability and implementation of pre- and post-test counselling, which are considered important components of screening *(15)*, cannot be drawn from the available data.

WHO recommends that people should not enter prisons until it has been confirmed that they do not have infectious TB, and that systematic passive and active case-finding should be carried out simultaneously *(15)*. WHO strongly recommends that GeneXpert MTB/RIF should be used as the initial diagnostic test in individuals suspected of having multidrug-resistant or HIV-associated TB *(15)*. The percentages of people being tested for new/relapse TB and people who have TB being tested for HIV both range from 0–100%. This appears to indicate that testing might be unavailable in some countries, or that all people are tested for TB and TB/HIV in some countries, consistent with WHO guidelines. This information alone is insufficient to draw any conclusions about the testing practices used by the responding countries, including whether active or passive case-finding is implemented.

**Report recommendations – disease screening**

**Recommendation 12.** Member States that currently do not screen for oral health issues on reception to prison should ensure that dental health-care services are available for assessment and treatment of oral health issues both on entry to prison and throughout imprisonment.

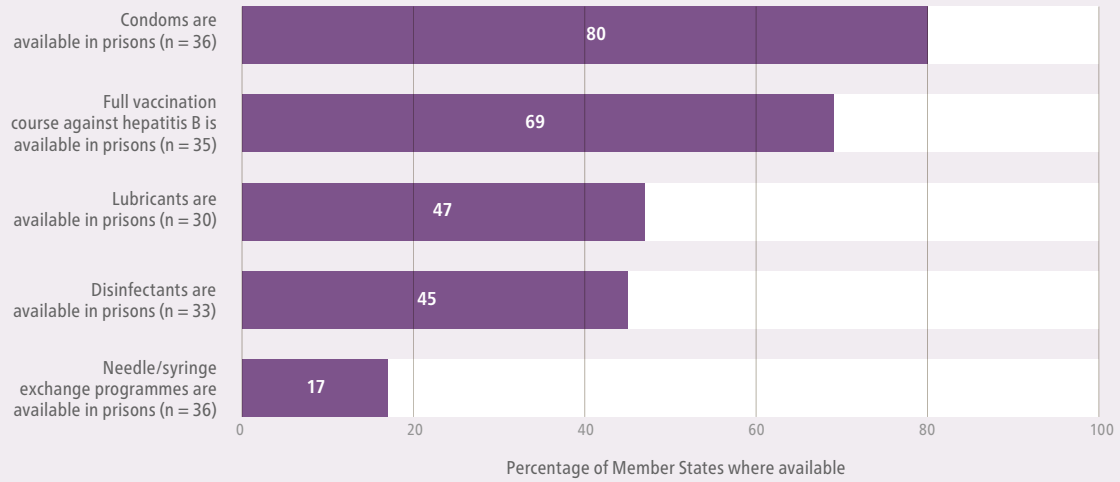
**Recommendation 13.** Member States should ensure that: testing is available, but not mandatory, for HIV, hepatitis B, hepatitis C and STIs on entry to prison; pre- and post-test counselling is available; and appropriate treatment or vaccination is available in prison.

**Recommendation 14.** Testing for TB on reception to prison should be implemented in all Member States and treatment commenced for individuals testing positive to minimize the risk of transmission of TB within prisons.

## 3.6 PREVENTION OF INFECTION

The availability of resources for prevention of infection (lubricants, condoms, disinfectants, and needle and syringe exchange programmes) is presented in Fig. 18.

**Fig. 18. Availability of prevention measures for communicable diseases**




Of the 36 countries that provided data, 80% reported that condoms are available in prisons. Sixty-nine per cent of the 35 countries that provided data reported that a full vaccination course against hepatitis B is available, 47% of the 30 countries that provided data reported that lubricants are available, and 45% of the 33 countries that provided data reported that disinfectants are available.

A minority of countries (17%) indicated that needle and syringe exchange programmes were available in at least some prisons. A number of countries provided explanations for the lack of needle/syringe exchange programmes, including that it was simply not deemed necessary (n = 1), drug use is prohibited (n = 1) and that two pilot implementations conducted in 2009 were considered ineffective (that is, no needles or syringes were exchanged).

Of the 15 countries in which disinfectants were available, 87% reported that they are available free of charge. Eighty-six per cent of the 29 countries in which condoms are available in prisons reported that they are available free of charge. Of the 14 countries that reported that lubricants are available in prisons, 86% reported that they are available free of charge.

## WHO guidance

Easily, discreetly and freely available condoms and lubricants should be available in prisons *(15).*

Needle and syringe exchange programmes are one example of harm-reduction interventions that can be introduced to minimize the risk of transmission between people who inject drugs *(15).*

The provision of bleach or other disinfectants to people who are incarcerated should be considered as an option to reduce the risk of transmission of BBVs through the sharing of injection equipment, particularly when sterile injection equipment is not available *(15).*

### 3.6.1 NON-SUPERVISED FAMILY AND PARTNER VISITS

Thirty-seven countries indicated that data were available, 81% of which reported that non-supervised family/partner visits are available in prisons. Of these countries, 53% reported that non-supervised visits are available in all prisons, 37% that they are available in more than half of prisons, and 10% that they are available in fewer than half of prisons.

**WHO guidance**

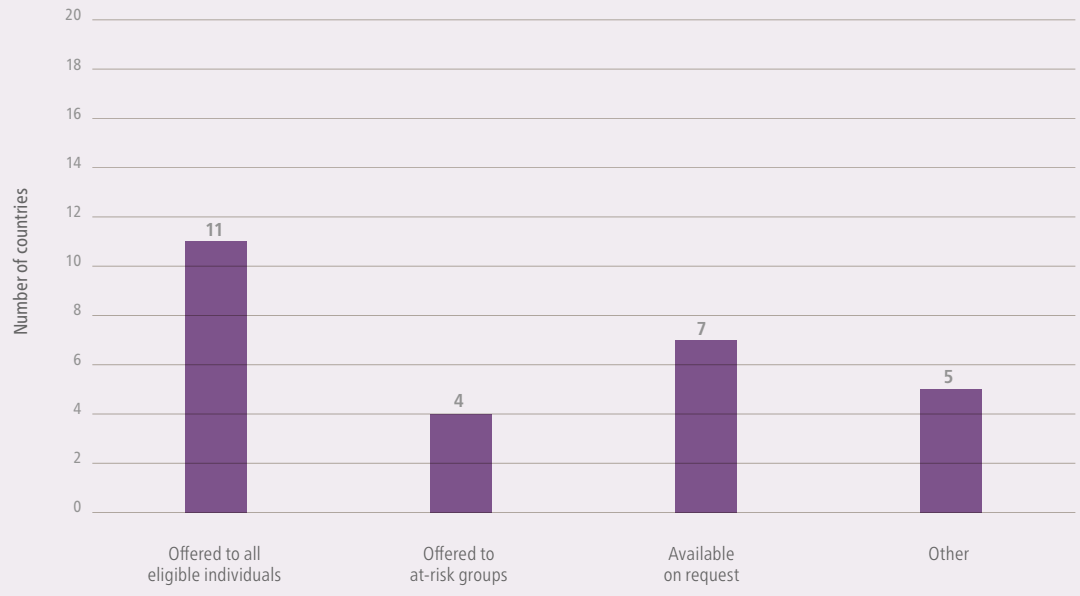
To create the best conditions for good health and effective health care, prisons should adopt a whole-prison approach to the provision of opportunities to maintain family links through visits *(15).*

### 3.6.2 HEPATITIS B PREVENTION

Among the 35 countries with national data available and which provided a valid response, 67% reported that a full vaccination course against hepatitis B is available in prisons, while 31% reported that a full vaccination course is not available. Data for the 24 countries that indicated a full vaccination course is available are summarized in Fig. 19. Of the five countries that reported other arrangements were in place for hepatitis B vaccinations, one offers the vaccination course to men who have sex with men, and another reported that it was available to a number of groups, including anyone who asks for the vaccine, people who use drugs, people from high-endemic regions, sex workers, people who are incarcerated and staff who face professional risks.

Two countries provided data for the percentage of incarcerated people who are fully vaccinated for hepatitis B (66% and 68.8%).

**Fig. 19. Availability of a full vaccination course against hepatitis B in prisons (n = 24)[a]**




[a] More than one response option is available.

**WHO guidance**

All people entering prison who are not know to be immune to hepatitis B due to a full vaccination course or previous infection should be offered the vaccine for hepatitis B on admission *(15).*

### 3.6.3 DISCUSSION AND RECOMMENDATIONS

Overall, harm-reduction strategies and resources for the prevention of STIs appear to be implemented or distributed rarely in European prisons. Where available, the information about how these strategies are implemented and how resources are distributed is limited, including whether the approaches are acceptable and anonymous. More information is needed about these strategies and resources, including information about barriers to implementation for countries, perceived need and perspectives.

WHO recommendations for the prevention of STIs include easily, discreetly and freely available condoms and lubricants, and rooms for conjugal visits with these resources available *(15)*. While the results of this survey indicate that condoms are available in most countries (74%), they were unavailable in the prison administrations of seven countries (18%), similar to findings of a previous national survey of 27 European countries in which condoms were unavailable in nine (33%) *(32)*. While the majority of countries that reported condoms were available also reported that they are free of charge (n = 25), several reported that condoms were available to people in prison only at a cost (n = 4), raising questions about the accessibility of these products. Additionally, fewer than half of countries (n = 14) reported that lubricants were available in prisons and two indicated they were available only at a cost, which indicates that most countries are not meeting WHO's guidelines for prevention.

WHO recommends a harm-reduction approach to injection drug use through the provision of injection kits to minimize the risk of transmission between people who inject drugs. The provision of health-promotion information, bleach and needles to people in prison is recommended to minimize the risk of unsafe tattooing and piercing equipment *(15)*. Implementation of these recommendations was rare: a minority of countries indicated that needle and syringe exchange programmes were available in prisons (n = 6, 15.4%) and even fewer reported that the programmes existed in all prisons (n = 2, 5.1%). More information is required about implementation efforts, barriers and perceived need of countries regarding these initiatives.

WHO recommends that all people entering prison who have not been vaccinated against hepatitis B should be offered the vaccine on admission, but few countries (n = 11) reported that a full vaccination course against hepatitis B was offered to all eligible incarcerated people on admission, or provided data on the prevalence of people vaccinated for hepatitis B.

**Report recommendations – prevention of infection**

**Recommendation 15.** All countries should ensure that evidence-based infection control measures, such as condoms, lubricants and disinfectants, are easily and discreetly available in prisons to help prevent the transmission of infections.

**Recommendation 16.** The implementation of needle and syringe exchange programmes in prisons should be considered by all Member States as an example of a harm-reduction intervention to minimize the risk of transmission of infections, in line with community practice to ensure equivalence of care.

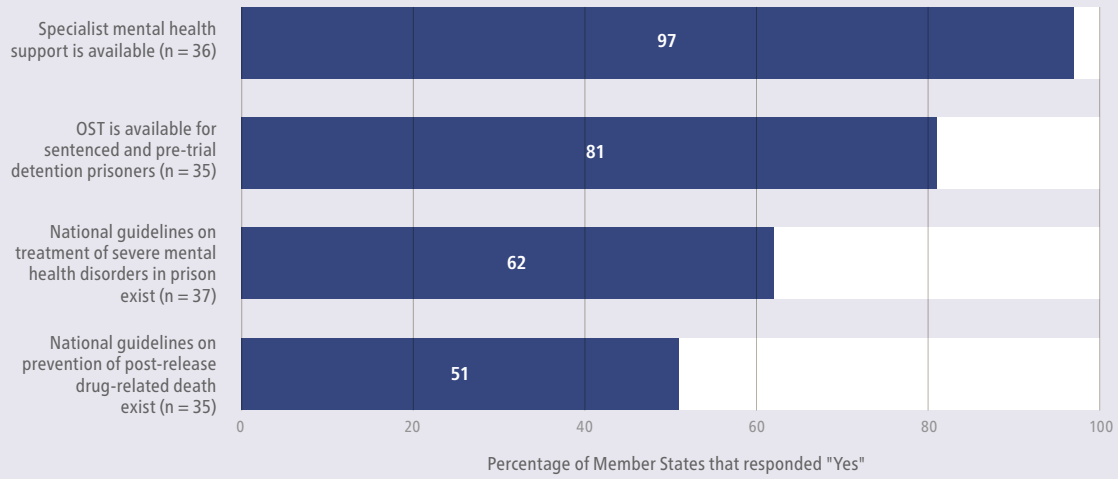
**Recommendation 17.** Member States should ensure that the full vaccination course for hepatitis B is offered to all individuals entering prison not know to be immune to hepatitis B due to a full vaccination course or previous infection.

# 3.7 TREATMENT

## 3.7.1 TREATMENT, INTERVENTIONS AND GUIDELINES FOR NCDs

Of the 36 countries that provided data on treatment for mental health and substance use disorders, 97% reported that specialist mental health support is available, while 81% of 35 responding countries reported that OST is available for both sentenced and pre-trial individuals. Sixty-two per cent of the 37 countries that provided a response reported that national guidelines for the treatment of severe mental health disorders in prisons exist, and 51% of the 35 countries that reported on the existence of national guidelines for the prevention of post-release drug-related deaths reported that such guidance existed (Fig. 20).

**Fig. 20. Availability of treatment, interventions and guidelines for mental health disorders and substance use disorders**



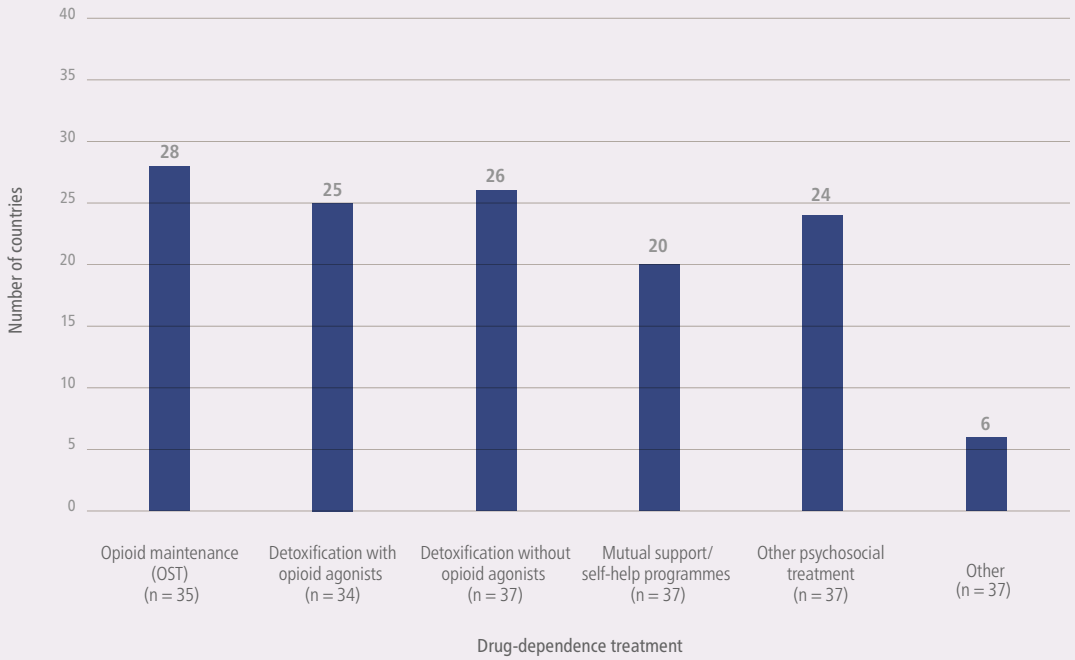

## 3.7.2 TREATMENT OF SUBSTANCE USE DISORDERS

Data about available treatment for substance use disorders in prisons are presented in Fig. 21. Examples of other treatments for drug dependence reported by six countries included music therapy programmes (n = 1), rehabilitation programmes (n = 1) and eye movement desensitization and reprocessing in some prisons (n = 1).

Thirty-two (89%) of the 36 countries provided data on OST, 89% of which indicated that it is available in prison. Among these countries, 81% reported that substitution treatment is available for people who either are sentenced or in pre-trial detention, while 19% reported that it is only available for people who are sentenced.

Among the 35 countries with national data and which provided a valid response, 51% reported the existence of national guidelines for the prevention of drug-related death after release.

**Fig. 21. Available treatments for substance use disorder**




## WHO guidance

OST and drug counselling are among recommended methods of substance use treatment *(15)*.

People who are incarcerated should not be released without adequate medication and appropriate arrangements for follow-up in the community *(15)*.

### 3.7.3 MENTAL HEALTH TREATMENT

Thirty-six countries reported on the accessibility of mental health support delivered by specialist health staff in prisons (including peer support workers, Samaritans, counselling support or psychological treatment), with 97% reporting that access to such mental health support was available in prisons.

Among the 37 countries providing a valid response, 62% reported that national guidelines for the treatment of severe mental health disorders in prison existed.

## WHO guidance

Mental health treatment for individuals with mental illness and mental health promotion for all people in prison are crucial parts of health care in prisons *(15)*.

### 3.7.4 DISCUSSION AND RECOMMENDATIONS

The majority of countries reported that access to mental health support delivered by specialist health staff in prisons (including peer support workers, Samaritans, counselling support or psychological treatment) existed in prison health systems, but a number reported that this was not implemented universally, despite WHO recommendations. Twenty-three countries reported the existence of national guidelines for the treatment of severe mental health disorders in prison and just 18 that national

guidelines for the prevention of drug-related death existed, which has important implications for how mental health and substance use treatment is operationalized in prisons.

All countries that provided data on the available treatments for drug dependence indicated that some sort of treatment was available. WHO has stated that drug-free units, OST and drug counselling are among the recommended methods of substance use treatment *(15).* The results of this survey indicate that OST is available in most countries (n = 32), but it was reported as unavailable in four. Given the importance of OST in reducing morbidity and mortality in this population, its lack in these prison administrations is a cause for concern. Previous findings indicate that access to, and coverage of, OST in prisons is higher in countries with a long history of such provision *(32)*, but few conclusions can be drawn using the results of the HIPED survey.

**Report recommendations – treatment for mental health and substance use disorders**

**Recommendation 18.** Member States that currently do not offer OST for both sentenced and pre-trial individuals should implement programmes in line with WHO guidance.

**Recommendation 19.** National guidelines for the treatment of severe mental health disorders in prisons should be developed, implemented and monitored by all Member States to ensure equivalence of care for those with mental health disorders in prison. This should include access to specialized mental health treatment for people with a mental health disorder and mental health promotion for all within prison.

**Recommendation 20.** All Member States should develop and implement national guidelines for the prevention of post-release drug-related deaths, including the provision of appropriate medication on release from prison and arrangements for continuity of care with community health services.

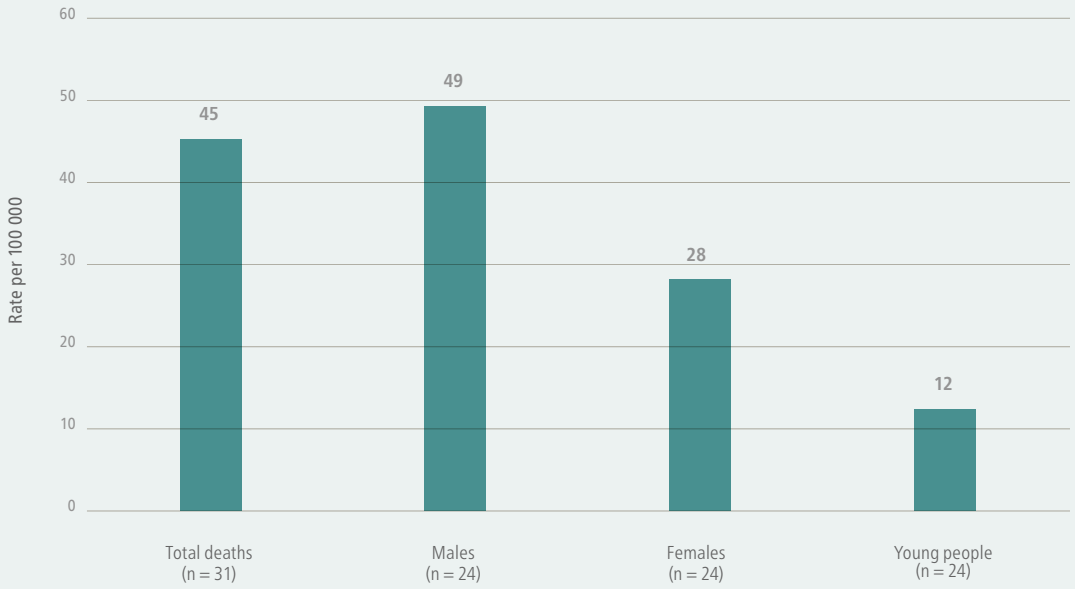
## 3.8 MORTALITY

The overall mortality rate in custody and the mortality rates for each subgroup per 10 000 person years in custody are presented in Fig. 22.

In total, 14% of deaths were from suicide (n = 13), and the suicide rate was 6.5 per 10 000 incarcerated people (n = 14).

The overall mortality rate calculated for all participating countries was substantially higher (45 per 10 000 individuals) than the median mortality rate reported in a Council of Europe survey (27 per 10 000 individuals) *(4).* The proportion of deaths by suicide reported by responding countries, however, was 10% lower than that reported for European prisons in 2014 *(4).* Consistent with what is known from the literature *(12)*, the mortality rate for men was higher than that for women. Conclusions about other causes of death, which has important implications for prevention and health-service planning to reduce the elevated risk of mortality following release, cannot be drawn from this survey.

**Fig. 22. Mortality rates per 10 000 incarcerated person years (2014–2016)**




## WHO guidance

All staff working in prisons should have a basic level of knowledge and understanding of health issues, including the management of suicide and self-harm risks *(15)*.

# 4. LIMITATIONS

Most countries indicated that there were no national data available for many indicators or did not provide a valid response (data were missing). Only one country was able to provide a valid response for one particular indicator. The incompleteness of this dataset hinders the interpretation and generalizability of the data for the entire European Region. It should also be noted that responses are not necessarily indicative of practice in all instances, and that the survey did not collect data on the extent of coverage of prison health services within a country; responses therefore may not reflect the entire spectrum of practice within a country's prison health system.

A number of countries found that some HIPED indicators and question formats were inconsistent with their data-collection processes and systems. In addition, some countries faced challenges with subnational governance arrangements, which is a consideration for future iterations of this survey.

Little is known about the data-collection practices of countries in the European Region, including variations in data collection and barriers to collecting data. This information is important to inform future data-collection efforts of this kind.

While the survey provided a broad summary of health systems and services, there were some limitations. More detailed and nuanced data about governance, prevention of illness, harm reduction, prevalence of other conditions overrepresented in this population, screening practices and pathways into treatment for communicable and noncommunicable disease are necessary to draw more concrete conclusions from the data and facilitate more meaningful comparisons between countries.

More information about continuity of care practices and policies, including post-release transitional support planning for health, is of great importance for comparing prison health systems across the European Region. Such data would assist in addressing key issues associated with the dovetailing of prison health systems and national health systems, ensuring adequate access to quality health care for people who experience incarceration, and promoting continuity and quality of care.

Another key limitation is the lack of data collected about young people in the criminal justice system, beyond the population extent and number of deaths. Given that data available about the number of young people in detention, let alone the health services that exist in detention, are limited, the survey findings make an important contribution. More information about the health status of young people in detention and the health systems and services that exist to serve them nevertheless is essential. Similarly, no data were collected about specific programmes and services for women and older people, who have unique health needs both in prison and after release. Collecting this information is essential to ensuring that the unique health needs of specific populations are met in prison.

# 5. CONCLUSIONS

HIPED is one of the first regional data-collection efforts that aims to amass comprehensive, comparable data on prison health systems in the European Region across eight key domains of prison health-care governance, systems and health-care services.

In summary, the findings suggest that some WHO recommendations are being met by a considerable number of countries across the Region. Most of the responding countries reported implementing WHO guidelines on mental health screening, substance use treatment and non-mandatory screening for BBVs and STIs.

For a number of indicators, however, countries reported practices that were not in line with WHO recommendations. For example, a number reported that key screening processes or treatments were unavailable, or that mandatory screening practices were in place for BBVs and STIs, which raises ethical questions and concerns about health equity in European prison health-care systems. Additionally, few countries reported the availability of important harm-reduction strategies, such as needle and syringe exchange programmes and the provision of disinfectants.

Incomplete responses to some indicators suggests that important and essential data on the health status of people in prison are not be being collected by some countries. The WHO Lisbon conclusions state that health services must be evidence-based and should consider the transition of individuals from custody to community, requiring cross-sectoral collaboration and a systems leadership approach to health. Good-quality data on the health of prison populations are essential, as they provide an evidence base for developing and implementing effective policies. The availability of data on people in prison and prison health-care systems allows countries to assess their progress on achieving universal health care, address entrenched health inequities and "leave no one behind" in pursuit of the SDGs.

A further limitation of the HIPED data is that currently they are not harmonized with other information sources across European and international organizations. Future iterations of the HIPED could address this by harmonizing indicators through working with other data-collecting agencies.

Despite the limitations of the HIPED data, this database sheds light on what is known and unknown about the health status of people in European prisons and the health services that exist to meet their health needs. The findings of HIPED confirm the complexity of health problems experienced by people in prison and reaffirm the need for Member States to invest in quality health care for people experiencing incarceration. In addition, the collection of these data is an important prerequisite for developing evidence-based policy around prison health systems and services in the European Region. Improving prison health services depends on effective collection and use of information to inform policy and investment, and to enable evaluation of services and interventions. The data collated by the HIPED represent a promising step for developing future work to collect data on prison health systems and services both in the European Region and internationally.

# 6. KEY MESSAGES AND RECOMMENDATIONS

This first iteration of the HIPED is a major step toward understanding the health needs of those in prison and the structure of health-care systems in prisons across Europe. There is a real need, however, for improved data-collection systems in Member States to ensure that the whole picture of health in prisons is captured.

Many HIPED indicators lack responses from most Member States (for example, obesity prevalence was reported by only one country), so it is impossible to know the prevalence within the prison population, let alone compare prevalence to that in the community. WHO is committed to "leaving no one behind" in the pursuit of the SDGs and universal health coverage, but the incomplete responses for many HIPED indicators across Member States indicates that people in prison are still being left behind.

Until the health status of people in prison is completely understood, it will be challenging to show how health-care services in prisons are contributing to improved health and well-being for this vulnerable population. Member States need good-quality data to inform the development and implementation of evidence-based public health policies for prison health systems.

## 6.1 REPORT KEY MESSAGES

This report highlights a number of areas in which Member States, on the whole, are not complying with WHO guidance on health in prisons. Recommendations to remedy the situation are listed at the end of each section and are collated below in section 6.2.

The report also yields some key messages about the state of prison health in Europe and provides general recommendations that will help to ensure Member States can continue to monitor and improve prison health systems.

The first key message is that collection of national health data on individuals and prison populations is lacking. This is evident in the incomplete data for many of the HIPED indicators and represents a failure to understand the basic health needs of the prison population. Without these data, it is impossible to know whether health services in prisons are having a positive effect on the health of people in prison and addressing the significant health inequalities this vulnerable population faces. To achieve universal health care as part of the SDGs, the prison population must not be forgotten or left behind, and prison health must be seen as part of broader public health policies. It therefore is vital that Member States are able to monitor the health status of those in prison through comprehensive data-collection systems. Only then will the WHO HIPED be able effectively to compare health in prisons across Europe and contribute to policy decisions for prison health in the Region.

WHO recommends that Member States:

- develop surveillance and reporting systems for the health of people in prison, supported by WHO and other relevant stakeholders;
- ensure the availability of screening, treatment and mechanisms for the prevention of illness in all prison and youth detention settings across their administrations, respecting the rights and autonomy of people who are incarcerated, as articulated by WHO guidelines *(15,44)*;
- use valid approaches to screening and assessment, and evidence-based approaches to treatment and implementation of harm-reduction programmes; and

- support high-quality, independent research on the health of people who are incarcerated and on the impact of incarceration on health, including:
  - prospective studies to examine health outcomes after release from prison and youth detention (including the use of linked administrative data where feasible);
  - rigorous evaluation of health-focused interventions;
  - evaluation of diversion and alternatives to incarceration; and
  - economic evaluation of outcomes from a whole-of-government perspective.

The second key message is to emphasize the importance of creating a health-promoting environment in prisons in which individuals receive high-quality health care that is of an equivalent standard to that in the community, regardless of which ministry has the authority for health care in prisons. Prison is a setting in which health promotion can take place, so prisons need to be health-enabling environments that can contribute to an improvement in health and well-being. Prisons provide an opportunity to change lifestyles, and time spent in custody can be used to improve existing health conditions through appropriate treatments and modify health-risk behaviour for NCDs through, for example, cessation of tobacco-smoking and improved nutrition and physical activity.

There are many different models of prison health-system governance in the European Region, and most survey respondents reported that the responsibility for prison health services lies with the Ministry of Justice, rather than the Ministry of Health. It is essential that prison health is viewed as part of the broader public health agenda and that prison health policy is recognized and incorporated into general public health policy. Intersectoral working is essential to ensure close collaboration among ministries to promote improvements in prison health systems. By ensuring that the human rights of people in prisons are upheld, that health-care services are provided by clinically independent practitioners, and that individuals receive continuity of care on release from prison, Member States can contribute to "leaving no one behind" as part of the SDGs.

WHO recommends that Member States:

- recognize prisons and youth detention centres as health-care delivery sites of critical importance for identifying health needs at individual level and addressing health inequalities at population level;
- ensure that prisons and youth detention settings are included in all public health strategies, policies and planning by adopting the approach of prison health in all policies;
- implement an evidence-informed approach to decision-making about health systems and services in prison and youth detention settings, including with respect to coordination and continuity of care between prison/detention and community;
- recognize that effective, sustainable responses to the health needs of people who experience incarceration are contingent on continuity of care, which in turn requires close coordination of prison and community health services;
- prioritize continuity of care and effective flow of health information between prison/detention and community health services; and
- ensure that prisons, pre-trial detention centres and youth detention centres are included in national data collections and other routine monitoring regarding population health, health systems and services.

## 6.2 REPORT RECOMMENDATIONS

### Report recommendations

**Recommendation 1.** Member States should ensure that data are collected on the number of people entering and leaving prison, and demographics of people in prison. Health services in prisons must reflect the specific health needs of the population, based on formal health needs assessments.

**Recommendation 2.** Regardless of which ministry has the authority for prison health care, the responsibility for quality assessment of hygiene, health care and organization of health services in custody should sit with the ministry responsible for health. Health services must adhere to international human right laws, ensure the clinical independence of health-care staff and provide services that are of an equivalent standard to those in the community.

**Recommendation 3.** Member States that do not completely cover all necessary health-care-related expenses in prison should extend health-care coverage to all people for all necessary health services to ensure that universal health coverage includes people in prison.

**Recommendation 4.** All Member States should ensure that formal arrangements are in place to enable integration of prison health services with the wider public health system to achieve continuity of care for individuals released from custody and continuity of universal health coverage for this key population.

**Recommendation 5.** Member States should follow the WHO Framework Convention on Tobacco Control by giving consideration to the establishment of a smoke-free prison estate and ensure that appropriate support is provided to individuals to quit tobacco-smoking, including nicotine replacement therapy and counselling.

**Recommendation 6.** Fresh and nutritious food options should be provided in place of nutrient-poor meals in prisons to prevent NCDs and contribute to promoting healthy lifestyles and establishing a health-promoting environment.

**Recommendation 7.** The implementation or expansion of drug-free units in prisons is one mechanism by which prisons can become health-promoting environments.

**Recommendation 8.** On arrival at prison, all individuals should be screened as soon as practicable (using validated screening tools and protocols) for immediate risks, including signs of poor mental health, self-harm and suicide, substance use disorders and medicines reconciliation.

**Recommendation 9.** Within the first week of custody, all individuals should undergo a thorough health assessment to screen for all physical and mental health needs. Individuals requiring treatment should be referred to appropriate health-care services.

**Recommendation 10.** Member States should implement validated screening tools that capture information on NCDs, including cardiovascular disease, respiratory disease, diabetes and cancer, and their associated risk factors – tobacco-smoking, harmful alcohol use, nutrition and physical activity.

**Recommendation 11.** Data from health screening in prison should be captured and reported at national level to monitor: prevalence rates of diseases and risk factors; changes in health status; improvements in health outcomes in the prison population; and prison health systems' progress in addressing the health needs of the population.

**Recommendation 12.** Member States that currently do not screen for oral health issues on reception to prison should ensure that dental health-care services are available for assessment and treatment of oral health issues both on entry to prison and throughout imprisonment.

## Report recommendations contd

**Recommendation 13.** Member States should ensure that: testing is available, but not mandatory, for HIV, hepatitis B, hepatitis C and STIs on entry to prison; pre- and post-test counselling is available; and appropriate treatment or vaccination is available in prison.

**Recommendation 14.** Testing for TB on reception to prison should be implemented in all Member States and treatment commenced for individuals testing positive to minimize the risk of transmission of TB within prisons.

**Recommendation 15.** All countries should ensure that evidence-based infection control measures, such as condoms, lubricants and disinfectants, are easily and discreetly available in prisons to help prevent the transmission of infections.

**Recommendation 16.** The implementation of needle and syringe exchange programmes in prisons should be considered by all Member States as an example of a harm-reduction intervention to minimize the risk of transmission of infections, in line with community practice to ensure equivalence of care.

**Recommendation 17.** Member States should ensure that the full vaccination course for hepatitis B is offered to all individuals entering prison not know to be immune to hepatitis B due to a full vaccination course or previous infection.

**Recommendation 18.** Member States that currently do not offer OST and counselling for both sentenced and pre-trial individuals should implement programmes in line with WHO guidance.

**Recommendation 19.** National guidelines for the treatment of severe mental health disorders in prisons should be developed, implemented and monitored by all Member States to ensure equivalence of care for those with mental health disorders in prison. This should include access to specialized mental health treatment for people with a mental health disorder and mental health promotion for all within prison.

**Recommendation 20.** All Member States should develop and implement national guidelines for the prevention of post-release drug-related deaths, including the provision of appropriate medication on release from prison and arrangements for continuity of care with community health services.

# REFERENCES

1. Walmsley R. World prison population list, 12th edition. London: Institute for Crime & Justice Policy Research; 2018.
2. Walmsley R. World prison population list, 11th edition. London: Institute for Crime & Justice Policy Research; 2016.
3. Prevention of spread of HIV amongst vulnerable groups in South Asia. New Delhi: United Nations Office on Drugs and Crime, Regional Office for South Asia; 2008 (http://un.info.np/Net/NeoDocs/View/5538).[1]
4. Aebi M, Tiago M, Burkhardt C. SPACE I – Council of Europe annual penal statistics: prison populations. Strasbourg: Council of Europe; 2016 (https://wp.unil.ch/space/space-i/).
5. Fazel S, Danesh J. Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. Lancet 2002;359(9306):545–50. doi:10.1016/S0140-6736(02)07740-1.
6. Fazel S, Bains P, Doll H. Substance abuse and dependence in prisoners: a systematic review. Addiction 2006;101(2):181–91. doi:10.1111/j.1360-0443.2006.01316.x.
7. European Monitoring Centre for Drugs and Drug Addiction. Prisons and drugs in Europe: the problem and responses. Luxembourg: Publications Office of the European Union; 2012 (http://www.emcdda.europa.eu/publications/selected-issues/prison_en).
8. Fazel S, Xenitidis K, Powell J. The prevalence of intellectual disabilities among 12 000 prisoners — a systematic review. Int J Law Psychiat. 2008;31(4):369–73. doi:10.1016/j.ijlp.2008.06.001.
9. Dolan K, Wirtz A, Moazen B, Ndeffo-mbah M, Galvani A, Kinner S et al. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. Lancet 2016;388(10049):1089–102. doi:10.1016/S0140-6736(16)30466-4.
10. Herbert K, Plugge E, Foster C, Doll H. Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review. Lancet 2012;379(9830):1975–82. doi:10.1016/S0140-6736(12)60319-5.
11. Pratt D, Piper M, Appleby L, Webb R, Shaw J. Suicide in recently released prisoners: a population-based cohort study. Lancet 2006;368 (9530):119–23.
12. Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG et al. Release from prison – a high risk of death for former inmates. New Eng J Med. 2007;356(2):157–65. doi:10.1056/NEJMsa064115.
13. Fazel S, Hayes AJ, Bartellas K, Clerici M, Trestman R et al. Mental health of prisoners: prevalence, adverse outcomes, and interventions. Lancet Psychiatry 2016;3(9):871–81. doi:10.1016/S2215-0366(16)30142-0.
14. Moazen B, Moghaddam SS, Silbernagl MA, Lotfizadeh M, Bosworth RJ, Alammehrjerdi Z et al. Prevalence of drug injection, sexual activity, tattooing, and piercing among prison inmates. Epidemiol Rev. 2018;40(1):58–69. doi:10.1093/epirev/mxy002.
15. Enggist S, Møller L, Galea G, Udesen C, editors. Prisons and health. Copenhagen: WHO Regional Office for Europe; 2014 (https://apps.who.int/iris/handle/10665/128603).
16. Marmot M. Inclusion health: addressing the causes of the causes. Lancet 2018;391(10117):186–88. doi:10.1016/S0140-6736(17):32848-9.


[1] All weblinks accessed 12 October 2019.

17. Tripodi SJ, Pettus-Davis C. Histories of childhood victimization and subsequent mental health problems, substance use, and sexual victimization for a sample of incarcerated women in the US. Int J Law Psychiat. 2013;36(1):30–40. doi:10.1016/j.ijlp.2012.11.005.
18. Spjeldnes S, Jung H, Yamatani H. Gender differences in jail populations: factors to consider in reentry strategies. J Offender Rehabil. 2014;53(2):75–94. doi:10.1080/10509674.2013.868387.
19. Lazarus JV, Sperle I, Spina A, Rockstroh JK. Are the testing needs of key European populations affected by hepatitis B and hepatitis C being addressed? A scoping review of testing studies in Europe. Croat Med J. 2016;57(5):442–56. doi:10.3325/cmj.2016.57.442.
20. Williams BA, Stern MF, Mellow J, Safer M, Greifinger RB. Aging in correctional custody: setting a policy agenda for older prisoner health care. Am J Public Health 2012;102(8):1475–81. doi:10.2105/AJPH.2012.300704.
21. Kinner SA, Young JT. Understanding and improving the health of people who experience incarceration: an overview and synthesis. Epidemiol Rev. 2018;40(1):4–11. doi:10.1093/epirev/mxx018.
22. Travis J, McBride EC, Solomon AL. Families left behind: the hidden costs of incarceration and reentry. Washington (DC): Urban Institute Justice Policy Centre; 2003, revised 2005 (http://webarchive.urban.org/publications/310882.html).
23. Trenčin Statement on Prisons and Mental Health. Copenhagen: WHO Regional Office for Europe; 2008 (https://apps.who.int/iris/handle/10665/108575?search-result=true&query=5.%09Trencin+statement+on+prisons+and+mental+health&scope=&rpp=10&sort_by=score&order=desc).
24. Moscow Declaration on Prison Health as Part of Public Health. Copenhagen: WHO Regional Office for Europe; 2003 (http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health).
25. World Health Organization, United Nations Office on Drugs and Crime. Good governance for prison health in the 21st century. A policy brief on the organization of prison health. Geneva: World Health Organization; 2013 (https://www.who.int/hiv/pub/prisons/prison_health/en/).
26. Conclusions of the WHO international meeting on prisons and health Lisbon 2017. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2018/conclusions-of-the-who-international-meeting-on-prisons-and-health-2018).
27. Thirteenth general programme of work 2019–2023. Geneva: World Health Organization; 2019 (https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019-2023).
28. Everybody's business – strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007 (https://apps.who.int/iris/handle/10665/43918).
29. Dressing H, Salize H-J. Pathways to psychiatric care in European prison systems. Behav Sci Law 2009;27(5):801–10. doi:10.1002/bsl.893.
30. Blaauw E, Roesch R, Kerkhof A. Mental disorders in European prison systems: arrangements for mentally disordered prisoners in the prison systems of 13 European countries. Int J Law Psychiat. 2000;23(5–6):649–63 (https://www.researchgate.net/publication/12185224_Mental_disorders_in_European_prison_systems_Arrangements_for_mentally_disordered_prisoners_in_the_prison_systems_of_13_European_countries).

31. Aerts A, Hauer B, Wanlin M, Veen J. Tuberculosis and tuberculosis control in European prisons. Int J Tuberc Lung Dis. 2006;10(11):1215–23 (https://www.ingentaconnect.com/content/iuatld/ijtld/2006/00000010/00000011/art00006).
32. Zurhold H, Stöver H. Provision of harm reduction and drug treatment services in custodial settings – findings from the European ACCESS study. Drugs-Educ Prev Pol. 2016;23(2):127–34. doi:10.3109/09687637.2015.1112363.
33. Public health guidance on prevention and control of blood-borne viruses in prison settings. Stockholm: European Centre for Disease Prevention and Control, European Monitoring Centre for Drugs and Drug Addiction; 2018 (https://www.ecdc.europa.eu/en/publications-data/public-health-guidance-prevention-control-bloodborne-viruses-prison-settings).
34. Pont J, Stöver H, Wolff H. Dual loyalty in prison health care. Am J Public Health 2012;102(3):475–80. doi:10.2105/AJPH.2011.300374.
35. Pont J, Enggist S, Stöver H, Williams B, Greifinger R, Wolff H. Prison health care governance: guaranteeing clinical independence. Am J Public Health 2018;108(4):472–76.
36. Health in Prisons European Database (HIPED). In: World Health Organization [website]. Geneva: World Health Organization; 2016 (http://apps.who.int/gho/data/node.prisons).
37. Health in prisons: fact sheets for 38 European countries. Copenhagen: WHO Regional Office for Europe; 2019 (http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2019/health-in-prisons-fact-sheets-for-38-european-countries-2019).
38. Population estimates and projections. Washington (DC): World Bank; 2018 (https://datacatalog.worldbank.org/dataset/population-estimates-and-projections).
39. Walmsley R. World female imprisonment list, 4th edition. Women and girls in penal institutions, including pre-trial detainees/remand prisoners. London: Institute for Crime & Justice Policy Research; 2017.
40. WHO Framework Convention on Tobacco Control [website]. Geneva: World Health Organization; 2019 (https://www.who.int/fctc/en/).
41. Smoyer A, Minke LK. Food systems in correctional settings: a literature review and case study. Copenhagen: WHO Regional Office for Europe; 2015 (https://apps.who.int/iris/handle/10665/326323).
42. Hartwig C, Stöver H, Weilandt C. Final report Work Package 7. Report on tobacco smoking in prison. Brussels: European Commission Directorate-General for Health and Consumers. 2008 (SANCO/2006/C4/02; http://www.ohrn.nhs.uk/resource/policy/TobaccoSmoking.pdf).
43. Gray R, Gregory S. Dental health in prisons. In: Enggist S, Møller L, Galea G, Udesen C, editors. Prisons and health. Copenhagen: WHO Regional Office for Europe; 2014:99–103 (http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health).
44. Health in prisons: a WHO guide to the essentials in prison health. Copenhagen: WHO Regional Office for Europe: 2007 (https://apps.who.int/iris/handle/10665/107829).

# ANNEXES

# ANNEX 1. HEALTH IN PRISONS EUROPEAN DATABASE (HIPED) INDICATORS

| SECTION 1 – PRISON POPULATION STATISTICS | |
|---|---|
| **Indicator name in database** | **Specification for metadata** |
| Capacity | Total capacity of prisoners. Data as of 1 January (unless otherwise specified) |
| Total number of prisoners | Total number of prisoners. Data as of 1 January (unless otherwise specified) |
| Number of unsentenced/remand prisoners | Number of unsentenced/remand prisoners, excluding those in police custody. Data as of 1 January (unless otherwise specified) |
| Number of female prisoners | Number of female prisoners. Data as of 1 January (unless otherwise specified) |
| Number of underage prisoners | Number of prisoners under 18 years of age. Data as of 1 January (unless otherwise specified) |
| Number of prisoners over 55 years | Number of prisoners over 55 years of age. Data as of 1 January (unless otherwise specified) |
| Number of ethnic/racial minority prisoners | Number of prisoners from ethnic/racial minority groups. Data as of 1 January (unless otherwise specified) |

| SECTION 2 – PRISON HEALTH-CARE SYSTEM | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Prison health-care oversight** | Prison health-care authority | Agency/agencies with authority of prison health-care services |
| | Prison health-care budget administration | Agency/agencies administrating the prison health-care budget |
| | Prison health-care funding source | Funding source of health services utilized by prisoners |
| **Obligation for prisoner coverage of expenses** | General health services | Prisoners in the country are obliged to cover costs for general health services |
| | Prescription medication | Prisoners in the country are obliged to cover costs for prescription medication |
| | Other expenses | Funding source of health services utilized by prisoners |
| **Responsibilities of Ministry of Health or other public health authority** | Authorization of prison health services | Ministry of Health or other public health authority responsible for direct or indirect authorization of prison health services |
| | Assessment of prison health services | Ministry of Health or other public health authority responsible for assessment of prison health services |
| | Inspection of prison hygiene, nutrition and living conditions | Ministry of Health or other public health authority responsible for inspection of prison hygiene, nutrition and living conditions |
| | Medical document inspections | Ministry of Health or other public health authority responsible for inspection of medical documentation in prisons |
| | Prevention of infectious diseases | Ministry of Health or a public health authority responsible for prevention of infectious diseases in prisons |
| **National health-care complaint system** | National health-care complaint system | Existence of national health-care complaint system available to prisoners |
| **Number of complaints** | Number of complaints | Number of health-care complaints received from prisoners |

| SECTION 2 – PRISON HEALTH-CARE SYSTEM contd | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Number of staff** | Number of prison staff | Total number of prison staff working in prisons on the basis of full-time equivalents (including external service providers) |
| | Number of health-care staff | Total number of health-care staff (physicians, nurses, nursing assistants, etc., including external service providers) working in prisons on the basis of full-time equivalents |
| | Number of physicians | Total number of physicians (MDs, including external service providers) on the basis of full-time equivalents |
| | Number of psychiatrists | Total number of psychiatrists on the basis of full-time equivalents (including external service providers) |
| | Number of psychologists | Total number of psychologists on the basis of full-time equivalents (including external service providers) |
| | Number of dentists | Total number of dentists on the basis of full-time equivalents (including external service providers) |
| **Pharmacists and oral health-care workers** | Pharmacists | Pharmacists working in prisons (including external service providers) |
| | Dental hygienists/oral health promoters | Dental hygienists and/or oral health promoters working in prisons (including external service providers) |

| SECTION 3 – PRISON ENVIRONMENT | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Smoke-free cells** | Smoke-free cells | Availability of smoke-free cells |
| **Meal preparation** | Meal preparation | Meals produced in a centralized kitchen (institutional kitchen where meals are prepared for prisoners in one or more prison facilities) |
| **Alternative food systems** | Availability of alternative food systems | i) Self-cook kitchen areas (at least half of inmates can cook for themselves); ii) refrigerators in at least half of cells or housing units where prisoners can store personal food items; iii) prison store/commissary/vending machines with fresh food (e.g. fruit); iv) prison store/commissary/vending machines with packaged snacks; and v) other food options |

| SECTION 4 – RISK FACTORS FOR ILL HEALTH | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Prevalence of selected risk factors** | Tobacco use | Number and percentage of tobacco smokers identified on or close to reception among persons admitted to prisons |
| | Overweight | Number of cases and prevalence of overweight (body mass index (BMI) > 25) identified on or close to reception among persons admitted to prison |
| | Obesity | Number of cases and prevalence of obesity BMI > 30 identified on or close to reception among persons admitted to prison |
| | Raised blood pressure | Number of cases and prevalence of raised blood pressure (individuals above 18 years of age with a systolic blood pressure of > 140 mmHg and/or a diastolic blood pressure of > 90 mmHg on or close to reception among persons admitted to prison |
| | Current injecting drug use | Number of cases and prevalence of current injecting drug use (in the past 30 days) identified on or close to reception among persons admitted to prison |
| | Ever injecting drug use | Number of cases and prevalence of ever injecting drug use identified on or close to reception among persons admitted to prison |

| SECTION 4 – RISK FACTORS FOR ILL HEALTH contd | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Substance use screening** | Urine/sputum screening for illicit drug use screening | Urine/sputum screening for illicit drug use on or close to reception to prison |
| | Availability of screening for illicit drug use | Availability of non-mandatory urine/sputum screening on or close to reception |
| | Screening for harmful use of alcohol | Screening for harmful alcohol use on or close to reception |
| | Use of alcohol screening tool | Use of recognized screening tool for harmful alcohol use |
| **Biomedical testing for drug use** | Number of prisoners screened for drug use | Number of prisoners biomedically tested for drug use on or close to reception (if screening for illicit drug use is available) |
| | Percentage of prisoners screened for drug use | Percentage of prisoners biomedically tested for drug use on or close to reception (if screening for illicit drug use is available) |

| SECTION 5 – DISEASE SCREENING | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Mental health screening** | Mental health screening | Screening for severe mental health disorders by a trained mental health professional on or close to reception |
| | Diversion to mental health treatment | Diversion to a mental health treatment institution as a result of screening on or close to reception |
| **Oral health screening** | Screening for oral health problems | Screening for oral health problems by a dental health professional on or close to reception |
| **Communicable diseases screening** | Sexually transmitted infection (STIs) screening | Screening for STIs on or close to reception |
| | Availability of HIV testing | Availability of non-mandatory HIV testing |
| | Hepatitis B testing | Hepatitis B testing on or close to reception |
| | Availability of hepatitis B testing | Availability of non-mandatory hepatitis B testing on or close to reception |
| | Hepatitis C testing | Hepatitis C testing on or close to reception |
| | Availability of hepatitis C testing | Availability of non-mandatory hepatitis C testing on or close to reception |
| | HIV testing | HIV testing on or close to reception |
| **HIV testing coverage** | Number of prisoners tested for HIV | Number of prisoners tested for HIV on or close to reception |
| | Percentage of prisoners tested for HIV | Percentage of prisoners tested for HIV on or close to reception |
| **Prevalence of syphilis** | Number of syphilis cases among male prisoners | Number of cases of syphilis among males admitted to prison on or close to reception |
| | Percentage of syphilis cases among male prisoners | Percentage of cases of syphilis among males admitted to prison on or close to reception |
| | Number of syphilis cases among female prisoners | Number of cases of syphilis among females admitted to prison on or close to reception |
| | Percentage of syphilis cases among female prisoners | Percentage of cases of syphilis among females admitted to prison on or close to reception |
| **Prevalence of chlamydia** | Number of chlamydia cases among male prisoners | Number of cases of chlamydia among males admitted to prison on or close to reception |
| | Percentage of chlamydia cases among male prisoners | Percentage of cases of chlamydia among males admitted to prison on or close to reception |
| | Number of chlamydia cases among female prisoners | Number of cases of chlamydia among females admitted to prison on or close to reception |
| | Percentage of chlamydia cases among female prisoners | Percentage of cases of chlamydia among females admitted to prison on or close to reception |

| SECTION 5 – DISEASE SCREENING contd | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Prevalence of HIV** | Number of positive HIV tests among males | Number of HIV positive tests among males admitted to prison on or close to reception |
| | Prevalence of positive HIV tests among males | Prevalence of HIV positive tests among males admitted to prison on or close to reception |
| | Number of positive HIV tests among females | Number of HIV positive tests among females admitted to prison on or close to reception |
| | Prevalence of positive HIV tests among females | Prevalence of HIV positive tests among females admitted to prison on or close to reception |
| | Number of HIV tests in tuberculosis (TB) cases | Number of all TB cases with pulmonary localization tested for HIV |
| | Prevalence of HIV tests in TB cases | Prevalence of all TB cases with pulmonary localization tested for HIV |
| | Number of TB cases positive for HIV | Number of all TB cases with pulmonary localization positive for HIV |
| | Percentage of TB cases positive for HIV | Prevalence of all TB cases with pulmonary localization positive for HIV |
| **Prevalence of hepatitis B** | Percentage of prisoners tested for anti-HBs | Percentage of prisoners tested for hepatitis B (anti-HBs – hepatitis B surface antibody test) on or close to reception |
| | Positive anti-HB tests | Positive hepatitis B tests (anti-HBs – hepatitis B surface antibody test) on or close to reception |
| | Percentage of prisoners tested for HBsAg | Percentage of prisoners tested for hepatitis B (HBsAg – hepatitis B surface antigen test) on or close to reception |
| | Positive HBsAg tests | Positive hepatitis B tests (HBsAg – hepatitis B surface antigen test) on or close to reception |
| **Prevalence of hepatitis C** | Percentage of prisoners tested for anti-HCVs | Percentage of prisoners tested for hepatitis C (anti-HCVs – hepatitis C surface antibody test) on or close to reception |
| | Positive anti-HCV tests | Positive hepatitis C tests (anti-HCVs – hepatitis C surface antibody test) on or close to reception |
| | Percentage of prisoners tested for HCV-PCR | Percentage of prisoners tested for hepatitis C (HCV-PCR – hepatitis C polymerase chain reaction test) on or close to reception |
| | Positive HCV-PCR tests | Positive hepatitis C tests (HCV-PCR – hepatitis C polymerase chain reaction test) on or close to reception |
| **Prevalence of TB** | Number of new/relapse TB testing | Number of prisoners tested for new/relapse TB with pulmonary localization |
| | Percentage of new/relapse TB testing | Percentage of prisoners tested for new/relapse TB with pulmonary localization |
| | Number of new/relapse TB cases detected | Number of new/relapse TB cases with pulmonary localization detected |
| | Percentage of new/relapse TB cases detected | Percentage of new/relapse TB cases with pulmonary localization detected |
| | Number of prisoners completing TB treatment | Number of prisoners completing a treatment programme for TB |
| | Number of MDR tests in new/relapse TB cases | Number of new/relapse TB cases with pulmonary localization tested for MDR (multidrug-resistance) |
| | Number of MDR cases in new/relapse TB cases | Number of cases of MDR (multidrug-resistance) detected among new/relapse TB cases with pulmonary localization |

| SECTION 6 – PREVENTION | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Drug-related problems** | Availability of needle/syringe programmes | Needle/syringe exchange programmes for people who inject drugs implemented in prisons |
| | Drug-free units | Drug-free units in prisons |
| | Responsibility for infectious diseases prevention | Ministry of Health or a public health authority responsible for prevention of infectious diseases in prisons |
| **Drug-free units** | Number of prisoners in drug-free units | Number of prisoners in drug-free units |
| **STIs and bloodborne viruses** | Availability of disinfectants | Disinfectants (tablet and/or liquid solution) that can be used for cleaning of syringes, razors, tattoo equipment etc. available in prisons |
| | Disinfectants free of charge | Disinfectants available free of charge |
| | Condoms available | Condoms available in prisons |
| | Condoms free of charge | Condoms available free of charge |
| | Lubricants available | Lubricants available in prisons |
| | Lubricants free of charge | Lubricants available free of charge |
| **Hepatitis B vaccination availability** | Hepatitis B vaccination availability | Availability of full vaccination course against hepatitis B in prisons |
| | Hepatitis B vaccination coverage | Hepatitis B vaccination available at reception to pre-trial detention |
| **Hepatitis B vaccination coverage** | Number of hepatitis B vaccinations | Number of prisoners fully vaccinated against hepatitis B |
| | Percentage of hepatitis B vaccinations | Percentage of prisoners fully vaccinated against hepatitis B |
| **Possibility for family/partner visits** | Possibility for family/partner visits | Non-supervised family/partner visits possible (including the possibility for sexual intercourse) |
| **Community health links** | Community health links | Links between the prison health system and the community health system for health treatments (concerning e.g. HIV or hepatitis treatment, treatment for drug dependence) of prisoners |

| SECTION 7 – TREATMENT | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Drug treatments and overdose prevention** | Available treatments for drug dependence | Availability of: i) maintenance treatment (e.g. long-term opioid agonist pharmacotherapy); ii) detoxification treatment (e.g. short-term opioid agonist pharmacotherapy); iii) detoxification without opioid agonists treatment (e.g. benzodiazepine pharmacotherapy); iv) mutual support/ self-help treatment (e.g. 12-step programme, Alcoholics Anonymous, Narcotics Anonymous); v) open-access treatment (e.g. computer-based interventions); vi) other psychosocial treatment (e.g. cognitive behavioural therapy); and vi) other treatment |
| | Drug-deaths prevention guidelines | National guidelines on prevention of post-release drug-related deaths (e.g. covering referral to community services, counselling on increased risk and prevention, naloxone therapy) |
| **Prisoners in substitution treatment** | Prisoners in substitution treatment | Number of prisoners in substitution treatment (treatment with opioid agonists, e.g. methadone or buprenorphine) for opioid addiction |
| **Substitution treatment eligibility** | Substitution treatment eligibility | Population eligible for substitution treatment |

| SECTION 7 – TREATMENT contd | | |
|---|---|---|
| **Grouping** | **Indicator name in database** | **Specification for metadata** |
| **Mental health** | Mental health treatment guidelines | National guidelines for the treatment of severe mental health disorders among prisoners |
| | Mental health support access | Access to mental health support for prisoners (e.g. a peer support worker, Samaritans, counselling or psychological treatments) delivered by specialized health staff |
| **HIV and hepatitis C** | HIV treatment | Number of prisoners in antiretroviral treatment for HIV, if available |
| | Hepatitis C treatment | Number of prisoners in antiviral treatment for hepatitis C, if available |

| SECTION 8 – MORTALITY | |
|---|---|
| **Indicator name in database** | **Specification for metadata** |
| Total number of deaths | Total number of deaths among all prisoners (regardless of the location (within or outside prison) at which death occurred) |
| Number of male deaths | Number of male deaths among all prisoners (regardless of the location (within or outside prison) at which death occurred) |
| Number of female deaths | Number of female deaths among all prisoners (regardless of the location (within or outside prison) at which death occurred) |
| Number of underage deaths | Number of deaths among prisoners below 18 years of age (regardless of the location (within or outside prison) at which death occurred) |
| Number of suicides | Number of deaths by suicide among all prisoners (regardless of the location (within or outside prison) at which death occurred) |

# ANNEX 2. PARTICIPATING MEMBER STATES

| Member State | ISO[a] code | Member State | ISO[a] code |
|---|---|---|---|
| Albania | ALB | Malta | MLT |
| Armenia | ARM | Monaco | MCO |
| Azerbaijan | AZE | Montenegro | MNE |
| Belgium | BEL | Netherlands | NLD |
| Bosnia and Herzegovina | BIH | Norway | NOR |
| Bulgaria | BGR | Poland | POL |
| Croatia | HRV | Portugal | PRT |
| Cyprus | CYP | Republic of Moldova | MDA |
| Czechia | CZE | Romania | ROU |
| Denmark | DNK | Russian Federation | RUS |
| Estonia | EST | Serbia | SRB |
| Finland | FIN | Slovakia | SVK |
| France | FRA | Slovenia | SVN |
| Georgia | GEO | Spain | ESP |
| Germany | DEU | Sweden | SWE |
| Iceland | ISL | Switzerland | CHE |
| Ireland | IRL | Tajikistan | TJK |
| Italy | ITA | United Kingdom of Great Britain and Northern Ireland | GBR |
| Latvia | LVA | Ukraine | UKR |
| Lithuania | LTU | | |

[a] ISO: International Organization for Standardization.

# ANNEX 3. SUMMARY OF DATA PROVIDED BY COUNTRIES IN THIS REPORT

| 1 | PRISON POPULATION STATISTICS | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Total capacity** | | | | | |
| 1.1 | 2016 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, RUS, SRB, SVK, SVN, SWE, UKR | 33 (85) | 5 (13) | 1 (3) | NA |
| | 2015 | ALB, BEL, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 32 (82) | 6 (15) | 1 (3) | NA |
| | 2014 | ALB, BEL, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 33 (85) | 6 (15) | NA | NA |
| | **Total daily number of people incarcerated** | | | | | |
| 1.2 | 2016 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, RUS, SRB, SVK, SVN, SWE, UKR | 32 (82) | 4 (10) | 3 (8) | NA |
| | 2015 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 33 (85) | 3 (8) | 3 (8) | NA |
| | 2014 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 34 (87) | 3 (8) | 2 (5) | NA |
| | **Total daily number of people remanded/unsentenced** | | | | | |
| 1.3 | 2016 | ALB, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, POL, PRT, RUS, SVK, SVN, SWE, UKR | 26 (67) | 9 (23) | 4 (10) | NA |
| | 2015 | ALB, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, POL, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 28 (72) | 8 (21) | 3 (8) | NA |
| | 2014 | ALB, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, POL, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 27 (69) | 8 (21) | 4 (10) | NA |

| 1 | PRISON POPULATION STATISTICS contd | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Total daily number of females incarcerated** | | | | | |
| 1.4 | 2016 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, NLD, POL, PRT, RUS, SRB, SVK, SVN, SWE, UKR | 30 (77) | 6 (15) | 3 (8) | NA |
| | 2015 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 31 (79) | 4 (10) | 4 (10) | NA |
| | 2014 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 31 (79) | 4 (10) | 4 (10) | NA |
| | **Total daily number of young people (under 18 years) incarcerated** | | | | | |
| 1.5 | 2016 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, NLD, PRT, RUS, SRB, SVK, SVN, SWE, UKR | 29 (74) | 7 (18) | 3 (8) | NA |
| | 2015 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, NLD, PRT, RUS, SRB, SVK, SVN, SWE, UKR | 28 (72) | 8 (21) | 3 (8) | NA |
| | 2014 | ALB, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, NLD, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 27 (69) | 8 (21) | 4 (10) | NA |
| | **Total daily number of seniors (over 55 years) incarcerated** | | | | | |
| 1.6 | 2016 | ALB, BEL, BGR, BIH, DNK, ESP, EST, FIN, GEO, IRL, ISL, ITA, PRT, RUS, SRB, SVN | 16 (41) | 18 (46) | 5 (13) | NA |
| | 2015 | ALB, BEL, BGR, BIH, DNK, ESP, EST, FIN, GEO, IRL, ISL, ITA, PRT, ROU, RUS, SRB, SVN | 17 (44) | 17 (44) | 5 (13) | NA |
| | 2014 | ALB, BEL, BGR, BIH, DNK, ESP, EST, FIN, GEO, IRL, ISL, ITA, PRT, ROU, RUS, SRB, SVN | 17 (44) | 17 (44) | 5 (13) | NA |
| | **Total daily number of people from ethnic/racial minorities incarcerated** | | | | | |
| 1.7 | 2016 | ALB, BEL, BGR, BIH, DNK, ESP, EST, FIN, GEO, IRL, ISL, ITA, PRT, RUS, SRB, SVN | 16 (41) | 18 (46) | 5 (13) | NA |
| | 2015 | ALB, BEL, BGR, BIH, DNK, ESP, EST, FIN, GEO, IRL, ISL, ITA, PRT, ROU, RUS, SRB, SVN | 17 (44) | 17 (44) | 5 (13) | NA |
| | 2014 | ALB, BEL, BGR, BIH, DNK, ESP, EST, FIN, GEO, IRL, ISL, ITA, PRT, ROU, RUS, SRB, SVN | 17 (44) | 17 (44) | 5 (13) | NA |

| 2 | PRISON HEALTH-CARE SYSTEMS | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Prison health-care governance** | | | | | |
| 2.1 | Prison health-care authority | All countries | 39 (100) | NA | NA | NA |
| 2.2 | Prison health-care budget administration | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 38 (97) | 1 (3) | NA | NA |
| 2.3 | Prison health-care funding source | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 1 (3) | 1 (3) | NA |
| | **Health-care costs paid by people who are incarcerated** | | | | | |
| 2.3.1 | General health services | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 1 (3) | 1 (3) | NA |
| | Prescription medication | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 38 (97) | 1 (3) | NA | NA |
| | Other expenses | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 36 (92) | 1 (3) | 2 (5) | NA |
| | **Responsibilities of Ministry of Health or other public health authorities** | | | | | |
| 2.4 | Assessment of prison health services | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 1 (3) | 1 (3) | NA |
| | Inspection of hygiene, nutrition and living conditions | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 1 (3) | 1 (3) | NA |
| 2.5 | Medical documentation inspection | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 38 (97) | 1 (3) | NA | NA |

| 2 | PRISON HEALTH-CARE SYSTEMS contd | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **National health-care complaints system** | | | | | |
| 2.6 | Existence of system and availability in prisons | ALB, AZE, BEL, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 36 (92) | 3 (8) | NA | NA |
| | **Number of staff in prison (full-time equivalents)** | | | | | |
| 2.7 | Prison staff | ALB, BEL, BGR, BIH, CHE, CZE, ESP, EST, FIN, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE | 27 (69) | 8 (21) | 4 (10) | NA |
| | Health-care staff | ALB, AZE, BEL, BGR, BIH, CHE, CZE, ESP, EST, FIN, FRA, GEO, HRV, IRL, ITA, LTU, LVA, MDA, MLT, MNE, NOR, POL, PRT, ROU, RUS, SRB, SVK, SWE, UKR | 29 (74) | 7 (18) | 3 (8) | NA |
| 2.8 | Physicians | ALB, AZE, BEL, BGR, BIH, CZE, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 31 (79) | 7 (18) | 1 (3) | NA |
| | Psychiatrists | ALB, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 32 (82) | 7 (18) | NA | NA |
| | Psychologists | ALB, BEL, BGR, BIH, CYP, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, POL, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 28 (72) | 11 (28) | NA | NA |
| | Dentists | ALB, AZE, BEL, BIH, CZE, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, LTU, LVA, MCO, MLT, MNE, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 26 (67) | 10 (26) | 3 (8) | NA |
| | **Existence of staff working in prison** | | | | | |
| 2.8.1 | Pharmacists | ALB, ARM, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, LTU, LVA, MCO, MDA, MLT, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 35 (90) | 4 (10) | NA | NA |
| 2.8.2 | Dental hygienists and/or oral health promoters | ALB, ARM, AZE, BEL, BGR, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, LTU, LVA, MCO, MDA, MLT, MNE, NLD, POL, PRT, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 33 (85) | 6 (15) | NA | NA |

## 3 PRISON ENVIRONMENT

| Question number in survey | Domain and indicator | Countries with available data | Data available (n (%)) | No national data (n (%)) | Missing (n (%)) | Not applicable (n (%)) |
|---|---|---|---|---|---|---|
| 3.1 | Smoke-free cells available | ALB, AZE, BEL, BGR, BIH, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 32 (82) | 7 (18) | NA | NA |
| 3.2 | Meals produced in centralized kitchens | ALB, ARM, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 2 (5) | NA | NA |
| 3.2.1 | Alternative food systems available | ALB, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SVN, SWE, TJK, UKR | 32 (82) | 6 (15) | 1 (3) | NA |

## 4 RISK FACTORS FOR ILL HEALTH

| Question number in survey | Domain and indicator | Countries with available data | Data available (n (%)) | No national data (n (%)) | Missing (n (%)) | Not applicable (n (%)) |
|---|---|---|---|---|---|---|
| | **Prevalence of risk factors on admission** | | | | | |
| 4.1 | Tobacco-smoking | ESP, EST, MCO, RUS, SVK | 5 (13) | 32 (82) | 2 (5) | NA |
| 4.2 | Overweight (body mass index (BMI) > 25) | DNK, MNE, RU | 3 (8) | 36 (92) | NA | NA |
| | Obesity (BMI > 30) | MNE | 1 (3) | 37 (95) | 1 (3) | NA |
| 4.3 | Raised blood pressure | AZE, BGR, BIH, DNK, FIN, MDA, MNE, RUS | 8 (21) | 29 (74) | 2 (5) | NA |
| | **Urine/sputum testing** | | | | | |
| 4.4 | Availability | ALB, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK | 33 (85) | 6 (15) | NA | NA |
| 4.4.1 | Testing if not mandatory | ALB, BEL, BGR, BIH, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, MCO, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN | 25 (64) | 1 (3) | 2 (5) | 11 (28) |
| | **Biomedical testing for substance use** | | | | | |
| 4.4.2 | Percentage tested | BIH, ESP, GEO, HRV, MCO, SVK | 6 (15) | 29 (74) | 4 (10) | NA |
| | **Prevalence of injecting drug use identified on admission** | | | | | |
| 4.4.3 | Current injecting drug use | ESP, GBR, ITA, MCO, SVK | 5 (13) | 32 (82) | 2 (5) | NA |
| 4.4.4 | Lifetime injecting drug use | AZE, ESP, GBR, HRV, ITA | 5 (13) | 28 (72) | 6 (15) | NA |
| | **Screening for harmful alcohol use on admission** | | | | | |
| 4.5 | Availability | ALB, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SVK, SVN, SWE, TJK, UKR | 34 (87) | 5 (13) | NA | NA |
| 4.5.1 | Use of a recognized screening tool | BGR, CYP, DNK, ESP, EST, FIN, FRA, GBR, HRV, IRL, ISL, ITA, LVA, NLD, POL, ROU, SVK, SVN, SWE | 19 (49) | 1 (3) | NA | 19 (49) |

| 5 | DISEASE SCREENING ON ADMISSION | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Severe mental health disorder screening on admission** | | | | | |
| 5.1 | Availability | ALB, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SWE, TJK, UKR | 35 (90) | 4 (10) | NA | NA |
| 5.1.1 | Availability of diversion to a mental health institution resulting from screening | ALB, AZE, BEL, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 29 (74) | NA | 1 (3) | 9 (23) |
| | **Screening for other communicable and noncommunicable diseases on admission** | | | | | |
| 5.2 | Availability of oral health screening | ALB, AZE, BEL, BGR, BIH, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 35 (90) | 3 (8) | 1 (3) | NA |
| 5.3 | Availability of sexualy transmitted infection screening | ALB, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 34 (87) | 5 (13) | NA | NA |
| | **Prevalence of syphilis on admission** | | | | | |
| 5.3.1 | Men | AZE, BGR, BIH, DNK, ESP, GEO, HRV, ISL, MNE, RUS | 10 (26) | 25 (64) | 4 (10) | NA |
| | Women | ALB, AZE, BGR, BIH, DNK, ESP, GEO, HRV, LVA, MDA, MNE, RUS | 12 (31) | 26 (67) | 1 (3) | NA |
| | **Prevalence of chlamydia on admission** | | | | | |
| 5.3.2 | Men | ALB, BIH, FIN, HRV, MDA, MNE | 6 (15) | 32 (82) | 1 (3) | NA |
| | Women | ALB, BIH, FIN, HRV, MNE | 5 (13) | 32 (82) | 2 (5) | NA |
| | **HIV testing on admission** | | | | | |
| 5.4 | Availability | ALB, AZE, BEL, BGR, BIH, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 35 (90) | 3 (8) | 1 (3) | NA |
| 5.4.1 | Testing if not mandatory | ALB, AZE, BEL, BGR, BIH, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, SRB, SVK, SVN, SWE, UKR | 31 (79) | NA | 1 (3) | 7 (18) |
| 5.4.2 | Percentage tested | BGR, BIH, ESP, FIN, GBR, GEO, HRV, LVA, MCO, MDA, MNE, RUS, SVK, SWE, UKR | 15 (38) | 19 (49) | 5 (13) | NA |
| 5.4.3 | Prevalence of positive tests in males | AZE, BGR, DNK, ESP, GEO, ISL, MCO, MDA, MNE, PRT, UKR | 11 (28) | 23 (59) | 5 (13) | NA |
| | Prevalence of positive tests in females | AZE, BGR, ESP, GEO, MCO, MLT, MNE, PRT, ROU | 9 (23) | 26 (67) | 4 (10) | NA |

| 5 | DISEASE SCREENING ON ADMISSION contd | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Hepatitis B testing on admission** | | | | | |
| 5.5 | Availability | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 36 (92) | 2 (5) | 1 (3) | NA |
| 5.5.1 | Testing if not mandatory | ALB, AZE, BEL, BGR, BIH, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 31 (79) | NA | 2 (5) | 6 (15) |
| 5.5.2 | Percentage tested for anti-HB | ESP, MDA, MLT, MNE | 4 (10) | 27 (69) | 5 (13) | 3 (8) |
| | Percentage of positive anti-HB tests | AZE, ESP, FIN, MDA, MLT, MNE | 6 (15) | 27 (69) | 3 (8) | 3 (8) |
| | Percentage tested for HBsAg | ESP, GEO, MCO, MDA, MLT, MNE, PRT, SVK | 8 (21) | 25 (64) | 3 (8) | 3 (8) |
| | Percentage of positive HBsAg tests | ALB, ESP, GEO, MCO, MLT, MNE, PRT, SVK | 8 (21) | 26 (67) | 2 (5) | 3 (8) |
| | **Hepatitis C testing on admission** | | | | | |
| 5.6 | Availability | ALB, AZE, BEL, BGR, BIH, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 35 (90) | 3 (8) | 1 (3) | NA |
| 5.6.1 | Testing if not mandatory | ALB, AZE, BEL, BGR, BIH, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 32 (82) | NA | 1 (3) | 6 (15) |
| 5.6.2 | Percentage tested for Anti-HCV | ESP, EST, GBR, GEO, MDA, MNE, PRT, SVK, SWE | 9 (23) | 21 (54) | 5 (13) | 4 (1) |
| | Percentage of positive anti-HCV tests | AZE, ESP, EST, FIN, GBR, GEO, MDA, MNE, PRT, SVK, SWE | 11 (28) | 21 (54) | 3 (8) | 4 (1) |
| | Percentage tested for HCV RNA | ESP, GBR, GEO, MLT, MNE, SWE | 6 (15) | 25 (64) | 4 (10) | 4 (1) |
| | Percentage of positive HCVRNA tests | ALB, ESP, GBR, GEO, MDA, MLT, MNE, SWE | 8 (21) | 24 (62) | 3 (8) | 4 (1) |
| | **Tuberculosis (TB) testing** | | | | | |
| 5.7 | Percentage tested for new or relapse TB | AZE, BGR, ESP, EST, GEO, MCO, MLT, MNE, NLD, PRT, RUS, SVK | 12 (31) | 23 (59) | 4 (10) | NA |
| | Percentage of new or relapse TB cases detected | BEL, BGR, ESP, FIN, GEO, MDA, MNE, NLD, PRT, SVK | 10 (26) | 20 (51) | 7 (18) | 2 (5) |
| 5.7.3 | Percentage of TB cases tested for HIV | BEL, ESP, GEO, LTU, MCO, MDA, MLT, MNE, NLD, PRT, RUS, SVK, UKR | 13 (33) | 21 (54) | 5 (13) | NA |
| | Percentage of TB cases positive for HIV | ESP, GBR, GEO, LTU, NLD, SVK, UKR | 7 (18) | 23 (59) | 6 (15) | 3 (8) |

| 6 | PREVENTION OF INFECTION | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| 6.1 | Infectious disease prevention | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 1 (3) | 1 (3) | NA |
| 6.2 | Needle/syringe exchange programme availability | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 36 (92) | 3 (8) | NA | NA |
| | **Disinfectants** | | | | | |
| 6.3 | Availability | ALB, ARM, AZE, BEL, BGR, BIH, CZE, DNK, ESP, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 33 (85) | 6 (15) | NA | NA |
| 6.3.1 | Availability free of charge | ARM, BGR, DNK, ESP, FIN, FRA, GBR, GEO, ITA, LTU, NOR, PRT, RUS, TJK, UKR | 15 (38) | NA | NA | 24 (62) |
| | **Condoms** | | | | | |
| 6.4 | Availability | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, SRB, SVK, SVN, SWE, UKR | 36 (92) | 3 (8) | NA | NA |
| 6.4.1 | Availability free of charge | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, ISL, LTU, MDA, MLT, NLD, NOR, PRT, ROU, SRB, SVK, SVN, SWE, UKR | 29 (74) | 1 (3) | NA | 9 (23) |
| | **Lubricants** | | | | | |
| 6.5 | Availability | ALB, ARM, AZE, BEL, BGR, BIH, CYP, CZE, ESP, EST, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LVA, MCO, MDA, MLT, MNE, POL, PRT, ROU, SRB, SVK, SVN, SWE, UKR | 30 (77) | 9 (23) | NA | NA |
| 6.5.1 | Availability free of charge | ARM, AZE, BEL, BGR, BIH, ESP, FRA, GBR, MDA, MLT, ROU, SVK, SWE, UKR | 14 (36) | 1 (3) | NA | 24 (62) |
| | **Non-supervised family/partner visits** | | | | | |
| 6.6 | Availability | ALB, ARM, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 2 (5) | NA | NA |
| | **Drug-free units** | | | | | |
| 6.7 | Availability | ALB, ARM, BEL, BGR, BIH, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, LTU, LVA, MCO, MDA, MLT, MNE, NLD, PRT, ROU, SRB, SVK, SVN, UKR | 29 (74) | 7 (18) | 3 (8) | NA |

| 6 | PREVENTION OF INFECTION contd | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Hepatitis B vaccine** | | | | | |
| 6.8 | Availability | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 35 (90) | 2 (5) | 2 (5) | NA |
| | **Continuity of care** | | | | | |
| 6.9 | Links between prison health and community health systems | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 36 (92) | 2 (5) | 1 (3) | NA |

| 7 | TREATMENT | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Treatment for substance use/dependence** | | | | | |
| 7.1 | Maintenance treatment available | AZE, BGR, DNK, ESP, GEO, ISL, MCO, MDA, MNE, PRT, UKR ARM, AZE, BEL, BGR, BIH, CHE, CYP, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 35 (90) | 2 (5) | 2 (5) | NA |
| | Detoxification treatment available | ARM, AZE, BEL, BGR, CHE, CYP, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 34 (87) | 2 (5) | 3 (8) | NA |
| | Detoxification without opioid agonists available | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 37 (95) | 2 (5) | NA | NA |
| | Mutual support/ self-help treatment available | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 37 (95) | 2 (5) | NA | NA |
| | Other psychosocial treatment available | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 37 (95) | 2 (5) | NA | NA |
| | Other treatment available | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 37 (95) | 2 (5) | NA | NA |
| 7.2.1 | Population eligible for substitution treatment | ALB, ARM, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, HRV, IRL, ISL, ITA, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, SRB, SVN, SWE, UKR | 32 (82) | NA | NA | 7 (18) |

| 7 | TREATMENT contd | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **National guidelines for treatment for substance use and mental health** | | | | | |
| 7.3 | Existence of national guidelines on post-release substance-use related death | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, SRB, SVK, SVN, SWE, UKR | 35 (90) | 2 (5) | 2 (5) | NA |
| 7.4 | National guidelines for treatment in prison for severe mental illness | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 37 (95) | 1 (3) | 1 (3) | NA |
| | **Mental health support** | | | | | |
| 7.5 | Accessible in prisons | ALB, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR | 36 (92) | 3 (8) | NA | NA |

| 8 | MORTALITY | | | | | |
|---|---|---|---|---|---|---|
| **Question number in survey** | **Domain and indicator** | **Countries with available data** | **Data available (n (%))** | **No national data (n (%))** | **Missing (n (%))** | **Not applicable (n (%))** |
| | **Number of deaths** | | | | | |
| 8.1 | Total | ALB, AZE, BEL, BGR, BIH, CHE, CZE, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 33 (85) | 5 (13) | 1 (3) | NA |
| 8.1.1 | Males | ALB, AZE, BGR, BIH, CZE, ESP, EST, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 27 (69) | 11 (28) | 1 (3) | NA |
| | Females | ALB, AZE, BGR, BIH, CZE, ESP, EST, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 27 (69) | 11 (28) | 1 (3) | NA |
| | Young people (under 18 years) | ALB, AZE, BGR, BIH, CZE, ESP, EST, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, PRT, ROU, RUS, SVK, SVN, SWE, UKR | 26 (67) | 12 (31) | 1 (3) | NA |
| 8.1.2 | Suicide | ALB, AZE, BEL, BGR, BIH, CHE, CZE, ESP, EST, FRA, GBR, GEO, HRV, ISL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR | 31 (79) | 7 (18) | 1 (3) | NA |

# ANNEX 4.
# DATA AVAILABILITY AND RESPONSES FOR REFERENCE GROUP INDICATORS

| | | | Reference group provided (n = provided prevalence estimate) | | Reference group if provided (n = Yes) | | |
|---|---|---|---|---|---|---|---|
| **Number in survey** | **Indicator** | **Provided prevalence estimate (n)** | **Yes (n)** | **No information provided (n)** | **All incarcerated people** | **Sentenced only** | **Another population** |
| 4.1 | Tobacco-smoking | 5 | 5 | NA | 4 | NA | 1[a] |
| 4.2 | Overweight (body mass index (BMI)) | 3 | 1 | 2 | 1 | NA | NA |
| | Obesity (BMI > 30) | 1 | 0 | 1 | NA | NA | NA |
| 4.3 | Raised blood pressure | 8 | 7 | 1 | 5 | 1 | NA |
| 4.4.3 | Current injecting drug use | 5 | 5 | 0 | 4 | NA | 1 |
| 4.4.4 | Lifetime injecting drug use | 5 | 5 | 0 | 5 | 2 | 1 |
| 5.4.3 | Prevalence of positive HIV tests in males | 11 | 10 | 1 | 7 | 1 | 2 |
| | Prevalence of positive HIV tests in females | 9 | 9 | 0 | 7 | 1 | 1 |
| 5.5.2 | Percentage tested for anti-HB | 4 | 3 | 1 | 3 | NA | NA |
| | Percentage tested for HBsAg | 8 | 7 | 1 | 7 | NA | NA |
| 5.6.2 | Percentage tested for anti-HCV | 9 | 9 | 0 | 9 | NA | NA |
| | Percentage tested for HCV RNA | 6 | 6 | 0 | 6 | NA | NA |
| 5.7 | Percentage tested for new or relapse tuberculosis (TB) | 12 | 11 | NA | 9 | 1 | 1[b] |
| | Percentage of new or relapse TB cases detected | 10 | 10 | NA | 7 | 2 | 1 |
| 5.7.3 | Percentage of TB cases tested for HIV | 13 | 12 | 1 | 10 | NA | 2 |
| | Percentage of TB cases positive for HIV | 7 | 6 | 1 | 4 | NA | 2[c] |

[a] Refers to people in pre-trial detention. [b] Refers to people who were born in countries with a high prevalence of TB (greater than 10 cases per 100 000 people); people who had a past TB diagnosis; people who had previously served a sentence in a foreign prison in the past five years; or people who had clinical symptoms. [c] Refers to people who are incarcerated who entered the specialized prison medical and rehabilitation centre for TB (n = 1).

# ANNEX 5. SUMMARY OF COUNTRIES PROVIDING RESPONSES

## 1 PRISON POPULATION STATISTICS

| Indicator or calculation | n | Countries |
|---|---|---|
| Provided complete data across prison population statistics in 2016 | 6 | ALB, BIH, DNK, IRL, ISL, ITA |
| Provided data to calculate change in incarceration rate from 2014 to 2016 | 32 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, RUS, SRB, SVK, SVN, SWE, UKR |
| Provided data to calculate overcrowding | 30 | ALB, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, NLD, POL, PRT, RUS, SRB, SVK, SVN, SWE, UKR |
| **Provided data for subgroup proportions compared with total prison population (2016)** | | |
| People from ethnic/minority backgrounds | 8 | ALB, BIH, CHE, DNK, IRL, ISL, ITA, NLD |
| People who are senior (over 55 years of age) | 16 | ALB, BEL, BGR, BIH, DNK, ESP, EST, FIN, GEO, IRL, ISL, ITA, PRT, RUS, SRB, SVN |
| Young people (under 18 years of age) | 29 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, NLD, PRT, RUS, SRB, SVK, SVN, SWE, UKR |
| Females | 30 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, NLD, POL, PRT, RUS, SRB, SVK, SVN, SWE, UKR |
| Unsentenced/remanded people | 26 | ALB, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, POL, PRT, RUS, SVK, SVN, SWE, UKR |

## 2 PRISON HEALTH-CARE SYSTEMS

| Indicator or calculation | n | Countries |
|---|---|---|
| **Prison health-care service authorities** | | |
| Ministry of Justice | 23 | ALB, ARM, BEL, BIH, CHE, DEU, EST, HRV, IRL, LTU, LVA, MCO, MDR, MNE, NLD, POL, PRT, SRB, SVK, SWE, CHE, TJK, UKR |
| Ministry of Health and other public health authorities | 17 | ALB, ARM, CHE, CYP, CZE, DNK, ESP, FIN, FRA, GBR, ISL, ITA, LTU, MLT, NOR, SVK, SVN |
| Health-care department of the prison system | 8 | ALB, AZE, CZE, DNK, GEO, ISL, MDA, ROU |
| Ministry of Interior | 2 | ESP, CHE |
| Other | 3 | CZE[a], ISL[b], MLT[c] |
| Combination (more than one authority) | 11 | ALB, ARM, CHE, CZE, DNK, ESP, ISL, LTU, MDA, MLT, SVK |

[a] Under authority of prison health service but authorized by Ministry of Justice. [b] Some staff are employed under the Prison and Probation Administration.
[c] Department of Correctional Services, care of Ministry for Home Affairs and Security.

## 2 PRISON HEALTH-CARE SYSTEMS contd

| Indicator or calculation | n | Countries |
|---|---|---|
| **Administration of the budget for prison health-care services** | | |
| Ministry of Justice | 22 | ALB, ARM, BEL, BGR, BIH, CHE, CZE, EST, HRV, LTU, LVA, MCO, MDA, MNE, NLD, POL, PRT, SRB, SVK, SWE, TJK, UKR |
| Ministry of Health and other public health authorities | 13 | ALB, ARM, CHE, CYP, ESP, FIN, FRA, GBR, ISL, ITA, LTU, NOR, SVN |
| Health-care department of the prison system | 8 | ALB, DNK, GEO, IRL, ISL, MLT, ROU, RUS |
| Ministry of Interior | 2 | CHE, ESP |
| Other | 3 | AZE[a], BIH[b], MLT[c], ROU[d], SVK[e] |
| Combination (more than one authority) | 10 | ALB, ARM, BIH, CHE, ESP, ISL, LTU, MLT, ROU, SVK |

[a] Main Medical Management. [b] Independent prison budgets. [c] Department of Corrective Services, care of the Ministry of Home Affairs and Security. [d] Prison hospitals.
[e] Health insurance companies and independent prison budgets.

| | | |
|---|---|---|
| **Funding sources of prison health systems** | | |
| Ministry of Justice budget | 17 | ALB, BEL, BGR, BIH, CHE, DNK, EST, IRL, NLD, POL, PRT, ROU, SRB, SVK, SWE, TJK, UKR |
| Government budget | 17 | ALB, ARM, AZE, FIN, FRA, GBR, GEO, HRV, ISL, LTU, LVA, MCO, MDA, MNE, NOR, RUS, SVN |
| Ministry of Health and other public health authorities budget | 10 | ALB, CHE, DNK, ESP, FIN, FRA, GBR, ITA, MLT, SWE |
| Compulsory health insurance | 6 | ALB, CHE, CZE, HRV, ROU, SVK |
| Ministry of Interior budget | 5 | CHE, ESP, MDA, ROU, TJK |
| Other | 3 | ALB, BIH[a], UKR |

[a] Independent prison budgets.

| | | |
|---|---|---|
| **Responsibilities of Ministry of Health or other public health authorities** | | |
| Assessment of prison health services | 17 | CYP, EST, FIN, FRA, GBR, ISL, ITA, LTU, LVA, NOR, PRT, RUS, SVK, SVN, SWE, TJK, UKR |
| Inspection of hygiene, nutrition and living conditions | 22 | ALB, BIH, CYP, CZE, DNK, EST, FIN, FRA, GBR, HRV, ITA, LTU, LVA, MLT, NLD, NOR, POL, PRT, SRB, SVK, SWE, TJK |
| Infectious disease prevention | 17 | BEL, BIH, FIN, FRA, GBR, HRV, ISL, ITA, LVA, MCO, MLT, NOR, RUS, SRB, SVK, SVN, TJK |
| **National health-care complaints system** | | |
| Exists and is available in prisons | 33 | ALB, AZE, BEL, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MCO, MDA, MLT, NLD, NOR, POL, PRT, RUS, SRB, SVK, SVN, SWE, TJK, UKR |
| **Links between prison health systems and community health systems for health care** | | |
| Exist | 33 | ALB, ARM, BGR, BIH, CHE, CZE, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR |

## 2 PRISON HEALTH-CARE SYSTEMS contd

| Indicator or calculation | n | Countries |
|---|---|---|
| **Provided data for prison staff ratios (2014–2016)** | | |
| Prison staff | 23 | ALB, BGR, BIH, CHE, CZE, ESP, EST, FIN, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, POL, PRT, ROU, RUS, SRB, SVK, SWE |
| Health-care staff | 25 | ALB, AZE, BGR, BIH, CHE, CZE, ESP, EST, FIN, FRA, GEO, HRV, IRL, LTU, LVA, MDA, MNE, POL, PRT, ROU, RUS, SRB, SVK, SWE, UKR |
| Physicians | 25 | ALB, AZE, BGR, BIH, CZE, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, LTU, LVA, MDA, MNE, POL, PRT, ROU, RUS, SRB, SVK, SWE, UKR |
| Psychologists | 22 | ALB, BGR, BIH, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, LTU, LVA, MDA, MNE, POL, PRT, ROU, RUS, SVK, SWE, UKR |
| Psychiatrists | 25 | ALB, AZE, BGR, BIH, CZE, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, LTU, LVA, MDA, MNE, NLD, POL, PRT, ROU, RUS, SVK, SWE, UKR |
| Dentists | 21 | ALB, AZE, BIH, CZE, ESP, EST, FIN, FRA, GEO, HRV, IRL, ISL, LTU, LVA, MNE, PRT, ROU, RUS, SVK, SWE, UKR |

## 3 PRISON ENVIRONMENT

| Indicator or calculation | n | Countries |
|---|---|---|
| Smoke-free cells available in at least some prisons | 25 | ALB, AZE, BGR, BIH, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, MCO, POL, PRT, ROU, RUS, SVK, SVN, SWE |
| Meals produced in centralized kitchens in at least some prisons | 35 | ALB, ARM, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR |
| **Alternative food systems available** | | |
| Self-cook kitchens | 12 | DNK, FIN, GEO, ISL, LTU, MDA, NLD, NOR, POL, ROU, RUS, SWE |
| Refrigerators | 18 | ALB, AZE, BEL, BIH, CYP, CZE, DNK, FIN, ITA, LTU, LVA, MCO, MDA, MLT, MNE, NLD, NOR, RUS |
| Fresh food | 18 | AZE, BIH, CZE, DNK, ESP, FIN, GEO, HRV, ISL, ITA, LTU, LVA, MDA, MNE, NOR, POL, PRT, RUS |
| Packaged snacks | 17 | AZE, CZE, DNK, EST, GEO, HRV, ISL, ITA, LTU, LVA, NOR, POL, PRT, RUS, SVN, SWE, UKR |
| Other | 12 | BGR, BIH, GEO, IRL, ISL, LTU, MCO, MLT, ROU, SWE, TJK, UKR |

## 4 RISK FACTORS FOR ILL HEALTH

| Indicator or calculation | n | Countries |
|---|---|---|
| Screening for harmful alcohol use on admission available in at least some prisons | 20 | BGR, CYP, DNK, ESP, EST, FIN, FRA, GBR, HRV, IRL, ISL, ITA, LVA, NLD, POL, ROU, SVK, SVN, SWE, TJK |
| Urine/sputum testing available on admission but not mandatory | 12 | BEL, BGR, GBR, GEO, HRV, ISL, ITA, POL, PRT, SRB, SVK, SVN |

## 5 DISEASE SCREENING ON ADMISSION

| Indicator or calculation | n | Countries |
|---|---|---|
| Screening for severe mental health disorders on admission available in at least some prisons | 30 | ALB, AZE, BGR, BIH, CYP, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, MCO, MDA, MLT, MNE, NLD, NOR, POL, ROU, RUS, SRB, SVK, SWE, TJK, UKR |
| At least some diversion to mental health treatment available as a result of this screening | 24 | ALB, AZE, BGR, BIH, CYP, ESP, EST, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, MCO, MDA, MLT, MNE, NLD, ROU, SRB, TJK, UKR |
| Oral health screening available in at least some prisons | 23 | ALB, AZE, BGR, BIH, CZE, ESP, FRA, GBR, GEO, IRL, LTU, MCO, MDA, MLT, NOR, POL, PRT, ROU, RUS, SRB, SVK, TJK, UKR |
| Screening for sexually transmitted infection on admission available in at least some prisons | 25 | ALB, BEL, BGR, BIH, CYP, CZE, ESP, EST, FIN, FRA, GBR, GEO, IRL, ITA, LTU, LVA, MCO, MDA, NLD, PRT, ROU, RUS, SVK, TJK, UKR |
| **HIV testing requirements on admission** | | |
| Testing available on admission but not mandatory | 14 | ALB, BEL, BGR, BIH, CZE, DNK, HRV, IRL, ITA, MNE, NLD, NOR, POL, SRB |
| Testing routinely offered on an opt-out basis but not mandatory | 16 | AZE, ESP, EST, FIN, FRA, GBR, GEO, ISL, LTU, MDA, MLT, PRT, ROU, SVN, SWE, UKR |
| **Hepatitis B testing requirements on admission** | | |
| Testing available on admission but not mandatory | 15 | ALB, BEL, BIH, DNK, EST, HRV, IRL, ISL, ITA, LVA, MNE, NLD, POL, SRB, SWE |
| Testing routinely offered on an opt-out basis but not mandatory | 11 | AZE, ESP, FIN, FRA, GBR, GEO, MDA, MLT, PRT, ROU, SVN |
| Available but other arrangements in place | 2 | BGR[a], LTU[b] |
| **Hepatitis C testing requirements on admission** | | |
| Testing available on admission but not mandatory | 14 | ALB, BEL, BIH, DNK, EST, HRV, IRL, ITA, MLT, MNE, NLD, NOR, POL, SRB |
| Testing routinely offered on an opt-out basis but not mandatory | 12 | AZE, ESP, FIN, FRA, GBR, GEO, ISL, MDA, PRT, ROU, SVN, SWE |
| Available but other arrangements in place | 2 | BGR[a], LTU[b] |

[a] Offered by a nongovernmental organization. [b] Only conducted on the basis of clinical suspicion.

## 6 PREVENTION OF INFECTION

| Indicator or calculation | n | Countries |
|---|---|---|
| Disinfectants available in at least some prisons | 15 | ARM, BGR, DNK, ESP, FIN, FRA, GBR, GEO, ITA, LTU, NOR, PRT, RUS, TJK, UKR |
| Disinfectants available free of charge | 13 | ARM, DNK, ESP, FIN, FRA, GBR, GEO, LTU, NOR, PRT, RUS, TJK, UKR |
| Condoms available in at least some prisons | 29 | ALB, ARM, AZE, BEL, BGR, BIH, CHE, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, ISL, LTU, MDA, MLT, NLD, NOR, PRT, ROU, SRB, SVK, SVN, SWE, UKR |
| Condoms available free of charge | 25 | ALB, ARM, AZE, BEL, BGR, BIH, CHE, DNK, ESP, EST, FIN, FRA, GBR, GEO, ISL, LTU, MDA, NLD, NOR, PRT, ROU, SRB, SVN, SWE, UKR |
| Lubricants available in at least some prisons | 14 | ARM, AZE, BEL, BGR, BIH, ESP, FRA, GBR, MDA, MLT, ROU, SVK, SWE, UKR |
| Lubricants available free of charge | 12 | ARM, AZE, BEL, BGR, BIH, ESP, FRA, GBR, MDA, ROU, SWE, UKR |
| Non-supervised family visits available in at least some prisons | 30 | ALB, ARM, AZE, BEL, BIH, CZE, DNK, ESP, EST, FIN, FRA, GEO, HRV, ISL, LTU, LVA, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVN, SWE, TJK, UKR |

## 6 PREVENTION OF INFECTION contd

| Indicator or calculation | n | Countries |
|---|---|---|
| **Hepatitis B vaccine availability in prisons** | | |
| Offered to all eligible people who are incarcerated | 11 | ESP, FIN, FRA, GBR, IRL, ISL, ITA, MLT, PRT, RUS, SWE |
| Offered to at-risk groups | 4 | ARM, CZE, EST, NOR |
| Available on request | 7 | BEL, CZE, DNK, HRV, SRB, SVK, SVN |
| Other | 5 | CHE[a], ISL, MLT, NLD[b], POL |

[a] Available to a number of groups, including anyone who asks for the vaccine, people who use drugs, people from high-endemic regions, sex workers, as well as people who are incarcerated and staff who face professional risks. [b] Offered to men who have sex with men.

## 7 TREATMENT

| Indicator or calculation | n | Countries |
|---|---|---|
| Drug-free units available in at least some prisons | 16 | ALB, ARM, BEL, CZE, DNK, ESP, EST, FIN, GBR, ISL, LTU, MDA, PRT, SRB, SVK, SVN |
| Available mental health support delivered by specialized staff | 35 | ALB, AZE, BEL, BGR, BIH, CYP, CZE, DNK, ESP, EST, FIN, FRA, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, TJK, UKR |
| **Available treatments for substance use** | | |
| Maintenance treatment | 28 | ARM, BEL, BGR, BIH, CHE, DNK, ESP, EST, FIN, FRA, GBR, HRV, IRL, ISL, ITA, LVA, MCO, MDA, MLT, MNE, NLD, NOR, POL, PRT, ROU, SRB, SVN, SWE |
| Detoxification treatment | 25 | BEL, BGR, CHE, CYP, DNK, ESP, EST, FIN, FRA, GBR, HRV, IRL, ISL, ITA, MCO, MLT, NLD, NOR, POL, PRT, ROU, SRB, SVN, SWE, UKR |
| Detoxification without opioid agonists | 26 | AZE, BEL, BIH, CYP, CZE, ESP, EST, FIN, GBR, GEO, HRV, IRL, ISL, ITA, LTU, MNE, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR |
| Mutual support/self-help treatment | 20 | BGR, CHE, DNK, ESP, EST, FRA, GBR, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, PRT, ROU, RUS, SVN, SWE |
| Other psychosocial treatment | 24 | AZE, CHE, CYP, CZE, DNK, ESP, EST, FIN, GBR, HRV, ISL, ITA, LTU, LVA, MLT, NOR, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE |
| Other treatment | 6 | ALB, CHE, ESP, GBR[a], IRL[b], RUS[c] |
| Substitution treatment available for people who are sentenced or in pre-trial detention | 26 | ALB, ARM, BEL, CHE, CYP, DNK, ESP, EST, FIN, FRA, GBR, IRL, ISL, ITA, LVA, MDA, MLT, MNE, NLD, NOR, POL, PRT, SRB, SVN, SWE, UKR |
| **National guidelines for treatment** | | |
| Guidelines on post-release substance-use-related death exist | 18 | ALB, ARM, BEL, BIH, CHE, CZE, DNK, FRA, GBR, IRL, ITA, MDA, MLT, NLD, NOR, PRT, ROU, SVN |
| Guidelines for treatment in prison for severe mental illness exist | 23 | ALB, ARM, AZE, BGR, BIH, CYP, DNK, ESP, FRA, GBR, GEO, ITA, LTU, MDA, MNE, NLD, NOR, PRT, ROU, RUS, SVK, TJK, UKR |

[a] Eye movement desensitization and reprocessing in some prisons. [b] Music therapy programmes. [c] Rehabilitation programmes.

## 8 MORTALITY

| Indicator or calculation | n | Countries |
|---|---|---|
| Provided complete data to calculate mortality rate (2014–2016) | 31 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, ESP, EST, FIN, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR |
| Provided complete data to calculate mortality rate for men (2014–2016) | 24 | ALB, AZE, BGR, BIH, CZE, ESP, EST, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, NLD, PRT, ROU, RUS, SVK, SVN, SWE, UKR |
| Provided complete data to calculate mortality rate for women (2014–2016) | 24 | ALB, AZE, BGR, BIH, CZE, ESP, EST, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, NLD, PRT, ROU, RUS, SVK, SVN, SWE, UKR |
| Provided complete data to calculate mortality rate for young people (2014–2016) | 24 | ALB, AZE, BGR, BIH, CZE, EST, GBR, GEO, HRV, IRL, ISL, ITA, LTU, LVA, MLT, MNE, NLD, PRT, ROU, RUS, SVK, SVN, SWE, UKR |
| Provided complete data to calculate ratio of deaths by suicide and suicide rate (2014–2016) | 30 | ALB, AZE, BEL, BGR, BIH, CHE, CZE, ESP, EST, FRA, GBR, GEO, HRV, ISL, ITA, LTU, LVA, MDA, MLT, MNE, NLD, POL, PRT, ROU, RUS, SRB, SVK, SVN, SWE, UKR |

**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.

**Member States**

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

9 789289 054584 >

**World Health Organization**
**Regional Office for Europe**

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel: +45 45 33 70 00  Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int