| **HEALTH PROMOTION AND DISEASE PREVENTION**<br>**A Handbook for Teachers, Researchers, Health Professionals and Decision Makers** | |
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| **Title** | **Health Policy in Prisons** |
| **Module: 2.6** | **ECTS: 1** |
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| **Key words** | Health policy, prison health, primordial prevention, |
| **Learning objectives** | After completing this module students and public health professionals should:<br>• understand the pitfalls of the technicistic approaches to health policy;<br>• understand the advantages of the complex approach to health policy;<br>• get familiar with the concept of social determinants of health;<br>• understand the importance of the primordial prevention;<br>• get the basic knowledge of the health in the prison environment. |
| **Abstract** | The subject of the prison policy is mostly male population (there are, 5-7% of woman among prison inmates). Most of them are living under the harsh physical, psychical and social conditions. In addition, many prison inmates came to serve their sentence with developed risky life styles. That is why prisons are breeding an array of health problems. Typical are mental health problems, drug addiction and infectious diseases among which dominant role have tuberculosis, AIDS and hepatitis. The prison health care is rather neglected area. Recently, there were efforts to change this situation. The most prominent changes were characterized by measures of primary prevention, screening and systematic check-ups. That orientation has brought some improvements. However, introducing of the concept of the social determinants of health brought into the domain of the prison health care additional demands. From the point of view of these demands, the health policy in prisons should be based on two principles: the holistic principle, and the principle of human rights. The two blind alleys should be avoided: biomedical approach because of its superficiality and the risk factors approach because of its partiality. The four priorities should be followed: the professional one, the contextual one, the developmental one, and the economical one. The engagement should focus on the primordial prevention, domain of meanings, psycho- social development and sustainability. This is the health directed approach and not the medical one, and it can be allied with the similar engagement of other professionals working along the similar directions. |

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| **Teaching methods** | • Lecture: Social determinants of health and primordial prevention;<br>• small group discussion: students are reporting how they react when they are under the stress and what are the typical obstacles meeting their compensatory strategies;<br>• Small group discussion: biomedical approach to health and its deficiences;<br>• Small group discussion: the risk factors approach to health and its defficiences;<br>• Lecture: Basic priorities of health policy;<br>• Seminar: students prepare and report the basic problems of physical, mental and social health in a prison environment;<br>• Small group discussion: Students are matching basic problems in prison environment and basic priorities of health policy;<br>• Presentation: students prepare and present the basic elements of health npolicy in a virtual prison;<br>• Simulation: students in role of prison inmates criticize, and students in the role of health policy planners defend the presented health policy;<br>• Conclusions; |
| **Specific recommendations for teachers** | 1 ECTS (work under teacher supervision - 10h / individual and group students' work – 20h). |
| **Assessment of Students** | Presentation and simulation stand instead of multiple choice questionnaire and other evaluation methods (structured essay, seminar paper, case problem presentations, oral exam, attitude test etc). |

# HEALTH POLICY IN PRISONS

**Vuk Stambolovic**

## Introduction

The health policy in prisons should be based on two principles: the holistic principle, and the principle of human rights.

The holistic principle means that the health policy in prisons should deal with the prison population as a whole, i.e., that it must cover both prison inmates and staff. The specific position of prison inmates is by itself demanding attention. However, the prison staff should be taken care of as well. The point is that the prison environment is stressful for them also and that their life context is typically adding to that job induced stress load. In addition, the health of prison inmates and the health of the prison staff are interconnected. Namely, because of the significant disbalance of power, very often, both ill health and bad moods of staff members can have harmful effect on the health of prison inmates (1).

The health policy in prisons should also be in accord with international standards dealing with human rights of prison inmates. Among them the three documents are of a special importance:

- Guidelines of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2);
- United Nations Standard Minimum Rules for the Treatment of Prisoners (3);
- Recommendation of the Council of Europe Concerning the Ethical and Organizational Aspects of Health Care in Prison (4).

Of course, there are professional guidelines which are of a significant importance as well.

The first one is «The Health in Prison Project» which was initiated in 1966 by World Health Organization (5). Within this Project several good practice guides have been developed like: «Mental Health Promotion in Prisons», «Status Paper on Prisons, Drugs and Harm Reduction», «Status Paper on Prisons and Tuberculosis», «Public Health Consequences of Imprisonment», «Promoting the Health of Young People in Custody», «HIV in Prisons» etc. (6).

The short prison health agenda could be found in «Declaration on Prison Health as Part of the Public Health», known also as «Moscow Declaration» (7).

It is also important to take into consideration that in prison conditions three groups of nosological entities are prevailing: drug addiction (8), mental health problems (9), and infectious diseases, particularly tuberculosis (10), AIDS (11,12), and hepatitis (13).

It is also important to consider that the prison walls are not tight proof. There is the continuous social exchange between prison and the «outside world». That exchange is making possible the penetration of dominant prison pathology into the population living outside, and vice-versa, which means that the health policy in prison is the integral part of the health care of the general population (14).

## A. Typical blind alleys

The prison context (like other contexts) is under the influence of various interests. These interests are producing specific approaches which can frame the health policy in prisons in a way which is undermining the required health care. Two rather frequent approaches are the typical examples.

1. Within the first approach the health care is not the principal issue. This approach is based on the relation of power, embodied in the principle of punishment. As such, that approach is typical for the countries in which the prison health care is under the control of ministries of police or justice. Within that setting every prison inmate asking for the medical care is, first of all, the prisoner, and not the patient (15). The dominant attitude of the staff (and of the medical personnel as well) is that prison inmates are in the prison because of the punishment, and not because of the health care. That is why the principle of control is always more important then the principle of human rights, the rights of a person with ill-health including. That principle is blocking the access to health care in prisons and it actually serves as the additional punishment. In that way, often (and in the case of the «new penology» systematically)[1], (16), the health care is directly included in the system of the control of prison inmates. So, it happens that even necessary medical interventions are delayed, and sometimes denied (17).
2. The second typical way of planning which is compromising optimal health care in prisons is the technicistic approach. The technicistic approach is originating from two opposite technical interests.
   a) Under the influence of the first technical interest (the interest of medical professionals clinging to the concept of biomedicine) the central focus is put on the disease (18). That is why the main emphasis is put on the efficacy and on the strict professional criteria regarding both diagnosis and treatment. This is the classical biomedical attitude within which medical professionals respond to the complaints of sick prison inmates. That approach does lead to the alleviation, and sometimes to the successful treatment of many health problems, however it has an important shortcoming (especially within the prison context!) - it is partial. Namely, within this approach, medical professionals are just reacting to the demands of prison inmates while completely neglecting the permanent and massive production of suffering and ill-health in prison conditions.
   b) Within the second technical interest (the interest connected with the preventive medical bureaucracy) the central focus is put on the risk factors. According to the basic argument of this approach the prison inmates are belonging mostly to the marginalized social groups, so they are coming to prison with established risky life stiles (19). That is why the prison is visualized as the ideal corrective environment, the one which is offering excellent possibilities for the control and supervision, as well as the possibilities for the guided primary health care intervention in a way which is not possible in circumstances outside the prison walls (20).

The health intervention, in that way becomes specific kind of a social engineering within which medical professionals are on the one side, in the role of the behavioral manipulators, an the prison inmates, as patients, are on the other side, as the object of the expert manipulation. That approach is praised with the argument that, in this way, it is possible to make the maximal use of the efforts aimed to improve health of prison inmates while at the same time unwanted effects are kept on minimum (21).

The problem with this approach is its positivist nature, and that indicates its superficiality. Namely, the focus on the risk factors is interrupting connections between life and the human suffering. The point is that risk factors are usually defined as separate entities, which have

1 The new penology is a movement and theory within which the main emphasis is put on the control of prison inmates. There, even a punishment and sometimes intentional hurting of prison inmates is used to achieve their complete obedience.

appeared from nowhere, like the expression of a personal voluntarism. Almost no one cares to ask why the particular person have chosen the particular life style, no one cares to ask which motives or interests have formed the life of that person and determined his/her allegedly personal choices (22). And these motives and interests are very real, and tend to influence strongly life choices. Life in prison, as the source of chronic stress, is a typical example (23). The average prison inmate is yearning for something which could relieve his anxiety. He is yearning for something which could make easier his problem of time structuring. He is yearning for something which could make him feel stronger, braver and more resilient. He is yearning for something which could change the routine, which could provide the escape from reality. He is yearning for something which could provide the sense of security, most of all by belonging to a small community. If at least some of these, even for a short time, could be provided (and it often can!) by drugs or cigarettes, by unsafe sex or self injuring, by rebellious or antisocial behavior, then the prison inmates, through personal reflection, will not classify them among »things» that they should be deprived of. In spite of doctors' advices and explanations they will, generally, conceptualize the medical procedures directed against their way of relief as:

- The attempt to deprive them of one of rare pleasures (in the prison environment deprived of stimulants);
- The attempt to deprive them of rare personal expressions over which they have control;
- The attempt to abolish some of important factors belonging to their Strategy of survival.

The consequence is that the promoters of programs against risk factors are being transformed – from rescuers to persecutors.

**B. Priorities**

In order to avoid blind alleys, i.e. in order to avoid the trap of tehnicistic interests, any planning, especially planning of the prison health policy, have to be based on the establishing of priorities.

According to that, four groups of priorities should be kept on mind of the health policy in prison planner. These are:

- professional priority (which is based on the best knowledge and estimates of medical professionals);
- contextual priority (which is based on the connection of meanings of both the whole and its part which is the focus of planning);
- developmental priority (which means that the chosen policy must be in accordance with the developmental needs, i. e. that it does not promote stagnation or leads into regression);
- economic priority (which means the applying of the principle of sustainability).

**1. Professional priority**

The first professional priority in planning the health policy in prisons is primordial prevention. Primordial prevention is a social health engagement which is dealing with specific population or specific groups. On the priority list it is higher in regard to the primary prevention because it is preventing the very penetration of risk factors in the specific psycho social environment (24). In planning the health policy in prisons the primordial prevention

should be introduced to prevent the grounding of risk factors among prison inmates. The key element of that prevention is the change of psycho - social and environmental conditions breeding risk factors typical for prison setting (25). That is why the primordial prevention is the way to deal with the vulnerability of the prison population. At the same time, primordial prevention is influencing the inequality of distribution of protective health factors. It is also influencing the distribution of exposure to harmful factors typical for prison environment. Primordial prevention is also important for the health of the prison staff and it could relate to various conditions of their life and work.

**2. Contextual priority**

Successful planning of prison health policy is demanding a careful consideration of dominant contexts, especially the dominant values and meanings as well as tendencies of a prison social dynamics. Namely, the values and meanings, as well as the social dynamics should determine the health policy at the micro and the macro level. That is why, while planning the health policy in prisons, two kinds of meanings and values should be considered:

- the values and meanings which are dominant at the present time;
- the values and meaning which should be stimulated in accordance with the optimal developmental tendencies of social dynamics (26).

Paying attention to the context is especially important in environments which are, like prisons, known as the total institutions, because in total institutions the heath is far from being the priority issue (27)? Namely, without taking care about the context, with emphasis on dominant meanings and the basic social dynamics, the health policy can not be developed in an optimal manner.

**3. Developmental priority**

There is no successful health policy without promotion of development. Namely, all living systems (individuals as well as social groups formed by them) are dissipative structures (28). Development is therefore the main prerequisite of health. Development is, actually, the continuous succession of transitions. Each transitional phase has two segments: the static one and the dynamic one. The static segment is responsible for increasing of the complexity of the developing system. The dynamic segment has three steps: differentiation (which means the conscious comprehension that the present level of development is nit satisfactory any more and that some kind of change is necessary), identification (which means the conscious comprehension that the new level of development is the one which is satisfactory) and the integration (which means that the developing system had achieved «piece» with his/her/its former intentionality, behavior, values and structures), (29). Without development, i.e. without constant increase of complexity as its prerequisite, stagnation and regression are evolving as the direct signs of degradation, degeneration and disease. Health policy, therefore, has to be in the function of all phases of transition, on macro and micro level. Otherwise it would be in the contradiction with its proclaimed purpose.

**4. Economic priority**

Medicine is a typical extensive activity both in scope and in costs. That is why the key priority of health policy has to be the introducing of the principle of sustainability.

In health policy the principle of sustainability is being introduced on three levels:

- level of medical technologies based on sustainable development (30);

- level of management based on the resource productivity instead on the increase of labor productivity (31);
- level of evaluation which has to follow –
  a) the maintenance of achieved health benefits;
  b) the institutionalization of introduced changes;
  c) The ability of the community to engage in health improvement (32).

Without these principles, most often, there would be a tendency to establish some kind of forceful equilibrium of assets and liabilities of the prison health care, at the expense of health of both staff and prison inmates (33).

**C. The case study Serbia**

The planning of the health policy starts with the analysis of the existent conditions. Of course, the analysis is also influenced by various interests. That is why it should be based on fundamental principles and priorities, i.e. Holism and human rights, as well as professionalism, context, development, and sustainability.

**Professional approach**

Primordial prevention (as the prerequisite of the professional approach to prison health) requires the analysis of prison milieu at the first place. Namely, the prison milieu is by itself inducing the chronic stress both in prison inmates and in members of the prison staff (34). The level of stress effects is rising in both populations if the order and safety of prison inmates are not secured and it is manifested by an array of risk factors (35, 36, 37).

a) In the study of prisons in Serbia (2004-2005) after interviews of 701 of prison inmates in 29 prisons, it was found out that the significant number of interviewed prison inmates reported that:
   - the Prison rules are not applied to all prisoners equally;
   - members of the prison staff do not respect Prison rules;
   - members of the prison staff are corrupted;
   - exemplary behavior of prison inmates is not stimulated;
   - prison inmates are maltreating other prison inmates and that the prison staff is not reacting properly;
   - there is no justice in prison everyday life (1).

All that indicates that prisons observed in the study were not institutions in the full meaning, i. e., that the environment of the observed prisons was building up the sense of insecurity and injustice among prison inmates, and the sense of insecurity among members of the prison staff.

In the same study it was found out that the personal security of prison inmates is additionally violated by fear of prison staff and fear of other prison inmates, by threats and violence performed by both staff and other prison inmates, by permanent violation of human dignity as well as by direct humiliation of prison inmates. It was also found out that the basic survival strategies of prison inmates were the use of physical force and various kinds of corruptive practices (1).

b) At the same study 615 members of the prison staff were interviewed as well. It was found out that, by their own estimates, their health was not satisfactory. In addition 90% of interviewed declared that they were living under the stress. Accordingly, 56% of interweaved staff members were smoking, 54% were drinking various alcohol

beverages, 11, 5% were regularly taking sedatives, 3, 5% other psycho stimulants, and 85% were having cholesterol rich diet. More then half of interviewed members of staff (52%) reported that they do not have adequate working space. Significant majority of the prison staff members also answered (89%) that in the last year they have not got any information regarding healthy life styles. Members of the prison staff have also shown neglect toward improvement of their health. Their passive attitude they were explaining most often by lack of time and energy (60%), (1).

**Context**

The study of prisons in Serbia has also indicated the high level of violence, as well as the high level of various kinds of manipulation and exploitation (1). Namely, more then 51% of interviewed prison inmates reported that other prison inmates are violating their personal dignity; also, 54% reported that their personal dignity was being violated by members of the prison staff. According to the interviewed prison inmates the best protective strategy in the prison environment was the physical force. The physical force was reported as particularly important in the case of a long term imprisonment (1 year and more). In this case it was bringing equal protection as the Prison rules (42, 1% physical force and 42, 2% Prison rules). However, under the so called strict prison regimen, the physical force is more important protective strategy then the Prison rules (44, 6% physical force and 38, 8% physical force), (dva puta se ponavlja physical force) (1). These data are leading to the conclusion that in the observed prison environment there was a constant production and affirmation of egocentric and violent level of psycho-social existence (26). That is the level in which one lives:

- from day to day;
- with intensive feeling of insecurity,;
- in conditions of a jungle law;
- in the midst of arbitrary and poorly restricted violence of all kinds.

That means that the context produced by prison is the context of insecurity, of humiliation and of constant hurt, and that kind of context is creating the chronic stress. Within that context it is logical that prison inmates, yearning for respite and relief, constantly try to find some outlet, no matter how much harm it could bring them in the near or distant future.

It is also logical that in that context prison inmates are prone to violent behavior in relations with the members of the prison staff. And that explains the high level of stress among them.

It is important to have in mind as well that the prison context is not separated from the contexts ruling out of the prison walls. In the case of Serbia, the general dominant context was the identical to the one in prisons (38).

**Development**

The development is the key element of health. That is why the development should be stimulated in all social segments both on the micro and on the macro level. The development becomes especially important at the third level of the psycho-social existence, because at that level the prison, as institution, gets additional importance. Namely, the third level of psychosocial existence (which is the level of egocentrism, violence and manipulation) should enter into a transition to the fourth level of psycho-social existence (which is the level of order and justice). That transition would not be possible without the institution of punishment which should also be based on the principles of order and justice. The prison context which is

producing insecurity, humiliation and hurt among prison inmates is producing stagnation and regression, and not the development. As the result of that situation the punishment becomes arbitrary, and that means that the development toward psychosocial existence based on order and justice is severely undermined. That means also that the health (both among prison inmates and the prison staff, in a prison and in the outer environment) is constantly being undermined as well. So, the careful work on the increasing of complexity of life in prison, and then the work on the gradual development of stages of the dynamic segment of transition are of utmost importance for any professionally designed prison health policy.

The reports of the interviewed members of the staff (high level of stress, compensatory practices, passive attitude toward personal health) are showing that they are also stuck, and in need for change regarding development, in order to achieve better health.

**Sustainability**

According to the study of prisons in Serbia, there is a significant disproportion between the health needs of prison inmates and the «manifested» capacity of the prison health system. This disproportion was managed by specific mixture in which was combined:

- low priority of primary health care
- restricted distribution of medicaments, and
- Restricted accessibility to health services.

Namely, only 13, 4% of prison inmates reported that they have seen some leaflets with health promoting information in prison. Also, 64.5% of prison inmates were complaining that their families had to provide medicaments prescribed to them by prison physician. One third of all interweaved prison inmates, and 49, 6% of those with long term imprisonment, were complaining that they had difficulties to contact prison physician in the case of need (1).

In that way, the prison health care system was maintaining the specific «sustainability», the one which was harmful for prisoner's health.

## D. Suggestions

### 1. Primordial prevention

Primordial prevention should be the first priority of the health policy in prisons. In a typical prison context the primordial prevention would mean engagement devoted to the establishment of prison as the institution. That means existence of the strict Prison Code and the strict implementation of that Code. The typical prison should progress from the egocentric level of the psychosocial existence to the level characterized by order and justice so the Prison Code should be based on the three elements:

- the human rights of prison inmates, having on mind that the additional punishment should not be added to the punishment imposed by court;
- the human rights of persons who have suffered or who had damages because of the deeds for which the prison inmates were sentenced
- the rights of the institutionalized community which is responsible to punish its members who are not respecting democratically passed laws, and who are by that disrespect hampering the development of the community.

### 2. The meaning

The second priority of the health policy in prisons should deal with meanings. Namely, it should impose the meaning that the prison is the institution in the service of the community

development. The prison can exercise that task if it is providing context and conditions within which the prison inmates will serve their sentence under the clearly defined and strictly imposed rules, with no exceptions. Nat (do you mean Net) is an important factor of the primordial prevention within prison. However, this is also important factor of the primordial prevention in the wider community. Namely, the principle of the just punishment is the inescapable element in the psycho-social transition from the psycho-social level dominated by principle of force to the psycho-social level dominated by principle of order and justice. The force which is violating accepted laws and regulations must be institutionally punished. Without that punishment there is no transition, and without transition there is no promotion of health.

**3. Development**

The third priority of the health policy in prisons is the facilitation of development. In the prison health policy the development has two important aspects. The first one is the stimulation of the socio-centric orientation of both prison inmates and the members of the prison staff. The socio-centric orientation is characterized by:

- conventional moral attitudes, i.e. attitudes needing the approval of others (39);
- the level of development within which the need of belonging is taking over the need of security (40);
- the position in which the conformist self-sense is replacing the impulsive self-sense, the one which is dominated by the urge of self defense (41).

Sociocentric orientation is important as the basic position of the level of psychosocial existence characterized by order and justice.

The second aspect which should be chosen as the developmental priority is dealing with the pent up energy of prison inmates. Namely, structural conditions should be established in order to secure this energy to externalize constructively.

**4. Sustainability**

The annual median cost of incarcerating a prisoner in a secure custody in 2003-4 was about $28 000 per state prisoner in the United States, $45 000 in Australia, and $53 000 in United Kingdom. (US state prisoners' annual healthcare costs averaged 12% of total costs, around $3350) (42). With rising rates of incarceration, greater needs among inmates for health care, and limited budgets, prison health care is becoming harder to fund adequately. Therefore, the achieving of sustainability becomes an important issue of a prison health policy. In efforts to achieve sustainable prison health care, the important asset could be implementation of integrated health care in prisons. The integrated health care means cooperation between medical doctors and practitioners of alternative medicine (43). The key contribution to the sustainability of health care for both prison inmates and members of staff could be provided by alternative therapies which are efficient, low cost, and leave no harmful effects. These contributions of alternative therapies were confirmed in several studies. (44, 45, 46).

**E. Together**

The suggested approach to the prison health policy might seem difficult to realize.

It is.

However, medical professionals determined to take it would not be alone. During our study of prisons in Serbia we have found out that there were quite a few of other professionals

employed in prisons, or being engaged there who were working along the similar directions. We have registered that these professionals were contributing to the welfare of the prison inmates, as well as to the welfare of the prison staff in three domains: «to HAVE», «to BEE», and «to LOVE»» (46). Within the domain of»to HAVE», they have been engaged to improve the «hardware» of the prison, from the improving of ventilation to the engagement of the chef to cook for the prison inmates. Within the domain of «to BEE» they have been engaged to provide possibilities for meaningful engagement of prison inmates either in creative, or in educational activities. In the domain of «to LOVE» they have been engaged in establishing relations: between prison and the community, between specialized prison staff and families of prison inmates, between prison inmates and the members of the prison staff (1).

There are records of countless of other similar engagements recorded in the literature.

So, why should not we join?

**Conclusion**

The prison health care is, globally, in rather poor and neglected conditions. The global acceptance of the principle of human rights, including right to health, has made this conditions unacceptable. In these circumstances there was a tendency to apply «quick fix» solutions. So far, the two such solutions appeared most attractive. The first one was the biomedical concept of health care reduced to the very simple transaction: demand of a patient - response of a physician. The other was the confrontation of risky behaviour including the use of prison mechanisms of surveillance and control..

Both of these apoproaches, especially in the prison context, are not professionaly adequate. Namely, they are not confronting typical conditions of the prison environment which are producing the chronic stress and through that various health problems of prison inmates. The starting point of the health policy in prisons should be the primordial prevention. This is the professional answer to both health needs and human rights of prison inmates. The health policy is one of indicators that human rights and health are closely connected.

***References***

1. Stambolović V, Vuković D, Marinković J, Terzić Z, Šantrić Milićević M, Zatvori i zdravlje. Beograd, Institut za socijalnu medicinu Medioinskog fakulteta, 2005.
2. 3rd General Report on the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, activities covering the period 1. January to 31. December 1992. Available from: http://www.cpt.coe.int/en/annual/rep-03.htm (Accessed: July 1, 2007).
3. United Nations. Standard Minimum Rules for the Treatment of Prisoners Available from: http:www.hrw.org/advocacy/prisons/un-smrs.htm (Accessed: July 3, 2007).
4. Council of Europe, Committee of Ministers. Recommendation No. R (98) 7 Concerning the Ethical and Organizational Aspects of Health Care in Prison (Apr. 8, 1998). Available from: http://www1umn.edu/humanrts/instree/coerecr98-7.html (Accessed: July 4, 2007).
5. Author. Health in Prisons Project. Available from: http://www.hipp-europe.org/background/0020.htm (Accessed July 5, 2007).
6. Author. Health in Prisons project. Publications. Available from: http://www.euro.who,int/prisons/publications/20050610_1 (Accessed July 7, 2007).
7. WHO Europe. Declaration on Prison Health as Part of Public Health. Moscow, October 24, 2003. Available from: http://www.euro.who.int/Document/HIPP/Moscow_declaration_eng04.pdf (Accessed: July 8, 2007).
8. Stöver H, Study On Assistance To Drug Users in Prisons, European Monitoring Centre for Drugs and Drug Addiction, Lisboa, 2001. Available from: http://www.archido.de/eldok/docs_en (Accessed: July 9, 2007).
9. Fazel S, Danesh J. Serious mental disorder in 23.000 prisoners: a systematic review of 62 surveys. The Lancet, 2002: 359(9306): 545-50.
10. Reyes H, Coninx R. Pitfalls of tuberculosis programmes in prisons. British Medical Journal, 1997; 315(7120):1447-50.

11. Burgermeister J. Three quarters of Russia's prisoners have serious diseases, British Medical Journal, 2003; 327(7423):1066.
12. Spaulding A, Stephenson B, Macalino G, Ruby W, Clarke J, Flanigan TP. Human Immunodeficiency Virus in Correctional Facilities: A Review. (Available from: http://www.idsociety.org/TemplateRedirect.cfm?template=/ContentManagement/ContentDisplay.cfm&ContentID=7845 (Accessed: July 10, 2007).
13. Allwright S, Bradley F, Long J, Barry J, Thornton L, Parry JV. Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: Results of a national cross sectional survey. British Medical Journal, 2000;321(7253):78-82.
14. Marquarat JW, Merianos D. Thinking about the relationship between health dynamics in the free community and the prison. Crime & Delinquency, 1996; 42(3):331-61.
15, Squires N. Promoting health in prisons. British Medical Journal, 1996;313(7066):1161.
16. Shichor D. Three Strikes as a Public Policy: The Convergence of the New Penology and the McDonaldization of Punishment. Crime & Delinquency, 1997; 43(4): 470-92.
17. Weinberger L-E, Sreenivasan S. Ethical and Professional Conflicts in Correctional Psychology: Research and Practice. London, SAGE, 1994.
18. Caelleigh SA. Prisoners. Academic Medicine, 2000;75(10):999-1001.
19. Author. Health in Prisons Project, Healthcare study of the Irish Prison Population. Available from: http://www.hipp-europe.org/resources/internal/irish-prisons/0040.htm (Accesed: July 11, 2007).
20. Voelker R. New Initiatives Target Inmates' Health. Journal of American Medical Association, 2004;291(13):1549-51.
21. Author. Health in Prisons Project - Why promote health in prisons?. Avilable from: http://www.hipp-europe.org/background/0030 (Accessed: July 12, 2007).
22. Stambolović V, Preface. In: Stambolović V, Šešić N, Šilić R, Čičić B, editors. Alternative Medicine [In Serbian]. Beograd, 1987:7-11.
23. Haney C, The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment, 2001. Available from: http://aspe.hhs.gov/hsp/prison2homeo02/Haney.htm (Accessed: July 14, 2007).
24. Strasser T. Reflections on cardiovascular diseases. Interdisciplinary Science Rewiew, 1978;3:225-30.
25. WHO Study Group. Primary prevention of coronary hearth Disease. EURO Reports and Studies 98. Geneva, World health Organization, 1985.
26. Beck DE, Cowan CC. Spiral Dynamics. Oxford, Blackwell Publishers, 2000.
27. Goffman E. Asylums Essays on the Social Situation of Mental Patients and Other Inmates. Harmondsworth, Penguin Books, 1975.
28. Prigogine I, Stengers I. New Alliance - Metamorphosis of the Science [In Croatian]. Zagreb, Globus, 1982.
29. Wilber K. Sex, Ecology, Spirituality. Boston & London, Shambhala, 1995.
30. Stambolović V. Alternative Medicine [In Serbian] - Approaches to Health Policy [In Serbian]. Zdravstvena zaštita, 1989;18(5):25-8.
31. Weizsäcker E Von, Lovins A B, Lovins LH. Factor Four:Doubling Wealth – Halving Resource Use. London, Earthscan Publications Ltd, 1997.
32. Shediac – Rizkallah MC, Bone LR. Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. Health Education Research, 1998;13(1): 87–108.
33. Rosenthal M. Presription for Disaster: Commercializing Prison Health Care in South Carolina. Available from:http://www.soros.org/initiatives/justice/articles_publications/publications/gl_prescription_2004041/Prescriptionfordisaster.pdf (Accessed: July 15, 2007).
34. Haney C. The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment, 2001. Available from: http://aspe.hhs.gov/hsp/prison2homeo02/Haney.htm (Accessed: July 16, 2007).
35. Westman M, Eden D, Shirom A. Job stress, cigarette smoking and cessation. Social Science & Medicine, 1985;20(6):637-44.
36. Piazza PV, Le Moal M. The role of stress in drug self-administration, Trends in Pharmacological Science, 1998;19(2):67–74.
37. Brady KT, Sonne SC. The Role of Stress in Alcohol Use, Alcoholism Treatment and Relapse. Alcohol Research and Health, 1999;23(4):263-71.
38 Stambolović V. The Case of Serbia-Yugoslavia: An Analysis through Spiral Dynamics, Medicine, Conflict and Survival, 2002;18(1):59-70.
39. Kohlberg L. Essays on moral development.,Vol 1. San Francisco, Harper, 1981.
40. Maslow A. Toward a psychology of being. New York, Van Nostrand Reinhold, 1968.
41. Loevinger J. Ego development. San Francisco, Josey-Bass, 1977.
42. Awofeso N. Making prison health care more efficient. British Medical Journal, 2005; 331(7511):248-9.

43. Peters D, Woodjam A. Integrated Medicine. London/New York, Dorling Kindersley, 2000.
44. Peters D, Chaitow L, Farris G, Morrison S. Integrating Complementary Therapies in Primary Care. Edinburgh, London, New York, Churchil Livingstone, 2002.
45. Sarnat RL, Winterstein J. Clinical and cost outcomes of an integrative medicine IPA. Journal of Manipulative and Physiological Therapeutics, 2004;27(5):336-47.
46. Montani M, Novak I, Miklić M. Klinical and economical impacts of homeopathic treatment of angina pectoris. In: Quakity Collaboration for Healthier Individual [In Croatian]. Zagreb, Croatian Society for Natural, Energetic and Spiritual Mrdicine, 2001;37-46.
47. Allardt E. Experience from the Comparative Scandinavian Wellfare Study, with a Bibliography of the Project. European Journal of Political Research, 1981;9:101-11.