



The problem

Incarcerated individuals have been reported to have a higher chance of respiratory diseases, including asthma (1). In one study, respiratory diseases were the second most common self-reported condition in prison, reported by 17% of individuals assessed (2). Chronic obstructive pulmonary disease (COPD) in those aged over 50 has been reported as ranging from 4% to 18% in prison (3), compared to 3% found in the general population (4).

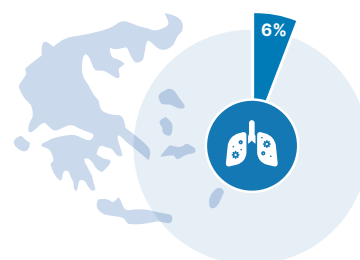


The causes

Chronic respiratory diseases, such as chronic obstructive pulmonary disease, are among the leading causes of death globally, and tobacco is a major risk factor (5).

Smoking prevalence in prisons was found to be over 50%, more than twice as high as in the general population (1).

A field study in Greece reported COPD to be present among 6% of inmates, increasing with age and length of sentence. Not surprisingly, this same study also showed that 79% of these individuals had marked smoking habits with intense associated nicotine dependence (6).



The solutions and enabling factors

Effective smoking cessation interventions in the general population, including policy changes, pharmacological and non-pharmacological approaches, have successfully been used in prisons. Cessation programmes in prisons (pharmacological and nonpharmacological) were found to increase in the probability of quitting smoking while in prison and of abstinence post release (7). Evidence-based smoking cessation interventions must be supported for long-term benefits to be fully achieved (8). Policy attention needs to focus on supporting people who formerly lived in prisons to access subsidized smoking cessation pharmacotherapy (9). When these therapies are available and free of charge, they help to ensure that equivalent care is available upon release and that continued care is sustained. Therefore, WHO recommends additional investments are put on continuity of care between prison health services and community health services.



In many countries in the WHO European Region legislation banning smoking in public spaces has been extended to prisons; prison systems are well placed to support the public health gains inherent in such legislative initiatives. In some countries there are no measures in place to ban smoking in prison premises; people admitted to prison may even increase their tobacco use and dependence, which suggests that prisons present a unique opportunity to intervene. Other countries may allow smoking in prisons but have invested in creating smoke free cells. However, there is evidence that partial bans cannot prevent exposure to secondhand smoke because tobacco smoke moves easily from smoking to nonsmoking areas in the same building. Therefore, WHO recommends full implementation of the Framework Convention on Tobacco Control (WHO FCTC) in all detention settings.



References

- 1 Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *J Epidemiol Community Health*. 2009;63(11):912–9. doi:10.1136/jech.2009.090662.
- 2 Wright NM, Hearty P, Allgar V. Prison primary care and non-communicable diseases: a data-linkage survey of prevalence and associated risk factors. *BJGP Open*. 2019;3(2):bjgpopen19X101643. doi:10.3399/bjgpopen19X101643.
- 3 Munday D, Leaman J, O'Moore É, Plugge E. The prevalence of non-communicable disease in older people in prison: a systematic review and meta-analysis. *Age Ageing*. 2019;48(2):204–12. doi:10.1093/ageing/afy186. PMID: 30590404.
- 4 Kouyoumdjian FG, McConnon A, Herrington ERS, Fung K, Lofters A, Hwang SW. Cervical cancer screening access for women who experience imprisonment in Ontario, Canada. *JAMA Netw Open*. 2018;1(8):e185637. doi:10.1001/jamanetworkopen.2018.5637.
- 5 Don't let tobacco take your breath away. Choose health not tobacco. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/bitstream/handle/10665/312260/WHO-NMH-PND-2019.3-eng.pdf>, accessed 9 November 2021).
- 6 Bania EG, Daniil Z, Hatzoglou C, Alexopoulos EC, Mitsiki E, Gourgoulidis KI. COPD characteristics and socioeconomic burden in Hellenic correctional institutions. *Int J Chron Obstruct Pulmon Dis*. 2016;11:341–9. doi:10.2147/COPD.S89027.
- 7 de Andrade D, Kinner SA. Systematic review of health and behavioural outcomes of smoking cessation interventions in prisons. *Tob Control*. 2016;26(5):495–501. doi:10.1136/tobaccocontrol-2016-053297.
- 8 Clarke JG, Stein LA, Martin RA, Martin SA, Parker D, Lopes CE et al. Forced smoking abstinence: not enough for smoking cessation. *JAMA Intern Med*. 2013;173(9):789–94. doi:10.1001/jamainternmed.2013.197.
- 9 Puljević C, de Andrade D, Carroll M, Spittal MJ, Kinner SA. Use of prescribed smoking cessation pharmacotherapy following release from prison: a prospective data linkage study. *Tob Control*. 2018;27(4):474–8. doi:10.1136/tobaccocontrol-2017-053743.

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