



UK Health
Security
Agency



UK Overseas Territories Prison Health Needs Assessment Toolkit

UKOTs Public Health Strengthening Programme

April 2023

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Introduction

Improving the health of the 11 million people in prison globally addresses the Sustainable Development Goals and underpins the programme of work agreed at the 2019 World Health Assembly, with the aim of improving universal health coverage and healthier populations.

Prisons also contain people who are often vulnerable to ill health because of their background, their environment and their behaviour in prison. International evidence shows that people in prison experience a higher burden of communicable and non-communicable disease, mental health and substance misuse problems than the general population and often come from marginalised and underserved groups in the community. As a result, the demand for prison health services can be different and even greater than that for community health services. Despite this, prisons usually receive far less support in the form of resources and healthcare funding.

It should be noted that prisons offer an important opportunity for tackling health problems in a way that can deliver benefits to the individual and to the community. Addressing the health needs of people in prison gives an opportunity to improve health outcomes for an underserved population group in the community. However, as much as we should aspire to use time in prison as a positive, rehabilitative experience, it is recognised that prisons are not a healthy environment.

Prison, for most, is a transitional setting along a life course – most people return to the wider community. Therefore, addressing health in prisons has an impact on wider community health outcomes (e.g. infectious diseases) as well as many drivers of criminal behaviour being related to health (e.g. substance misuse, mental health). Action on health can also reduce reoffending and potentially reduce later costs in healthcare and community safety.

Maintaining international standards

There are several international standards informing prison health. The UN Standard Minimum Rules for the Treatment of Prisoners (2015) comprises 122 rules over 9 thematic areas, including medical and health services, staff training, vulnerable groups in prison, investigation of deaths and preserving the inherent dignity of people in prison. The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders considers the specific needs of women. These standards provide a human rights-based approach to the health of people in prison which puts the identity of patients before prisoners.

The WHO advocates for the need to strengthen prison health systems, and policymakers must take this into account in their strategic planning. These strategic and policy-related decisions must be based on an understanding of the health needs of the population that they are related to.

This toolkit is aimed at providing support and guidance to the UK Overseas Territories in developing and delivering a prison health needs assessment to support strategic and policy-related decisions ensuring appropriate allocation and utilisation of resources and funding for health care.

UK Overseas Territories

There are 14 UK Overseas Territories (UKOTs), not all of which are populated, but 10 of which have a prison population. Whilst the responsibility for health in the UKOTs remains with the government of the country, the responsibility for justice in the UKOTs remains with the UK government. This provides a challenge and an opportunity to ensure collaborative cross sector working across health and justice.

| UK Overseas Territory (+ approx. size of entire population¹) | Operational capacity of prison system² |
|--|--|
| Anguilla (15,094) | 60 |
| Bermuda (63,918) | 385 |
| British Antarctic Territory (0 pop) | - |
| British Indian Ocean Territory (0 pop) | - |
| British Virgin Islands (30,030) | 150 |
| Cayman Islands (64,948) | 233 |
| Falkland Islands (2840) | 18 |
| Gibraltar (33,701) | 98 |
| Montserrat (5,900) | 52 |
| Pitcairn Islands (67) | 2 |
| St Helena, Ascension Islands, Tristan da Cunha (4255) | 21 |
| South Georgia and the Sandwich Islands (0 pop) | - |
| Sovereign Base Areas of Akrotiri and Dhekelia (18,195) | 12 |
| Turks and Caicos Islands (38,191) | 83 |

Figure 1: Table of UKOTs and estimated prison operational capacity

¹ Estimates from World Bank figures. These may not be up to date.

² Taken from current figures on the World Prison Brief (Institute of Crime and Justice Policy Research, University London, Birkbeck) and from Ministry of Justice (UK) data.

Target audience

This document is intended for people and organisations who want to carry out a comprehensive assessment of the health system and health-related needs in a prison system. It may be especially useful for public health teams, health specialists, such as doctors and nurses working in prisons, researchers, or managers of health programmes.

Where to use the guide

Although the document is concerned mainly with prisons, the approach set out in it and the tools, may be used in other places of detention as well, such as police stations or immigration detention centres.

Guiding principles

The document is guided by the following principles:

- prisoners must have equal access to health care, regardless of their legal situation³
- good prison health is good public health⁴
- the health and well-being of detainees is a “whole-of-government responsibility”⁵
- strong health systems are essential for improving health outcomes⁶

Contents

This document consists of a practical guide divided into 9 chapters including a set of tools (interview guides, checklists, and questionnaire) available in the appendices.

³ United Nations Basic Principles for the Treatment of Prisoners, 1990, Principle 9.

⁴ WHO, Declaration on Prison Health as Part of Public Health, 2003.

⁵ WHO Regional Office for Europe, Good Governance for Prison Health in the 21st Century, 2013.

⁶ WHO, Systems Thinking for Health Systems Strengthening, WHO, Geneva, 2009.

Aim and specific objectives

The aim of a health needs assessment is to provide the pertinent authorities with an overview of the prison health system and of the health-related needs of people in prison. Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.⁷

Qualitative and quantitative data collected during an assessment can support the development of evidence-based priorities, allocation of resources and action planning to improve access to health care and health outcomes for people in prison.

The specific objectives of the assessment are to:

- Provide a description of the prison population of the country and of their health problems
- Analyse the physical and social determinants of health in prisons
- Evaluate the performance of the prison health system, and its linkage to the national health system
- Assess the extent to which existing health services meet the needs of people in prison
- Identify the strengths and shortcomings of the prison health system and means to address the latter
- Provide a baseline for developing projects and programmes to strengthen the prison health system and meet health needs

⁷ Cavanagh, S. and Chadwick, K. (2005). Health needs assessment: a practical guide. National Institute for Health and Clinical Excellence (Great Britain)

Organising an assessment

In the UKOTs it is essential that there is engagement with the key stakeholders in prison health to ensure the appropriate level of support for the HNA and its outcomes, including the consideration of any resources required to conduct the HNA as well as implementing any recommendations.

Examples of key stakeholders in prison health in the UKOTs:

- Premier of UKOT/Permanent Secretaries with portfolios for health and justice
- Governor's Office
- Chief Medical Officers/Directors of Public Health
- Prison Superintendent
- Health authority providing healthcare

Detailed planning and preparation before conducting an HNA is required. The following preparations are recommended:

1) Establishing a working body at the ministerial level

A working body, permanent or temporary – such as a steering committee for prison health – must be set up before the assessment. Ideally, this should be done by the ministry responsible for prison health and must consist of officials from the other ministries involved – preferably from their central level – and from the implementing organisation. The working body will be responsible for the following:

- Developing the terms of reference for the assessment.
- Approving the composition of the assessment teams (see below).
- Approving the country-specific assessment methodology and data collection tool.
- Approving the assessment implementation plan.
- Liaising with the national ethics committee and obtaining its approval (if required).
- Coordinating and facilitating the fieldwork of the assessment teams, which includes visiting selected detention facilities and meeting with senior members of the prisons' management teams, public health authorities and the various stakeholders working in prisons.

An example of a terms of reference for a steering committee and a working group (which may carry out the operationalisation of the work) is given in the appendices.

2) Forming assessment teams

Organising and assessing a prison's health system and detainees' health needs is a multidisciplinary exercise. To ensure the objectivity of an assessment, and to make sure that

it has an added value, the assessment teams must be independent of the ministry responsible for prison health. Public health teams in the UKOTs are ideally placed for this activity.

The assessment should be led by a core team made up of health professionals and containing representatives of the independent organisation conducting the HNA. The size and make-up of the team will depend on the context of the UKOT, size of the prison population/sample to be assessed and the available resources and capacity of the independent organisation.

The core team should be led by a principal assessor, who will be responsible for designing and carrying out the assessment. This person should have skills in public health or work experience in a related field, particularly health systems strengthening and epidemiology including qualitative study designs and sampling methods.

A medical doctor or nurse who has worked in prison settings, preferably in the country concerned is also a key professional that will be useful in developing and delivering the HNA.

The core team can be assisted by other people from the implementing organisation forming an assessment support team. This team can conduct individual interviews with detainees and collect information on the determinants of health. It may include non-specialist personnel visiting prisons in the country concerned (e.g. third sector organisations such as charities, church groups), interpreters, and/or experts in water and hygiene, food and nutrition, and prison systems.

The assessment teams must be debriefed regularly while the assessment is in progress.

Tasks of the core assessment team:

- Carrying out a desk review of national policies and frameworks, and other country-specific information related to health in prisons.
- Choosing the methodology of the assessment.
- Adapting generic tools, questionnaires, and interviewer checklists to the context.
- Drawing up a list of relevant stakeholders.
- Drafting an implementation plan.
- Indicating any ethical issues related to the assessment.
- Determining the composition of the assessment support team.
- Defining the tasks of each member of the assessment support team.
- Training the assessment support team (this includes doing practice interviews with them) and organising debriefing sessions.
- Doing fieldwork (visiting the prison and interviewing prison staff and detainees and other stakeholders outside the prison).
- Entering and analysing data collected during the visits and interviews.
- Preparing a report (to be co-ordinated by the principal assessor).
- Making a formal presentation of the assessment's findings.
- Administrative and logistical support for the assessment teams should be ensured.

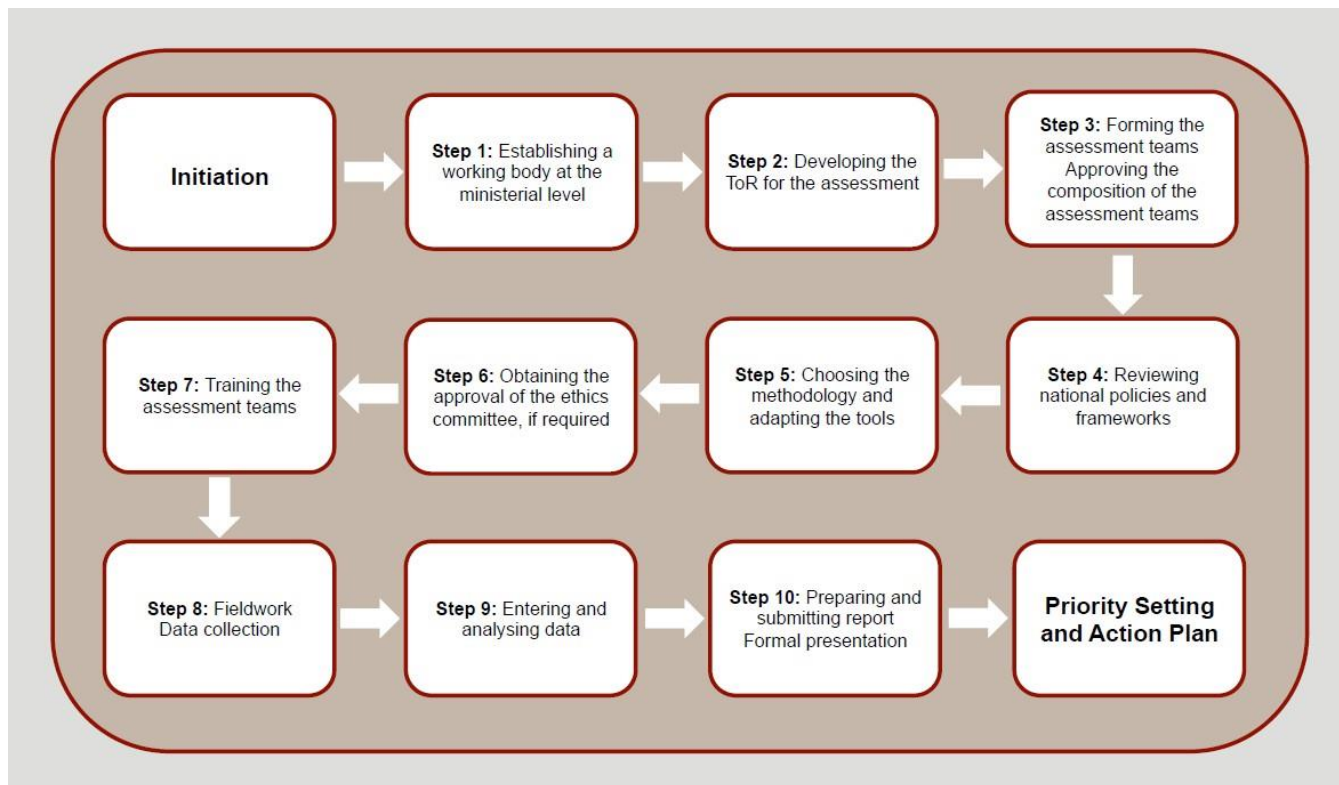


Figure 2: A step by step plan for organising a prison health needs assessment⁸

Training the assessment teams

Giving the teams the necessary training is crucial for the success of the assessment. It is particularly important to ensure that all team members understand the objectives of the assessment and the approach being employed, and that they have the requisite interviewing skills. Enough time should be set aside for training.

Some general tips for conducting interviews

- Remain neutral, but attentive.
- Do not say anything to give the interviewee the impression that he or she is being judged.
- Focus on what the interviewee is saying, and do not interrupt.

⁸ ICRC (2018). Healthcare in Detention. Health systems and needs assessments in prisons. A practical guide and toolkit.

- If the interviewee gets off the subject, guide the conversation back to the question at hand.
- If the interviewee does not understand a question or gives an answer unrelated to it, repeat or reformulate the question.

In relatively small prison populations such as in the UKOTs, it is recommended that individual interviews are conducted with people in prison rather than in groups.

Consideration with the prison needs to be given as to whether interviews need to be supported by the presence or near presence of prison officers – this consideration should only be made in view of security risks, particularly in keeping any members of the assessment team safe. It is imperative that people in prison are given the opportunity to express their thoughts and experiences without the influence of prison staff to ensure an objective and accurate assessment.

Ethical considerations

The ethical aspects of the assessment must be given thoughtful consideration. Participants, both authorities and detainees, should be given all information pertinent to the assessment, to ensure that they understand and accept its principles and aim. Participation in the assessment must be voluntary. Before interviewing detainees, secure their informed consent, orally or in writing.

Participants have the right to withdraw from an interview at any time. It should be made clear to them that refusing to participate in the assessment, or withdrawing from it at some stage, will not jeopardize the quality of the care to which they are entitled. The anonymity of the participants must be safeguarded.

The approval of the national ethics committee should be obtained if required. An example of a consent form is given in the appendix.

For further considerations, please see “A Scoping Review of Qualitative Research Methods Used with People in Prison”.⁹

⁹ Abbott, P. et al. (2018). A Scoping Review of Qualitative Research Methods Used With People in Prison. *International Journal of Qualitative Methods*, 17(1). <https://doi.org/10.1177%2F1609406918803824>

Assessment design

There are two main kinds of assessment or study design: qualitative and quantitative. They differ in the methodologies they use and in the information they target and collect. The core assessment team must therefore define the design according to the objectives of the assessment and the available resources.

If this is the first assessment conducted for the prison, it might be informative to carry out a qualitative assessment first. This can help in shaping future assessments and provide context and understanding of the prison health system.

Ideally a quantitative assessment should be conducted after the initial assessment, bearing in mind the context and target groups. In this case, a biostatistician or lead in health informatics should be involved in the study design and analysis of the data collected.

Qualitative study designs usually take the form of qualitative interviews, focus-group discussions, or direct observation. They do not always search for statistical significance, but they seek deeper exploration of certain concepts, patterns and the perceptions of participants. Quantitative study designs, usually surveys or epidemiological data collection, seek to obtain generalisable information that can be expressed numerically: as percentages, means/medians, or ratio measures. A design of this kind should use statistical analysis if possible.

Combining both has numerous important advantages: for instance, a qualitative study can be carried out before a survey to ascertain the types of question that should be put to participants; or afterwards, to explore in a more detailed way the patterns revealed by the survey.

The sampling methodology will be determined by the study design. Quantitative studies require sampling methodologies to obtain a representative sample in statistical terms, so that the percentages, means/medians or ratio measures calculated from it can be used to make inferences about the whole sample. Qualitative studies, on the other hand, require samples that are representative of patterns and perceptions and do not have to yield statistics.

Sampling methodology

The UKOTs that do have prisons, generally have one prison, which may be on multiple sites (e.g. female prison, juvenile detention). Given the small prison populations, it is recommended that as many people as possible are interviewed from each of the sites/wings of the prison.

In larger prisons, a sample should be taken from the detainee population ensuring that a sample for each category of detainee is included, to reflect the differences and similarities in experience and perception. If possible, a sample size of 10 to 20 per subgroup should be used.

Alongside ensuring certain groups are included in the assessment, in larger prisons, a more purposive sampling method can be used if helpful, which considers the specific focus or purpose of an assessment to determine which categories of detainee should be selected. Purposive sampling can be advantageous because it entails interviewing specific types of detainees to gain insight into specific issues.

Examples of subgroups:

- Men
- Women
- Juveniles/young people
- Older adults
- Detainee-helpers (e.g. dormitories, kitchen, health-care facility, etc.)
- Detainees with specific health conditions (e.g. TB, HIV/AIDS, non-communicable diseases, inpatients, drug users, etc.)
- Detainees in solitary confinement
- Detainees who used health services and/or had a referral
- Immigration detainees

Some detainees will refuse to participate in the assessment. Experience shows that the rate of refusal is usually very low, therefore, there is no need to adjust the sample size. When one detainee declines to be interviewed, the assessment team can select another.

If it is difficult to obtain a representative sample, the core assessment team may decide to use a non-representative sample and afterwards mention or draw attention in the report to this limitation of the sampling methodology.

Exclusion criteria to consider:

- Detainees who were in the selected facility for a very short period (e.g. Less than two weeks), and who were therefore less likely to have used the health services.
- Detainees suffering from psychosis if there is a risk of their giving incoherent responses.
- Accompanying children (but their mothers can give information on health care for them).

Close working with the prison is essential to understand the internal dynamics of the facility (e.g. access to health services for detainees, gatekeeping system, etc.), and include the most vulnerable detainees in the sample. The layout of the detention facility should be considered while doing the sampling. In facilities with separate wings or units, the sampling should include each area.

Data collection methods

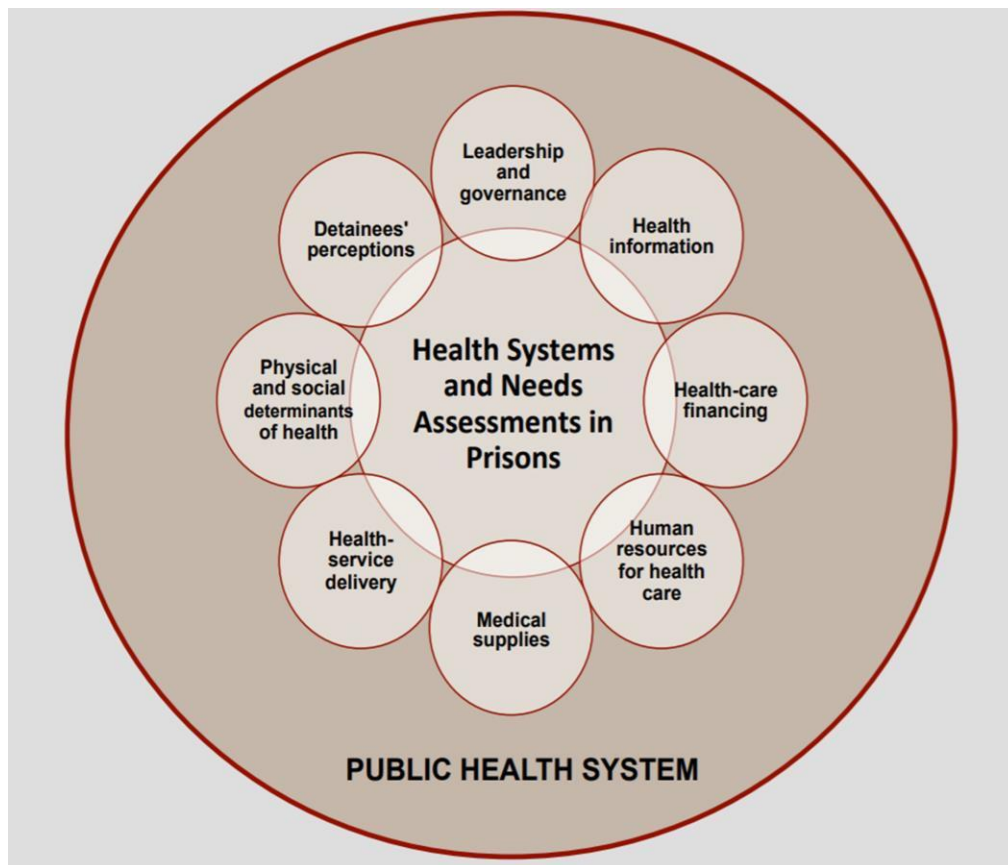


Figure 3: ICRC’s areas of enquiry for a prison health needs assessment

The World Health Organization Health System Framework¹⁰, which describes health systems in terms of six core components or building blocks, can be used to frame the areas of enquiry for the prison health needs assessment. Two other building blocks or core components – “Physical and social determinants of health” and “Detainees’ perceptions” – are added to the WHO framework, to enable objective or impartial assessment of the general conditions of detention and to capture detainees’ views on the provision of health services. Furthermore, detainees are regarded not only as beneficiaries or service users, but as actors capable of influencing the system.

¹⁰ WHO, Systems Thinking for Health Systems Strengthening, WHO, Geneva, 2009.

The data that are collected should be pertinent to the aim and the specific objectives of the assessment and should always be kept confidential.

Review of national policies and frameworks, and other country specific information related to health in prisons (secondary data source)

It is important to understand the context within which a prison health system operates.

Therefore, when setting out to collect data, begin by:

- Identifying and reviewing potential sources of data, such as the domestic legislative framework, specifically laws and decrees related to the penitentiary system, standard operating procedures at prisons, and prison reports.
- Collecting information about the types of prison and their capacity, and the legal and demographic profiles of the detainee population.

The assessment will also rely on in-country sources of data on health. These sources include:

- National health policies and strategic plans.
- The country's epidemiological profile and health reports from the ministry of health, who reports, acts, or laws on patients' rights, sop at prisons, including protocols for managing specific diseases (e.g. Tb and hiv/aids).
- All essential information available about the prevalence of various diseases and illnesses in prisons.

Interviews with prison and health authorities, healthcare providers prison staff, detainees, and stakeholders outside prisons (primary data source)

When setting out to collect data from the various stakeholders, begin by interviewing the prison and health authorities, explaining the objectives and the methodology of the assessment to them.

Interviews with prison staff, healthcare providers at prisons and referral health facilities (e.g. hospitals), detainees (service users) and relevant stakeholders outside prisons – such as organisations (national and international), involved in the provision of health care in prisons or supporting people in prison (e.g. church groups, independent monitoring boards) – are crucial for evaluating the performance of prison health systems and for assessing detainees' needs.

It is also important to interview the prison and health authorities at the central, decision-making level (Permanent Secretaries, Chief Medical Officers, Prison Superintendents and representatives of the Governor's Office) to have their views on the strengths and weaknesses of the prison health system, and on ways to address the latter.

Data from interviews should always be treated as sensitive and kept confidential, with only the core assessment team to have access to it. Information governance guidance should be followed, for example keeping data in locked facilities and maintaining a record or log of people accessing it.

Conducting the interviews

Enough time should be set aside for each interview. Using the tools in this guide, an interview with a detainee usually takes about 45 minutes but an hour should be scheduled to allow for filing paperwork, organising the interview room, comfort breaks.

Interviews should be conducted, whenever possible, in a comfortable location, one that is also free from the risk of interruption. To ensure confidentiality, those locations should be chosen that afford the greatest amount of privacy. As previously stated, interviews with detainees should be conducted out of earshot of custodial staff. This should be agreed upon in advance with the prison and prison authorities must guarantee the security of assessment teams conducting interviews in their prisons.

Observations made during prison visits also provide a rich source of information about the general environment, the prison health facility, and the referral health facility. These direct observations should focus on the physical and social determinants of health (also known as the 'general conditions of detention'): living conditions, clothes, bedding, general and personal hygiene, water, food, occupational and educational activities, etc.

The assessment tools

The tools in the appendices have been adapted from other instruments. These tools are designed to give the assessment teams a framework and guidelines for conducting interviews at various levels; and to enable uniform and comprehensive data collection. They should be adapted further for local use with the oversight of the prison health steering committee or working body for the HNA.

As described above, the core of the interview schedules is based on the International Committee of the Red Cross and the guidance provided in "Healthcare in detention: Health systems and needs assessments in prisons"¹¹.

Specific questions in the questionnaire for women consider a gender specific approach to healthcare in prison. The interview schedule for people in prison was also supplemented with questions on current health status from the WHO STEPwise approach to NCD risk factor surveillance (STEPS) instrument¹² for collecting data and measuring risk factors for non-communicable disease, to deepen understanding of established risk factors that determine the major disease burden. A decision can be made as to whether there are resources available to build on the core data fields from the STEPS instrument, and use the extended versions, which require physical or biochemical measurements.

The core data fields included questions on tobacco use, alcohol consumption, diet, physical activity, as well as history of raised blood pressure, diabetes, cholesterol, and any lifestyle advice given by health professionals.

The data extraction fields were developed from the Public Health England Prescribed places of detention: health needs assessment toolkit¹³. A copy of these fields can be found in the appendix.

Experience shows that it is best not to solely rely on a set list of questions while interviewing prison and health authorities at central and local levels. Interviewers should be ready to discuss any issue raised by stakeholders, who should feel free to express their views.

¹¹ International Committee of the Red Cross (2018). Healthcare in detention: Health systems and needs assessments in prisons. Geneva.

¹² <https://www.who.int/ncds/surveillance/steps/instrument/en/>

¹³ Public Health England (2015). Prescribed places of detention: health needs assessment toolkit. London. <https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

The questionnaire for detainees and the checklists consists mainly of closed questions, which makes it possible to gather qualitative and quantitative data that can then be compared.

The checklists can be used with various groups of people (not only those mentioned here), as required by the assessment.

There is no specific guide for interviewing representatives of organizations involved in the provision of health care in prisons. These interviews should be open, but relevant questions from the interview guides and the checklists may be asked.

Composition of the assessment tools

One interview guide:

- For use with prison authorities and health authorities at central and local levels, such as officials from the ministries responsible for prisons and senior members of the management team at selected detention facilities, as well as those providing healthcare at the prison or for people in prison.

Three checklists for in-depth interviews with key stakeholders:

- One for health-care providers at prisons.
- Another for the head of the central pharmacy.
- The third for health-care providers at referral health facilities.

Two questionnaires:

- Designed for individual interviews with detainees.
- For use with families or social networks to assess the wider impact of incarceration.

Suggested data fields for epidemiological data collection are also included.

Data analysis

The results of the analysis should be interpreted carefully, so that conclusions can be formed, and recommendations formulated.

The first step in data analysis is to arrange or file all the data that have been collected under categories corresponding to the contents of the report. The following approaches may be helpful:

Interviews with prison and health authorities, health-service providers, prison staff and stakeholders outside prisons:

Focus on one area at a time and group the answers of each respondent accordingly

For interviews conducted with the help of the interview guides and the checklists, a SWOT matrix (strengths, weaknesses, opportunities, threats) might be helpful in structuring information.

Interviews with detainees:

Detainees' answers to open and closed questions from the questionnaire for detainees should be coded and analysed. Depending on sample sizes, the appropriateness and practicality of using statistical analysis software should be considered. Alternatively, it is also possible to enter data into Microsoft Excel spreadsheets for basic descriptive analysis.

Focus on one area at a time and group the statistics and information gathered from detainees' responses accordingly.

Epidemiological data:

Focus on the health conditions that are most prevalent and most serious among detainees, and on the corresponding indicators selected for measurement. A set of data fields from the Public Health England (now known as the UK Health Security Agency) prison and detained settings needs assessment toolkit is given in the appendices. If possible, comparison should be made with similar health indicators for the general population of the country.

Observations:

Identify and analyse patterns revealed by direct observation at the selected detention and referral health facilities, and by information gathered from the prison staff and from pertinent documents, reports, and reviews. Note where there is evidence of concordance or disparity.

Documents:

Ensure that the documents are readily accessible by organising them by category: policies (legal and health), laws, standard operating procedures, reports, etc.

Comparators and benchmarks

The analysis should consider all eight components or blocks of the prison health system. The qualitative information drawn from primary and secondary sources should be supplemented with the relevant quantitative indicators for monitoring health systems. Because of the dynamic links between the building blocks, the indicators may also have relevance of more than one kind.

It is recognised that the public health potential of prison health services is contingent on effective identification of health needs, delivery of quality care in custody, and integration of prisons as part of the continuum of care in community health services.¹⁴ Understanding the prison health system through the building blocks requires that ideally each block be compared with the national health system where possible.

Alternatively, comparison between other prison health systems could be helpful. Despite public investments in prison health services little is known internationally about the health needs of people in prison in smaller communities. Additionally, there is a notable lack of evidence from low- and middle-income countries¹⁵. Many studies on prison health are skewed, from countries with large, incarcerated populations such as the USA, UK and Australia. This makes identifying suitable comparators for the UKOT prisons challenging. It is hoped that the UKHSA UKOT Public Health Strengthening Programme will have the opportunity to encourage prison health needs assessments across the UKOTs in the coming years, some of which might be more useful as comparators.

Areas of inquiry and examples of indicators

1. Leadership and governance

This is one of two cross-cutting areas that can ensure effective national guidance for developing an efficient prison health system. 'Leadership and governance' play a role in each of the other areas of inquiry and can have a positive or negative effect on the whole prison system. Without good governance it can be a challenge to address gaps in the system and implement changes.

¹⁴ McLeod KE, Butler A, Young JT, Southalan L, Borschmann R, Sturup-Toft S, Dirkzwager A, Dolan K, Acheampong LK, Topp SM, Martin RE, Kinner SA. Global Prison Health Care Governance and Health Equity: A Critical Lack of Evidence. *Am J Public Health*. 2020 Mar;110(3):303-308. doi: 10.2105/AJPH.2019.305465

¹⁵ Stuart A Kinner, Jesse T Young, Understanding and Improving the Health of People Who Experience Incarceration: An Overview and Synthesis, *Epidemiologic Reviews*, Volume 40, Issue 1, 2018, Pages 4– 11, <https://doi.org/10.1093/epirev/mxx018>

Examples of evidence for this area include:

- a legal framework
- organisational and administrative structures with defined roles and responsibilities
- national policies, regulations and standards
- links to and agreements with the ministry of health, or examples of inter-ministerial coordination
- monitoring, evaluation and quality assurance mechanisms (which will require standards to measure against)
- existence of a prison health policy covering such areas as regulations and procedures, services, procurement of medicines and equipment, financing and human resources
- a strategy or operational plan for prison health, reflecting specific needs and priorities
- documents or reports, such as annual service performance reviews or board reports a consistent set of indicators for the services provided to the prison or place of detention
- one or more coordination mechanisms between the ministry in charge of the prison and the ministry of health

2. Health information system

This is the second cross-cutting area. It provides a basis for understanding needs and serves as a starting point for planning. It will always be necessary to use a variety of sources to gather data on the health status of detainees.

At the prison level, these sources can take various forms: medical registers, records of reception health assessments, statistical reports on prison health, or prison health staff and the views of detainees themselves. Information can also be obtained from other stakeholders involved in prison health, such as community health services and volunteer or faith organisations.

The Five Nations Prison Health Surveillance Model¹⁶ is based on the established and tested Centers for Disease Control and Prevention (CDC) guidelines for public health surveillance and could provide a foundation for developing work in this area.

¹⁶ S Perrett, E Plugge, P Conaglen, E O'Moore, S Sturup-Toft, The Five Nations model for prison health surveillance: lessons from practice across the UK and Republic of Ireland, *Journal of Public Health*, Volume 42, Issue 4, December 2020, Pages e561–e572, <https://doi.org/10.1093/pubmed/fdz122>

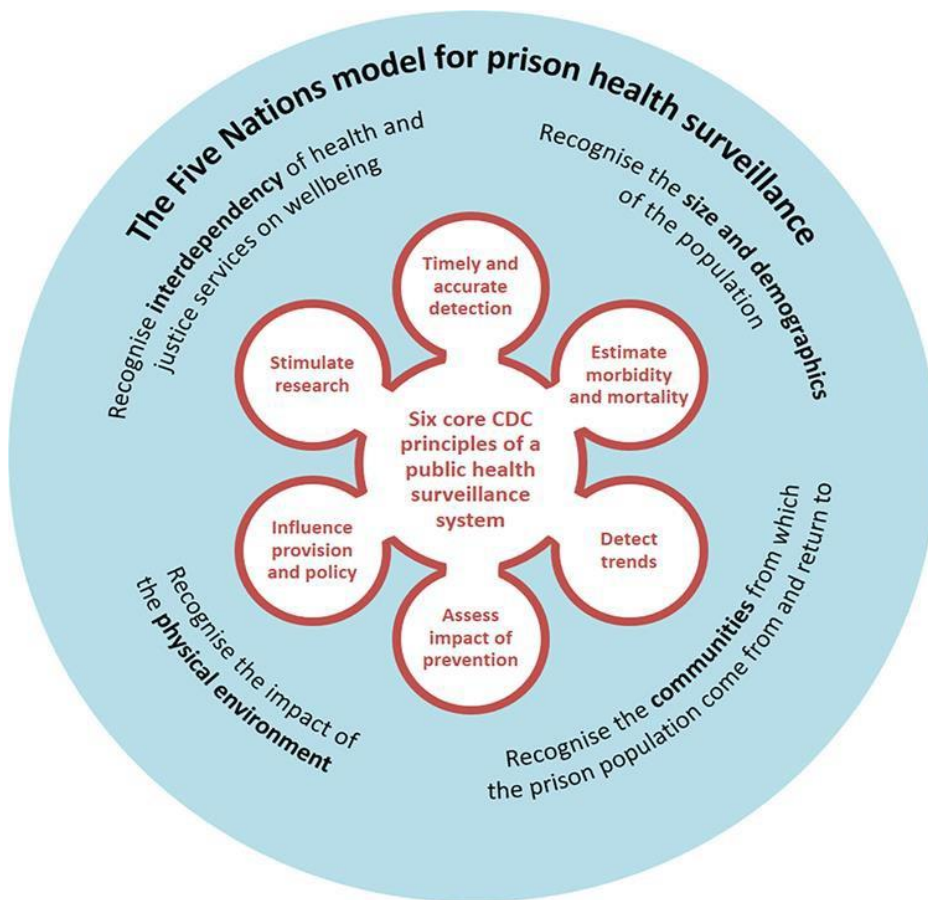


Figure 4: Five Nations Prison Health Surveillance Model (2020).

Examples of evidence for this area include:

- National policies and regulations mandating prison health facilities to report indicators selected by the national health authority/public health team.
- Availability of standards and guidelines for data collection and reporting procedures.
- Availability and accessibility of data sources.
- Availability of enough numbers of qualified staff to collect, provide and analyse health-related information.
- Information governance arrangements in place and assured to keep medical records and data confidential.

3. Health-care financing

Health-care financing is essential for ensuring the equitability, effectiveness, and sustainability of prison health services. Expenditure for health care in prisons should cover all the activities of a prison health system. Analysis of such expenditure,

together with a detailed knowledge of the health needs of detainees, enables resources to be allocated more effectively.

Any policy for financing health care in prisons should seek to ensure that detainees can obtain the services they need free of charge¹⁷.

Examples of evidence in this area include:

- A clearly defined prison health budget and a budget allocation structure
- Ability to describe the total expenditure on detainees' health.
- Description of total expenditure on detainees' health as percentage of total expenditure on public health at the community level.
- Percentage of expenditure on health care in prisons derived from external sources of finance (donor funding).
- Percentage of health budget allocated to each category (human resources, medical supplies, equipment, etc.).
- Percentage of health budget spent on-site (in prison) and off-site (hospital) care, including expenditure on prison escorts to off-site healthcare and bed watches.
- Any out-of-pocket expenditure for medicines.

4. Human resources for health care

The right of everyone to enjoy “the highest attainable standard of physical and mental health”¹⁸ imposes on authorities an obligation to guarantee the availability of enough numbers of trained health staff to prisons. Ensuring appropriate support and professional development for people working with prison populations is crucial to being able to achieve this.

As in the national health system, human resources for a prison health system should include clinical staff (doctors, nurses, pharmacists, laboratory technicians, etc.), and managerial and support staff (managers, health data managers, financial officers, etc.). In the UKOTs, these

¹⁷ The Nelson Mandela Rules (United Nations Standard Minimum Rules for the Treatment of Prisoners), 2015, Rule 24.

¹⁸ Article 12, International Covenant on Economic, Social and Cultural Rights, 1976.

may be the same people across the community and prison, however, the responsibility for including prison health in their remit requires definition, clarity, training and professional support, if required.

In general, the ratio of physicians and nurses to detainees should be the same as or higher than that at the community level¹⁹. Although staffing requirements for healthcare in prisons has not been formally defined at the international level, staffing should be able to cover the health needs of detainees, including access to healthcare services both during the day and night, and on weekends.

This requirement does not always necessitate the presence of an on-site inpatient unit which would create specific human resource pressures. The exact nature of the provision will depend on the level of care required and local resources. Importantly, staff should be appropriately qualified as required for community healthcare provision and adequate working conditions in terms of health facilities, medical supplies, salaries and training opportunities should be standard. In all these areas, the prison health system must operate, at the very least, at the same level as the public or community health system.

Examples of evidence in this area include:

- Number of physicians/nurses per 100 detainees.
- Availability of continuing education programmes for prison health staff.
- Mechanisms to monitor and improve the performance of health staff.
- Services and support for prison health staff including clinical supervision to enable reflective practice, stress management and health promotion.

5. Medical supplies

This area of the prison health system focuses on policies, laws and regulations related to medical supplies and expenditure on pharmaceuticals and equipment, and to the procurement, storage, use and accessibility of these items. Like the building block on service delivery, its concerns are the availability and the provision of health care for detainees.

National standards should define what must be available in prison health facilities, according to the type of facility, its purpose, and its capacity in terms of human resources, including essential drugs and medication.

Equipment should fit the services offered at the prison's health facility. Standard lists are useful because they can define how various facilities should be equipped, based on their

¹⁹ International Committee of the Red Cross (2018). Healthcare in detention: Health systems and needs assessments in prisons. Geneva.

size and capacity in terms of human resources, the availability of specialised services, the distance to the nearest hospital, etc.

Examples of evidence for this area include:

- Existence of standard operating procedures for procuring pharmaceuticals and equipment.
- Ability to report the total expenditure on pharmaceuticals and equipment (percentage of total expenditure on health care in prisons).
- Existence of an essential medicines list for prisons.
- Availability of essential medicines and frequency of stock-outs.
- The prison health facility meeting standards for storing and dispensing drugs.
- National standard treatment protocols, and availability of these treatment protocols in prison health facilities.

6. Healthcare service delivery

The following are the key areas to evaluate while assessing the delivery of health services in prisons:

- Availability and effectiveness of prison health services.
- Access for detainees to primary health services on site (in prison) and to secondary and tertiary care (hospital).
- Equity in delivery of health services and ultimately, health outcomes.
- Quality of health services.
- Sustainability of health services.
- Health outcomes.

Primary health care is the basis of a prison health system, as it is for the public health system that serves the community outside prison. Primary health care in prison includes:

- Medical examinations on entry/reception.
- Management of communicable diseases.
- Management of non-communicable and chronic diseases.
- Antenatal and postnatal care.
- Dental and eye care.
- Mental healthcare, including treatment for substance use disorders.
- Health promotion and prevention of disease.

The effectiveness of the prison health system also depends on a system that ensures continuity of care from community to prison and back to community. There are certain pressure points in this justice pathway that can make it challenging to achieve this, such as when detainees enter prison, when they leave and re-enter prison before and after court visits, when they are transferred to another prison and when they are discharged from custody.

Examples of evidence for this area include:

- Provision of a minimum primary health care package required by prison health policy.

- Proportion of detainees attending daily outpatient consultations on site (in prison).
- The crude mortality rate.
- Prevalence of most frequent serious diseases among detainees (tb, hiv/aids, etc.).
- Existence of standard operating procedures for referral to specialist services.
- Average waiting time for referral (urgent and non-urgent conditions).
- Transfer rate (number of patients transferred to hospital divided by total number of such requests made by prison health facility).
- Use of national protocols to treat common health conditions.
- Equity in the delivery of health services.
- Technical and supportive supervision, and other processes assuring quality of health care.

7. Physical and social determinants of health

Health is inextricably linked to physical and social determinants, and these become key factors in prison health.

The following areas are examined and analysed under this building block:

- Accommodation
- Clothes and bedding
- General and personal hygiene
- Water: quality, quantity, and safety
- Food: quality, quantity, and safety
- Outdoor access
- Social support and social interaction
- Occupational and educational activities/time out of cell in purposeful activity.

8. Detainees' perceptions

To understand how a health system works or evaluate its effectiveness, the consideration of the perceptions of the people it serves is crucial. Detainees' perceptions should be included in any assessment of a prison health system and its components, as they will provide indispensable information on the gap between policy goals and achievements and on detainees' needs and priorities.

Further evidence of regular engagement with detainees is important for this area, such as a prison health council/committee, suggestions box, surveys, informal mechanisms for detainees to share their views outside of any prison HNA process.

The report

The format of the report can be guided by the prison health steering committee or working body, but it will be important to document the methods used.

Acknowledging that in the UKOTs the sample sizes might be small, it is still important to highlight issues that come up. Regular assessments will show if these issues are systemic and require more in-depth actions.

Ensuring the confidentiality of participants is especially important in a prison setting and in small communities. How data and views are presented needs careful consideration.

The assessment report is not the end of the process, and it should serve as a springboard for the authorities to discuss and agree priorities and an action plan for improving access to health care and health outcomes for detainees.

[An example report outline:](#)

Executive summary

Section I: Aim and specific objectives

Section II: Background

- Context and dynamics of detainee population
- National public health system
- Guiding principles

Section III: Methodology

- Sampling methodology
- Data-collection methodology

Section IV: Findings

- Population profile of the detainee sample
- Health profile of the detainee sample
- Physical and social determinants of health
- Prison health system
 - Leadership and governance
 - Links with the ministry of health, the criminal justice system, and other stakeholders
 - Health information system
 - Medical records and medical confidentiality
 - Health-care financing
 - Human resources for health care
 - Availability
 - Recruitment and assignments
 - Continuing education and training
 - Medical supplies and management

- Health service delivery
 - Health facility infrastructure
 - Organisation of prison health services
 - Access to health care at prison level/primary- health-care services
 - Secondary and tertiary care
 - Mental health and substance use services
 - Health care for specific groups
 - Through-care
 - Terminal illness and death in custody
 - Health promotion and prevention of disease among detainees
 - Health promotion and stress management among staff
 - Quality of care
 - Equity in delivery of health services
 - Patient-detainees' satisfaction ratings

Section V: Summary of stakeholders' and detainees' suggestions for strengthening the prison health system

Section VI: Conclusions and recommendations Section VII: Appendice

Section VII: Appendices

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UKHSA is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats. We provide intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation health secure.

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Version 2

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Published: April 2023
Publishing reference: GOV-XXXX

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