World Health Organization

REGIONAL OFFICE FOR Europe

Final report of the

Network Meeting on Prison and Health

Abano Terme, Italy, 4-5 October 2011

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Tuesday 4 October 2011

1. Welcome

Dr Lars Moller, WHO Regional Office for Europe
Dr Oreste Velleca, Deputy Director of Prisons, North East Italy
Dr Andrew Fraser, Co-Director, WHO Collaborating Centre

Dr Moller welcomed everyone to 16th meeting of the Network for Prison and Health, thanked The Veneto Region for hosting the meeting and introduced Dr Velleca.

Dr Velleca welcomed participants to Abano Terme and delivered the best wishes of the General Director Dr Felice Bocchino for a successful meeting.

Dr Velleca provided some information on health in prisons in Italy. In 2008 a decision was made to transfer the responsibility for health in prisons in Italy from the Ministry of Justice to the Ministry of Health. This was an important decision but the process is complex and responsibility has not yet been transferred in all parts of Italy.

Drug addiction is a big problem for prisons in Italy but it is difficult to address adequately due to the lack of human and financial resources.

Dr Velleca spoke of the need to link with health services in the community and to form real networks and collaborations. He said it is important that the general health community see prisons as 'part of the territory' and not as 'islands'.

Dr Velleca recognized the importance of the issues being discussed over the following two days and wished everyone a successful and productive meeting.

Dr Fraser thanked Dr Velleca for his comments and added his welcome to the meeting. Dr Fraser commented that it was good to have representation from such a wide range of countries and organizations at the meeting. In particular he drew attention to the good representation from NGOs and reminded the meeting of the important role which NGOs play in working towards improving health in prisons.

2. Update from WHO Health in Prisons Programme and WHO Collaborating Centre for Prison Health

Dr Lars Moller, WHO Programme Manager Prison Health
Dr Andrew Fraser, Co-Director, WHO Collaborating Centre

Dr Moller reported that the Network now has 45 Member States – 18 from Western Europe, 16 from Central Europe, 11 from Eastern Europe – as well as a number of international partner organizations.

Activities this year have included:

- Copenhagen Network meeting 2010.
- Bilateral meetings with CC.
- Expert group meeting on Stewardship of prison health.
- Development and publication of checklists on women's health in prison (together with UNODC), as a follow up on the Declaration.
- Prison Health Guide, second edition in production.
- First draft of paper on Stewardship of prison health.
- Country activities in Kyrgyzstan, Armenia, Estonia and Serbia.
- Participation in international conferences and meetings.
- Publications.

Activities planned for next year include:
- Publication of an updated version of 'Health in Prisons. A WHO guide to the essentials in prison health'
- Development of a WHO guidance framework on the Stewardship of Prison Health.
- Publication on naloxone and naltrexone.
- Country activities in Moldova, Serbia, Kosovo, Latvia, Georgia, Ukraine, Croatia.
- Ongoing development of web pages – more examples of best practice needed.
- Network meeting.
- Fundraising – help is needed!

Dr Moller emphasized the current financial crisis facing the Programme. He recognized that Member States and partner organizations are likely to be facing financial difficulties of their own but asked them to consider any possibilities for providing financial support – perhaps through a secondment – in order that the work of the Programme can continue.

Dr Fraser gave Paul Hayton's apologies as he was unable due to illness to be present; he then outlined how the Collaborating Centre has worked in support of the Programme during the past year. In particular, he focused on the development of the work on the Stewardship of prison health which arose as a priority topic during the 2010 Network meeting. Dr Fraser emphasized that he hoped this work would be useful to all countries, not just those embarking on a change of responsible Ministry. He gave an update on progress in Scotland, which is in the process of transferring responsibility from the Ministry of Justice to the Ministry of Health, although he reported that it is too early to demonstrate whether services have improved due to the new arrangements. Dr Fraser called for the increased involvement of research institutions in evaluating the effects of changes of management responsibility for prison health.

Dr Fraser discussed the future of WHO HIPP and concluded that there is still a need for the Network as it provides a valuable opportunity to exchange experiences and to discuss problems and solutions with counterparts in other countries. The UK Government remains committed to the Collaborating Centre and there is an appreciation of the work of the Programme within WHO – for example, he was heartened by the recognition of prison health and

marginalized populations at the recent WHO Regional Committee meeting in Baku, raised by United Kingdom. Dr Fraser also acknowledged the support of the Netherlands for the Programme over the years, particularly in recent years through the funding of Brenda van den Bergh's secondment.

In looking forward, Dr Fraser commented that the next six months would be crucial in ensuring the future of the Programme. He invited participants to read and discuss Gerda van't Hoff and Alex Gatherer's paper as a contribution to setting the future agenda for WHO HIPP in the context of difficult financial and political circumstances.

3. Stewardship of Prison Health

Ms Brenda van den Bergh, Technical Officer, WHO Regional Office for Europe
Dr Alex Gatherer, Adviser, WHO Health in Prisons Programme

Ms Van den Bergh gave an update on progress with this work since the 2010 Network meeting in Copenhagen.

At the last Network meeting, in Copenhagen in October 2010, discussions were held based on the briefing paper 'Patient or Prisoner'. It became clear that there was great enthusiasm for HIPP to develop this work and issue guidance to Member States.

An expert group was established comprising members from WHO and the Collaborating Centre, Denmark, France, Georgia, Netherlands, Norway, ICRC, ICPA, NDPHS, UNODC and the University of Oxford. The group met in June 2011 to discuss the direction for this work and review the first draft of the Stewardship guidance document. The group also discussed information collection and agreed that this should take the form of a checklist to be included in the final guidance document. It is envisaged that this could be used by Member States wishing to review their current position and for those wishing to explore the possibility of a transfer of Ministerial responsibility.

Following the expert group meeting a revised draft guidance framework was produced and distributed to all Network members in advance of this meeting.

Ms Van den Bergh stressed that the document is still at draft stage and WHO would welcome input from this meeting. She also acknowledged that the issue of stewardship of prison health is a sensitive one and made it clear that WHO would not be recommending one particular model.

Dr Gatherer on behalf of Paul Hayton provided additional feedback from the expert group meeting. The meeting had tried to consider the question posed at last year's Network meeting: 'Does it matter which government Ministry is responsible for prison health?' The meeting concluded that there is a lack of evidence to provide a definitive answer to that question and instead opted for a SWOT (strengths, weaknesses, opportunities and threats) analysis of each model for inclusion in the document. The meeting also decided that the

emphasis for the guidance document should move towards considering the questions:

- What should a good prison health service look like?
- Is the choice of Ministry likely to make important differences to the extent and quality of service provided to prisoners?

Dr Gatherer also drew attention to the case studies which have been included in the draft document. The case studies show examples of both systems apparently working well. Dr Gatherer appealed to members to provide more case studies for inclusion in the final document.

Finally, Dr Gatherer urged participants to use the group work session to help WHO to shape the guidance framework document to be as useful as possible to all involved in the debate around the stewardship of prison health.

4. Group work session: Stewardship of Prison Health

Participants were asked to consider and comment on the draft document 'Stewardship of Prison Health: a guidance framework'. In particular groups were asked to:

- Comment on the **principles** in the report – are they clear, comprehensive and useful?
- Consider the **strengths, weaknesses, opportunities and threats** outlined in the document – are they complete and are they written in an unbiased way?
- Offer any specific advice which could be incorporated into the next draft of the document.

Feedback from the groups was as follows:

Group 1:
There is a shortage of health professionals in many former Soviet countries. Salaries for prison doctors and other health professionals are lower than for those working in the community.

Prison health is usually the responsibility of Ministry of Justice or Ministry of Interior – in a lot of cases this means that the priority for health services to prisoners is higher than for those in the community – prisoners often get a broader range of services. In general terms, the principles were accepted. Equivalence is a clear and understandable term but we should not talk about equivalence where community health services are worse than those available in prisons.

Ministry of Health does not always have access to services (as they are provided by Ministry of Justice) in order to check the quality and adherence to

professional standards. Ministry of Health is often reluctant to take responsibility for prison health services – not much enthusiasm from Ministries of Health for a transfer of responsibility.

Kyrgyzstan and Azerbaijan have set up health departments which report to the Ministry of Justice or the Government – general opinion is that this has improved the situation, is a good way of resolving problems and has raised the image of health professionals working in prisons. They must pay doctors more to attract them to work in prisons. The economic situation in a country is important – to improve standards will take additional funding.

Group 2:
Principles:
In broad agreement with these but we should add something about putting the patient at the centre of the care and the need to treat the prisoners as a patient first. There should be reference in the principles to the conflict of interests and the professional dilemmas met by health staff in prison work.

Strengths/Weaknesses of different systems:
Ministry of Justice strengths: all staff working for one system, following same rules, aids communication.

Ministry of Justice weaknesses: medical confidentiality could be a problem, standards of care already exist under Ministry of Health but not under Ministry of Justice, conflict of interest for doctors employed by Ministry of Justice.

Ministry of Health strengths: independent decision making, opportunities for health professionals are same as in community, opportunities to set standards.

Group 3:
Principles:
'Equivalence' should focus on *equity* and this should permeate the whole of prison health and all principles – equivalence is not enough. Look at individuals' unique needs and meet them – consider the outcomes for individuals.

Medical teams in prisons should have certain qualifications – under Ministry of Health accreditation and quality review would occur more readily than under Ministry of Justice. Should follow example of those countries that have community doctors working some sessions in prisons.

Transition has to happen to provide equity – but the need to be aware that the transition from Ministry of Justice to Ministry of Health is an evolutionary one.

Group 4:
SWOT analysis is a useful basis for discussion but not as a tool for deciding between the two systems as there were so many arguments on each side.

Strengths/Weaknesses of different systems:
Ministry of Justice strengths: disagree that there are organizational strengths because there is still the problem with dual loyalty.

Ministry of Justice weaknesses: the list should include the dual loyalty issue.
Ministry of Health strengths: transparency and prevention of dual loyalty should be included in the list.

Ministry of Health weaknesses: the weaknesses described are actually threats rather than weaknesses.

The list of what a basic prison health service should provide should include:
- Standards (accepted by Ministry of Health and Ministry of Justice).
- Monitoring and transparency of monitoring, on health status of prisoners.
- Dedicated budgets for health care and health promotion.
- Communication between all partners (regardless of model).
- Respect.
- Equivalence (in terms of health care, training and standards).

WHO and the Expert Group will consider all comments in the ongoing development of this guidance. It is anticipated that the document will be published mid 2012.

5. Social Determinants of Health, European Review; the work of the WHO Venice Office on Health Inequalities
Dr Erio Ziglio, Head of WHO Venice Office

Dr Ziglio started with congratulations to the Network as he was impressed by the progress made. He explained some of the work of the WHO Venice Office in dealing with the economic and social determinants of health and gave a brief outline of the new WHO European policy framework for health 'Health 20:20'.

The main activities of the WHO Venice Office are:

Helping countries to foster synergy between Health and Development
- To synergise the promotion of health with local, regional and national development;

- To reduce health inequities and provide added value to social and economic development; and
- To strengthen institutional arrangements & human resources.

Providing technical assistance to increase intersectoral capacity in countries

Action to influence the social determinants of health must come from within and outside the health sector. It should involve the whole of government and civil society. Therefore, policies and programmes must not be limited to the health sector but must include all sectors, for example industry, finance, business, agriculture, tourism and transport.

Providing the know-how to strengthen Health Systems to address the social determinants of health

The aims are to:

- Decrease differential exposure
- Decrease differential vulnerability
- Decrease differential access
- Decrease differential consequences
- Increase health 'assets'

Supporting countries in their efforts to improve trends in health inequalities

Firstly the size and nature of the problems are assessed and then plans are put in place to assist the country in tackling those problems. The focus is on targeting vulnerable groups in society, identifying the gap between them and the rest of society and looking at policies to reduce those inequalities. The traditional public health approach of reducing risk is combined with that of improving people's 'assets' (their resilience, social networks etc.).We need to ask what are the salutogenic factors in particular situations and look for what works.

Working with countries to strengthen their capacity to address the social determinants of health and health inequalities

This includes the following elements:

- Sustained policy commitment
- Robust and equity oriented Health System
- Active intersectoral working
- Sustained funding mechanism
- A high priority for health
- Social capital and cohesion for health
- Public engagement and community participation
- Accountability for SDH/HI
- Health intelligence
- Monitoring of system performance
- Communication and advocacy
- Other according to country context

Research is encouraging a re-orientation as to what is meant by health and by public health. Until now, much of public health has been aimed to control

risk factors or behavioral factors. Now it is necessary to add new factors such as poverty and social isolation as is found with prisoners, leading to low self-esteem and self-blame. These together give a robust and systematic approach to public health.

Dr Ziglio drew the attention of the meeting to the new European health policy 'Health 2020'. The policy, which is aimed at reducing health inequalities, sets out an action framework to accelerate attainment of better health and well-being for all. Its purpose is to strengthen health systems, revitalize public health infrastructures and institutions, engage the public and a range of health actors, and develop coherent and evidence-based policies and governance solutions capable of tackling health threats and sustaining improvements over time.

The policy will provide a framework to help to ensure coordination and coherence across all work that WHO Europe, Member States and partners carry out on behalf of and with the population.

Health 2020 will be presented for approval to the 62nd session of the Regional Committee in September 2012. Dr Ziglio stressed that WHO is still open to advice and comments on the policy.

In responding to a question as to why HIPP was not WHO-wide, Dr Ziglio said he was convinced by the case in principle and we need to consider how this could be facilitated.

6. Member State Presentations

The Netherlands and Belgium:
GHB: a new drug, a new challenge for prison health?
Ms Gerda van't Hoff, Senior Policy Maker, National Agency for Correctional Institutions, the Netherlands
Dr Sven Todts, Head of Medical & Dental Service, Prison Health Care Service, Belgium

MS van't Hoff reported that the Netherlands is encountering an increase in GHB addiction (gamma hydroxy butyrate). In 2010 there were 5 reported cases of people being severely addicted to GHB, but that number has risen rapidly over the past year to 279. GHB is a drug which has a small therapeutic width, a short half life, fast tolerance, fast addiction and many side effects. Risk of overdose is high. It was not developed as an anaesthetic agent due to the side effects. It is easily made and all ingredients are easy to buy.

If arrested, addicts will usually suffer abrupt withdrawal as police and prison cells are not equipped to provide the 24 hour specialist nursing care with specialist medical back-up which is needed during detoxification.

There are a number of detoxification pilot projects in operation in prisons and police cells in the Netherlands but there is not yet an evidence based protocol

for withdrawal. Detoxification treatments are expensive due to the high levels of nursing and medical care and supervision needed. Research into different detoxification treatments is now underway and in 2013 the Ministry of Health will decide which treatment to use.

Dr Todts gave a brief summary of the situation with GHB in Belgium. The extent of morbidity and mortality related to GHB in Belgium is not known. There has only been one confirmed case of lethal overdose on mono use of GHB although it has been present in a number of overdoses where several drugs and alcohol were mixed. There is no evidence that it is being used as a 'date rape drug' (drink-spiking) in Belgium.

Of the 35 prisons in Belgium, it is only the two pre-trial institutions which are reporting problems with GHB. Night time nursing is not available in either of these prisons. The usual approach to detoxification is to provide benzodiazepines and to hospitalize the patient in the event of problems. Both prisons have had to hospitalize prisoners for GHB detoxification (less than 10 cases per year) because of threatening delirium but these did not lead to serious problems once the patients were hospitalized.
In Switzerland, it is treated in hospital emergency departments, perhaps due to a different legal position

Kyrgyzstan:
Comprehensive approach for HIV prevention in the penitentiary system of Kyrgyzstan
Dr Zhakshylyk Toktosunov, Head of Medical Unit, Department of Penalty Execution, Ministry of Justice of the Kyrgyz Republic

Dr Toktosunov outlined a number of HIV prevention initiatives in prisons in Kyrgyzstan. The HIV harm reduction programme includes the provision of educational material to prisoners, a peer education programme (supported by MSF, AFEW and the Global Fund) and an awareness raising programme for staff. Syringe exchange services and methadone substitution therapy are available to prisoners.

A comprehensive HIV prevention pilot scheme has recently started in a remand centre in Kyrgyzstan which includes information on safe behaviour, needle exchange, condoms, voluntary testing/counselling and medical consultations.

Kyrgyzstan has clinical protocols for methadone substitution treatment, and diagnosis and treatment of HIV. It also has a draft 2012-2016 State program for HIV which has yet to receive government approval.

Dr Toktosunov also informed the meeting that the Atlantis rehabilitation programme is successfully operating in 7 prisons in Kyrgyzstan. The programme, which is provided by NGOs, uses the 12 step Minnesota abstinence model and is available to drug and alcohol dependent prisoners.

Latvia:
Prisoners' health care and the present economic situation in Latvia
Dr Regina Fedosejeva, head of Medical Service, Latvian Prison Administration

Dr Fedosejeva updated the meeting on recent developments in the prison health system in Latvia. Since 2009 a number of services have been cut and there has been a substantial reduction in prison hospital beds and prison health staff. Funding to prisons has been reduced by 43%, with funding for prison health staff reduced by 70%. This has resulted in the number of prison staff being reduced by 19% and the number of prison health staff being reduced by 60%. Salaries of health workers in Latvia have fallen by 30-40% in recent years.

As a result of these reductions in staff and services the last two years has seen a dramatic increase in the number of prisoners whose health needs are not being met. A number of prison hospitals and polyclinics have closed down and if prisoners are referred for treatment to community health services the prison has to pay 100% of the costs of treatment. Out patient care for prisoners is only funded in a limited number of circumstances such as emergency medical and dental care and partial care for acute conditions.

Prison health services in Latvia are the responsibility of the Ministry of Justice, Ministers having previously rejected the idea of transferring responsibility to the Ministry of Health. In 2011, however, there has been renewed co-operation between the Ministry of Justice and the Ministry of Health to discuss the functions, responsibility and funding of prison health.

Republic of Moldova:
Health assistance in prisons of Moldova at the crossroads
Dr Ilona Burduja, Medical Unit of the Department of Penintentiary Institutions, Ministry of Justice

Dr Burduja reported that the prison health system is suffering similar problems to those in Latvia and is almost in a state of collapse. There are a large number of consultations often caused by 'non-medical' factors which puts increased pressure on the doctors and reduces the amount of health care available to prisoners. There is a high incidence of self harm, suicide (5 or 6 cases per year) and hunger strikes in Moldovan prisons. There is a high degree of behavioural problems and mental health problems but there are no psychiatric services available in prisons. Prisoners are not covered by the national medical insurance system.

Moldovan prisons also have staffing problems. There is a shortage of staff and salaries for medical staff are low compared to those in the community. There is a lack of professional independence for medical staff and this dual loyalty issue makes the general climate very difficult.

Dr Burduja outlined some of the actions which she feels necessary for the improvement of prison health services in Moldova:

- Reorienting the approach from treatment to prevention;
- Ensuring inmates access to quality health services by prioritizing the development of primary care in prisons;
- Improving the management of health care services by strategic planning;
- Enhancing the quality of health services; a better health care in prison hospitals; better medical equipment;
- Strengthening public health surveillance, preventing maladies and the control of transmissible diseases (HIV, TB etc) and non transmissible ones with a high impact on public health;
- A more efficient HR management of the current medical personnel, as well as attracting new skilled personnel;
- A better use of financial resources;
- Improving the mandatory medical insurance mechanism (retired inmates, juveniles, pregnant female inmates, inmates with disabilities);
- A more active partnership with the Health Ministry of Moldova.

7. Prison Health Research

Organization of knowledge on Justice Health: The Cochrane Collaboration Justice Health Field

Dr Catherine Gallagher, Associate Professor and Director, Cochrane Collaboration College for Policy, George Mason University

Dr Gallagher explained that the Cochrane Collaboration Justice Health Field is concerned with adolescents and adults who are incarcerated or supervised in the community and those otherwise affected by contact with the justice system. It is based in the US but is not US focused. Its primary aims are to:

- Organize existing knowledge
- Prioritize clinical and systems of care questions
- Conduct systematic reviews on effectiveness of interventions
- Identify gaps in primary research
- Disseminate findings to networks
- Reduce duplication of effort
- Increase global representation

Dr Gallagher spoke of the need for the organization and accessibility of global research on the health needs and service provision for incarcerated adults and adolescents. She encouraged Network members to participate in the work of the Cochrane Justice Health Field by submitting questions, registering their own research, becoming partners on Cochrane systematic reviews and attending conferences and meetings.

The Development of a European prison health research network

Dr Emma Plugge, Director MSc Global Health Science, Department of Public Health, University of Oxford

Dr Plugge discussed the need for more research in the prison health field. She outlined ideas for the development of a European prison health research network which would aim to develop prison health research across the European Region in order to improve the evidence base for health service delivery within all prison settings. Dr Plugge suggested that the network would:

- provide a forum for exchanging ideas;
- be inclusive - linking researchers to policy makers and practitioners;
- involve large collaborations to improve the chances of getting funding;
- provide a network for dissemination; and
- build capacity by encouraging further prison health research.

Dr Plugge went on to say that one of the main benefits of such a network would be an increased quantity and quality of research to enable countries and WHO to better define and address the health needs of prisoners.

Dr Plugge noted that the role of WHO HIPP would be critical in establishing the research network and opened the floor for comments and questions. A number of comments were made with regard to the involvement of prisoners in the research process and also the need to make sure that any research is of benefit to prisoners. The potential for problems around the practicalities of conducting research in prisons was also discussed. Dr Plugge agreed that 'user involvement' and the prisoner's perspective would be very important aspects of any proposed research.

Dr Plugge will continue to explore the potential for establishing the European research network with WHO HIPP. It is anticipated that the first year will involve sourcing funding, developing a website and establishing a virtual email network.

8. Global Developments

Update Standard Minimum Rules on the Treatment of Prisoners

Dr Fabienne Hariga, United Nations Office on Drugs and Crime

Dr Hariga provided a status update on work to review the Standard Minimum Rules (SMR) on the treatment of prisoners which were originally adopted in 1957. Preliminary consultation concluded that:

- SMR continue to be held in high regard – they are the main reference point in terms of measuring minimum standards within the prison environment;
- the rules need to be interpreted within the context of existing international law relating to imprisonment, as well as of the development of national legislation relating to the use of prisons;
- recognition that the current understanding of what constitutes good practice in the management of prisons has changed;
- the terminology used in a number of rules no longer reflected modern understanding of culture and values; and
- care should be taken not to undermine the integrity of the current rules and their international standing.

In December 2010 United Nations General Assembly requested the Commission on Crime Prevention and Criminal Justice (CCPCJ) to establish an open-ended intergovernmental expert group to exchange information on best practices, to exchange information on national legislation and existing laws relating to prisons and to consider the revision of the SMR with a view to making recommendations to the Commission on possible next steps.

Dr Hariga reported progress with this work to date:

- UNODC mandated to take this forward by CCPCJ
- Note verbale sent to all countries (February 2011)
- High-Level Expert Meeting in the Dominican Republic on good practices on the implementation of the Standard Minimum Rules in Latin America and the Caribbean (3 -5 August 2011)
- Development of a draft annex
- Expert group meetings (October 2011)
    - On health aspects in Abano Terme, 3 October
    - On other aspects in Vienna 6-7 October
- Intergovernmental EGM (2012) will prepare recommendations to the CCPCJ
    - 3 possible developments:
        - Adopt separate commentary in an annex
        - Revise the SMR
        - Propose to revise one part only

The outcome of the process is not known at this stage. Dr Hariga will continue to update the HIPP Network on progress with this work.

American Public Health Association
Dr Robert Cohen, American Public Health Association

Dr Cohen presented his 'notes from the United States' to give a flavour of some current issues in the US justice system. In particular, Dr Cohen discussed the issue of solitary confinement which is an increasingly common feature of life in US prisons; indeed the US has prisons which are just for solitary confinement. At the time of the meeting, thousands of prisoners in California were staging a hunger strike, the second in recent months, as a protest against the practice of solitary confinement.

Dr Cohen also drew attention to the issue of severe overcrowding in prisons which has resulted in the lack of provision of decent medical care to prisoners. In May 2011 the US Supreme Court ruled that conditions in California's overcrowded prisons were so bad that they violate the 8th Amendment's ban on cruel and unusual punishment and ordered the State to reduce its prison population by more than 30,000 inmates. The Court described the prison system as one which '...failed to deliver minimal care to prisoners with serious and mental health problems and produced "needless suffering and death"'. The prison population in the US is now slowly decreasing for the first time since 1972 and Dr Cohen is encouraged by some 'new thinking' that incarceration is not the only approach.

Dr Cohen also reminded the meeting that the United States continues to carry out the practice of capital punishment.

World Federation of Public Health Associations
Dr Alex Gatherer, Adviser, WHO Health in Prisons Programme

Dr Gatherer reported that, with the backing of the APHA and UKPHA, the World Federation of Public Health Associations (WFPHA) passed a resolution at its general assembly in May 2011 referring to the work of the WHO Health in Prisons Project and accepting the public health case for prison health.

The resolution encourages the development of collaborative initiatives aimed at increasing public health awareness of the health needs of prisoners, encourages governments to adequately address the health needs of prisoners and urges Public Health Schools to include the topics of health needs of prisoners and prison health in their curriculum.

Dr Gatherer suggested that the WFPHA could be of great assistance in advocating prison health as part of public health and asked the meeting to consider how WHO HIPP can best make use of the resolution. Anyone with ideas about this, or anyone wanting to know more about the WFPHA should contact Dr Alex Gatherer.

9. Closing remarks day 1
Dr Lars Moller, WHO Regional Office for Europe
Dr Andrew Fraser, Co-Director, WHO Collaborating Centre

Dr Moller thanked speakers for their excellent presentations. He also thanked participants for their comments on the Stewardship document which would be considered carefully in the re-drafting process. The next draft of the document will be circulated for comments in Spring 2012, with publication in Summer 2012. Dr Moller also highlighted the need to do more to promote research in prisons.

Dr Fraser also drew attention to the ongoing Stewardship work and noted that examples presented today suggest that we need to look at the impact of where the power and finances are placed when considering the transfer of stewardship of prison health. Ministries of Health may not always be receptive to a change of responsibility from Ministries of Justice. Issues of professional standards and ethics also need careful consideration. Dr Fraser also noted the importance of more research; in particular the need to find out about prisoners' experiences and finding what they want in terms of services and research.

Wednesday 5 October 2011

1. **European Committee for the Prevention of Torture (CPT)**
   Dr Stefan Krakowski, Chair of Medical Group, CPT, Council of Europe

   Dr Krakowski explained the work of the European Committee for the Prevention of Torture (CPT).

   The CPT organizes visits to places of detention, including prisons, police stations, immigration centres, juvenile detention centres and psychiatric hospitals, in order to assess how persons deprived of their liberty are treated.

   CPT delegations have unlimited access to places of detention, and the right to move inside such places without restriction. They interview people in private, and communicate freely with anyone who can provide information. After each visit, the CPT sends a detailed report to the State concerned. This report includes the CPT's findings, and its recommendations, comments and requests for information. The CPT also requests a detailed response to the issues raised in its report. These reports and responses form part of the ongoing dialogue with the States concerned. The goal is not to criticize but to facilitate and assist governments. CPT does not take on individual cases but looks at specific conditions.

   The provision of health care for prisoners is of direct relevance to the CPT and the CPT supports the principle that prisoners are entitled to the same level of health care as those living in the community at large. When assessing health care for prisoners CPT has an extensive checklist of areas which are assessed, this includes:

   - Numbers of staff
   - Staff training and qualifications
   - Availability of specialist services and back up services
   - Transfer of prisoners and emergency procedures
   - Dental services
   - Drug addiction services
   - HIV, Hepatitis and TB screening and treatment
   - Supplies of medication
   - Certificates re: traumatic injuries
   - Evidence of ill treatment
   - Involvement of doctors in decision making
   - Medical supervision of isolation
   - Role of doctors in hunger strikes
   - Care of pregnant women
   - Files and records
   - Confidentiality
   - Quality of consultations
   - General relationships between prisoners and medical staff

Dr Krakowski reported that the CPT is currently discussing the Stewardship of prison health care and supports the transfer of responsibility for prison health from the Ministry of Justice to the Ministry of Health.

In discussion, the issue of automatic access to medical records without the individual's consent was raised. Also, the long term detention of asylum seekers in prison cells was mentioned.

2. Migrant health in places of detention

Dr Zaza Tsereteli, International Technical Adviser, Northern Dimension Partnership in Public Health and Social Well-being (NDPHS)
Ms Mariya Samuilova, international Organization for Migration

Dr Tsereteli gave some background to the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) which was established in 2002. The Network's partner countries are Canada, Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, Russia and Sweden and its partner organizations are BEAC, BSSSC, CBSS, EC, ILO, IOM, NCM, UNAIDS and WHO. Dr Tsereteli is the International Technical Adviser of the NDPHS Expert Group on Prison Health and Primary Health Care Systems (EG PPHS).

NDPHS EG PPHS nominated migrant health as a priority area in 2010. Dr Tsereteli outlined the work of the migrant health in places of detention in partnership between NDPHS, IOM and WHO, who met in June 2011.

NDPHS set the following key activities related to migrant health:

- **Advocacy**: Advocate for health-inclusive migration management policies and programmes, as well as migrant-inclusive health policies and programmes.
- **Health Policy Development**: Assist in the development of evidence-based national, regional and global policies to promote and protect the health of migrants
- **Health Service Delivery**: Provide, at the request of and in agreement with concerned States, migration health services, and facilitate, provide and promote equitable access of all migrants to comprehensive health care.
- **Capacity-Building**: Raise awareness and knowledge of governments, Regional Economic Communities (RECs), civil society and migrant groups on migrant health issues. Build and strengthen technical, operational and coordination capacity of States and other stakeholders to develop and implement migrant health initiatives.
- **Research and Dissemination**: Strengthen understanding of migrants' health issues by facilitating and conducting research to ensure evidence-based programming, policy and dialogue. Disseminate information on migration health issues to inform and mobilize States and other stakeholders on migrant health issues.

Ms Samuilova outlined the work of the IOM on migration health. Migration health addresses the physical, mental and social needs of migrants and the public health needs of hosting communities. The main areas of work which IOM engages in relating to migrant health are:

- health assessments and travel health assistance;
- health promotion and assistance for migrants and crisis affected populations; and
- health policy development and advice.

Ms Samuilova presented information on some practical projects undertaken by the IOM such as the three year (2007 – 2010) collaborative project 'Increasing public health safety alongside the new Eastern European border line' which aimed to minimize public health risks, build capacity for border management and public health staff, and facilitate appropriate healthcare to migrants as a fundamental human right.

The project resulted in the development of a template for a migrant health database, multidisciplinary training materials for health professionals and border guard staff and a set of evidence based guidelines for public health in border management and detention procedures designed primarily to support the capacity of border management personnel to deal with migration health concerns and public health risks related to migration and to promote good practices and standards for border management and health personnel working and dealing with significant health risks.

3. International Committee of the Red Cross – Health in Detention
Dr Robert Paterson, International Committee of the Red Cross (ICRC)

Dr Paterson explained the Health in Detention work undertaken by the International Committee of the Red Cross (ICRC). ICRC carries out visits to places of detention to assess and monitor treatment and conditions of detention and to ensure that detainees are being treated in accordance with applicable international standards and norms. It is a structured, systematic process which looks at access and modalities. Following the visits ICRC produces confidential reports of its findings and enters into dialogue with the relevant authorities. ICRC is able to provide adapted technical advice and /or material support to authorities and can also provide individual assistance to inmates.

Dr Paterson provided a 'snapshot from the field' giving some information about Health in Detention activities undertaken between January and June 2011:

Health in detention visits:
ICRC health staff participated in 1704 visits in 379 places of detention in 39 countries.

Individual medical follow-up and assistance:
203 victims of Ill-treatment including torture in 17 countries
32 hunger strikers in 7 countries

1118 other medical cases in 30 countries
142 inmates - financial or material assistance
19 requests for release on medical or humanitarian grounds

Collective medical assistance:
Support to 121 prison health centres in 18 countries.
Scabies campaigns in 9 prisons - 8002 inmates in 6 countries.
Nutritional programmes (therapeutic/supplementary) in 54 prisons, benefiting 5134 malnourished people in 7 countries.

Support to prison health systems:
Support National TB/HIV programmes in prisons in 4 countries.
Technical support to prison health services, at prison and/or national levels.
Supporting prison services in health-related areas (water, sanitation, shelter, food, nutrition) at prison and/or national levels.

Dr Paterson concluded by summarizing the main activities of the small Health in Detention team at ICRC HQ in Geneva which are:

- support to the field (advice, supervision, missions);
- development of institutional policies, tools and guidelines;
- training of health staff (ICRC and external);
- emergency responses and detention visits (for example in Syria and Libya);
- networking; expanding ICRC and developing a 'pool of expertise'; and
- human resource management (recruitment and professional development).

4. Staff Training
Dr Andrew Fraser, Co-Director, WHO Collaborating Centre
Dr Lucia Mihailescu, National Administration of Penitentiaries, Romania

Dr Fraser introduced his discussion paper on the training of prison staff. The training framework proposed by Dr Fraser includes three elements covering all prison staff; managers, leaders and decision makers and healthcare professionals.

All prison staff – all staff working in prisons need a basic level of knowledge and understanding of health issues.
Managers, leaders and decision makers - when training senior and middle managers the principles of health and disease, the organization and objectives of health care should be core subjects of any induction programme.
Health professionals – the basic training of health staff should be the same as for other doctors or nurses working in the community health services in that country.

Other issues covered in the paper are clinical governance and performance monitoring, facilities and arrangements for staff training, and staff health.

Dr Fraser asked Network members to consider the proposals outlined in the paper and also consider how HIPP should best approach the issue of training, for example by specific groups of staff or by addressing particular problems.

Medical training for staff in Romania
Dr Mihailescu presented a national perspective on training and explained the type of initial and ongoing medical training for staff in the Romanian prison system. The length and type of medical training for staff depends on their experience upon appointment and is carried out in a combination of schools belonging to the National Administration for Penitentiaries, special classes in medical military institutes and universities and on the job training.

Initial training:
Those staff having the required experience in their profession receive 10 days initial training which comprises:

- The legal framework, including the right to health care
- Security matters
- First aid
- Human Rights, including ethical issues in prison health care

Those staff not having the required experience in their field receive one year of initial training comprising:
Within the 2 weeks of their introductory course -

- The legal framework, including the right to health care
- Human Rights, including ethical issues in prison health care

Within one of the two periods of 'specializing residential 'school' the doctor from the training facility provides training on:

- Rights of prisoners to health care provided by law
- Organization of health care in prisons
- First aid
- Health programmes implemented in prisons.

Continuous training:
Health care staff:
The ongoing training for medical staff is equivalent to the CME required for doctors and nurses in the community.

Other staff:
The ongoing medical training for other prison staff is not very consistent. However, training on the newly developed 'A Manual of First Aid for Security Staff' will soon commence. All staff receive training on TB prevention which is delivered via an eLearning platform.

5. Violence and Prisons

Dr Jens Modvig, Rehabilitation and Research Centre for Torture Victims, Denmark

Dr Modvig presented information on violence in prisons which is an important problem for prisoners' health, well-being and safety. It is often underreported

and underestimated and sometimes neglected. The spectrum of violence in prisons may comprise:

- Fights amongst prisoners
- Attacks on prison staff by prisoners
- Harassment and assaults of minority groups
- Excessive use of force by prison staff
- Torture
- Suicide (or attempted suicide) sexual assaults between prisoners
- Deprivation of necessary medical treatment of time in open air
- Imprisonment of severely mentally ill people

Dr Modvig outlined a proposed approach to tackling violence in prisons which includes the following strategies to be applied as appropriate to the setting and the nature of the problem:

- Setting standards
- Provision of information through registration and documentation
- Identification of risk factors through screening on admission
- Improvement of the prison climate
- External monitoring

Dr Modvig asked participants to consider the strategies outlined in his paper and in particular his assertion that much violence can be prevented through collaboration between prison management, security and health staff.

6. Scoping WHO HIPP

Ms Gerda van't Hoff, Senior Policy Maker, National Agency for Correctional Institutions, the Netherlands

Ms van't Hoff introduced the discussion paper on the future of HIPP prepared by Ms van't Hoff and Dr Alex Gatherer. The paper reflects on the current political and economic climate throughout Europe and asks, given the current context, what approach HIPP should take to get attention, support or funding in order to continue its work.

The paper asks Members to consider the strengths and weaknesses of the programme, and asks how strongly we agree on the following statements:

- HIPP is important at this juncture because we have to combat the current problems by joint efforts, by learning from each other, and by doing research.
- We are not just looking back, we have plans for the future, important plans which will produce worthwhile results.
- While we recognize that prison is the place of last resort, prison health contributes to the conditions necessary for a socially acceptable life after prison, it may even help to reduce recidivism.
- Prison health remains important for public health and for public safety.
- Good prison health means more manageable prisons, cheaper prisons and more effective prisons.

Participants were asked to discuss these statements and the future direction for HIPP, in particular whether we need a change of tactics, more widely in the group work session.

7. Group work session

Groups were asked to discuss the previous presentations on staff training, violence in prisons and the future of WHO HIPP and consider whether they agree with specific statements in relation to each topic.

Staff training

Statement 1:
Training modules for prison officers should have a stronger focus on health issues in prisons, such as drug and alcohol dependencies and mental health problems.
Summary of feedback:
All groups agreed with the statement.
Suggest that training on blood-borne diseases, harm reduction and violence be included.
Suggest that 'prison officers' be replaced by 'prison staff' or 'prison non-healthcare staff' to avoid confusion.
The health of staff as well as prisoners should be included.

Statement 2:
Professional isolation of prison-based health professionals is inevitable, regardless of which Ministry is responsible for health care in prison settings.
Summary of feedback:
All groups agreed that professional isolation exists but all felt that it is not inevitable.
Extra support and training should be available to overcome the isolation.
Risks of isolation are higher if medical staff are employed by Ministry of Justice.
Health care staff have a responsibility to maintain professional standards and contacts.
The degree of isolation depends to a large extent on the degree of integration with the community.
The problem can be overcome to some extent if doctors work part time in prisons and part time in the community.

Violence in Prisons

Statement 1:
Violence in prisons is an important problem for prisoners' health, wellbeing and safety. It is sensitive and therefore often underreported, underestimated and sometimes even neglected.
Summary of feedback:
All groups agreed with the statement.
Suggest that the statement should include violence against and amongst staff.
Standardization of definitions of what constitutes violence would be helpful.

Underreporting is also caused by the lack of tools/adequate mechanisms for reporting.

Statement 2:
Much violence can be prevented through collaboration between prison management, security staff and health staff.
Summary of feedback:
Suggest that prisoners should be included in this statement.
Need to engage prisoners in the collaboration to prevent violence.
Confidentiality is a complex issue when collaborating.
Suggest a collaboration to develop a violence prevention strategy.
Independent processes which ensure collaboration should be in place.
Structural factors, such as overcrowding, need to be addressed.
Outside agencies/NGOs should be involved to make the issue of violence more visible.
Clarification of roles according to law is required before embarking on collaboration.

Scoping HIPP

Statement 1:
After 15 years the WHO Health in Prisons Programme has fulfilled its assignment in prison health. Now it is time for a new international network which lays emphasis on overall working and living conditions in prisons and human rights.
Summary of feedback:
Groups did not agree with this statement.
It is useful to evaluate the work of the project and think about future direction.
HIPP should continue, and should keep its focus on health rather than expanding its work in line with the above statement.
It is important for the WHO Euro HIPP to continue as, after 15 years, WHO HQ has not integrated prison health structurally or visibly.
There is a need for a 'renewal' of the Network to broaden its activities somewhat whilst remaining focused on health issues.
Network meetings should have more space for expert-level input and discussions – there are currently too many short presentations.
More recognition should be given to the fact that countries are at different stages of development.

Statement 2:
As politics, views and ideas on (international) public health have changed, WHO should choose a more compelling approach towards governments and ministries responsible for prison health.
Summary of feedback:
WHO has a moral authority which can be used when approaching Governments.
The WHO role with government ministries is mandated to some extent.
WHO should have a prison health unit for all Regions, not just the European Region.

8. WHO HIPP Best Practice Awards

The Best Practice Awards aim to recognize, share and support good practice in prison health across Europe. Awards are made in three categories:

1. An example of best practice regarding health care services provided to prisoners
2. An example of best practice which demonstrates effective co-operation between a prison and the outside community, in the area of health improvement
3. An example of best practice which demonstrates effective co-operation between a prison and the outside community, in the area of health improvement

Dr Lars Moller presented the following 18 awards on behalf of WHO:

Category 1: An example of best practice regarding health care services provide to prisoners		
England	HMP Eastwood Park	Provision of Primary Care on the Community Model within a High-Risk All Female Remand Prison Environment
Estonia	Harku and Murru Prison	Gynaecological care in prison settings
Georgia	Prison #8	Methadone Treatment program in prison
Ireland	Mountjoy Prison	Establishing a High Support Unit for Mentally Disordered Offenders and Vulnerable Prisoners in an Irish Sentenced Prison
Netherlands	PI Flevoland	Prison Health Care Team
Romania	National Administration of Penitentiaries	HIV/AIDS prevention and care among IDUs in prison settings in Romania – Needle syringe programs
Spain	Centro Penitenciario de Málaga	Implementation in a penitentiary of the "Comprehensive Care Program for Mental Patients in Prison" (PAIEM).
Switzerland	Champ-Dollon	Improvement of measles immunity among migrant populations: lessons learned from a prevalence study in a Swiss prison.

Category 2: An example of best practice regarding any of the following, or a combination of the following: prevention, health education or health promotion services provided to prisoners.		
England	HMP High Down	Healthcare Representatives
Ireland	Wheatfield, Cloverhill and Shelton Abbey	Community Based Health and First Aid – Irish Red Cross Prisoner Volunteers
Kyrgyzstan	Department of Penal Execution at the State Execution Service	Providing support to people living with HIV in prisons
Scotland	HMP and YOI Cornton Vale	Improving the Nutrition of Prisoners
Switzerland	Champ-Dollon	Needle and syringe exchange programs in correctional settings: feasible, safe and necessary!

Category 3: An example of best practice which demonstrates effective co-operation between a prison and the outside community, in the area of health improvement		
England:	HMP & YOI Styal	Gardens and Recycle – GOOP project
Italy:	Casa di Reclusione	Good information by bad people
Moldova:	9 prisons of Moldova	11 years of harm reduction in prisons of Moldova
Netherlands:	PI Vught	High standard, customized forensic mental healthcare for detained, psychiatrically disturbed, sex-offenders: innovative cooperation between a Dutch prison and a Forensic Psychiatric Center.
Spain:	Centro Penitenciario de Ceuta (Los Rosales)	Multicultural Integration Program

The meeting received short presentations from three of the award winners:

Moldova
11 years of harm reduction in prisons in Moldova
Larisa Pintilei

Ms Pintilei presented details of harm reduction activities carried out in Moldova over the past 11 years. This has included:

- Harm reduction in 18 prisons in Moldova.
- Needle exchange points in 9 prisons.
- Distribution of condoms and disinfectants.
- Advocacy for HIV-INFECTED prisoners.
- Training for prisoners on HIV, STD and hepatitis prevention.
- Seminars for penitentiary institutions staff.
- Selecting volunteers (among prisoners) and providing activities on peer-to-peer basis.
- Distribution of informative materials.
- Psychological rehabilitation of injecting drug users detained in penitentiaries.

The results of these activities are:

- Decrease in number of new cases HIV among injecting drug users.
- Decrease in discrimination of HIV-infected and drug-dependent prisoners.
- Decrease in new cases of STDs and HCV.
- Increasing access to drug-dependency treatment for IDUs.
- Increasing the quality of life for IDUs, improving their psychosomatic state.
- Increasing the quality of life for HIV positive prisoners and improving their compliance to ARV treatment.

Georgia
Methadone treatment programme in prison #8
Giorgi Khojevanishvili

Mr Khojevanishvili presented a video message of acceptance from The First Lady of Georgia, Mrs Sandra Roelofs, Chairperson of the CCM, Chairperson of the Supervisory Board for Prison Healthcare Reform.

Mrs Roelofs thanked WHO for the Best Practice Award, which she said is a great encouragement to those working in prison health care in Georgia. Mrs Roelofs reported that Georgia is undertaking, with the support of ICRC, an ambitious programme of reforms in prison health care. Prison health services in Georgia are currently in transition towards the provision of services based on the primary health care model, corresponding to national standards.

Mrs Roelofs extended an invitation to WHO HIPP to hold the 2012 Network meeting in Georgia.

Mr Khojevanishvili provided further detail about the reforms of the prison health care system being undertaken in Georgia. He also gave specific details about the methadone detoxification programme in Prison #8:

- On 15 December, 2008 with the support of the First Lady of Georgia and based on the joint Decree of the Ministry of Justice and the MoLSHA, Methadone Treatment Program was launched in the Penitentiary Establishment N8.
- Supervision of the programme is by the “Supervisory Committee” approved by the joint decree of the Ministry of Justice and the MoLHSA. The programme is implemented through Research Institute on Addiction (Civil Sector).
- Preliminary dose of methadone and treatment duration is defined and approved by the medical consultation committee. The duration of treatment period is varied between 1 to 4 months
- The methadone treatment programme is available for treatment of 50 patients at a time. 506 patients have been through the programme to date (from December 2008 to September 2011). 488 people have already completed the Detoxification treatment, 18 patients are continuing treatment currently.
- Expansion of the program is planned in Western Georgia for 30 beds.

England
Gardens and Recycle – GOOP Project
Michelle Baybutt

Ms Baybutt presented details of the 'greener on the outside for prisons' (GOOP) project which is part of a regional programme which has the overall aim of reducing inequalities and achieve sustainable improvements in health, well-being and learning outcomes for offenders and their families, with a particular focus on mental health, physical activity and healthier eating.

The GOOP project is based at HMP Styal which is an institution for female offenders. Approximately 60 prisoners are engaged in gardening and recycling. The women learn about gardening, growing food, turning food waste into compost and bee keeping.

The prisoners learn about the process of gardening and growing food, produce recipe cards and cook the produce which they grow. As well as the educational aspects, the project has the benefits of providing fresh air, being active, working together, encouraging healthy eating, reducing stress and peer mentoring using green spaces to identify positives rather than focusing on offending behaviour.

9. Closing remarks day 2
Dr Lars Moller, WHO Regional Office for Europe

Dr Moller thanked all speakers and participants for a lively and stimulating meeting and highlighted three key themes from the meeting:

Stewardship
The need for guidance is clear. WHO needs to do whatever it can to encourage Ministries of Health to be involved in prison health. The guidance framework document will be published in summer 2012.

Research
There is a need for more research on prison health. Without good prison-based research we cannot produce evidence based guidance.

Migrant Health/Health in Detention/Violence in Prisons
We need to do further work on these issues. There are new chapters on these subjects in the 2nd edition of the Prison Health Guide.

Dr Moller also stressed the importance of the Best Practice Awards. They are useful in recognizing and disseminating best practice throughout the European Region and can be very important at local level for the prisons concerned in attracting press interest and raising the issue of prison health up the public health agenda.

Dr Moller informed the meeting that preliminary offers to host next year's Network meeting have been received from Slovenia and Georgia.

Finally, Dr Moller reminded the meeting participants that HIPP is facing challenging circumstances and made a plea for funds/support to all Member States and partner organizations.