HEALTHCARE IN PRISON

CPT

EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

PRISON STANDARD

CPT/Inf (2025) 37

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European Committee
for the Prevention of Torture
and Inhuman or Degrading Treatment
or Punishment (CPT)

Council of Europe

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Contents

The considerations which have guided the CPT when examining a prison healthcare service are set out under the following 10 headings:

HEALTHCARE IN PRISON

INTRODUCTION

1. Persons admitted to prison[1] have a fundamental right to live a safe, humane and healthy life while deprived of their liberty. The functioning and quality of a prison healthcare service is of direct relevance to the CPT's mandate.

2. The European Court of Human Rights (the Court) has repeatedly emphasised that Article 2 (right to life) and Article 3 (prohibition of torture) of the European Convention on Human Rights (the Convention) impose a duty on the state to protect the life, health and well-being of persons deprived of their liberty, which implies an obligation on the authorities to provide them with the necessary and effective healthcare. This may also include appropriate mental healthcare and treatment. The standard of healthcare provided in a prison should be "compatible with the human dignity" of a prisoner. As such, the Court has held on many occasions that a lack of appropriate healthcare may amount to inhuman or degrading treatment, contrary to Article 3 of the Convention, or – where a death occurred in detention – to a breach of Article 2.

3. Prison healthcare services play an important role in preventing ill-treatment and combatting impunity not only within prisons but in other places where persons may be deprived of their liberty (in particular, in police establishments prior to being transferred to prison). Moreover, healthcare professionals are well placed to make a significant contribution to the overall quality of life of prisoners and to the working conditions of staff in the establishment within which they operate.

4. The positive impact of prison healthcare services goes beyond the limits of imprisonment. This is an issue of wider public health, as time spent in prison may be an opportunity to identify and treat prisoners with transmissible or chronic diseases or to adequately support those persons with substance use or mental disorders, before their release into the community.

> **An inappropriate level of healthcare may amount to inhuman or degrading treatment**

5. This paper constitutes a consolidated update of the views expressed by the CPT in previous General Reports, and is based on the findings of visits carried out to numerous prison establishments across Europe over the past 35 years.[2] It also takes into account the relevant case law of the European Court of Human Rights,[3] as well as the relevant standards set out in various legal instruments adopted within the Council of Europe and at the level of the United Nations.[4]

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1. For the sake of brevity, this paper will use the term «prisoner» to refer to a person admitted to prison.
2. In particular, the substantive section of the 3rd General Report (paragraphs 30-77) and the supplementary remarks made by the Committee regarding prison healthcare in its 9th General Report (paragraphs 37-41), 10th General Report (paragraphs 26-33), 11th General Report (paragraph 31), 21st General Report (paragraphs 62-63), 23rd General Report (paragraphs 71-84), 26th General Report (paragraphs 71-73), 30th General Report (paragraphs 67-68), 31st General Report (paragraphs 97-99) and 33rd General Report (paragraphs 116-125).
3. See for example the Court's Key theme on Prisoners' rights – healthcare in prison (August 2025).
4. See for instance the United Nations (UN) Standard Minimum Rules on the Treatment of Prisoners (*Nelson Mandela Rules*) and the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (*Bangkok rules*).

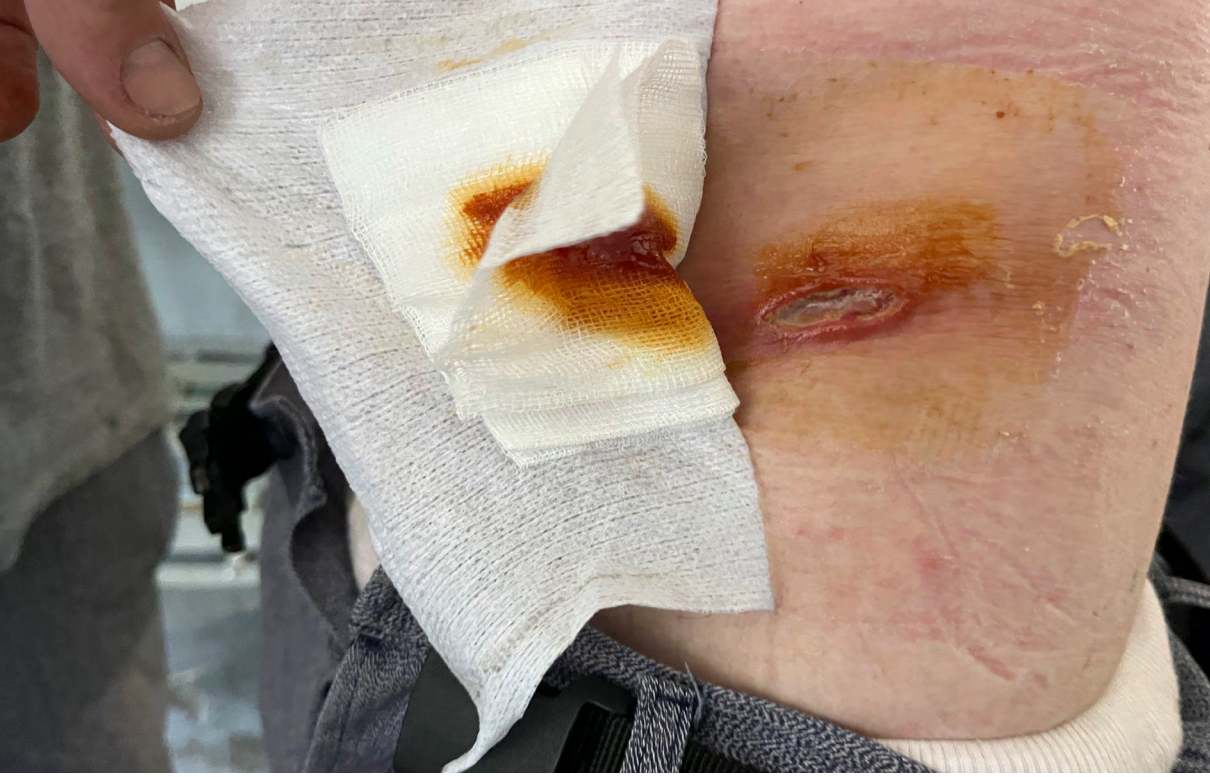
1 - EQUIVALENCE OF CARE AND PROVISION OF FREE HEALTHCARE

6. Prisons are high-risk environments for morbidity due to the higher prevalence of many diseases and substance-use when compared with the outside community. Moreover, many persons entering prisons are in poor health and, given their specific healthcare needs, prisoners should enjoy at least the same standards of healthcare as those available in the community.

> **Prisoners should receive healthcare at least equivalent to that available in the community**

7. Attaining the appropriate level of healthcare for prisoners requires that:
   - prison healthcare services are organised in close relation with the general health administration of the community;
   - health policy in prison is integrated into, and compatible with, national health policy;
   - the level of healthcare prisoners receive addresses their specific needs and takes into account their higher morbidity; an equitable care approach may consequently need to go beyond the level required for patients in the wider community;
   - various other requirements are met, such as continuity of care after admission to and release from prison, professional training and independence of prison healthcare staff, access to nationwide epidemiological screening programmes, and monitoring and independent inspections of prison healthcare services.[5]

5. These issues are elaborated for instance in paragraph 28 as well as sections 8, 9 and 10.



8. It is also essential that prison healthcare services be governed by the same ethical and professional principles as those applicable to patients in the community, in line with relevant European and international standards.

9. Further, prisoners should not be required to pay for healthcare services that are medically indicated. The principle of free healthcare should apply regardless of prisoners' legal status. This principle overrules equivalence with community as mentioned above, meaning that if the public health system foresees that some services (for example, dental care) are not provided by the general insurance schemes outside, such services should still be provided for free to prisoners.

2 - HEALTH SCREENING UPON ADMISSION

10. Upon admission to prison, every person should undergo a comprehensive medical examination by a healthcare professional (a medical doctor or a fully qualified nurse reporting to a doctor) as soon as possible and, save for exceptional circumstances, no later than 24 hours after their admission.

All prisoners should undergo a comprehensive medical examination within 24 hours of their admission

11. In the context of this examination, healthcare professionals should pay particular attention to the existence of any injuries. They should also screen for transmissible diseases (including systematic screening for signs of tuberculosis and voluntary testing for HIV and hepatitis B and C), chronic diseases and long-term conditions (such as diabetes, epilepsy or conditions requiring treatment with anticoagulants). In addition, healthcare professionals should be attentive to signs of and risk factors for mental disorders, self-harm and suicide. They should also be alert to the specific needs of newly admitted persons from certain groups (such as women, children, older persons, people who use substances, transgender persons and persons with disabilities).

12. Upon admission, a single individual medical file should be opened for every newly arrived prisoner.[6]

13. The health screening should also include the provision of information, preferably in writing, on access to, availability and operation of the healthcare service in the establishment, as well as on basic measures of hygiene. The information should be available in a language and form which the prisoners understand.

14. Whenever healthcare professionals are unable to communicate with prisoners during medical consultations[7] due to language or other barriers, interpretation and translations of professional quality (be they in-person, remote, or by means of electronic devices) should be available to all prisoners requiring such services. Using other prisoners or prison staff with relevant language skills as interpreters should be avoided.

3 - RECORDING AND REPORTING OF INJURIES

15. Prison healthcare services can play a central role in preventing and combatting instances of ill-treatment (by prison officers or, prior to admission, by police officers) and inter-prisoner violence, through the detection and systematic, methodical recording of injuries and, where appropriate, the provision of information to the relevant authorities.

16. In the context of the health screening upon admission, a detailed record, including documentation of any signs of injury, should be established. The same procedure should be applied following any violent incident within the prison, including instances of use of force by staff.

Such a screening may also be carried out when a prisoner is returned to the prison after a transfer to an external location, such as a temporary stay with the police for the purposes of investigative actions or a court hearing, or if a person wishes to be examined.

The role of prison healthcare services is central in preventing ill-treatment

6. See also paragraphs 39 on documentation and 66 on confidentiality.
7. For the purposes of this paper, the term "medical consultation" also covers "medical examinations".

17. Whenever injuries are observed during the above-mentioned medical examination, the healthcare professional should draw up a record which contains:

- i) an account of statements made by the person which are relevant to the medical examination (including the person's description of their state of health and any allegations of ill-treatment);
- ii) a full account of the objective medical findings based on a thorough examination (supported by a "body chart" for marking traumatic injuries and colour photographs of injuries); and
- iii) the healthcare professional's observations in light of i) and ii), indicating the consistency between any allegations made and the objective medical findings.

18. The record should also contain the results of additional examinations performed, detailed conclusions of any specialised consultations carried out, a description of treatment given for injuries and of any further procedures conducted.

19. Recording of the medical examination in cases of traumatic injuries should be made on a special form provided for this purpose and kept in the prisoner's medical file.

20. The results of every medical examination, including the above-mentioned statements and the healthcare professional's observations, should be made available to the prisoner concerned and their lawyer, upon request.

21. In addition, a special trauma register should be kept in which all types of injury observed should be systematically recorded.

22. Procedures should be in place to ensure that whenever recorded injuries are consistent with allegations of ill-treatment made by a prisoner – or which, even in the absence of an allegation, are clearly indicative of ill-treatment – the record is immediately and systematically brought to the attention of the relevant independent investigative authority. Healthcare professionals should advise the prisoners concerned that the writing of such a record – and forwarding it to the competent investigative authority – falls within the framework of a system to prevent ill-treatment and that such a reporting procedure is not a substitute for the lodging of a formal complaint.

23. Healthcare professionals (and the prisoners concerned) should never be exposed to any form of reprisals when they fulfil their reporting duty.

24. Healthcare professionals should be provided with special training on recording, interpreting and reporting injuries, as well as on interviewing persons who may have been subjected to violence or other potentially traumatic experiences.[8]

8. See also section 8 on professional competence.

4 - PROVISION OF HEALTHCARE

Access to healthcare

25. Throughout their imprisonment, prisoners' requests to see healthcare staff should be transmitted promptly to the prison's healthcare service. They should be seen by the healthcare staff without undue delay, according to medical necessity, irrespective of their legal status or detention regime.

Continuity of care should be ensured after admission to and release from prison

26. Prisoners should be able to contact the healthcare service in a confidential manner, for instance, by means of a request in a sealed envelope, dedicated letterboxes managed exclusively by healthcare staff, or through secure electronic means. Other members of the prison staff should not screen requests to consult a healthcare professional.

27. Access to a hospital to which prisoners may be referred or admitted should be available. Where appropriate, medical consultations may also be arranged by means of telemedicine. Whenever prisoners need to be hospitalised or examined by a specialist outside the prison, they should be transported with the promptness and in the manner required by their state of health.

28. All necessary arrangements should be made to ensure continuity of care after admission to and release from prison, as well as following a transfer from another prison establishment. The continuity of out-patient treatment of prisoners should be managed by healthcare staff. Generally, it is not sufficient for the provision of follow-up care to depend upon the initiative being taken by the prisoner concerned.

29. Where a prisoner receiving treatment (such as insulin, anticoagulants, anticonvulsants, psychotropic drugs, or a treatment for tuberculosis) or who uses specific medical devices (for example, insulin pumps, ventilators, etc.) is to be transferred to a prison in another country, the prison's healthcare service should ascertain to which establishment the prisoner will be transferred, communicate relevant information to the healthcare service of the receiving establishment, and ensure that the prisoner concerned has both sufficient medication and the medical devices they may require for the duration of the transfer.

Healthcare staff

30. Healthcare staffing levels for general practitioners, dentists, nurses (including mental health nurses) and other healthcare professionals should be tailored to the prisoners' specific healthcare needs.[9]

31. The following should be guaranteed at all times (including at night and during weekends):

- the presence of a healthcare professional (either a doctor or a qualified nurse reporting to a doctor) on prison premises, or their availability on call;
- the presence of a qualified nurse in the prison's in-patient infirmary, where applicable;
- immediate access to emergency care;[10]
- the presence of a staff member – preferably someone with a nursing qualification – with first-aid certification (including cardiopulmonary resuscitation and the use of an automated external defibrillator) on prison premises.

32. Prisoners tend to experience a significantly higher prevalence of mental disorders compared to the general population, often linked to traumatic childhood experiences, substance-use disorders and socio-economic disadvantage. It is crucial that psychiatrists, clinical psychologists and mental health nurses be part of the multidisciplinary healthcare service within every prison, either employed full-time or as part of a mental health in-reach team with regular and on-call presence in the establishment.[11]

33. In prisons which accommodate women (including mothers with infants) or children, the primary healthcare team should have sufficient training and skills to meet the particular needs of these categories and be complemented by the services of obstetricians/gynaecologists and paediatricians.

Otherwise, access to specialist outpatient consultations and hospital care should be provided when medically indicated, and regularly offered to specific groups, including, for instance, geriatricians in establishments with a significant number of older prisoners.

9. The required number of healthcare staff for every prison is best determined by a needs assessment, performed by healthcare professionals with appropriate documentation of the workload, consultation frequencies and duration, patients' needs for primary and secondary healthcare, and prevalence of pathologies. Compiling such information is best facilitated by an electronic healthcare data management system.
10. See paragraph 37 on the distribution of prescribed medication by healthcare staff.
11. See also in this context paragraphs 43 and following on the provision of mental healthcare.

34. Further, it would be desirable for healthcare staff, including mental health professionals, to routinely and proactively reach out and engage with prisoners (and custodial staff), through direct contact and regular visits to prison accommodation areas. By doing so, they will also obtain a better understanding of the establishment, its dynamics, and the day-to-day conditions in which prisoners live.

Healthcare facilities and medication

35. Healthcare in prison should be provided in designated premises, fully-equipped consultation rooms, and facilities which support a range of tailored interventions and therapies aligned with the specific functions of the healthcare unit. For instance, dental care should be provided in an appropriately equipped dental surgery. Further, emergency equipment, such as automated external defibrillators and oxygen, should be available.

36. Every prison healthcare service should have sufficient supplies of all medication essential to primary healthcare and to the treatment of those health disorders prevailing amongst prisoners. Any additionally required medication should be accessible without delay.

37. Appropriate arrangements should be made for the management of the pharmacy, including the safe and confidential distribution of medication. The preparation of prescribed medicines should always be entrusted to a qualified healthcare professional (for example, a pharmacist or a nurse).

38. Further, medication should preferably be distributed by a healthcare professional. In exceptional circumstances, healthcare professionals may give guidance on the safe and confidential administration of medication by non-healthcare staff to ensure that prisoners continue receiving their treatment in the absence of healthcare staff.

In any case, the relevant health authorities should draw up a list of medication which should only be distributed by healthcare professionals (such as anti-psychotics, medication for opioid use disorders, and antiretroviral drugs, etc.).

Documentation

39. The single individual medical file should contain comprehensive medical information as well as a record of the prisoners' ongoing treatment or care, including documentation of any findings and interventions (somatic, dental, mental health or other specialist care) which they have undergone. This includes interventions by external medical teams; in such cases, steps must be taken to ensure that a report is provided to the prison's healthcare service and filed in the individual's medical record.

40. All medical files and data should be stored in a secure manner to ensure confidentiality. In this context, healthcare professionals should take all necessary measures to ensure the reliable identification of the prisoner, so that their personal health-related data remains secure throughout every stage of their care.

Somatic healthcare

41. A prison healthcare service should be able to provide primary healthcare in at least the same conditions as those enjoyed by patients in the wider community. This includes prevention,[12] diagnostics (such as cancer screening), medical treatment, rehabilitation and nursing care. As a minimum, it should provide emergency treatment and outpatient consultations. A range of dental treatment should also be offered, including conservative dental care.

42. Prisoners undergoing specific treatment should also be followed closely to ensure they do not suffer from any interruption of treatment (for instance, in the case of medication for opioid use disorders, antibiotics, hormonal treatment, insulin, anticoagulants, etc.).

12. See also section 6 on preventive healthcare.

Mental healthcare

43. The healthcare service, alongside prison management, plays a key role in the early identification of prisoners with mental health disorders or psychological need. This responsibility should also include the facilitation of necessary adjustments to the living environment and daily regime of affected prisoners, in order to better support their mental well-being.

The needs of prisoners with a mental disorder not requiring (or no longer requiring) treatment in a specialised medical facility should be met through accommodation in dedicated prison units with specially-trained staff providing close supervision, pharmacological therapy, and a range of occupational and therapeutic activities.

Prisoners' mental health disorders or psychological need should be detected early to better support their well-being

44. The effectiveness of this approach can be enhanced through targeted multi-agency mental health awareness training for all healthcare personnel and designated custodial staff.

45. Prisoners with severe mental disorders – such as acute psychosis or major depression – particularly where associated with acute suicidal intention should not be kept in a standard prison setting. These prisoners should immediately be referred to a psychiatric hospital (whether civil, forensic or a facility within the prison system), which can offer the necessary therapeutic environment, tailored treatment programmes, and qualified specialist staff.

46. Involuntary treatment for a mental disorder should not take place in prison but in hospital units.[13]

47. The decision to admit a prisoner to a psychiatric hospital should be based solely on medical criteria, applying the same standards as for persons in the community. It must not be obstructed by the prison administration or any other authority.

Means of restraint

48. Instruments of mechanical restraint, such as restraint beds and straitjackets, should never be used in prisons.

49. Prisoners displaying agitated behaviour which poses a serious risk to themselves or others may be temporarily isolated in an appropriate cell until they regain their composure, only as a measure of last resort, and for the shortest possible time, when all other reasonable options (such as de-escalation strategies vis-à-vis the prisoners concerned) have failed to contain these risks satisfactorily. Further**,** there is no justification for additional means of restraint such as ankle- and handcuffs to be applied to a prisoner with agitated behaviour once placed in an isolation room. Indeed, such a practice may well amount to inhuman and degrading treatment inflicted for punitive purposes.[14] If the person does not calm down within a reasonable time, they should be transferred to a suitable healthcare facility (within or outside the prison system).

13. See Council of Europe CM Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorders.
14. See also paragraph 84 on the need for a therapeutic approach to acts of self-harm.

Instruments of mechanical restraint should never be used in prisons

50. Means of restraint during the transfer of prisoners to a hospital or an external specialist should not be applied in a systematic manner, but only on the basis of an individual risk and needs assessment.

51. Prisoners accommodated in a hospital or visiting one for outpatient purposes should never be physically attached to their beds or other items of furniture, or systematically restrained for security reasons (for example, with handcuffs). Other means of satisfactorily meeting security requirements can and should be found. When recourse is had to a civil hospital, security arrangements and ethical considerations should be discussed by the management of the prison and the hospital. For example, secure rooms or wards in community hospitals for patients deprived of their liberty allow healthcare professionals to provide adequate inpatient care in a manner which respects human dignity. Such secure facilities should have features such as a separate entrance and waiting room, segregated from civil patients, to ensure privacy and should be guarded by prison officers or security staff.

5 - PRISONERS' AUTONOMY AND MEDICAL CONFIDENTIALITY

Informed consent, autonomy and biomedical research

52. As a general principle, all prisoners should be placed in a position to give their free and informed consent to (preventive, diagnostic or therapeutic) medical interventions, and every prisoner should be free to refuse these interventions. It is self-evident that consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the prisoner's condition, the treatment proposed and its possible side effects, and the possibility of withdrawing consent.

Medical interventions require prisoners' free and informed consent

It must also be based on the condition that the prisoner -patient concerned has the capacity to give valid consent at the moment when it is sought. Moreover:

- all reasonable measures must be taken to support the patient's decision-making;
- when the patient does not have capacity to give valid consent/refusal, whenever possible, a consultation process must be applied which allows the patient to have their views and preferences taken into consideration;
- when the patient does not have capacity to give valid consent/refusal, the law must provide for representation, independent of the prison authority and the healthcare service, to demand and authorise interventions in the patient's interest;
- healthcare services must be provided with protocols guiding healthcare staff in these issues and with rules for evaluating and supporting patients' decision-making capacity.

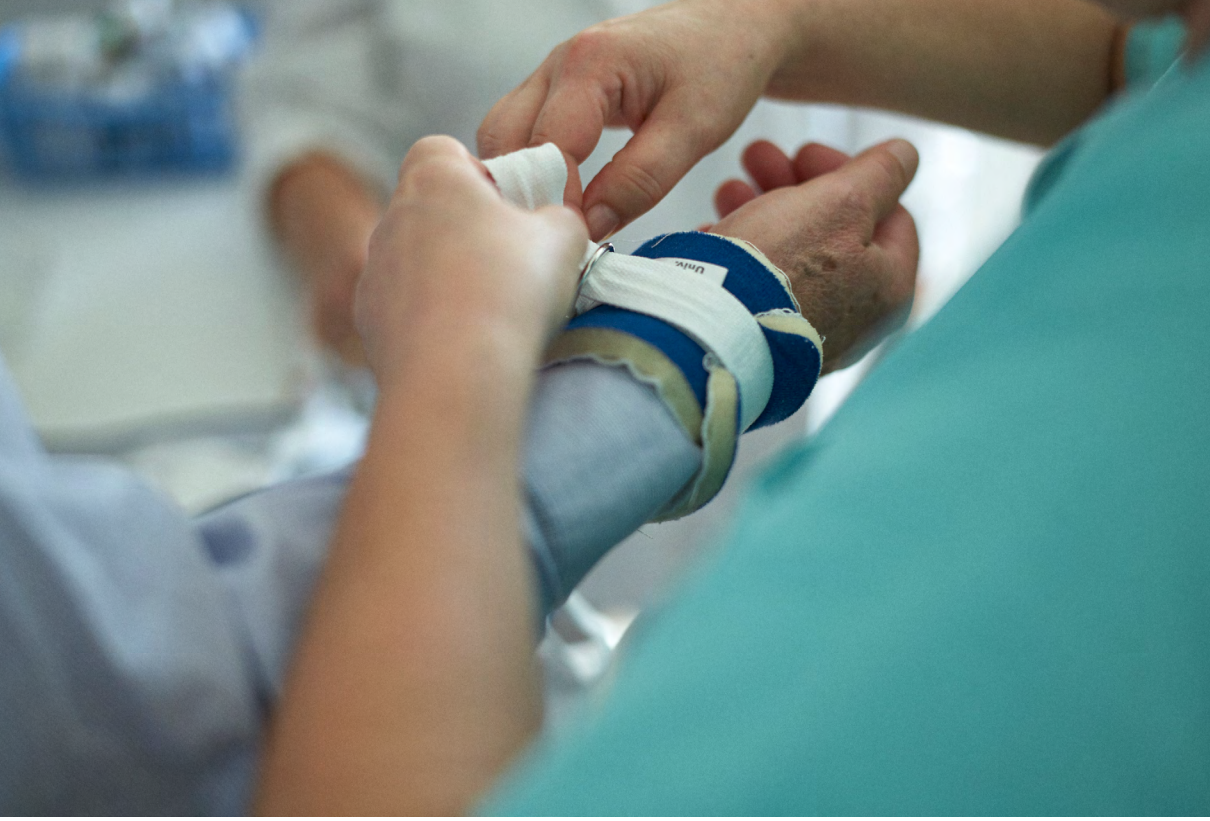
53. Any derogation from these fundamental principles should be based upon law, limited to clearly and strictly defined exceptional circumstances, and accompanied by appropriate safeguards (equivalent to those applicable in the outside community).

54. In various prison systems, situations of food and/or fluid refusal ('hunger strikes') may occur more or less frequently. These may take place in order to press demands, protest against an authority or to demonstrate support for a cause.

55. The management of food and/or fluid refusals in prison is a very sensitive matter that raises many fundamental questions, in particular of an ethical, medical and legal nature, including the question of the individual autonomy of the patient concerned and the respect of the doctor-patient relationship.

56. Healthcare services should have at their disposal a protocol on their role and conduct in respect of food and/or fluid refusal.

57. Healthcare staff should identify the prisoner's reasons for refusing nutrition. It is essential to perform a psychiatric evaluation of the prisoner concerned with the aim of assessing their mental capacity and to ascertain whether the refusal of food and/or fluids is symptomatic of a mental disorder. There should also be repeated verification both of the absence of any outside pressure on the person, and of their decision-making capacity.



58. Rapid and repeated medical assessment is important to determine the risks to health (for example, dehydration, kidney failure, metabolic disturbances and vitamin deficiency). Healthcare professionals should provide the prisoner concerned with objective information about risks to health and, in advanced cases of food and/or fluid refusal, about risks to life. Starvation for prolonged periods involves metabolic changes and can cause severe, and sometimes irreversible or even fatal complications. Moreover, the phase of re-alimentation should be carefully planned, as re-feeding syndrome is a potentially fatal metabolic disturbance occurring in malnourished individuals when aggressive nutritional support leads to dangerous shifts in fluids and electrolytes. Hospitalisation should be considered in prolonged cases of food and/or fluid refusal, or if there are clinical risk factors.

59. Biomedical research involving prisoners should be approached with extreme caution. Prisoners are vulnerable to exploitation and abuse through research as the coercive environment of imprisonment may easily undermine their free consent. As a matter of principle, children held in detention should never participate in biomedical research programmes.[15]

60. Whenever biomedical research on (adult) prisoners is allowed under national legislation, the research should entail only minimal risk and burden, and strict safeguards should be in place (such as the involvement of an independent ethics committee) to ensure that every participating prisoner has given their free and fully informed consent and is entitled to withdraw it. Further, the prisoners concerned should be provided, upon request, with information on the outcome of the research.[16]

15. See Rule 72.2 of the European Rules for juvenile offenders subject to sanctions or measures.
16. See also Additional Protocol to the Convention on Human Rights and Biomedicine concerning Biomedical Research (2005) and Rule 48 of the European Prison Rules.

Medical confidentiality

61. Medical confidentiality should be observed in prisons in the same way as in the wider community. This should apply equally to medical examinations and interventions when prisoners are transferred to a community hospital.

62. As a general rule, all medical consultations of prisoners should be conducted out of both the sight and the hearing of anyone not involved in the therapeutic relationship with the patient (such as prison staff, other prisoners or civilians), and under conditions that fully guarantee medical confidentiality.

Healthcare services in prison should fully guarantee medical confidentiality

The presence of others can undermine the establishment and maintenance of a trusting doctor-patient relationship. Moreover, the presence of anyone not involved in the therapeutic relationship with the patient during medical consultations may discourage the person concerned from disclosing sensitive information to the healthcare professional (for example, experiences of ill-treatment, substance use, or transmissible diseases).

63. Prisoners should only be examined individually, and never in groups.

64. Taking due account of the need to ensure the safety of healthcare staff while exercising their duties, the presence of non-healthcare staff during the consultation at the request of the healthcare professional may be warranted in exceptional cases.

Any such exception should be specified in the relevant regulations and should be limited to those rare cases in which, based on an individual risk assessment, and after due consideration of less intrusive security measures, the healthcare professional considers the presence of prison officers necessary to fully contain the perceived risks posed by the prisoner. For instance, consideration should first be given to ensuring the presence of additional healthcare personnel. Another option may be the installation of a call bell system, whereby healthcare staff would be in a position to rapidly alert prison officers in those exceptional cases when a prisoner becomes agitated or threatening during a medical consultation.

65. All healthcare professionals should receive training on the applicable rules and on responses to high-risk situations. Further, prison officers should, when appropriate, fully apprise the healthcare professional of any relevant prior behaviour of the prisoner, but the final decision regarding the presence of non-healthcare staff during the consultation should rest with the healthcare professional.

66. Medical files and other records (both physical and electronic) should only be accessible to healthcare professionals who are in a therapeutic relationship with the patient. Exceptions to the confidentiality of medical data should only be allowed with the explicit consent of the prisoner concerned, or pursuant to specific requirements based on law, or when unavoidable in averting an imminent danger to the prisoner's or another person's life or health.

Prisoners have the right to access and receive copies of their medical records

67. Prisoners should have the right to access their medical records, to receive – upon request – a copy thereof, and to request that medical information be communicated to their families, legal representatives or an external healthcare professional of their choice.

68. Whenever a prisoner is transferred to another prison, the medical file should be forwarded without delay, sealed or electronically protected, to the healthcare service of the receiving establishment.

6 - PREVENTIVE HEALTHCARE

Health promotion and harm reduction measures

69. The task of prison healthcare services should not be limited to treating sick prisoners. Prevention and health promotion should be focused on the most prevalent health disorders of prisoners. It should include screening and the dissemination of awareness-raising information. Health promotion should be a system-wide approach involving all persons working or detained in prisons. This includes health and psycho-social education and participation in health promotion initiatives by the relevant authorities.

70. Focused prevention and harm reduction measures such as counselling and psychosocial support, health education programmes, vaccination, disinfectant distribution and measures to prevent sexually transmitted infections (such as condom distribution) should be offered. It would also be desirable for the relevant authorities to explore the introduction of needle and syringe exchange programmes, as well as arrangements for safe tattooing and piercing in prisons.

Harm reduction measures support the promotion of better health and prevent the transmission of diseases

71. Further, if relevant for the health of prisoners, the healthcare professionals should report to and advise the prison management on general issues such as prisoners' hygiene, the cleanliness of sanitary facilities, the quantity and quality of food, access to clean drinking water, the material conditions of accommodation areas (including living space, bedding, state of repair, ventilation and heating) and the provision of exercise and purposeful activities, which may have a direct impact on prisoners' mental and physical health.[17]

Transmissible diseases

72. In various countries, the spread of transmissible diseases and, in particular, respiratory diseases, sexually transmitted infections, meningococcal infections and skin infections related to scabies or bed bugs have become a major public health concern.

73. Material conditions can readily lead to an increased risk of transmission of a number of airborne infections, such as tuberculosis and other respiratory diseases, and skin infections. If a prison is overcrowded it acts as an incubator of diseases, which released prisoners, staff and visitors can then bring outside, thereby adversely affecting the health of the population as a whole.

74. In the context of preventing and managing the spread of transmissible diseases, the following measures or facilities should be regularly reviewed:

- screening processes and voluntary testing (for example, HIV and hepatitis B and C);
- stocks of personal protection equipment (such as masks);
- isolation and quarantine premises;
- updated and comprehensive information about transmissible diseases available both to prisoners – in a language and form which they understand – and prison staff alike, before and – in the case of a positive result – after any screening test;
- organisational preparedness for respiratory epidemics and the spread of other transmissible diseases.

17. See also Rules 44, 45.1 and 45.2 of the European Prison Rules.

75. Where appropriate, tracing of those persons with whom a particular prisoner has had regular contact (including fellow prisoners, prison staff, and visitors) – for the purpose of epidemiological control – should be carried out.

76. Further, any restrictive measure taken vis-à-vis prisoners to prevent the spread of a transmissible disease should have a strict medical justification and be based upon law.

77. Decisions to segregate a prisoner for health reasons should be grounded on principles of necessity, proportionality and respect for human dignity. Segregation should be limited in duration. Rules in prison for isolating and quarantining contagious prisoners, as well as those suspected of being contagious, should not differ from those in the community. If isolation or quarantine is imposed, the person concerned should be entitled to daily outdoor exercise and be provided with meaningful human contact every day.

78. There can be no medical justification for segregating prisoners (via isolation or quarantine measures) based solely upon the presence of a blood-borne viral infection, such as HIV.

79. Ongoing training on measures preventing and managing the spread of transmissible diseases should be provided to healthcare professionals and custodial staff.

80. To be effective, all efforts to prevent and manage the spread of diseases require close co-ordination between all relevant authorities and agencies.

Prevention of self-harm and suicide

81. Many persons entering prison have a mental disorder and/or will experience psychological distress while in prison. Social isolation, solitary confinement, long sentences, the periods immediately before and after trial and, in some cases, the pre-release period often involve an increased risk of self-harm and suicide. Consequently, early identification of mental disorders or psychological need, including risk factors for self-harm and suicide, upon admission to the prison, along with timely professional support and treatment is decisive in preventing the deterioration of a prisoner's mental health.

82. Prisoners identified as being at risk of self-harm or suicide should be supported and closely supervised by a multi-disciplinary team including both healthcare and custodial staff alike. Self-harm and suicide prevention, and safety-reinforcing protocols should include a wider range of activities and increased opportunities for contact with staff and the outside world. Electronic supervision (CCTV) cannot replace personal observation and direct contact with staff. The prisoners concerned should benefit from psychological treatment and regular social support in accordance with the assessed degree of risk and need.

Self-harm should be addressed therapeutically and never as a ground for disciplinary sanction

83. The prevention of acts of self-harm and suicide inherently involves reducing prisoners' access to means, such as ligature points, along with adequate awareness-raising throughout and, as appropriate, between establishments. Healthcare and custodial staff should receive relevant training to recognise risk factors for self-harm or suicide. A dynamic security approach by staff will be supportive of any self-harm and suicide prevention policy.

84. Acts of self-harm should be approached from a therapeutic rather than a punitive standpoint. Such acts should never be considered as a ground for disciplinary sanction and prisoners who self-harm should not be required to reimburse any related medical expenses. Further, the separation and isolation of the prisoners who self-harm is likely to exacerbate any distress. All cases of self-harm should be medically assessed immediately after an incident, to evaluate and treat any injuries, and to provide appropriate care and implement further preventive measures.

Passive smoking

85. Prison management should provide an environment free from passive smoking to all prisoners, especially for those who request this and those particularly vulnerable to passive smoking (such as pregnant women, children, and prisoners with respiratory illnesses), without prejudice to their access to appropriate living conditions and out-of-cell areas. This should include the designation of smoke-free accommodation and the prohibition or restriction of smoking in commonly used indoor areas.

86. Frameworks and policies which regulate smoking in the community should also apply in prisons. Further, programmes should be offered to assist prisoners who smoke in ending their nicotine dependence.

7 - SUPPORT FOR PERSONS WITH SPECIFIC NEEDS

87. Certain categories of prisoner have specific needs or vulnerabilities which may make detention in prison more difficult for them to cope with than others. The reasons may be multiple, such as the prison does not provide sufficient protection from abuse, or the prison conditions do not meet their basic needs. It is an important task of healthcare professionals to swiftly identify the specific vulnerabilities of prisoners – preferably already during the health screening upon admission – and subsequently to advise prison management with regard to their particular needs, placement and protection.

People who use substances

88. Prisoners experiencing substance use disorders (SUDs) often find themselves in vulnerable situations which may entail marginalisation, isolation and abusive relationships within the prison population. Healthcare professionals should be particularly attentive to the increased risks of self-harm and suicide, and to the potential victimisation of the persons concerned.

89. An evidence-based approach should be taken when developing programmes for prisoners who have a history of psychoactive substance use (such as opioids, benzodiazepines, cocaine or alcohol etc.), or who experience substance use-related problems while in prison.

90. The approach towards SUDs in prison should be part of an overarching national strategy on the issue. In order to meet the complex needs of persons experiencing SUDs, systems addressing substance use should be comprehensive. They should include preventive interventions, psychosocial and medication-assisted treatment, as well as risk- and harm reduction programmes, such as the provision of sterile injection equipment (that is, clean needles and syringes). Where appropriate, alternatives to detention should be considered.

91. Health screening upon admission should include a detailed assessment of the prisoner's history and treatment related to substance use.

92. Tailored treatment (such as medication for opioid use disorders) and substance use recovery services should be offered to prisoners at the level at least equivalent to that available in the community and must not be discontinued upon their admission to prison given the serious potential harm this may cause them. It is also important that the persons concerned are able to begin a treatment programme in prison. All prisoners experiencing withdrawal symptoms should receive appropriate care, including pharmacotherapy.

93. Further, appropriate psychosocial support as well as other types of social therapy for substance use disorders should be provided and co-ordinated by the healthcare service. In addition, ready access to naloxone should be available in order to manage overdoses from opioid and polysubstance use.

94. Healthcare staff should ensure that the prison population and all prison staff have access to relevant information on the risks of drugs for the health and safety of prisoners.

95. Healthcare professionals, and where appropriate prison staff in general, should be trained to provide treatment, rehabilitation programmes and harm reduction measures to persons with SUDs, with due consideration of potential comorbidities, including mental health issues.

96. It would be desirable for the healthcare service to gather and analyse comprehensive data on substance use in prison and the effects of the measures implemented to reduce risks and harm. This data should be made available to relevant stakeholders.

Women

97. It is essential for all prison services to take into account the need for enhanced healthcare for women in detention. Although women represent a small proportion of the prison population, they have specific needs, particularly with regard to health and screening, which should be met.

98. A comprehensive health screening upon admission should include a detailed assessment of the gender-specific needs and vulnerabilities of women in prison. This should include any reproductive health issues. A second screening should aim at detecting – in a sensitive manner – in the first few weeks following their admission, any history of sexual abuse or other forms of gender-based violence they may have experienced prior to admission.

99. Women in prison should be provided with gender-specific healthcare at least equivalent to that available in the community. Women in prison should benefit from gender-specific healthcare services, including preventive healthcare as well as treatment and psycho-social or educational programmes, as appropriate.

100. For instance, screening for breast and cervical cancer, information on sexually transmitted infections or blood-borne viruses, termination of pregnancy and support to women experiencing menopause or substance-use problems should be offered in prison. Prescribed contraception or hormone replacement therapy should not be withheld from women wishing to take it.

101. Healthcare, including mental healthcare, should be made available, as need be, in a manner that is individualised, gender-sensitive, trauma-informed and comprehensive.

102. Whenever a female prisoner asks to be examined or treated by a female healthcare professional, this request should be complied with as far as possible. If a male healthcare professional is required to carry out the consultation contrary to the preference of the female prisoner, she should be offered the possibility of having a female member of healthcare staff present.

Prison healthcare should be gender-sensitive and trauma-informed

103. The specific hygiene needs of women should be adequately addressed. In particular, women should have ready access to sanitary and washing facilities as well as safe disposal arrangements for blood-stained articles. They should also be provided with an appropriate range of essential hygiene products, such as sanitary towels, tampons or menstrual cups, in sufficient quantities and free of charge.

104. Healthcare and other relevant prison staff should be provided with specialised training in women's health and made aware of their specific needs for appropriate support.

Pregnant women and mothers with infants

105. Alternatives to detention should be sought as far as possible for pregnant women and mothers with infants.[18]

106. As a matter of principle, children should not be born in prison. Women should be able to give birth in a hospital outside prison, in a dignified manner. Under no circumstances should women be attached to the bed using hand- or ankle-cuffs or any other means of restraint during labour or childbirth or immediately thereafter.

107. Pregnant and breastfeeding women as well as the infants held in prison should be provided – free of charge – with the necessary food supplements and nutrients. Pregnant women and women with infants in prison should be appropriately followed by the relevant qualified healthcare professionals (such as an obstetrician, midwife and nursery nurse, etc.) to provide appropriate ante- and post-natal healthcare, support and information.

108. Infants should stay in prison with their mother only when this is in the best interests of the infant concerned and in accordance with national law.

109. The relevant authorities have a responsibility to ensure the right of a child to the highest attainable standard of health.[19] Infants living with their mothers in prison should be provided with appropriate healthcare services. Their healthy development must be closely monitored by appropriate specialists, in collaboration with community health services. Infants should be provided with the necessary clothing and hygiene products (including nappies), and be able to freely access open-air areas in the prison.

110. Suitable long-term care arrangements, particularly in the context of the child's transfer into the community, should be undertaken with sensitivity and closely co-ordinated with community healthcare and psychosocial services.

Children

111. Childhood is a vital stage for personal development and a period of significant physical, psychological and social change. It is an important time for laying the foundations of good health and reducing the potential for long-term psychosocial challenges, a process which is likely to be complicated by a prison stay.

112. Children in detention often have a history of childhood trauma, such as loss or bereavement, domestic violence, impaired care-giving and emotional abuse, which requires appropriate healthcare.

> **Authorities have a duty to ensure the right of every child to the highest attainable standard of health**

Further, children in detention also tend to have high rates of sexually transmitted infections and mental health issues, which require targeted screening and interventions by the healthcare service.

18. See also Council of Europe Recommendation CM/Rec(2018)5 concerning children with imprisoned parents (paragraph 10).
19. See *inter alia* Article 24 of the United Nations Convention on the Rights of the Child.

113. The provision of health education relevant to children should, in particular, include information about the risks of substance use and transmissible diseases.

114. Healthcare staff should also play an active part in monitoring the quality of the food provided to children in prison. Children should be provided with a nutritious diet which takes into account their age, health, physical condition and the activities they undertake while detained, among other aspects. This is particularly important for children who may not yet have reached their full growth potential.

115. Healthcare professionals and, where appropriate, dedicated prison staff should receive training on specific healthcare issues related to children.

Transgender persons

116. Transgender persons may be particularly vulnerable in a prison environment. There may be an increased risk of self-harm or suicide, as well as violence- and transphobia-related trauma for many transgender persons. It is therefore important to assess the risk of self-harm and suicide among transgender persons and to discuss any past experiences of prejudice or violence, in order to prevent further victimisation.

117. Transgender persons should have access to multidisciplinary health services and standards of care at least equivalent to those available in the community.

118. The relevant authorities should allow access to gender-affirming procedures such as hormone treatment and surgery, together with psychological support, for those transgender persons in prison who request them, following appropriate clinical assessments.

119. Authorities should also allow access to relevant psychological treatment, including special counselling for those victimised prior to imprisonment, allowing for the meaningful engagement of the person concerned. These services should be systematically offered upon admission and throughout their stay in prison.

120. Healthcare professionals and, where appropriate, the prison staff in general, should receive training on transgender-specific health issues.

Older prisoners

121. Aging often progresses faster in the prison population than for persons living in the outside community. Prisoners are generally considered 'older' once beyond the age of 60 and, in some countries, even over 50. Their specific needs, in particular regarding any prevalence of disabilities, hearing loss, decrease of vision and/or cognitive impairments, should be identified upon admission and addressed throughout their imprisonment. This involves close co-ordination with the prison management in the context of placement and accommodation.

Healthcare professionals should support applications for release if prisoners' health condition is no longer compatible with detention

122. Healthcare and custodial staff dealing with older prisoners should be trained and able to act accordingly, with due consideration of the vulnerabilities of the persons concerned. If the deterioration of their health condition is no longer compatible with their continued imprisonment, healthcare professionals should, with the person's consent, support their application for release on humanitarian or medical grounds. Provision of appropriate care in the outside community should be arranged prior to release from prison.

Prisoners with disabilities or other specific needs

123. Prison populations may include prisoners with disabilities or other specific needs, such as sensory or physical impairment, intellectual or developmental disabilities, or who are neurodivergent. In addition to running the risk of becoming victims of discrimination or neglect, their state of health may deteriorate due to the effects of inadequate detention conditions. In order to provide them with the necessary support and care, their needs should be assessed immediately upon admission.

124. The healthcare service is well placed to arrange the supply of therapeutic tools and assistive devices (such as wheelchairs, glasses, orthoses, etc.) and, where appropriate, to develop psychosocial support programmes. Further, arrangements should be made for prisoners with special dietary needs (for example, people with diabetes).

125. Persons with disabilities should be provided with adequate accommodation and support from trained staff, including as regards communication.

126. For persons with reduced mobility, the premises should be barrier-free (in particular, sanitary facilities, the outdoor exercise yard, and physical access to the healthcare service).

Prisoners with a terminal prognosis or serious illness, and policy on deaths in prison

127. Prisoners with a terminal prognosis or serious illness (including serious mental disorder) who cannot be appropriately accommodated in the facilities offered to the general prison population should not be held in such an environment. Without the appropriate nursing care or other arrangements, such settings may create an intolerable situation in which continued imprisonment may create increased physical and mental suffering. In such cases, it is the responsibility of the prison's healthcare service to report to the responsible authority, with a view to finding suitable alternative arrangements for their care. These might include compassionate release or transfer to a facility better equipped to meet their specific needs.

128. There should be a clear policy and a comprehensive procedure for the identification of the causes of death of prisoners – including when death occurs in (or on the way to) hospital – as well as clear criteria for the classification of deaths as suicides. Prison management should be required to inform the competent investigative authority without delay, taking immediate steps to preserve the place of death and relevant evidence, record preliminary details of the circumstances of death, and inform the person's next of kin.

Every prison death should be analysed to learn lessons and identify preventive measures, especially concerning suicide

129. The relevant authorities should ensure that a thorough investigation is carried out into every death in prison by an authority independent of the prison system to ascertain, *inter alia* the cause of death, the facts leading up to the death, including any contributing factors, and whether the death could have been prevented.

130. Further, whenever a person dies in prison (or soon after transfer from prison), an autopsy should be carried out,[20] and the healthcare service of the prison informed of the outcome.

131. An analysis should be undertaken of every death in prison to consider what general lessons may be learned for the establishment in which the death occurred and whether, in the case of suicide, there are any systemic, local or nationwide preventive measures which must be taken in future.

132. Every prison should keep a register of all prisoner deaths.

20. The Committee acknowledges that there may be highly exceptional cases in which, as prescribed by law, an independent authority may decide that an autopsy is not required.

8 - PROFESSIONAL COMPETENCE

133. A high level of professional competence of doctors, nurses and other healthcare staff is required in order to meet the numerous medical and ethical challenges encountered when providing healthcare to prisoners.

134. In particular, all healthcare staff should receive initial and continuous training on prevailing health disorders, the frequency and epidemiology of illnesses, and on any other healthcare-related needs of prisoners. This includes primary healthcare and safe prescribing, as well as professional competence in relation to mental disorders, substance use disorders, self-harm and suicide, transmissible diseases, emergency care, and elaborating preventive measures and preparedness plans for epidemics. They should also receive training in interpersonal communication and cultural sensitivity, given the diverse backgrounds of prisoners.

Highly competent medical and healthcare staff are needed to meet complex medical and ethical challenges in prison

9 - PROFESSIONAL INDEPENDENCE

135. Prison doctors act as the personal doctors of prisoners. Establishing a genuine and trusting therapeutic relationship is crucial in ensuring the quality of healthcare. Their professional duty still persists even if a prisoner displays threatening or violent behaviour towards them, save for some exceptional situations.[21]

Trust between prisoners and doctors is key to appropriate healthcare

136. Healthcare professionals who aim to ensure optimal healthcare may, in certain circumstances, enter into conflict with the considerations of prison management and security. This can give rise to difficult ethical questions and choices. Avoiding conflicts of dual loyalty in the clinical care of prisoners in prison requires a strict separation of the tasks of healthcare professionals from those of custodial staff. Healthcare staff caring for prisoners should never become involved in medical activities which are incompatible with their therapeutic role.

137. Healthcare staff caring for prisoners should never, *inter alia*:

- participate in body searches or tests for the purposes of investigating substance-use for security reasons;[22]
- participate in decisions to segregate or impose other coercive measures on a prisoner for security reasons;
- certify prisoners as being fit to undergo disciplinary sanction (such as solitary confinement);
- wear a prison or military uniform when caring for prisoners; or
- perform any other medical interventions upon the request of an authority without the consent of the prisoner.

138. Addressing potential conflicts of interest also requires that the principles of professional medical ethics be made known to and accepted by all persons working in prisons; that is, prison officers, management and those working in the prison administration and on prisoner activities, as well as the prisoners themselves.

139. Healthcare staff should be very attentive to the situation of all prisoners subjected to solitary confinement (for disciplinary or security reasons). They should be informed of every such measure and should visit the prisoner concerned immediately after its application and thereafter on a regular basis, at least once a day. Healthcare staff should provide prisoners with prompt medical assistance and treatment as required, and raise immediate objections against the continuation of the measure if it is considered a risk to their physical or mental health.

21. On exceptions to this general rule, see paragraph 64.
22. This does not include collecting urine, hair, or blood samples for clinical reasons, such as ensuring the safety of prescriptions or other treatment interventions.

Solitary confinement demands heightened healthcare oversight

140. Likewise, after every instance of use of force by prison staff, the person concerned should be examined and cared for by a healthcare professional, with any injuries medically documented and, where appropriate, reported as set out in Section 3 above.

141. Further, treating healthcare professionals, including psychiatrists, should not act as court-ordered experts for their own patients or perform formal expert evaluations of their patients for legal purposes.

142. Despite the difficulties in recruiting healthcare professionals in many prison systems, custodial staff should not be involved in professional healthcare tasks, such as dispensing medication or nursing care.

143. Prison healthcare professionals should not provide healthcare to custodial or other staff, as this could considerably increase the workload of healthcare staff and is generally prejudicial to the limited time they have available for consultations with prisoners. Moreover, such a dual responsibility may also lead to a conflict of interest, which could ultimately compromise the perception of the professional independence of prison healthcare professionals. While it may indeed be necessary that prison healthcare services treat staff in emergency situations, this should not be a systematic practice.

144. Prisoners, even those with medical qualifications, should never be involved in healthcare tasks. They may be engaged in assisting other prisoners with the activities of daily living. However, they should never participate in therapeutic activities or have access to prisoners' healthcare records, and they should never be involved in the distribution of medication. In certain prison systems, prisoners provide support to other prisoners at risk of self-harm or suicide through a "buddy" system or listening programme, which is positive; they should not however be made responsible for the supervision of prisoners at risk of self-harm or suicide.

10 - GOVERNANCE AND CO-ORDINATION

145. Prison healthcare should be aligned as closely as possible with mainstream healthcare provision in the community at large, ideally affiliated to the national or regional health authorities. Health policy in prisons should be integrated into, and compatible with, national health policy. Prison health expertise should be preserved and constantly developed.

146. The most effective way of implementing these precepts is for the national or regional health authorities to also be responsible for providing healthcare in prison, as is the case in an increasing number of European countries. If this is not the case, the quality and effectiveness of healthcare provision within a prison should at least be assessed and overseen by an independent and qualified healthcare authority affiliated to the Ministry of Health.

147. The management and co-ordination of all relevant agencies and resources contributing to the health of prisoners should be a whole-of-government responsibility. Where a prison service has its own hospital(s) or healthcare facilities, they should be adequately staffed and equipped to provide appropriate care and treatment to the prisoners referred to them.

Coordinated policies for prisons should be integrated into comprehensive national public health strategies

148. The smooth operation of a healthcare service presupposes that doctors, nursing staff and other healthcare professionals – and, where appropriate, a member of the prison management – are able to meet regularly, in adequate premises, and under the leadership of a healthcare professional. This healthcare professional, generally a clinical doctor, should be able to provide clinical leadership by advising and guiding the healthcare service. This healthcare professional should also take responsibility for the quality of care provided in prison, and should set up effective prevention and epidemiological control plans.

149. Healthcare activities should be co-ordinated to ensure that all professionals collaborate and communicate effectively, in particular between somatic (including dental care) and psychiatric healthcare providers. Psycho-social professionals should also be closely associated with, and preferably integrated into, the healthcare teams. Further, the healthcare service should co-ordinate and communicate on a regular basis with prison management.

150. Registers, preferably in electronic format, on all cases of injury, self-harm, attempted suicide, food/fluid refusal and death in prison should be maintained, and periodically reviewed, in every prison by the healthcare service in order to track incidence levels and to evaluate the effectiveness of the preventive measures in place.

151. Finally, it would be desirable for comprehensive and reliable disaggregated data to be collected by the healthcare service, as this may contribute to enhancing the quality of healthcare in prison. Such data facilitates the reliable evaluation and planning of human resources and budgeting required for prison healthcare and, in co-operation with the health authorities, of health promotion and prevention programmes. By identifying trends, data analysis may help develop future policies aimed at improving the functioning of healthcare services in prison.

"NO ONE SHALL BE SUBJECTED TO TORTURE OR TO INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT"

Article 3 of the European Convention on Human Rights

Established in 1989 by the Council of Europe Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the CPT's aim is to strengthen the protection of persons deprived of their liberty through the organisation of regular visits to places of detention.

The Committee is an independent, non-judicial preventive mechanism, complementing the work of the European Court of Human Rights. It monitors the treatment of persons deprived of their liberty by visiting places such as prisons, juvenile detention centres, police stations, immigration detention facilities, psychiatric hospitals and social care homes. CPT delegations have unrestricted access to places of detention, and the right to interview, in private, persons deprived of their liberty. They may access all the information necessary to carry out their work, including any administrative and medical documents.

The CPT plays an essential role in promoting decency in detention, through the development of minimum standards and good practice for states parties, as well as through coordination with other international bodies. The implementation of its recommendations has a significant impact on the development of human rights in Council of Europe member states and influences the policies, legislation and practices of national authorities regarding detention.

Secretariat of the CPT
Council of Europe
67 075 STRASBOURG Cedex – FRANCE
+33 (0)3 88 41 23 11
cptdoc@coe.int – www.cpt.coe.int

PREMS 175925

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www.coe.int

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