



Improving Prison Conditions by Strengthening the Monitoring of HIV, HCV, TB and Harm Reduction

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Mapping Report - Portugal

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Improving Prison Conditions by Strengthening the Monitoring of HIV, HCV, TB and Harm Reduction

Mapping Report Portugal

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I. Introduction

1. Background and justification

The Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and Hepatitis C (HCV) – are a major health concern in prisons, evidenced by the fact that prevalence rates tend to be substantially higher among prison populations than in the general population.

Prisons and other places of detention are high-risk environments for the transmission of these diseases. This is related to the over incarceration of vulnerable and disadvantaged groups who carry a disproportionately high burden of disease and ill-health; the criminalization of drug users and high levels of injecting drug use; overcrowded and substandard prison conditions; inadequate health care; and the denial of harm reduction services.

Several international, regional and national human rights mechanisms are in place to monitor and inspect prison conditions in order to prevent torture and ill-treatment – including the Subcommittee on the Prevention of Torture (SPT), under the Optional Protocol to the UN Convention against Torture (OPCAT), with National Preventive Mechanisms (NPMs), as well as within the Committee for the Prevention of Torture of the Council of Europe (CPT) and national bodies in a number of European countries.

United Nations human rights bodies and the European Court of Human Rights (ECtHR) are increasingly finding that issues relating to infections in detention can contribute to, or even constitute, conditions that meet the threshold of ill treatment of prisoners. It is therefore critically important for human rights-based monitoring mechanisms that have a mandate to prevent ill treatment to meaningfully examine issues relating to infections in places of detention.

2. About this report

This report forms part of the EU co-funded project “Improving Prison Conditions by Strengthening Infectious Disease Monitoring” implemented under the lead of Harm Reduction International in 2015 and 2016.

The project aims to reduce ill-treatment of persons in detention and improve prison conditions through improved and standardised monitoring and inspection mechanisms on HIV, HCV and TB.

The research component of the project includes a mapping the current situation relating to these diseases in prisons in seven European countries (Greece, Ireland, Italy, Latvia, Poland, Portugal and Spain) as well as a mapping of practices among monitoring mechanisms in target countries, with particular reference to infections in prisons.

The project also mapped existing regional and international public health and human rights standards relating to infections in prisons and developed a user-friendly tool, including a set of key indicators, to generate better informed, more consistent, and sustained monitoring of infections in prisons by national, regional and international human rights monitoring mechanisms.

More about the project and its products can be found on Harm Reduction International website (www.ihra.net).

The current report, written by Nuno Henrique Pontes, presents the mapping situation in Portugal.

3. Methodology and methodological challenges

The fundamental problem with an independent research project seeking to look into any aspect of the Portuguese prison system is the difficulty in securing any kind of collaboration on the part of the prison authorities. It is not just a question of denial of access to the prisons; it is the wall of silence that a request for any sort of information meets with. The seriousness of this barrier becomes clearer as we discover (demonstrated in this report) that the Portuguese government's own departments crash against this very same wall in their efforts to collect data from the prisons, particularly on anything with respect to medical matters. Given this serious limitation to the development of our research, we were forced to rely on what information is available from other governmental and non-governmental sources. We scoured reports from every relevant state department, from every organization that deals with health care issues, and from what international bodies have been able to collect data on Portugal. We spoke with members of relevant NGOs and relied on our own experience with research into the Portuguese prison system. Of course all of this can only go so far in replacing that which does not exist: access to what is happening inside Portuguese prisons, for none of the sources used are immune to this lack of access.

II. National context

1. Overall political context

Portugal is a parliamentary representative democratic republic. The prime minister is the head of government, and the president, with a five year term, the head of state. Parliament has 230 members serving four year terms. Upon parliamentary elections the president invites the winning party, or coalition of parties if none has a majority of deputies, to form a government. The leader of the dominant party is appointed prime minister.

The political/administrative system encompasses the mainland and two autonomous archipelagos, Azores and Madeira. Throughout the country the most important internal administrative structures are the municipalities. There are over 300 of these, with regular elections and executive power being held by the Mayor. There is an ongoing dispute between local populations, who want more municipalities with the associated local services, and the central government's cost-cutting programme of, so far unsuccessfully, consolidating municipalities. Each municipality is further divided into boroughs, which also elect political representatives. In continental Portugal a policy of administrative decentralization has developed around five regions; North, Centre, Lisbon, Alentejo and Algarve.

The party system, although open to any registered party, has been dominated by two parties since 1975: the Socialist Party, on the centre left, and the Social Democratic Party, on the centre right. Deep entrenchment of corporate special interests and a culture of political cronyism pervade all levels of government and civil society. Recently this status quo has been complicated as Portugal, with Greece, Ireland and Spain, came under a protectorate established to ensure compliance with the austerity measures imposed by the EU. These measures were imposed as conditions for an economic bailout necessitated by the financial collapse that resulted from the Global Financial Crisis of 2008. Under austerity, Spain and Greece are undergoing a reorganization of the party and political systems. In Portugal, although there is hope that the same may happen at any moment, the status quo is holding.

Portugal is distinguished by its geographical location at the extreme Southwest of Europe and for having a low level of civic engagement relative to most other European societies. This civil apathy arises in part as a consequence of low levels of education (5.2% illiteracy, 23% did not completed compulsory education in 2011¹). Another factor is a disempowering dynamic of strong political control (in the tradition of the authoritarian national-Catholicism that lasted nearly half of the 20th century) crossed with the Masonic traditions and the democratic centralism that emerged from the Revolution of 1974.

One of the dimensions of this political control is institutional stagnation. This is particularly evident in how law is taught and the peculiarity of a justice system characterised

by experts as suffering from a strong formalism – an anachronistic reality which can make any attempt at engaging the establishment from a critical perspective a rather surreal experience. The concept of “lei para inglês ver” (law for English to see), dates back centuries as part of a political management approach by the Portuguese in their subordination to British power and interests. In order to appease English diplomatic pressures while advancing contradictory Portuguese priorities, the practice of enacting laws which were never meant to be implemented became a mainstay of the Portuguese establishment. With time and practice this diplomatic manoeuvre has so permeated institutional culture in Portugal that the law may mean only the will of those who wield the most power at any given moment. A situation which at the same time allows for the pride of having the best laws in the world and the argument frequently employed by the state that those same laws are mere suggestions impossible to comply with. In practice this means that often it is both impossible to enforce a law to which there is institutional resistance, and, for those who would try, impossible to reasonably challenge such a failure.

For the less privileged segments of the population, this insubstantiality of the rule of law means a practiced acceptance of official arbitrariness and, all too often, abuse. Unfortunately, centuries of educational and cultural neglect meant that, with the promising 1974 Revolution of the Carnations, nascent popular democratic movements could easily fall prey to savvier players who would soon surrender the revolutionary ardour of a hopeful population to larger political machines. Consequently, reforms that could otherwise have been meaningful were often merely cosmetic as powerful internal and external interests reasserted themselves to establish “order”.

The first post-revolution Constitution² enshrined many principles representative of the democratic/humanistic spirit catalysing popular movements. After decades of fascism, the preoccupation with establishing “fundamental rights” was one of the focuses of the Constitutional Assembly. The '76 Constitution specifically established the Universal Declaration of Human Rights as the defining basis for the fundamental rights it sought to guarantee and protect³. Article 64, the Right to Health, established a universal and free National Health Service, charged with ensuring every citizen’s preventative, curative and rehabilitative medical needs. This and many other rights and guarantees, such as the Principle of Equality⁴, the Right to Personal Integrity⁵, the Right to Liberty and Security⁶, the Right to Work⁷, the Right to Social security⁸, the Right to Housing⁹, reflecting that moment of preoccupation with fundamental human rights have remained, and in some cases been expanded, in the seven Constitution revisions that followed. The practical impact of this Constitutional effort is not so straight forward. As this report will show, the distance between law and practice is often broad.

With its entry into the European Union in 1986, Portugal embarked on a vast programme of infrastructure and institutional expansion. There was a sudden increase of employment opportunities for people across all classes. This and broad EU-driven agricultural and industrial reforms, translated into large population shifts from the country into urban centres. The middle class grew. For the elites this opportunity to bring the country up

to European living standards meant something else. Their success can be measured in the fact that, in spite of the still relatively high level of general poverty, Portugal has some of the best paid executives, contributing to what is one of the European Union's highest social inequality rates. Nevertheless, given the obvious progress it brought, until recently the Portuguese have been some of the strongest supporters of the European-Union project. Over the past few years, with the imposition of austerity policies, things have begun to change. On September 15, 2012, 10% of the population, 1 million people across the nation, came out onto the streets, not behind partisan politics, but in spontaneous protest. Corruption cases against bankers and politicians are on the news, and some are actually being prosecuted in court, even if not necessarily resulting in convictions¹⁰.

Quantifying the social gains accrued from the Revolution of '74 and the economic expansion between '86 and '08 is no easy task. There are remarkable achievements, and a few in particular are relevant to this study: Portugal's health care system, a legacy of revolutionary reforms and significant boom-times financial investment, was ranked 12th in overall performance by the World Health Organization (WHO) in its 2000 report rating the health care systems of the 190 UN member states; this while ranking 27th in per capita costs. It should be said that the picture is complex and the gains made in health care are tempered by serious structural and distribution problems¹¹. The ongoing economic crisis has led to severe cutbacks in many areas of state spending, especially health care, with serious negative consequences to some of the achievements in that front.

However the least well known and most remarkable social reform since the '74 Revolution is the creation of a complex legal and services infrastructure put in place quietly alongside the more attention-grabbing decriminalization of the consumption, purchase, and possession for consumption of all illicit drugs. This achievement, now beginning to be made evident by studies based on 14 years of implementation, is all the more remarkable given the previously described political and cultural dynamics: institutional ossification and chronic disinterest by the ruling class for the welfare of the lower classes. Something we will try to illuminate in more detail in the description of this reform that follows.

2. Economic context and prisons

Even if it achieves the IMF's projected growth of 1.6%, by the end of 2015, the Portuguese GDP will still be 6% lower than in 2010¹². During that same 5 year period, the government's budgets for social spending shrunk by much more. Reforms imposed as bailout conditions by the Troika, and enthusiastically applied by the Portuguese government, have further impacted budgets with those who are less susceptible to raise public protest being more severely affected. The prison system has especially suffered under this cutback regimen. Among reported consequences are shortages of food, cleaning supplies, staff and health care. The probation services have likewise been left with fewer resources.

The impact of cutbacks on prison health care is further complicated by an ongoing process begun in 2007, when the legislature enacted the integration of prison health care into the National Healthcare Service. The idea was to provide better care to prisoners by granting them access to the same high quality health services available to every other citizen. The shift of responsibility would also free budgetary resources within the prison system. Unfortunately it is difficult to ascertain much as to the progress of this transition due to the complete lack of official reporting. We do know that many services are still theoretically being provided by the prison system, and that some of these which are now the responsibility of the National Healthcare Service are sometimes not provided due to lack of resources at either end. To further complicate matters the trend has been toward the outsourcing of prison health care to private contractors, with supposed cost savings relating to those services which are still not under the purview of the National healthcare Service. The picture that comes from prisoner complaints forwarded to civil society organizations is of severely ineffective prison health care; be it due to lack of medical staff, medications, treatment, transportation or even access to basic diagnostic care.

3. Health context

Using life expectancy at birth statistics as a barometer for general public health, Portugal is at the top of the scale. Having made remarkable progress since 1990, going from an average (for both sexes) of 74 years in 1990, to 81 years in 2013 (2013 life expectancy at birth, men 78, women 84). Other markers are also encouraging: infant mortality went from 11.5 per 1000 live births in 1990 to 3.1 in 2013, and the maternal mortality rate per 100,000 live births declined from 15 in 1990 to 8 in 2013. The birth rate, on the other hand, continues its declining trend with 8.7 per 1000 population in 2013¹³. Nevertheless, most of these measures have been reversing (with the exception of birth rates) since 2011. Studies into the impact of the economic crisis on the Portuguese health system and the health of citizens paint an uncertain picture as to the direction that these markers are likely to take in the near future¹⁴.

Portugal is a signatory to the 2008 Tallinn Charter: Health Systems for Health and Wealth organised by the WHO. The Portuguese state is therefore required to develop and implement periodic National Health Plans, which, with the backing of the WHO and a number of other international organizations, sets out to, among other things, “invest in health systems and foster investment across sectors that influence health,” and “make health systems more responsive to people’s needs”¹⁵.

The policies establishing standards pertaining to health care are drawn by a department of the Ministry of Health, the Directorate-General of Health, whose legally defined mission is to “regulate, orient and coordinate health promotion and disease prevention activities; define the technical conditions for the adequate delivery of health care; plan and programme the national policy for quality in the health system, as well as ensure the elaboration and execution of the National Health Plan” (Decree-Law no.124/2011, of December 29).

In Portugal the auditing and accreditation of healthcare services is undertaken by the Department of Quality in Health (Departamento da Qualidade na Saúde) under the Directorate-General of Health. This is a very recent development, with the first accreditation standards being implemented in 1999, and its function is more one of incentivising standardisation rather than enforcing minimal standards¹⁶.

There are National Health Plans concerning HIV/AIDS and TB. Although HCV was a component of the existing HIV/AIDS strategy, a directive was issued on 14/05/2014 creating the National Strategy for Viral Hepatitis in articulation with the National Programme for HIV/AIDS. There is also an overall National Health Plan, the current version of which is the Portuguese National Health Plan 2012-2016 (now extended to 2020). The National Health Plan, as well as specific infectious diseases health plans, also have regional objectives with each of the Ministry of Health's five regional branches issuing their own locally focused plans. All of these plans lay out policies, goals and strategies for the combat and prevention of the target disease(s) within the National Health Plan's broader strategy of prevention and promotion of public health. Implementing these plans within the current economic context is more difficult, however.

[Out of pocket (OOP)] payments in Portugal are estimated to be among the highest in Europe. They accounted for approximately 23.1% of total health expenditure in 2006 and have been slightly above 23% since 2000. Following the conclusions of international studies [...], one may state that, overall, the theoretically progressive redistributive income tax system in Portugal turns out to be slightly regressive in health care financing due to a high share of OOP payments along with a heavy reliance on indirect taxes. Indirect taxes on goods and services account for 26.8% of total government revenue in 2008. The existence of a generous (by international standards) system of tax benefits to private health spending adds to this "regressivity" of health care funding. In other words, health expenditure falls relatively more heavily on low-income households. These contributors are less able to obtain a higher percentage refund from the tax system than the high-income households (6% versus 27%, when analysing the lower and upper groups of the income distribution)¹⁷.

Supposedly offset by raising the threshold for exemptions, and reducing tax subsidies for the wealthy,

"...arguably one of the measures implemented in the wake of the financial crisis with the greatest potential to impact access to healthcare was the increase in user co-payments. Following the recommendations of the MoU, the new rates clearly intend to encourage the use of primary over emergency care, rather than to hinder access to care altogether, nonetheless the increases were significant and potentially prohibitive"¹⁸.

And the situation has only worsened as state spending continues to be reduced, negatively affecting critical care, as well as all other areas of the public health system.

With this severely reduced purchasing power, a majority of the Portuguese public have less and less access to preventive, and in some cases critical, health care.

In an analysis of Portugal's 2012-2016 National Health Plan, the WHO strongly criticised the lack of focus on the development of minimal national standards. The report stated that there is a need to:

“...clarify the role of the private sector through appropriate regulations: develop and ensure compliance with requirements for public reporting, standards of quality and safety, rules for the dual employment of health professionals, and payment mechanisms rewarding performance for both the public and private sectors,” and “enforce the compliance of public and private providers with minimum standards and ensure reporting of a core set of performance indicators, and establish a platform for health professionals to share the best practices and develop mechanisms to promote continuous quality improvement of health services”¹⁹.

In an even more recent development, reconstituted to cover all healthcare providers by Decree-Law no. 126/2014 of August 22, the Health Regulatory Authority (Entidade Reguladora da Saúde) is an independent public service whose mission it is to regulate the activities of all healthcare facilities and providers. This new body is endowed with broad investigative and sanctioning authority, extending over all providers of health care, public, private and social. Among other things, the Health Regulatory Authority enforces requirements for the exercise of the health care activity, and the rights of access, as well as all other relevant rights of the patient (in Portugal, the right to adequate health care is constitutionally protected in Article 64 and further defined by various laws).

4. Criminal justice and prison context

Portugal decriminalised all drug use, purchase and possession (the last two within specific amounts deemed reasonable for personal use) in 2001. The impact of this radical policy change has been far reaching. The fundamental principle behind decriminalisation was the idea that drug use is a public health issue, and that as such it is better to treat than to punish users (see below). Sex work in Portugal is legal. Only exploitation of prostitutes and profiting from their activities by third parties are criminalised. Sex work is not regulated.

There are currently 49 facilities, including one prison hospital, that make up the Portuguese adult Prison system. As of December 31, 2014 there were 14,003 prisoners; 2,330 were pre-trial detainees, 11,534 sentenced and 139 under security measures; 13,162 were men, 841 women; 55 were youths between 16 and 18 years of age; 2,469 were foreigners, of which 2,264 men and 205 women (as of June 15, 2015, there were 14,307 prisoners. Of these 16.6% were pre-trial detainees and 83.4% sentenced; 6% were women and 94% men; 17.4% were foreigners and 82.6% Portuguese nationals). Also on the last day of 2014 there were 2,217 prisoners being held on drug related

offenses²⁰. There are no official statistics kept on other crimes such as theft, robbery, etc. in relation to drugs, but the study cited below offers some idea. There are no numbers given for offenses relating to prostitution.

The number of drug users in prison may have been impacted by the decriminalization policy. But overall prisoner numbers have continued to grow, and drug related crimes continue to make up a large proportion of those who are sent to prison. There have been three relevant studies on this issue. The first was completed in 2001, the second in 2007, and the latest one, originally projected for 2012, was eventually carried out at the end of 2014. The results of this last study have not yet been published *in toto*. An executive summary was published on the 26th of June 2015. The study, promoted by the Service of Intervention on Addictive Behaviours and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências) known as SICAD, was able to gather answers from a 20% sample of the total prison population, with 2149 valid questionnaires, having visited 47 of 49 prisons. Some of the findings:

30.9% of the sample were in prison for reasons directly related to drugs, compared to 42% in 2007 and 50.3% in 2001.

21.7% of the sample were in prison for reasons indirectly related to drugs, compared with 23.6% in 2007 and 22.6% in 2001.

Drug use among women in prison has risen to 45.1% of the women sampled, compared to 37.4% in 2007 and 33.9% in 2001.

69.1% of the sample acknowledged consumption of drugs at any point of their lives (compared with 63.6% in 2007 and 65.7% in 2001), of which 47.9% declared having consumed in prison²¹.

Penal reform

On 16 February 2004, Freitas do Amaral, head of the government-appointed Commission for the Study and Debate of Prison System Reform, published the Commission's findings and announced to the nation that if Portugal undertook the reforms put forth in the Commission's report, the Portuguese prison system could be brought within "European standards" in 12 years²². The then Minister of Justice, Celeste Cardona, claiming to be invested in realizing the report's objectives declared that, "Portugal will be different when it can think, believe and see that it has a secure and decent prison system"²³. A programme of construction of new facilities and the updating of old ones, begun in 2001, was re-pitched as proof of this reformist agenda. It is telling, however, that the Minister lauded the construction of a North-American style super-max prison as evidence of a more "secure and decent" system²⁴. The use of electronic monitoring would be increased to permit individuals serving short sentences to do so without occupying prison beds, so as to relieve any overcrowding problems.

In 2006 another Minister of Justice, Alberto Costa, announced that a transfer of responsibility for prison health services from the Ministry of Justice to the National Health Service would take place the following year. The aim of this transfer was to “rationalise and perfect synergies with respect to primary and follow-up care’ and ‘ensuring improved efficiency in the use of public funds”²⁵. How the transfer would be accomplished the Minister was not ready to say stating that, “it was premature to talk about how such a transfer of responsibility would be implemented”²⁶. The following year the transfer of prisoner health care was legislated, but as of yet, its progress is impossible to evaluate due to a lack of official reporting. In a 2012 report concerning drug-related healthcare in prison, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) described responsibility for prison health policies in Portugal as being “dealt with at regional or prison levels”²⁷.

2007 saw a series of procedural and criminal code reforms spurred on by an infamous child molestation case known as *Caso Casa Pia*²⁸. With sentencing reforms the trend of diminishing prison population (falling since 2002) was reversed, having risen continuously since 2008²⁹. 2008 was also when the Minister of Justice proclaimed that it would be the “year of the government fulfilling promises such as ending the practice of ‘slopping out’” (where prisoner access to toilets is restricted, forcing prisoners to use buckets to eliminate waste all or part of the time) as part of an ambitious plan soon to be announced³⁰. Meanwhile, the effects of the Financial Crisis of 2007-2008 brought the construction and renovation projects to a halt. As of 2012, according to the Committee for the Prevention of Torture of the Council of Europe (CPT), slopping out was still in use in at least one facility inspected that year³¹. Most other problems continue and have been aggravated by the economic crisis.

This year, with the arrest of an ex-Prime Minister, the issue of prisons and prison reform is again a topic of debate. The general ignorance among political appointees and legislators concerning penal law and the penal system is being criticised by those who argue that this lack of basic knowledge (which creates a sense of exemption from any responsibility among those who could and should establish the character of these institutions) is directly responsible for the state of the prison system. They argue that the prison services have grown resistant to anything perceived as interference with their affairs³². From this sense of self-defence arises a whole gamut of internal and external strategies of political and practical intimidation aimed at any external intervention in how they deal with the human beings entrusted to their care. Whether the airing of these realities will lead to an actual challenge to business as usual remains to be seen.

The current Minister of Justice, Paula Teixeira da Cruz, recently affirmed the government’s commitment to system wide investment and reform, the results of which will be evident by the end of 2015³³.

III. HIV, HCV and TB in prisons

1. Legal and policy context

The description of how the national health programmes (see section II.c above) relate to the prison system is not straightforward. Spurred on by public attention surrounding drug use, HIV/AIDS, etc., there have been resolutions adopted by the government and legislation enacted by Parliament specifically addressing the need to diagnose and prevent the spread of infectious diseases in prisons dating back to the release of the 1996 Report on the Prison System³⁴. Resolution of the Council of Ministers no. 62/96 of April 29, titled Action Programme for the Prison System, stated that

“the overcrowding of the prison system, [...], aggravated by the worrying incidence of infectious diseases among the prison population, [...], is the most significant characteristic of penal administration, making it therefore one of the most preoccupying areas of state administration, marked by insecurities and great fragility.”

Among other steps, the Resolution set forth several immediate administrative measures, such as 4.b)

“the conclusion of agreements, within 3 months, between the competent departments of the Presidency of the Council of Ministers and the Justice and Health Ministries establishing the epidemiological accompaniment on drug dependence and infectious diseases as well as the prophylactic measures to confront them...”, and 4.d) “the conclusion of an agreement, within 3 months, between the Justice and Health Ministries on general health matters, especially as it pertains to conditions for prisoner access to the services provided by the National Health Services.”

Three years later, Law no. 170/99 of September 18, titled “Adopting measures to combat the spread of infectious diseases in prison”, laid out a wide range of preventive and treatment measures, including granting complete access to the National Health Services to all prisoners. The practical impact of any of these measures is difficult to establish – it was only in 2007 that, with a prison reform push, other laws were enacted to transfer responsibility for prisoner healthcare to the NHS (itself an ongoing/obscure process). The problem here is that of the “law for English to see”, or as the previously mentioned government commissioned Prison Reform Study put it, as to the matter of already existing legislation dealing with “the health problems that are of particular concern within the prison context, it is necessary to mention, again, the enormous difficulty in transitioning from legislation to the practical application of the same; a process which, in the majority of cases, never happens.”³⁵.

In 2009, the Ministry of Justice published the “Procedures Manual for Provision of Health Care within Prison” to be implemented by the Directorate-General of Prison Services.ⁱ An extensive document with 56 annexes, to which another 22 have been added since. This manual sets out in detail what preventive measures are to be implemented, as well as what health services are to be provided, and how and when they are to be provided and/or afforded access to by the Prison Services. The document includes annexes specifically dealing with prevention and treatment of infectious diseases (TB, HCV and HIV/AIDS) as well as treatment of addiction. Annex 3 of this manual, titled “Tools for the Collection of Statistical Data on Health/Disease in Prison Facilities”, sets out the requirements, with numerous forms to be filled out by appropriate staff, for monthly, quarterly and biannual reporting of all relevant health services data. The government’s 2012-2016 National Health Plan states “Regarding health indicators, their monitoring has not been viable due to the lack of an information system on the health status of the inmate population and of prison employees”³⁶. Whether the other procedures outlined in the manual are being implemented we cannot ascertain.

What we do know is that, at least on paper, there is a protocol in place between the Directorate-General of Health and the Directorate-General of Prison Services establishing strict detection guidelines, care programmes and monitoring/reporting schedules for TB signed as late as 2014. As to HIV/AIDS and HCV, there are guidelines and plans for what should be done laid out in various plans and studies, but in concrete terms there seems to be nothing beyond the general procedures to deal with infectious diseases. The Procedures Manual for Provision of Health Care within Prison, although containing annexes dealing specifically with TB (3 pages), and HCV (1 diagram), offers no particular attention to HIV/AIDS.

2. Data on HIV, HCV and TB and analysis of data

In 2013 there were 62 cases of TB diagnosed in Portuguese prisons, representing a reduction of 15.6% relative to the numbers for 2012³⁷.

SICAD’s annual report for 2014 (released 7 January 2015), shows that as of 31 December 2013, among the 1,524 prisoners participating in drug treatment programmes under its administration within Portuguese prisons the prevalence of the relevant infectious diseases was HIV+ (15%), HCV+ (42%) e AgHBs+ (2%). Of the 15% HIV+, 76% were receiving antiretroviral treatment, and 59% were also co-infected with HCV³⁸. The report contains no further breakdown on the matter of prisoners with infectious diseases.

The just released executive summary of the yet to be published National Inquiry into Addictive Behaviours within Prison shows that of a 20% sample of all prisoners (from 47 of 49 total prison facilities), 3.8% of those questioned acknowledge being positive

ⁱ In 2012 the Directorate-General of Prison services (Direção-Geral dos Serviços Prisionais) became the Directorate-General of Reintegration and Prison Services (Direção Geral de Reinserção e Serviços Prisionais) as part of a government streamlining, restructuring strategy which brought reintegration services and prison services together under one single administration. Throughout this report, for the sake of consistency, we will keep on referring to the relevant prison services ministry as Directorate-General of Prison Services.

for HIV/AIDS, compared to 10% in 2007 and 16.3% in 2001³⁹.

Unfortunately the collection of data from Portuguese prisons is complicated by what seems to be an impulse not to allow any information to get out. We have no reason to question the data supplied by SICAD, nor the data supplied by the Directorate-General of Health. The problem is that the power of these government agencies to collect data ends at the prison gates (refer to above cited 2012-2016 National Health Plan on “lack of information system”). For example, the above cited numbers for TB cases diagnosed in prison constitute the only reference to prison populations throughout an 80 page national report of a yearly study on HIV/AIDS and TB published by the Directorate-General of Health. The possible repercussions of this lack of appropriate data with which to study and address the issues in question are many, but the most obvious are the needless waste of life and continued suffering that might otherwise be avoided.

3. Harm reduction policies and services in prison

To understand what drug use related harm reduction could be in Portuguese prisons it is necessary to briefly describe what might be one of the nation’s best kept secrets, the development of what today is the Service of Prevention and Treatment of Drug Addiction (Serviço de Prevenção e Tratamento da Toxicodependência, SICAD in short), the body overseeing what is perhaps the nations broadest and most successful government programme.

Intravenous heroin use grew rapidly following the 1974 Carnation Revolution and became a major concern for the Portuguese government. Troops returning from the colonial wars in Angola and Mozambique brought back some of the habits and substances acquired abroad. Democracy brought with it exposure to international cultures and trade. In the early 80’s, taking advantage of an extensive open coastline, international traffickers took over the market, further democratizing access to drugs. Heroin addiction rapidly spread, cutting across social strata, affecting a wide demographic and resulting in spiralling rates of HIV and drug-related AIDS (Hughes and Stevens 2010). By 1999 Portugal had the highest rate of AIDS amongst injecting drug users in the European Union⁴⁰.

In line with global interventions since the 1970s, after the Portuguese revolution the new governments put in place structures to deal with drug abuse and trafficking, as well as centres tasked with studying best practices in terms of medical and social treatment and preventative measures⁴¹. In 1977 two therapeutic communities opened (Restelo and Arco Iris) and the Porto Regional Directorate of the Centre of Investigation and control of Drugs (Centro de Investigação e Controlo da Droga or CEPED) started an opioid substitution programme, using methadone, in Boavista⁴².

The late 1970s also saw the opening of the first Centres of Integrated Responses (CRIs). CRIs provide public responses in terms of treatment, prevention, harm reduction

and reintegration through a multi-disciplinary teams (doctors, nurses, psychologists, social workers) approach. Initially run by the Ministry of Justice, in the late 1980s CRIs transferred to the Ministry of Health. A network developed nationally in the 1990s⁴³.

Today, CRIs hold and distribute methadone nationally, including to prisons. Some CRIs can have local arrangements with prisons in terms of visiting and supporting prisoners. CRIs hire services, like outreach and harm reduction proximity work by Street Teams.

In 1987, the first national integrated plan came into being. Project Life (Projecto Vida) encompassed measures in the fields of drug prevention, treatment, rehabilitation and social reintegration. It envisaged the creation of a specialised hospital emergency unit and a dedicated support centre. As a consequence, the Centro das Taipas was created in Lisbon. This was the first unit run by the Ministry of Health (rather than the Ministry of Justice) which was exclusively dedicated to the treatment of drug dependencies. Two more centres opened in the country in 1989, and a national network of support developed henceforth. In 1997, the number of public services was enlarged to cover every district, with at least one support centre in each⁴⁴.

The 1999 National Strategy for the Fight Against Drugs⁴⁵ enshrined in official policy the concept of addiction as a disease. An integrated strategy encompassing the areas of prevention, treatment, risk reduction, harm reduction and social reintegration was to be overseen by the Ministry of Health, but would involve numerous other Ministries. It remains the foundation of today's drug policy in Portugal. This strategy put forward a set of strategic options to guide public action in the drugs field. This included decriminalising (but still prohibiting) drug use; focusing on primary prevention; ensuring access to treatment; extending harm reduction interventions; promoting social reintegration; and developing treatment and harm reduction in prisons.

The national strategy is founded on principles of humanism and pragmatism, which both lead to the recognition of the importance of harm reduction policies.

Help and treatment are not dependent on abstinence; the aim is to help people reduce harm to themselves and others. This does not mean viewing addicts as "beyond cure." It means creating "a new type of intervention on addiction, complementing strategies of prevention with strategies of treatment and reintegration"⁴⁶. The harm reduction policies are also utilised to "promote and facilitate" the engagement of addicts with the health system⁴⁷.

The achievements of this strategy at the national level have been remarkable. Involving a wide range of providers and services, both at the local and national level, such as: social services, health services, charities, psychological support services, housing services, employment services, rehabilitation centres, drop-in centres, shelters, street teams, methadone vans, high-threshold programmes, low-threshold programmes, therapeutic communities, and so on, all combining and coordinating to assist anyone who is identified as a consumer, and all on the basis of voluntary participation. All

of this work is being coordinated by SICAD, with local programme development and management autonomy.

Harm reduction in Portugal

Harm reduction measures did not start until the mid-1980s, with screening for drug use and sexually transmitted diseases. This led to a push for easier access to contraceptives and to the sale of syringes in pharmacies. A more dynamic approach took shape in Coimbra in 1993, where the ‘Stop AIDS’ initiative involved the creation of a kit (syringe, condoms and information) to be distributed or exchanged in pharmacies. In the same year a national programme of syringe exchanges in pharmacies was implemented: this was “the most important and most effective harm reduction measure in the country to date”⁴⁸.

Outreach work and other localised services (e.g. drop in centres and refuges) started to develop around that time too.

As these measures evolved and eventually grew into the national harm prevention strategy coordinated by SICAD, harm reduction interventions in Portugal came to consist of:

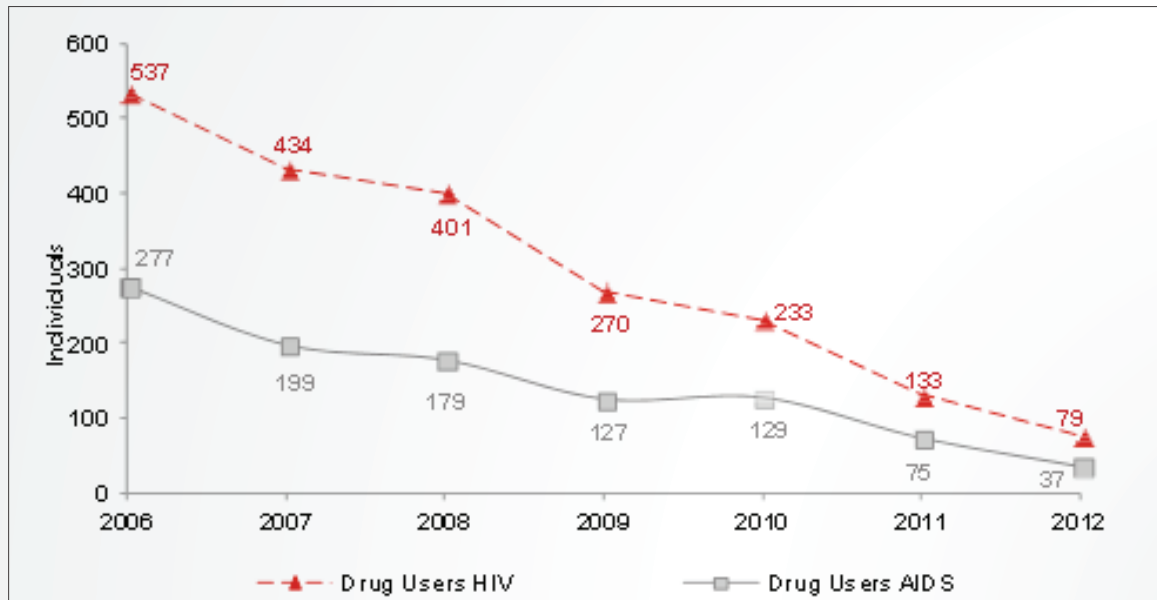
- Medical check-ups (free, or nominal charge depending on programme and income level);
- Psychosocial assessments (free);
- Regular blood sample collection for HIV, HBV, HCV and Syphilis control (free, voluntary and confidential);
- Daily medication distribution: methadone and, if needed antibiotics, anti-TB, antiretroviral, psychiatric meds, contraception etc. (free service to those enrolled in a programme which can be at a specific site or mobile unit);
- Syringe exchange and condoms distribution (free at any pharmacy,ⁱⁱ other syringe exchange sites, street teams, etc.);
- Lung x-rays (free, or nominal charge depending on programme and income level); Low threshold methadone programmes (whereby users are not required to give up consumption – the objective is safe consumption and keeping the person in as good a state of health as possible);
- Links with maternity wards and obstetrician services for pregnant women;
- Proactive social support services (a wide range of assistance whereby street teams’ elements and social workers contact users on a daily basis and offer all sorts of practical support, e.g. taking them to the doctor).

These measures are administered or facilitated nationwide by Street Teams, methadone vans, CRIs etc.

ii The pharmacy syringe exchange programme was suspended in 2012 as the existing protocol with the National Pharmacies Association expired. Subsequently the pharmacy syringe exchange programme was taken over by the national health clinic system. A new protocol with the National pharmacies Association was signed in July of 2014 and the phasing in of the pharmacies exchange programme started with pharmacies in some large cities in December of that year (Redação, 2014).

SICAD and its associated services collect very good data. As an example of what the programme has achieved among drug users at the national level we provide the following chart.

HIV and AIDS notifications associated to drug addiction by year of diagnostic (2006-2012)



Source: SICAD: DMI/DEI; INSA,IP: DDI-URVE/Núcleo de Vigilância Laboratorial de Doenças Infecciosas

2. Harm reduction measures in prison

Following a Council of Ministers Resolution no. 62/96 of 29 April 1997, a protocol was agreed between the Ministries of Justice and of Health. This was intended to set out collaborations between the Directorate-General of Prison Services and the regional health authorities (for generalist health care), and SICAD (in the area of addictions). If properly implemented this would permit prisoners with a substance addiction to access treatment programmes, either through Addicts Support Centres' (Centro de Apoio a Toxicodependentes, known as CAT) staff operating in prison or through prisoners being seen outside.

In practice the implementation of this protocol has been neither prompt nor linear. The various National Strategies to Combat Drugs have laid out a series of programmes intended to be implemented throughout the Portuguese prison system but their implementation has been selective and spotty. Nevertheless, the Ministry of Justice has developed new forms and structures of treatment offered at some facilities. 'Drug free wings' were created in Lisbon ('A' wing), Leiria, Porto, Santa Cruz da Bispo and Tires. 'De-medicalised' programmes of psycho-social therapeutic character are run in these 'protected' areas. The 'G' wing (a therapeutic community) in Lisbon, created in 1992, was doubled in size⁴⁹.

The 2006 National Strategy outlined a policy of harm reduction started in Portuguese

prisons. It focused on facilitating access to condoms and bleach, health education officers' training and prevention programmes⁵⁰.

Pilot substitution programmes (using methadone) were started in Lisbon and Porto prisons, funded by the Directorate-General of Prison Services. Following their evaluation in 1999, two more programmes were created and the Lisbon and Porto programmes were allowed to take on more patients⁵¹. Since then these programmes have become some of the most widespread, yet they are sometimes offered in accord to institution-specific policies which may not necessarily follow national guidelines. There are also reports of long waiting lists and difficulties in accessing programmes by interested inmates⁵²:

[Subsequent National Plans reiterate the need to go on] fostering the interaction/ intervention in Prison Establishments with the relevant services of the Ministry for Justice, strictly defining the intervention boundaries, setting out programmes based on pragmatism and scientific evidence that provide the prison population with all the necessary means to contain infectious diseases and psychic comorbidity, with a view to improving their health indicators⁵³.

After ten years of repeated attempts by various governments being defeated by public fears aroused by security staff unions, an experiment in needle exchange mandated by Parliament (Law no. 3/2007 of January 16) ran for six months (beginning in December 2007) in two prisons. Unfortunately the experiment failed due to prisoners' fears. As a subsequent study showed, prisoners believed that if they were to ask for the needles on offer they would inevitably face discrimination on the part of the authorities when it came to requests for weekend passes, early release, etc., as well as being subjected to more searches and other forms of harassment by guards. This might explain why, in spite of assurances of confidentiality, not a single prisoner asked for a syringe throughout the duration of the pilot programme. The same study also showed that 60% of the staff at the two participating prisons believed the prisoners' fears were well foundedⁱⁱⁱ.

As demonstrated by the concerns expressed by the CPT in its various visit reports, the consistency of infectious-disease screening on admission has been slow to establish even though the 2006 National Strategy declared a programme of compulsory system-wide infectious disease screening on admission to prison, with periodic retesting thereafter, to be already in effect (Ministerio da Saúde, 2006: p.186). Privately, members of SICAD, the only authorised distributor of methadone in the nation, have expressed frustration with obstacles within some prisons to inmate participation in the otherwise extremely successful replacement therapy programme even though SICAD itself funds the programme which, in principle, is available in all 49 prison facilities.^{iv} According to its 2014 Annual report, on December 31st 2013 there were 466 prisoners

iii See: Ministério da Justiça, annexes 17, 18 and 19 of "Relatório de execução do Plano de Acção Nacional para Combate à Propagação de Doenças Infecciosas em Meio Prisional"

iv SICAD's 2012 Annual Report, the last to list the specific institutions with prisoners enrolled in the pharmacologic programme, listed 15 prisons as participating

enrolled in pharmacological programmes^v across 5 prison facilities offering abstinence programmes⁵⁴.

The difficulties faced by SICAD, otherwise so successfully invested at the national level, in reaching into the prisons, can perhaps be measured by the expression of its ambitions in relation to extending its mission within Portuguese prisons. In its 2013-15 Strategic Plan, defining the national policy on matters of drugs and addiction for that period, there is one plan for the prisons: “realization of a national epidemiological study within the prisons”⁵⁵.

With its just released Executive Summary of the 2014 National Inquiry into Addictive Behaviours within Prison (full study forthcoming), SICAD may actually have realised its ambition, even if only in part. Some of this study’s findings may give an idea of the progress of harm reduction measures in Portugal^{vi}:

13.8% of the sample (+/-20% of the total prison population) acknowledged intravenous consumption at some point of their lives outside of prison, compared with 20.6% in 2007 and 32.3% in 2001.

3.1% of the sample acknowledged intravenous drug use at any time in prison, 1.1% acknowledge intravenous consumption during the current incarceration (compared with 3.1% in 2007 and 11.3% in 2001), and 0.7% acknowledged intravenous consumption during the past 30 days of incarceration.

Of the 1.1% acknowledging current intravenous drug use, 29% acknowledge having shared needles/syringes during the current incarceration.

79% of the sample acknowledge never using condoms during conjugal visits. 72.1% acknowledge never using condoms in other contexts, compared with 35.2% in 2007 and 46.8% in 2001.

Of the acknowledge consumers 45.6% has been in a treatment programme at some point outside of prison; 18.6% are currently in a treatment programme in prison, and 27.4% has already been in a treatment programme in prison⁵⁶.

v Both in and outside of prison, the latter pertaining low-level custody programmes with access to the outside

vi It is, however, difficult to distinguish between the impacts of the programmes available to consumers on the outside from whatever may be available in prison without much more detailed studies.

IV. Human rights monitoring in prison and infectious diseases

1. Prisoners' health: legal and policy frameworks

As previously mentioned, in 2007, the Portuguese government enacted what was understood to be a final and definitive transfer of responsibility for prison health care to the National Health Service. Since then no information (official or otherwise) has been made public as to how far this transfer has been affected in practice. From what is evident, little progress has been made to implement the law.

Presently the official website of the Directorate-General of the Prison Services describes the health care services they provide in the following manner:

The provision of health care is ensured by the S. João de Deus Prison Hospital (HPSJD) and by each prison's own health unit, some of which benefit from the services of nurses who cover various prison facilities in a particular area. Anytime that it is justifiable, prisoners have access to the National Health Services⁵⁷.

It should be noted that some prison health services have been privatised. In 2012, Hélder Rosalino, the then State Secretary of Public Administration, approved a maximum yearly expenditure of €4.2 million to be paid to private providers of prison health care. That same year a contract for such private services was rewritten to allow for only one more renewal. The expectation was that by 2014, prison health services would have been completely transferred to the National Health Service⁵⁸. As far as we can establish, however, such contracts continue to be renewed and new ones signed as privatization expands.

The Directorate-General of Health, in its National Health Plan 2012-16, defines responsibility for prison health services as:

.33. Health within the prison environment is under the responsibility of the Ministry of Justice, through the Directorate-General of Prison Services. Inmates are entitled to receive healthcare equal to that offered to the population who is not deprived of liberty, in compliance with the principle of equity and universality of the Portuguese National Health Service.

.34. The following are the specific legal frameworks for health promotion within the prison context:

Decree-Law No. 125/2007, establishing a model of internal organisation for the area of penitentiary treatment: matrix structure grouped by centres of expertise, particularly in the provision of healthcare;

National Action Plan for the Fight Against the Spread of Infection Diseases in Prison (PANCPDI), in the prevention and treatment of addictions and consumption-related pathologies;

DR 71/2011, each prison facility prepares a plan for the promotion of health and prevention of disease, with particular focus on reducing risk behaviours⁵⁹.

2. Human rights monitoring mechanisms

Access to prisons in Portugal is a very restricted privilege. There are four official bodies with a mandate to monitor prisons, although none are specifically charged with monitoring health or healthcare in prison. With the exception of the recently established National Preventative Mechanism (which may request the consulting services of healthcare professionals), none of the other national organizations which may have access to Portuguese prisons employ experts to conduct inspections, investigations and/or evaluations in the area of healthcare and/or infectious diseases.

National human rights organisations

National human rights organisations also have limited reach inside the Portuguese prison system. At the governmental level there is the National Commission for Human Rights (Comissão Nacional para os Direitos Humanos), housed within the Ministry of Foreign Affairs (Ministério dos Negócios Estrangeiros). Created by Council of Ministers Resolution no. 27/2010, of 8 April 2010, the Commission is an inter-ministerial coordination organisation, having an integrated approach to human rights by public and private entities competent in this area as an objective. In practice what this body does is difficult to define, and we have no information of any involvement of its part with the Portuguese prison system.

At the civil society level there are various organizations focusing on human rights in Portugal. Some of these are:

- Liga Portuguesa dos Direitos Humanos – Civitas (<https://ligacivitas.wordpress.com/>);
- Comissão dos Direitos Humanos da Ordem dos Advogados (http://www.oa.pt/Conteudos/temas/lista_temas.aspx?idc=119);
- Observatório Internacional de Direitos Humanos (<http://www.direitos-humanos.com/>);
- Amnistia Internacional Portugal (<http://www.amnistia-internacional.pt/>);
- Observatório dos Direitos Humanos (<http://www.observatoriodireitoshumanos.net/>);
- Associação Contra a Exclusão pelo Desenvolvimento (<http://iscte.pt/~apad/ACED/>).

Some of these NGOs are more or less focused on prison issues in Portugal, but none of them has any sort of regular access to Portuguese prisons.

National monitoring mechanisms

The first line is the Directorate-General of Prison Services-own **Service of Audit and Inspections** (Serviço de Auditoria e Inspeção) known as SAI. As laid out by Decree-Law no. 215/2012, Article 12, the agents of the SAI are appointed for three year terms from among qualified government careerists. The SAI is coordinated by magistrates appointed by the government for three year terms on the recommendation of the Director-General of the Prison Services, to whom the SAI agents report directly. Their duties are to:

- a) Regularly monitor the performance of the facilities, as to their smooth operation, coordination and improvement;
- b) Evaluate the efficiency of the management of the facilities;
- c) Verify compliance with laws, regulations and guidelines;
- d) Identify corrective measures for inadequate procedures and propose the adoption of norms, techniques and methods aiming to improve services and standardization of practices;
- e) Conduct inspections, audits and investigations, as well as initiate disciplinary or investigative proceedings;
- f) Conduct the investigative and disciplinary proceedings that may be passed on to them, namely those of greater complexity and those dealing with managerial level staff;
- g) Supervise and offer technical support in proceedings not conducted by the SAI.

In practice this service will open an investigation whenever there is news of a problem relating to the prisons or when ordered to do so by the Director-General of the Prison Services. They may also investigate an individual complaint. Their investigations may involve visiting prisons, forwarding questionnaires, running inquiries among staff, and interviewing prisoners. The SAI serves the Director-General of the Prison Services, therefore undoubtedly they could make surprise visits if s/he so chose it; whether that happens we do not know. Their investigations seek to confirm whether institutional practices conform to the relevant legal provisions. The SAI collects case processing and some general system-wide management data on a regular basis, but not on anything pertaining to conditions. As far as we can determine, they do not employ personnel with specific skills in areas such as human rights, health care, etc.; rather, their staff is made up of career bureaucrats, generally with a legal background.^{vii}

vii In the absence of any reports as to the investigations undertaken by the SAI, we gather information from ACED, the Associação Contra a Exclusão pelo Desenvolvimento (Association Against Exclusion for Development), a civil society organization that redirects the prisoner complaints that manage to reach its offices to the competent investigative authorities. ACED's aim is to elevate prisoners' complaints from the penitentiary framework to a higher social and administrative level, outside of the penal system. In 2014, ACED Forwarded 31 medical-related complaints to various competent authorities, including the SAI. The reply by ACED's director as to the practical results of the investigations conducted by the SAI, the Ombudsman, etc. reads, in part: "In the words of an ex director of the IGSJ, autonomous from the prison services, 'although it is difficult to prove anything that happens in the prisons, the fact of there being

The **General Inspectorate of Justice Services** (Inspeção-Geral dos Serviços de Justiça), known as IGSJ, is a central service of the Ministry of Justice, endowed with administrative autonomy. Its mission is to audit, inspect and supervise all entities, services and organs dependent on the Ministry of Justice or subject to its regulatory authority. Its aim is to correct illegalities or irregularities and the optimization of the functioning of all services.

In practice this service will open an inquiry any time it receives a complaint. Depending on the complaint it organises system-wide investigations around specific issues. Its investigations may involve visiting prisons, forwarding questionnaires, interviewing staff and prisoners. It is not clear if its agents may make surprise visits to prisons. Typically, its investigations involve the collection of information relevant to the complaint and inspecting the conformity of penal practices with the relevant legal provisions. The IGSJ regularly collects case processing and some general system-wide management data, but not on anything pertaining to conditions, its focus is strictly juridical. IGSJ agents are selected for their legal background; they are not hired for any sort of expertise beyond law. In its 2013 Action Report, the latest available, the IGSJ indicates that it conducted 11 inspections of prison facilities, of which one pertained to a medical complaint. The report offers no information as to conclusions from these investigations⁶⁰.

The **Ombudsman** (Provedor de Justiça) is constitutionally and statutorily endowed with a wide range of powers. From the Ombudsman's own website's English translation, Law no. 9/91, of 9 April 1991^{viii}, defines the Ombudsman's duties and powers as, among others:

Article 1, Duties, 1. In accordance with the Constitution, the Ombudsman is a State body elected by the Parliament whose main duties shall be to defend and to promote the rights, freedoms, guarantees and legitimate interests of the citizens, ensuring, through informal means, that public authorities act fairly and in compliance with the law. 2. The Ombudsman may also act as an independent national institution for monitoring the implementation of international treaties and conventions on human rights, when designated for that purpose.

Article 21, Powers, 1. In the performance of his duties, the Ombudsman shall have the following powers:

investigations, even if only to cover up the problems, tends, often, to cause those involved to be more careful.' More to the point, the SAI, having no autonomy from the Directorate-General of Prison Services, is subject to such anti-professional practices that I once was contacted by an inspector asking to be denounced, as the only way that he could find to be heard on a case that he was not being permitted to properly act upon (a case of violence by guards against prisoners). In matters of health, involving the infirmary and medical services, it is all the more complicated. For example, there was the case of a prisoner with a broken wrist who fought for many months to be treated. When he did manage to get to the hospital, the doctor presented him with the choice: either amputate the hand or leave it the way it was. An official inquiry later judged this as an expert opinion. The eventual involvement of the Prosecutor's Office led to the release of the prisoner (with or without treatment I don't know)."

viii Later amended by Law no. 30/96, of 14 August 1996, Law no. 52-A/2005, of 10 October 2005, and Law no. 17/2013, of 18 February 2013.

a) To make, with or without prior notice, inspection visits to any area of activity of the central, regional and local administration, including public services and civil and military prisons, companies and services of general interest, whatever its legal status, or to any other entities under his control, to hear their bodies and officials and to request them such information and documents as he may deem adequate;

b) To undertake such investigations and enquiries as he may deem necessary or convenient, where he may use, for the purposes of collecting and producing evidence, all reasonable means, provided that such means do not collide with the rights and legitimate interests of citizens;

c) To search, in cooperation with the competent bodies and services, the solutions which best serve the protection of the legitimate interests of citizens and the improvement of the Administration's activity. 2. Without prejudice to the provisions of the following article, the Ombudsman's actions and intervention shall not be limited by the judicial and administrative remedies foreseen in the Constitution and in the law, or by any such remedies being pending.

Article 28, Investigation, 1. The investigation shall consist of requests for information, inspections, examinations, inquiries or any other reasonable procedure that does not collide with the fundamental rights of citizens and it shall be undertaken through informal and swift means, without being subject to procedural rules on the production of evidence.

Article 28, Investigation, 2. Actions within the investigation process shall be carried out by the Ombudsman and his staff, but they may also be requested directly to Public Prosecution officials or any other public entities with priority and urgency if necessary.

Article 29, Duty to cooperate, 1. The bodies and officials of the entities mentioned in article 2, paragraph 1, are under the obligation to provide the Ombudsman with every information and clarification that the latter may request from them. [...]

Article 29, Duty to cooperate, 5. The Ombudsman shall be entitled to order any worker or representative of any of the entities referred to in paragraph 1 by means of a request addressed to the competent hierarchical authority, or any incumbent of anybody subject to his control to be present at his Office, or at any other place it may indicate based on the circumstances, so as to obtain the requested cooperation⁶¹.

Continuing through 46 articles, the law defines an impressive range of protections of office and from interference with any aspect of enacting its functions. Additionally

the law provides the Ombudsman with duties and powers to investigate, seek redress, and recommend legal remedies to any governmental, operational or bureaucratic malfunction.

The Ombudsman deals with issues pertaining to the prison and health systems through its Department of Other Fundamental Rights (Outros Direitos Fundamentais), one of six organizational units focusing on specific areas.

In practice, the Ombudsman will open an inquiry any time it receives a complaint. In the past (in 1996, 1999 and 2003), the Ombudsman also conducted inspections and published thorough prison conditions reports on each of the nation's prisons. Some of the findings presented in these reports, especially the 1996 report, have had a great impact on policies pertaining to prison health care in general and infectious diseases in particular (see section III-a above)^{ix}.

When investigating a complaint, which anyone may file, the Ombudsman might visit prisons, forward questionnaires and/or interview prisoners and staff, and it may do so at any time without prior notice. The Ombudsman services do not hire personnel with specific expertise on health, human rights, etc. Nevertheless, according to ACED the Ombudsman does sometimes make recommendations as to issues raised by a specific investigation which result in remedial changes being adopted at the local level. Yet, the same problem will continue to exist in other prisons, and with time similar problems continue to be reported at the facility where the remedial changes were implemented.

The Ombudsman does regularly collect case processing and some general management data, but not on anything pertaining to conditions. Statistical data regarding the number of complaints investigated, origin and processing are also presented in the Ombudsman's official website, the latest being for 2010, but it is unreadable^x. In 2009, 15.5% of all complaints to the Ombudsman originating from prisons pertained to medical issues⁶².

The **National Preventive Mechanism (NPM)** began operating in mid-2014. Portugal signed the Optional Protocol to the UN Convention against Torture (OPCAT) in 2004, and ratified it in 2013. Upon ratification, Council of Ministers Resolution no. 32/2013, published in the *Diário da Republica*, 1st Series, no. 96, of May 20, instituted a parallel, but independent position within the Ombudsman's Other Fundamental Rights department, with the current Ombudsman being appointed as NPM. In 2014, a document titled Regulations of the Support Structure to the National Prevention Mechanism (*Regulamento da Estrutura de Apoio ao Mecanismo Nacional de Prevenção*) was issued. The structure thus established is described in English on the Ombudsmen's Official site as follows:

ix Another such system-wide inspection was undertaken in 2013, but the resulting report was never published.

x See: <http://www.provedor-jus.pt/?idc=48&pos=0>, when accessing data, the format and low resolution of graphs and tables renders them illegible.

The creation of a system of regular visits to places where persons are deprived of their liberty, in order to prevent torture or subjection to cruel, inhuman or degrading treatment or punishment, led to the creation of a structure to assist the Ombudsman in the performance of the tasks of the National Preventive Mechanism, namely, the identification of places of detention, the planning, the conduct of visits, the data acquisition and its analysis.

The National Preventive Mechanism is therefore assisted by the Supporting Structure to National Preventive Mechanism.

This structure is open to the participation of people who, by their activity on certain entities which pursue the primary objective of guaranteeing citizens' rights, or because of its recognised individual merit, could contribute to the effectiveness of the tasks entrusted to the National Preventive Mechanism and consists of:

- a) Consultative Council;
- b) Coordinating Committee;
- c) Board of visitors;
- d) Administrative assistance.

The Consultative Council is the main organ of consultation of the National Preventive Mechanism, consisting of twelve members [among which are a lawyer, a medical doctor and psychologist], and exercises the powers laid down in article 7 of the Regulation of Supporting Structure to National Preventive Mechanism.

The Coordination Committee, consisting of three elements, executes the plan of activities, ensures the conduct of visits to places of detention through the Board of Visitors, as well as assists the National Preventive Mechanism in the development of its mission.

The board of visitors consists of nine people drawn from existing Ombudsman staff [Exercising this function beyond their normal Ombudsman duties] and appointed for that purpose, having as primary task the implementation of inspection visits and the preparation of the respective proceedings.

In order to achieve that goal, the National Preventive Mechanism may also request the participation of other members of the Ombudsman staff, as well as of experts on the technical and scientific knowledge appropriate to the purpose of each visit or taking into account the characterization of the places to visit.

The administrative assistance to the Supporting Structure to National Preventive Mechanism is provided by an official of the Ombudsman's staff designated for that purpose⁶³.

The implementation of the NPM structure as described is an ongoing process. The Ombudsman, José de Faria Costa, has publicly complained of a lack of resources with which to discharge the duties of NPM. Presently the budget available for its activities is a mere €26,800 which must come off the Ombudsman's own budget (no additional funds are allocated for the activities of the NPM within the Ombudsman). An amount that must cover all expenses, including travel to all places of detention throughout the mainland and islands. He described how all posts within the NPM are presently filled with Ombudsman staff who must fulfil NPM duties on top of their regular tasks. More important, he expressed the need to be able to contract experts in the various areas pertinent to its duties. The NPM does count with the support of various experts (medical doctors, psychologists and lawyers) made available by representatives of the respective professional guilds who sit on the Consultative Council.

From August 2014 to January of this year, 21 visits to places of detention were performed by the NPM⁶⁴. In its first annual report (published as an annex to the Ombudsman's yearly report to the National Assembly) for 2014, the NPM describes a total of 19 visits to places of detention (one of which counted with the participation of a "medical expert"), of which 9 were prisons. The findings of the NPM on each of these prison visits paint an overall very positive picture, with few problems to mention. One prison facility's psychiatric unit, Santa Cruz do Bispo, merited a short mention as to the lack of night and weekend infirmary staff (no recommendation was made by the NPM in this regard). Other than that there is no mention in the report of any healthcare or infectious diseases issues pertaining to the visited prison facilities⁶⁵.

The services outlined above do not generally interact with each other. Having received a complaint, or otherwise chosen or been called to do so, they may conduct parallel investigations, typically by forwarding a series of question to the party being investigated, or visiting a site, which may or may not yield similar results for each of the services. They may then issue a report, which may not necessarily be made public (some investigative reports are notoriously difficult to gain access to). They will generally provide the complainant with some sort of finding, more often than not repeating the justification provided by the party being investigated^{xi}. In such cases where they recognise the need for some sort of procedural alteration or redress, they will issue a recommendation to that effect. When a crime is judged to have occurred, the information is passed on to the Prosecutor's Office (Ministerio Público), and, if a criminal process (processo crime) is initiated, the investigation is handed over to the Prosecutor (Procurador).

As to monitoring and collecting information on health, including infectious diseases, and human rights issues, the lack of expertise in these areas among the investigators of any of the currently operating monitoring bodies, makes it difficult for any of them to competently fulfil those roles even if the will to do so were present at the organizational level.

xi This assessment is based upon the experience of over 17 years by ACED in forwarding prisoner complaints (many pertaining to healthcare matters) to all of the existing monitoring mechanisms.

As to what the eventual implementation of the NPM operational structure may mean in practical terms for the monitoring of health in prison it is very difficult to say. The hope, of course, is that it will mean the beginning of a change in the culture of appeasement, justification and laissez-faire which presently defines Portuguese monitoring mechanisms.

Regional/International monitoring mechanisms

The UN's Subcommittee on the Prevention of Torture has never visited Portugal.

The CPT has made 9 visits, in 1992, 1995, 1996, 1999, 2002, 2003, 2008, 2012 and 2013, with another scheduled for 2016. From its first inspection in 1992, the CPT made strong recommendations pertaining to matters of health and health care. Among others, the issue of insufficient doctors and nurses in attendance in Portuguese prison facilities was emphasised in the first CPT report⁶⁶. The fact that many of the health care tasks were performed by other prisoners was strongly criticised, as was the lack of appropriate and consistent medical screening on reception. Subsequent to its 1995 visit, the CPT declared the health care services at one of the inspected facilities to be "in a state of crisis"⁶⁷, and called particular attention to problems with TB, HIV/AIDS and HCV screening and care within the system as a whole. The report expressed serious concern over the absence of a systematic tuberculosis screening programme at some of the facilities visited. Among other related recommendations at that time:

The CPT also wishes to emphasise that a prison health care service should ensure that information about transmissible diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out⁶⁸.

In its 1998 report concerning the 1996 visit, the CPT, having inspected one single facility, declared itself pleased to see that staffing levels had been increased according to its previous recommendations. No mention was made as to any of its previously reported concerns and recommendations on the matter of infectious diseases.

In response to these reports the Portuguese government informed the Committee of a number of measures designed to develop prison medical services and enhance the health care provided to prisoners due to be completed in 1998⁶⁹.

By the time the CPT visited again, in April of 1999, things had seemingly continued to improve. The 2001 report of this visit indicates that, although much more needed to be done, significant progress had been made towards the realization of the measures the Portuguese government had committed itself to in improving health care services. Nevertheless, staffing levels were still considered inadequate, and again strong criticism was aimed at the employment of inmates to perform health care duties. On

the matter of infectious diseases and harm reduction the inspection found much to be desired:

It goes without saying that all prisoners - whatever their current attitude towards drugs - should be provided with adequate drug-awareness information. It is important to raise awareness about the aetiology of drug dependence and to develop harm reduction strategies. This should include information/training in respect of hygiene measures concerning the taking of drugs and the mechanisms of disease transmission and methods of prevention. The authorities should take all possible steps to minimise risk of contamination inter alia by HIV and Hepatitis B and C in prison.

It is also important to provide staff (prison officers of all grades, as well as other staff, including teachers, health assistants, etc.) with information and training concerning drug dependence and drug misuse.

The CPT's delegation found that the approach being followed in this respect in the establishments visited left much to be desired.

More particularly, the information about disease transmission provided to inmates (and to staff) was rather limited, and no written information was being systematically given to prisoners. Further, whilst bleach was available to inmates in all of the establishments visited, reference to the precautions to be adopted in the context of the taking of certain drugs (e.g. as regards the cleaning of needles/syringes) seemed to be taboo⁷⁰.

In response the Portuguese government cited the implementation of various awareness and harm-reduction programmes as well as measures to prevent and deal with infectious diseases reflecting how seriously the CPT's recommendations were being taken⁷¹.

On its return in 2002 (visiting only the Oporto prison) the CPT found things not only had not improved, but some of the previous progress seemed to have been short-lived. Published in 2007, the report of the 2002 visit found such things as the case of a bed-ridden patient with advanced AIDS kept in a prison infirmary without professional nursing oversight, being cared for by other inmates. Again the CPT admonished:

The distribution of medicines in the prison is also a source of concern. It was regularly carried out by prisoners, with little control as regards the identity of the inmates who received medicines (including prescription drugs) and no supervision from nursing staff.

The CPT would underline once again that the use of prisoners to provide health care services (cf. CPT/Inf (94) 9, paragraph 122, and CPT/Inf (2001) 12, paragraph 88) and to distribute medicines are highly undesirable practices. It

recommends that the current approach in this connection be reviewed⁷².

The frustration with the lack of significant progress after repeated CPT inspections is apparent in the tone of the report: “For their part, the Portuguese authorities have repeatedly expressed their commitment to address the situation, and the Committee recognises the efforts made in this respect. However, the information set out in this report clearly shows that those efforts have had only marginal effects, and that significant problems persist (violence, drugs, insufficient staff, overcrowding)”⁷³.

In 2003, the CPT visited five prisons and several other detention facilities, again to find that medical care had worsened. The continued lack of consistent progress is made clear by the Report’s admonition concerning something as basic as medical screening on reception in order to prevent the spread of infectious diseases, suicides, etc.: “The CPT reiterates its recommendation to the Portuguese authorities to take all necessary measures to guarantee de respect of this obligation in the whole of the Portuguese prison system”⁷⁴.

In 2008 the CPT returned to visit a total of 12 prisons and other detention facilities under the authority of the Ministry of Justice. This time the CPT found the general situation within the Portuguese prison system greatly alleviated by the implementation of recent legal reforms which were having an impact on the number of prisoners, with smaller prison populations putting less stress on resources that, although having improved since the previous visit, were still inadequate. The report states, “[t]he CPT’s delegation was informed by the Portuguese authorities that it was their intention to transfer the responsibility for health care in prisons from the Ministry of Justice to the Ministry of Health by 2010”⁷⁵, thus greatly improving the delivery of health care to prisoners. The old refrains were repeated, “The CPT recommends that health-care staffing levels be strengthened”⁷⁶, and “It is impossible to overemphasise the importance of medical screening of newly arrived prisoners, particularly in establishments which constitute points of entry to the prison system. Such screening is essential, particularly to prevent the spread of transmissible diseases and suicides, and for recording injuries in good time”⁷⁷.

In 2012 the CPT visited 7 establishments under the authority of the Ministry of Justice, this time finding a new dimension to the challenges of improving Portuguese prison health care:

At the time of the visit, the Ministry of Justice had recently completed the process of outsourcing a substantial part of the provision of health care services to a private company (Sucesso 24 horas), with other contractors also providing health care services in some prisons (for example, IAP in Setúbal Prison). In the prisons visited, some medical personnel were employed by the Ministry of Justice, but an increasing number were provided by the private contractor. The outsourcing has led to cost-efficiency gains, but it has also resulted in high levels of staff fluctuation within a prison establishment as the contractor often sends

different people to work the various shifts. This could lead to a lack of continuity in the provision of health-care, negatively impacting on information sharing and on staff-patient relationships.

The new arrangements for the provision of health care in prisons require the Ministry of Justice to put in place robust oversight and audit mechanisms to ensure that private contractor(s) provide a quality service to the standards required. The CPT recommends that the Portuguese authorities ensure that the new prison health care arrangements are properly monitored, taking into account the above remarks⁷⁸.

Not having happened by 2010, in 2012 “the CPT’s delegation was again informed about the planned transfer of responsibility for health care in prisons from the Ministry of Justice to the Ministry of Health”⁷⁹. Medical staff levels continued to be inadequate at some of the facilities visited.

On the positive side, some improvement was noted as to admission screening for infectious diseases, as well follow up care for diagnosed cases. The TB and HIV/AIDS screening and treatment programmes were highlighted as particularly successful system-wide programmes.

In its last visit to date, 2013, the CPT visited two prisons, Lisbon Central Prison and Monsanto High Security Prison, both of which had been visited before by the committee and the subject of extensive recommendations. In Lisbon the CPT found the same issues remained despite government assurances that steps had been taken to remedy them: medical staff levels were insufficient for the size of the population, and the reception medical screening procedures continued to fall short of minimum requirements.

The difficulties encountered by all who attempt to tackle prison issues in Portugal is illustrated by the following remarks by the CPT in its last report:

Regarding the health-care service in prisons, the CPT notes that, according to the Code on Execution of Criminal Sanctions, the National Health Service is responsible for prisoners. Several regulations were adopted in 2011 and 2012 to clarify a number of issues, in particular as regards financial costs. However, the transfer of responsibility for health care in prisons from the Ministry of Justice to the Ministry of Health appears to be blocked. At the time of the visit, the Ministry of Justice remained competent for providing health-care to prisoners. As an illustration, the medical doctor who was heading the health-care service at Lisbon Central Prison was employed by the Ministry of Justice. Therefore, the Committee would like to receive updated information on the current institutional arrangements for the provision and supervision of health care in prisons, as well as on the transfer process.

As was the case in 2012, a number of medical services were provided by private entities and the report on the 2012 visit recommended establishing robust oversight and audit mechanisms to control the outsourced services. In their response, the Portuguese authorities merely indicated that contracts with private companies providing health-care services contained a specific clause aimed at ensuring staff stability. This does not, however, address the central issue of the quality of services provided. The CPT considers that the necessary oversight measures should be taken to ensure the quality of service is upheld and to control the respect by private contractors of their obligations; to this end, it reiterates its previous recommendation⁸⁰.

In a system where laws are not necessarily in effect, and their being written can be justification for not taking corrective action as to the realities that said laws should have altered, it can be very difficult for any organization, national or international, to have a great deal of impact on how things are done within any state institution that wishes to maintain the status quo. That said, the CPT has brought a great many issues within Portuguese prisons to the light of day, elevating them to a level where it has been difficult for the Portuguese government to simply ignore their existence. In so doing, although progress has been slow and often inconsistent, the CPT has played a very important role in instigating important reforms within the Portuguese prison system, including in the areas of infectious diseases and harm reduction.

The courts

In theory prisoners can seek redress of medical issues in the Courts. The Portuguese Courts do have jurisdiction over matters of health care, in prisons as anywhere else, as healthcare rights are constitutionally established. In practice, however, access to the Courts is too cumbersome and costly a process for anyone but the most privileged to make use of. For those who could and would pay for such a process, if incarcerated, could also pay for their own private health care and thus would not suffer the type of related problems that are common to the general prison population. Portuguese prisoners do not benefit from a functioning legal aid system. We do not know of any relevant Portuguese Court decisions on matters of health care and/or infectious diseases relating to the prison context.

V. Conclusions and recommendations

The state of the Portuguese prison system on matters pertaining to health care, infectious disease control and harm reduction programmes leaves much to be desired. The challenges facing any effort to positively alter the current practices in these areas can be measured by the Portuguese government's other departments' difficulties in influencing what goes on within prison walls. Laws are enacted to no avail. Programmes and protocols are instituted only to be ignored. Queries for information go unanswered. Of course none of this is possible without the existence of some profound systemic problems lying well beyond the prison walls. This might explain how the knowledge that Portuguese prisons suffer a death rate that is twice the European Union's average can be accepted without anyone bothering so much as to try to justify the fact.

From this report we can glean that the problem stretches from the political establishment to every government department charged with implementing, enforcing and monitoring compliance with the law by those in authority within its prisons. We see too that the lack of engagement on the part of the civil society sector contributes to this state of affairs, in what might perhaps be a feedback loop of apathy the beginning of which is too complex for us to unravel here. But the picture is not hopeless. The report also shows that over the years, national and international efforts have spurred some reforms. They are too few and too slow to take hold, and when they do often that hold is tenuous, but things are edging forward. And within this process of wrenching the Portuguese prison establishment out into the light of day, those who take up that challenge will need all the tools they can get their hands on. To that end, a tool such as the one that is being developed and offered by this project might go a long way to both expose and empower all those involved. Those who might go in to collect the information may find themselves motivated by the potential the tool offers to inform every aspect of the process of fomenting reform; those whose lives will be reflected in the data collected will find voice in its dissemination; and those who think that their duties can only be safely performed in the dark might be relieved to find that they can do a whole lot more than they thought possible if only they free themselves from the burden of keeping the world from peering in.

Our work need not and should not end here, of course. In the matter of infectious diseases and harm reduction we should look not only at the problems within the main prisons but also in all other places of detention, such as:

- Juvenile detention centres;
- Immigration detention centres;
- Refugee centres;
- Psychiatric hospitals;
- Military prisons;
- Police custody facilities.

We should also look into why some prison systems are so zealous in their black-out of health care/medical information, and the possible link between this and physical abuse of prisoners by security staff. Although this report did not look at that aspect of prison conditions, previous studies have shown that in Portugal there is a very serious problem with physical abuse of prisoners by security staff, abuses which often involve (wittingly or otherwise) the complicity of medical staff⁸¹. If, as we believe, there is such a link, dealing with infectious diseases in prison may be dependent upon our confronting what else may be happening within some prisons: harm reduction should perhaps begin there.

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