

Access to HIV- viral hepatitis- and TB- services for people in prison and other closed settings in Europe

A comparative 10-country report

European HIV Legal Forum (EHLF),
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List of abbreviations

AAE	AIDS Action Europe
AIDS	Acquired Immune Deficiency Syndrome
EHLF	European HIV Legal Forum
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HVA	hepatitis A virus
MSM	men who have sex with men
NGO	non-governmental organizations
NSP	needle and syringe exchange programme
OST	opioid substitution therapy
PEP	post exposure prophylaxis
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	the Joint United Nations Programme on HIV/AIDS

Introduction

The mission of AIDS Action Europe's European HIV Legal Forum (EHLF) is to develop effective means of improving access to HIV prevention, counselling and testing, treatment, care and support for all those who have limited access to HIV services due to legal obstacles, through the united efforts of legal and policy experts with the aim of bringing into effect a rights-based approach to health as adopted by the European Commission.

In 2012, following growing interest within the AAE Steering Committee and the broader AAE network for mutual support and joint action on legal issues related to HIV, AAE developed the first steps towards the EHLF, which began with a pilot project initiated by five AAE member organisations (the 'EHLF partners') in Hungary, Italy, Netherlands, Switzerland and the United Kingdom.

The pilot focused on the legal situation affecting access to healthcare of migrants in an irregular situation (also known as 'undocumented migrants') who are living with HIV since it was felt by all five EHLF partners that there was an urgent need to act on this issue. A survey was devised by the EHLF partners and rolled out in the partners' countries. The results provided valuable insights into differences in health systems in the five countries and its effects on access to treatment and services for irregular migrants. By documenting the legal situation, providing a comparative analysis of each country's laws and how they were applied, the survey report identified good practice and innovative solutions consistent with international human rights, acting as a catalyst for change where practice remains poor.

Following the pilot phase, the EHLF was enlarged and the latest report covered 16 European countries legal situation and level of access to HIV- and co-infection services for migrants in an irregular situation.

In the project phase 2018-2019, EHLF partners with coordination from the AIDS Action Europe office produced a 10-country report on HIV-criminalization in European Union countries and the present 10-country report on access to HIV-, viral hepatitis-, and TB-services for people in prison and other closed settings.

Background

The Steering Committee of AIDS Action Europe identified tackling legal barriers in the response to HIV, TB and hepatitis as a core thematic area that the network should address and work on in the 2018-2021 strategic period.

Legal barriers remain challenging obstacles in many countries to apply all available instruments in the response to HIV, TB and Hepatitis. Universal access to prevention, testing, and healthcare services is often hindered by legal obstacles or how legislation is applied in practice. This is in particular true for key populations, i.e. sex workers, drug users, gay men and other MSM, who are often discriminated against in policies and even criminalized in legislation, making their access to services limited or impossible. Besides the clear negative effect on the individual's health, these restrictive legal barriers also pose a threat on public health and increase already existing health inequalities in Europe.

To benchmark national HIV and co-infection relevant legislation in order to advocate for policy changes the Steering Committee of AIDS Action Europe decided to work with 10 AAE member organizations and create a comparative 10-country report on access to HIV-, viral hepatitis-, and TB-services for people in prison and other closed settings as the basis for future advocacy activities in the issue.

People in prison and other closed settings are considered key populations by UNAIDS¹. According to their 2017 report "Update on HIV in prisons and other closed settings"² PLHIV are overrepresented in prisons and other closed settings globally, due to criminalization of HIV non-disclosure, exposure and transmission in many jurisdictions of the world and also due to criminalization of key populations who are most affected by HIV, such as sex workers or people who use drugs, trans people and gay men and other MSM. The higher burden of HIV and other communicable diseases such as TB in prisons is also due to the overcrowding of prisons and the lack of access to HIV and co-infection prevention, treatment and care services.

Although international law recognizes the right to the highest attainable physical and mental health of every individual regardless of being deprived of their liberty, people in prison and other closed settings often suffer worse health outcomes than those in the community outside these settings.

Methodology

This study will cover the following 10 European countries: Denmark, Finland, France, Germany, Greece, Italy, North Macedonia, Spain, Ukraine, and the United Kingdom.

These countries were chosen because they are considered representative of the epidemiological, political, geographical, and economic diversity of Europe.

The partners from each country were chosen based on their previous and current work on legal issues and/or prisons and closed settings from the AAE membership.

The information in the country profile section was provided by the EHLF member organizations via a standardized questionnaire and are based on public information and information requested from different relevant ministries and institutions, reflecting the state of affairs during the data collection period of June – November 2019.

EHLF Partners

AAE would like to acknowledge its members who were partners in the project, provided information on their national situation regarding access to HIV-, viral hepatitis- and TB-services in prisons, and other closed settings, and helped identify major issues.

Our partners that provided invaluable information and input to this report are:

Aids Fondet – Denmark

Positiiviset ry – Finland

AIDES – France

Deutsche Aidshilfe – Germany

PRAKSIS – Greece

Fondazione LILA Milano – Italy

Stronger Together – North Macedonia

CALCSICOVA – Spain

Charitable Organization “Free Zone” – Ukraine

National AIDS Trust (NAT) – the United Kingdom

Main findings

The ten countries covered in this report are different from each other regarding their definition and types of closed settings and also the financing and access to HIV-, viral hepatitis-, and TB-services for people in prison and other closed settings. However, they all show some common characteristics, which will be summarized in this section of the report.

For more detailed, country-specific information please check the following section, in which the situations in each of the 10 countries are described.

Reduced access compared to the general population

All EHLF partners from the 10 countries covered by the report found substantial differences between access to services in the community compared to access to services in prisons and other closed settings.

The reasons for limited access vary by country but in most cases are connected to issues of financing healthcare in the closed settings. In countries where healthcare in prisons and other closed settings are not under the ministries responsible for health, there are budgetary problems. Furthermore, outsourcing certain services mean that people in prison or other closed settings receive the bare minimum of services.

Another serious issue is the lack of guidelines for delivering health interventions in closed settings. Where guidelines exist they are often not followed and certain prevention measures, such as access to condoms or NSP services, are not available due to the fact that the existence of sexual relations and/or drug use in closed settings is denied.

Spain also reported a serious shortage of medical staff in its prisons, due to medical staff being underpaid in these institutions compared to those working in other healthcare settings. The number of healthcare personnel in prisons has been drastically reduced by 25% in recent years and it is further expected that 80% of staff will retire in the coming years.

Institutions for short-term detention, such as police custody and in some cases pre-trial detention, have even worse and less organized access to necessary prevention, treatment and care services.

Continuity of treatment and prevention services when people are detained and transferred to other institutions and/or at the time of release is not ensured. This is, due to limited access to services in the institutions and lack of proper referral systems between the general healthcare system and healthcare in prisons and other closed settings.

Lack of data and information

Another general issue reported by the EHLF partners is the total lack of, or limited data on detainees' health, especially concerning HIV, viral hepatitis, TB and other communicable diseases. Although in some cases the lack of data in this report is due to relevant authorities not cooperating in providing the information, in most cases data is not collected, or testing and screening services are not implemented according to guidelines and international standards.

Where data is available, however, prevalence of HIV, viral hepatitis, and TB infections in closed settings is much higher than in general populations. The reasons for higher prevalence are multifold but can be associated with two major issues in all of the participating countries:

- Due to reduced access to prevention, treatment and care services compared to the general population, people in prison and other closed settings are more vulnerable to HIV and viral hepatitis B and C infections. The lack or non-application of testing, and treatment and care programmes further increase incidence in closed settings. Chronic overcrowding of prisons and other closed settings is an issue all across the world and is the main source of high TB-prevalence in these institutions.
- Criminalization of PLHIV and key populations is the second issue responsible for the higher prevalence of communicable diseases in prisons and other closed settings. Criminalization of HIV-non-disclosure, -exposure, -transmission, and criminalization of drug use and sex work in some of the countries lead to the overrepresentation of PLHIV and other key populations.

Closed settings for migrants and refugees

Centres for migrants and refugees are set up differently in each country. Most of these settings are not considered to be closed settings, unless they are institutions where migrants and refugees whose request to stay in the country has been denied are placed before deportation.

However, some of the establishments can be considered a mix between closed settings and open institutions. For example, refugees arriving in Greece are confined to camps on the Greek islands until their applications are processed. These camps are technically not closed settings as their residents are free to leave the camp area but cannot leave the island. This can represent a serious problem when they require special medical attention that is not available on the island.

Another example is Italy, where reception centres for refugees and migrants are not closed settings in the traditional sense, as people staying in these institutions are free to leave during the day and only required to return at night. However, due to their set up, functions and conditions are similar to other closed settings when it comes to the needs, issues, and barriers regarding accessing HIV-, viral hepatitis-, and TB-services.

In all of the countries covered by the report, the EHLF partners reported considerably worse levels of access to services in centres for migrants and refugees than what are available both for the general population and for those held in other closed settings. There is hardly any data available on the prevalence of communicable diseases; testing and linkage to care and treatment services are problematic. A substantial gap in providing support services was reported; for those in reception centres or exit centres where data is available, the numbers of suicidal thoughts and suicide

attempts/suicides of are many times higher than among people in the community.

Besides problems with accessing services, refugees and migrants in these settings often face xenophobia, islamophobia, and racism from staff and the community, often fuelled by public discourse.

Other concerns

Most EHLF partners reported issues with confidentiality of medical data and information. Although most institutions have guidelines on how to handle sensitive data, practice differs from official regulations, especially when medical information concerns HIV-status, due to irrational fears and stigma from prison staff and inmates. Storage of medication in some of the settings is problematic and this can unintentionally disclose an individual's health condition to others.

The practice of some European countries where PLHIV are detained separately from others, usually in a separate ward of a prison

hospital (e.g. Greece and Hungary, which is not covered by this report) further complicates this situation: keeping HIV-status confidential in these cases is impossible.

Trans people and non-binary individuals can also face serious problems with accessing hormone therapy in prisons and closed settings. Furthermore, they are placed based on the sex indicated in their ID or other official documents rather than according to their gender identity.

NGOs and their services in prisons and other closed settings

NGOs play an important role in providing a variety of services for people in prison and other closed settings in most of the countries covered by this report. However, their access to entering these institutions is sometimes limited or not allowed at all. Those who have access (e.g., human rights watchdog organizations) cannot provide necessary support services or information on prevention of communicable diseases.

Country profiles

The information in the following country profiles were provided by the organizations that collaborated in the project. In case of questions or need for further information, please contact the AIDS Action Europe office at info@aidsactioneurope.org or directly the organizations listed under EHLF partners on page 7.

The organizations reported difficulties when accessing information to the survey questions, because either the information or data is not collected, thus not available, or due to the lack of cooperation of relevant authorities that were requested to provide information and data.

For the easier reading of the report, we decided to omit those sections that lack data and information from each country profile.

Denmark

Country statistics

The population of Denmark is 5,800,000. The HIV prevalence in the country is 0.1% with 5,800 diagnosis; HBV prevalence is 0.26% with 15,000; HCV prevalence is 0.29% with 17,000; and the TB incidence is about 300 cases per year.

The estimated number of drug users is 84,430 persons (2019)

The prevalence of people suffering of mental illness 10% (580,000 persons). The definition of mental illness includes stress. There are 600 cases of suicide annually.

The data on prevalence of STIs is not available.

Access in the general population

The general population has good access to all tools and methods of prevention and they have access to treatment of HIV, HBV, HCV, and TB.

Definition of closed setting – closed settings relevant in the national context

There is no definition used for closed settings in Denmark. They include prisons; pre-trial detention; police custody and centres for refugees and migrants.

Funding for prevention and health interventions in closed settings

Denmark is divided into 98 municipalities, 5 regions, and 1 state level. Health care services are paid for either by the state (general practitioners) or by the region (hospitals).

Health care in prisons are paid for by the state as part of the annual budget of the Danish Probation Service. However, this is not always the case. Should an inmate require or request other assistance from either a specialist or a hospital then the expenses will be covered by the given region.

As for the migrant centres, they function the same way; as a rule, each centre has a medical clinic, which is paid for by the state. Should special assistance be required then the expenses are covered by the region.

Prison statistics

The size of prison population was 3,945 (October 2019)

The prevalence (or estimate prevalence) of HIV was 5 cases (estimated 0.13 percent). The prevalence (or estimate prevalence) of HBV was 11 cases (estimated 0.27 percent). The prevalence (or estimate prevalence) of HCV was 21 cases. There were no credible estimates of TB prevalence.

The prevalence of mental illness was 400 cases (8 percent) and the rate of suicide thoughts was 1900 (47.3 percent), suicide rate was 8 persons in 2018 among detainees.

There were no credible estimates available of STIs in prisons.

Access and policies vs practice in prisons

The Danish Probation Service does not distinguish between pre-trial detention and prison - the data and information in this section covers both pre-trial detention and prisons.

In Danish prisons condoms and disinfectants (e.g. for hands, tattoos and piercings) are available as prevention methods. Treatment for HIV, HBV, HCV, and TB are available.

Regarding police custody, a person in Denmark has to be presented to a judge within the first 24 hours after apprehension. During these 24 hours, any medication that is indicated by the person's journal to be necessary must be made accessible to the apprehended individual.

All data related to inmates falls under the jurisdiction of the Danish Probation Service (Kriminalforsorgen). They do not register any diseases in a central database. The health data of inmates is included as part of the respective Danish region's data. It is always possible for the inmates to request a test for any of the mentioned conditions. Inmates that are required to stay for longer than 3 months will have a doctor and a nurse assigned.

Other issues in prisons

PLHIV and patients of viral hepatitis and TB are detained together with other inmates.

For necessary medical check-ups both visits by a specialist and a transfer to the closest hospital is possible upon preference of the person in detention.

The placement of inmates will always be a specific assessment. The Danish Probation Service does not register the gender identity of the inmates, but the gender of the person will be part of the placement assessment if the inmate informs that they are non-binary. Inmates can gain access to hormonal therapy upon request.

Doctor's appointments are always private and thus confidential. The policies are followed in practice.

PLHIV and patients with viral hepatitis or TB do not receive any special service. There are no special services offered to inmates based on their health status beside the proper medical service.

The health costs in the prisons are either paid for by the given region (if special medical assistance is required, if hospitalization is needed also) or by the state (the prison's own doctor).

Centres for refugees and migrants statistics

In Denmark there are four main types of centres: residence centres (7 centres with a total max capacity of 1,870), exit centres (3 centres with a max capacity of 1,400), child centres (3 centres with a max capacity of 214) and reception centres (1 centre with a max capacity of 600).

The practical operation of the centres are handled either by a local municipality or by the Danish Red Cross. The latter operates a total of 8 out of 14 centres. Of the people detained at the time (2019). The Red Cross oversees the well-being of 1,536 refugees and migrants out of the total of 2,512. The remaining 976 are being overseen by three different municipalities.

It is worth mentioning that there is a significant difference between the occurrences of mental illness in the centres operated by municipalities versus centres managed by Red Cross. The prevalence of mental illness in the Red Cross centres is 35.8 percent whereas the same prevalence in the centres operated by the municipalities is 1.8 percent. It has not been possible to locate the reason for this inconsistency.

Finally, the prevalence of STIs is so low in all centres that it is not seen as probable data and it is not possible to make a credible assessment.

For among others these reasons the Danish AIDS-Foundation finds that the data registered by especially the municipalities to be associated with some uncertainty. The Danish AIDS-Foundation is considering actions to take.

The prevalence of HIV is reported at 0.72% (18 cases), HBV is 1.11% (28 cases), HCV is 0.24% (6 cases), TB is 0.24% (6 cases).

The prevalence of mental illness is reported at 23.29% (585 cases) and in 2016 there were 120 reported suicide attempts in these centres.

Access in centres for refugees and migrants and policies vs practice in centres for refugees and migrants

Testing and screening is offered on an opt-in basis in these centres and there is no difference between policies and practice.

Condoms are available for free at most centres, while lubricants are only available on purchase and femidoms are not accessible.

PrEP and PEP are offered to those at risk or after exposure to those who request it.

NSP is offered through hospitals/substance abuse centres. OST is in theory handled by local substance abuse centres (each refugee/migrant centre has one assigned) However, in practice there is no known cases of opioid substitution in the Danish refugee/migrant centres according to Danish Red Cross. Naloxone is not available.

Vaccination for HAV and HBV is available but not for free.

Disinfectants and information leaflets are provided in the centres.

Treatment for HIV, viral hepatitis and TB are provided in the centres.

Other issues in centres for refugees and migrants

PLHIV, TB -, and hepatitis patients are together with other refugees and migrants. In general, they are transported out of the centres for check-ups. However, there is a difference in the course of action when a detainee needs (any) medication. Most centres have their own doctors present – but others require detainees to pick-up medication from local pharmacies.

Trans individuals and non-binary people are placed according to their expressed preference.

All medical data is strictly confidential and policies and regulations are kept in this regard in the centres.

Special services are not offered based on health status or condition. However, it is worth noting that psychological support is offered on a general basis, and detainees are encouraged to contact local organizations with special expertise – such

as the Danish AIDS-Foundation with regard to PLHIV.

Local NGOs are monitoring the centres closely, offering a wide variety of services, workshops, and so forth.

Finland

Country statistics

Population of the country was 5,519,586 as of 31st May 2019.

The HIV prevalence in the country was <0.5%; HBV prevalence <2%; HCV prevalence <1%; and TB incidence in 2018 was 4.1/100,000.

The estimated number of problematic drug users is 21,000.

There is no official data on the prevalence of people who are suffering of mental illness or on suicide rate.

There was a chlamydia incidence of 270/100,000; syphilis incidence 3.4/100,000, and gonorrhoea incidence 9.7/100,000.

Access in the general population

Prevention tools and methods, and treatment for communicable diseases are in general available for the public.

Definition of closed setting – closed settings relevant in the national context

There is no definition of closed settings; in Finland, they include prisons; centres for refugees and migrants; and other detention units.

Difference of prevalence in closed settings vs general population

In prisons, there is a lot of drug use and people who inject or have injected drugs, which makes the HCV prevalence much higher in prisons than among the general population.

Funding for prevention and health interventions in closed settings

The purpose of the Health Care Services for Prisoners is to provide all prisoners in Finland with health care services. They provide most of the primary health care services, oral health care services, and psychiatric specialised medical care independently. Other advanced-level specialised medical care services and emergency care services are outsourced.

Their personnel is highly experienced and trained. They particularly have expertise in somatic care as well as substance abuse and mental health care. They follow a principle of normality: they offer the same public health care services as public health care providers while taking into account certain limitations imposed by the conditions. Health care is Government funded, under the ministry of social affairs and health.

Prison statistics

The size (or estimate size) of population in 2018 was approx. 2,910 per day (foreigners 17%).

There was estimate HIV prevalence of 1% (last were published in 2010)

The estimate prevalence of HBV was 7.6% while for HCV it was 42.3%

TB prevalence were estimated around 1.1%. The prevalence of mental illness or mental disorder was around 70%, with 90% of inmates ever diagnosed during their lifetime.

The prevalence of chlamydia 19.7%, syphilis 0.3%, and gonorrhoea 8.4% were respectively.

Access and policies vs practice in prisons

There is or there should be access to prevention services, and treatment and care in prisons, similar to the general population. The testing policy is on an opt-in basis.

However, HIV has become a bit forgotten disease in prisons and therefore an HIV-test is not always remembered to be offered. In some prisons it is the same with HCV. At the moment the aim is to have HIV and HCV offered on an opt-out basis and upon arrival as well during the stay. TB is screened if there are symptoms / indicators / reasons for it. In addition, in those cases it is on an opt-out basis. TB is rather rare in Finnish prisons; 3 cases were reported in the past 3 years.

Other issues in prisons

PLHIV and viral hepatitis and TB patients are detained together with others.

If needed, their transport to medical check-ups by specialized staff is arranged.

Trans individuals have access to hormonal therapy if it has started already before imprisonment.

All services that are needed are available through health care. Positiiviset have offered sometimes peer support to prisons. Controlling communicable diseases in prisons is also a state responsibility under the Communicable Diseases Act. HIV and hepatitis infections are tackled in prisons through health education and protection. Each hygiene kit provided to each prisoner includes instructions on how to use a condom and how to clean and dispose of injection equipment, as well as personalized disinfectant supplies. These disinfectant supplies are not in the kit anymore.

Prisoners can have access through prison outpatient clinics to cleaning supplies for their own use. Voluntary testing is used to detect infections as early as possible. Prisoners are provided with free hepatitis A and B vaccines in prisons. In particular, IDUs are encouraged to seek HIV testing in prisons. Prisons mainly produce primary health care, oral health care, and specialized psychiatric care. They buy other demanding specialized medical care and emergency services elsewhere. Sources: thl.fi³

The law is the same to pre-trial detention as in prisons.

Centres for refugees and migrants statistics

The size (or estimate size) of population in centres for refugees and migrants were 79,782 (2018)

The HIV prevalence in 2016 was 0.1%; the prevalence of HBV in 2016 was 1.4%. There were no estimates of prevalence for HCV or TB.

There was a prevalence of 0.53% for syphilis in 2016.

Access in centres for refugees and migrants and policies vs practice in centres for refugees and migrants

In theory access to the prevention tools, and treatment and care services are the same for people in centres of refugees and migrants as in for people in prison.

There is a list of countries where tests are indicated to be offered / taken upon arrival, preferably within two weeks after arrival. Not all refugees and migrants are tested at all. In addition, this qualifies to refugees and asylum seekers. You can migrate to Finland without being offered any kind of health care.

Probably you can get tests on an opt-in basis. However, they are not necessarily offered.

Other issues in centres for refugees and migrants

PLHIV and viral hepatitis and TB patients are held together with others.

If needed, their transport to medical check-ups by specialized staff is arranged.

Trans individuals can access hormonal therapy.

There is training available for staff of these centres on HIV and there are policies in place for confidentiality.

NGOs sometimes provide support for PLHIV in these centres.

Detention Centres

Finland has two detention units.

An asylum seeker can only be detained in situations that are specified in the law. You may be detained for example if your identity is unclear or there are reasonable grounds to suspect that you would try to stop the police from removing you from Finland. A person may also be detained if there is a reason to suspect that they will commit a crime in Finland.

The detention units are closed areas, which the detained persons cannot leave. The decision to detain someone is made by a police or a border guard. The detained person must be immediately informed of the grounds of the detention. He or she must also be given information about the processing of the matter that concerns the detention, and about his or her possibility to receive legal aid.

The Finnish Immigration Service is responsible for the steering, planning and supervision of practical detention unit operations. Treatment and care services available only if needed / and always in an emergency like situation. Prevention services and tools - most likely not available.

France

Country statistics

The population of France was 70 million in 2019.

Prevalence of communicable diseases
In the 2019 HIV prevalence in the country was 0.4% (172,000 PLHIV). The HBV prevalence was 0.3% in 2016 (135,700 people across the 18-75 age group in mainland France) while the HCV prevalence was 0.3% (133,500 people across the 18-75 age group in mainland France). There were 4,741 reported tuberculosis cases in 2015 (20.8/100,000) with an average incidence of 10 cases/100,000.

In 2016, the number of people diagnosed with chlamydia infection was estimated at 267,097, equating to a rate of 491 per 100,000 inhabitants. The infection was predominantly observed in women (592/100,000 versus 380/100,000 in men). An estimated 49,628 people were diagnosed with gonococcal infection in 2016. 5,000 diagnosed cases of syphilis were reported in 2015⁴.

Estimated number of drug users

According to the study of the French Monitoring Centre for Drugs and Drug Addictions⁵ 2.1 million people already had an experience with cocaine, with 600,000 in the last 12 months. 1.9 million people already had an experience with MDMA/Ecstasy with 400,000 in the last 12 months.

500,000 people already had an experience with heroin and OFDT estimated the number

of injecting drug users in mainland France at 148,000 lifetime users with the NEMO 2011 study, with 105,000 users in the last 12 months of 2014 (80,000 men and 25,000 women), and 86,000 users in the last 30 days (65,000 men and 21,000 women)

Prevalence of people who are suffering of mental illness and suicide rate

2.4 million people were admitted in health centres in 2015 due to mental health problems and there were 8,948 deaths by suicide in mainland France in 2015, equating to 13 per 100,000 inhabitants.

Access in the general population

In France the general population has access to all prevention methods and tools including HIV-self testing kits that were introduced in 2017 and national coverage of PrEP for free since 2016.

The population also has access to treatment for HIV, viral hepatitis and TB.

Definition of closed setting – closed settings relevant in the national context

In France a closed setting is defined as a place (public or private) where a person is held (placed and retired), or may be held at the behest of any judicial, administrative or other authority, or at their direction, with their knowledge or tacit consent (formal and informal places of detention) under in custody, imprisonment or guardianship,

which the person has no right to leave of their own free will or is not able to exercise that will (by physical or material condition).

In France the following are considered closed settings: prisons; pre-trial detention; police custody (after arrest); centres for refugees and migrants; and correctional colonies or arrest houses

Difference of prevalence in closed settings vs general population

The estimated prevalence of HIV⁶ is at 2% in detention, i.e. two to four times higher than in the general population. The prevalence rate of hepatitis C is estimated at 4.8%, which is five to eight times higher than in the general population.

Drug users, migrants, and people living in precarious conditions are over-represented in the prison population, thus combining factors of vulnerability in a context of promiscuity and structural prison overcrowding.

On August 1st, 2019 the French Ministry of Justice indicated that 70,519 people were in detention for an operational capacity of 59,800 , including 20,336 defendants (people awaiting trial), namely 28.8%. The average occupancy rate is 118%.

In France 75% of drug users have been imprisoned at least once in their lifetime⁷. The law of December 31st, 1970, which criminalises the use, possession, or sale of drugs in France and may lead to criminal sanctions, is a fertile ground for detention. In 2015, according to the French Ministry of Justice, 14.7% of the prison population was convicted of a drug-related offence.

Funding for prevention and health interventions in closed settings

Criminal policy, detention environment and conditions, the management and training of supervisors in charge of escorting, extracting, providing harm reduction tools (e.g. bleach, access to sterile equipment), and prison integration services fall under the purview of the French Ministry of Justice. The organisation of care in detention is governed by the law of January 18th, 1994, which states the principle that access to care and prevention must be similar for inmates and free citizens.

The French Ministry of Health and the public hospital service are responsible for the organisation and quality of care provided to inmates. They are directly affiliated with the general social security scheme. Health expenses are covered by the state and social security.

According to a Senate information report, the consolidated cost of healthcare expenses for inmates was estimated at around €360 million for the year 2016. This report also highlights chronic under-budgeting by the state, which regulates government expenditure by transferring this budget onto the social security scheme, i.e. borrowing from the social security budget.

Detention care is run in a prison medical unit for outpatient care. The hospital staff (general practitioners, specialists, psychologists, dentists, pharmacists) carry out their consultations in dedicated rooms, the frequency and procedures of which differ from one establishment to the next. Inter-regional high-security hospitalisation units (unités d'hospitalisation sécurisées interrégionales UHSI) and specially equipped hospital units (unités hospitalières spécialement aménagées UHSA) are regional hospitals (i.e. outside detention

centres) that can admit inmates for more than 48 hours.

UHSIs are dedicated to somatic care while UHSAs provide psychiatric care. UHSIs are regularly under-occupied (occupancy rate of 66% in 2016), and there are major regional disparities. Psychiatric care provided by UHSAs in particular is struggling to meet all demands.

Furthermore, the overall deterioration of prison facilities means adequate premises to provide quality care are sometimes unavailable. In practice, continuity of care is rarely ensured upon release from prison. The 2010 PREVACAR survey revealed that only half of health units had a formal procedure in place for the inmates' release from prison.

Many testimonies converge to highlight that, in many cases, prison release can break up care pathways often initiated in prison. Indeed, it can prove difficult for prison and medical staff to exchange patient information, as they often do not exactly know when the inmate will be released. Consequences for inmates include failure to recover their medical file, not having a prescription to ensure continuity of treatment, not receiving a brochure to refer them to outside health facilities, etc. However, the PREVACAR survey did point out that specialised consultations were a positive factor in establishing a prison release protocol.

Structurally, there is a blatant lack of coordination between judges, prison officers, and health professionals. For instance, according to the data provided by Lille UHSI, in 2016 17% of planned hospitalisations were cancelled because the patient had already been released. Furthermore, the prevalence of a security logic in prisons, which results in strong

control and dependence on prison staff to access medical facilities, constitutes a major obstacle for inmates to access healthcare.

Moreover, inmate self-censorship is a mechanism regularly highlighted by many community stakeholders. The difficulty in preserving medical confidentiality in prison contributes to this self-censorship mechanism. Promiscuity in a context of prison overcrowding, the absence of confidentiality areas in health units and cell searches are some additional factors that do negatively impact access to care, overall health, and care continuity (treatment interruption, poor adherence to treatment).

Finally, the dilapidated state of prison facilities (unsanitary conditions, defective showers, presence of rats, bedbugs, poor insulation, etc.), prison overcrowding (average occupancy rate of 118%) and lack of staff create conditions that make it impossible to provide dignified healthcare.

Prison statistics

The size (or estimate size) of population as of April 1, 2019 was 71,828 people detained for an operational capacity of 59,870.

The HIV prevalence (or estimate prevalence) of 2% (compared to 0.4% in the general population)⁸.

There is no existing data for HBV prevalence (or estimate prevalence) while the HCV prevalence (or estimate prevalence) of HCV 4.8%⁹.

According to the French Institute for Public Health Surveillance (Institut de veille sanitaire – InVS), the prevalence for TB was 106.9/100,000 and in the mandatory tuberculosis reporting prisoners

represented 1.4% of all reported cases in France in 2013 (61 cases including 53 cases with lung involvement, thus potentially contagious). This number has remained relatively stable over the past 12 years. The latest data show that tuberculosis in prison mainly affects men (94%), who are rather young (median age is 31 years old).

There were 55% of people with psychiatric history and 27.4% psychiatric disorders in detention.

The suicide rate is 167/100,000, 7 times higher than in the general population.

There is no data available regarding the prevalence of STIs in prisons.

Access in prisons

Compared to the general population, access to prevention methods are limited in French prisons.

Condoms have limited availability and not diversified access, almost exclusively at the prison health unit or family life units. Inmates may keep condoms on them or in their cells. Some institutions do not provide any. Inmates can keep condoms on them or in their cells. Most USMPs provide condoms. Only 20% of prisons report condoms as available elsewhere than the health unit, mainly in the library and visiting rooms.

Femidoms and lubricants are available in theory. In practice lubricant is less often available (51%), female condoms even less so (21% of prisons with female inmates) as pointed out in the PRI2DE survey.

Both PrEP and PEP are still to be deployed to people in prison. Access to post-exposure prophylaxis is possible in case of blood-

exposure accidents for healthcare workers, prison staff, and inmates. Based on the PRI2DE survey, 53% of prisons consider that inmates are insufficiently informed about post-exposure prophylaxis (PEP) compared to 69% for carers. Over 12 months and 171 USMPs, 16 prescriptions for PEPs were issued, including 3 for inmates.

In the survey carried out in Île-de-France, 3 USMPs out of 6 report that a protocol has been put in place, only one indicates that they inform inmates, and only one has prescribed a PEP. Inmates appear to be insufficiently informed, and USMPs prison and medical staff seem unfamiliar with the procedure and do not know whether PEP is available at the Health Unit or at the referral hospital's emergency room.

Access to Needle and Syringe Exchange is enshrined in the legislation (2016) but not implemented. In 2016, adoption of the law to modernize the French health system and its article 41 which recommends "The extension of the risk reduction policy in the prison environment". However, the implementing decree has still not been published under pressure from the unions of prison guards. As of the time of this report, Syringe Exchange is still forbidden in France.

The ANRS-Coquelicot study reports that among drug users who have been incarcerated at least once in their lives (61% of respondents), 12% have used injection drugs in prison, 30% of whom have shared needles during a period of incarceration. The law on modernisation of the health system of January 26th, 2016 and the adoption of article 8 on the risk-reduction policy for drug users provide the possibility of setting up needle exchange programmes in detention.

The lack of implementing decree prevents the effective rollout of prison needle

exchange programmes. The distribution of bleach titrated at 12° is supposed to be systematic since the Health-Justice circular of December 5th, 1996 and the Health-Justice note of August 9th, 2001.

While cleaning and disinfection measures are effective in eradicating HIV, they are less potent in eliminating HCV. However, in practice, distribution is far from systematic and is typically not accompanied by a sufficiently clear and explicit risk-reduction message. In reality, inmates most often use bleach to clean their cells. On the outside, risk-reduction messages emphasise the use of single-use equipment rather than bleach disinfection.

According to the PRI2DE survey, “only 22% of health unit managers felt that the information provided to prisoners about the use of bleach (sterilisation of injection equipment in particular) was easily accessible and understandable”. Bleach distribution (in line with recommendations, i.e. every two weeks) is effective in only 36% of prisons. According to the PRI2DE survey, around 10 sites out of 103 do provide sterile water, disinfectants, and needle containers in compliance with the 2005 risk-reduction standard for drug users. In the survey carried out in Île-de-France, two sites reported the intervention of a CAARUD, with provision of an inhalation kit. How accessible are substitution treatments.

Opioid Substitution Therapy is recommended but not always with sufficient choice or prescription monitoring, despite a guide from the French Directorate-General for Health (Direction générale de la santé). According to the Observatoire des structures de santé des détenus, in 2014 approximately 14,900 people received opioid substitution treatment. High-dose buprenorphine was prescribed in 61.6% of cases, compared to 38.4% for methadone

(more than twice as many as in 1998). Molecule diversity is insufficient, dosages are at times unsuitable, and some delivery methods may compromise medical confidentiality.

There is vaccination for HAV and HBV with a large majority of teams (96%) report offering hepatitis B vaccination, with the vaccine being provided by the hospital, which the person is assigned to in 97% of cases. However, this data does not allow us to estimate the number of people who were actually vaccinated.

Disinfectants (e.g. for hands, tattoos and piercings) are not yet available and are to be deployed.

Treatment and care services for people in prisons for HIV, HBV, HCV, and TB are available in theory.

Policies vs practice in prisons

Article D. 384-3 of the CPP19 (Code de procédure pénale / Code of Criminal Procedure) highlights the importance of facilitating access to testing.

“Every incarcerated person must have access, with their consent, to personalised information and counselling on infection by the human immunodeficiency virus (HIV) and, if necessary during medical consultations, be prescribed a screening test and provided with the results”.

The health strategy plan for people under criminal justice control published in April 2017 reaffirms the principle of mandatory counselling upon entry into custody and a systematic offer for HIV, HCV and HBV testing, and contribution to screening for potential suicidal risks. It also gives the opportunity to offer a medical check-up

“relating to the consumption of narcotic drugs, psychotropic drugs, alcohol and tobacco” in order to identify addictions.

Screening is, in most cases, provided by the prison health unit (unité sanitaire en milieu pénitentiaire USMP). However, the circular of December 5th, 1996 provides that screening can also be carried out by the Free Information, Screening and Diagnostic Centre (centre gratuit d’information, de dépistage et de diagnostic – CeGIDD) that operates within the health unit. The CeGIDD’s scope is broader than the one of the previous system’s and, in addition to HIV/AIDS and STI screening, it can provide vaccination against hepatitis B and A as well as the human papillomavirus, and prescribe contraceptive methods based on a comprehensive sexual health approach.

If there is a CeGIDD office within the prison, its operations must be led “in close coordination with the USMP”, namely to ensure continuity of care. However, screening test results provided by CeGIDD doctors may only be transmitted to USMP doctors with the prior consent of the person concerned.

In reality, CeGIDDs are not particularly active in detention centres. According to the regional inventory of HIV care in Île-de-France and the data from the Observatoire des structures de santé des détenus (Observatory of Prisoners' Health Facilities), in 2016 only two out of twelve prisons listed CeGIDDs as partners involved in detention facilities. This finding is likely similar at national level. However, in the PREVACAR survey regarding the provision of care for HIV and hepatitis infections in French prisons in 2010, 95% of prison health units systematically reported offering HIV, HBV, and HCV testing upon entry in detention.

The offer for STI screening at entry was more uneven. Result deliveries differ from one health unit to the other since it is effective in only 66% of cases. The national practice survey conducted in 2015 confirms these trends. HIV and HCV screening was systematically offered upon entry into detention (98%), with an average completion rate of 70%. Screening was carried out by USMPs in 74% of cases, followed by CeGIDDs (20%). Results were systematically reported in 72% of USMPs.

Although not quantified, many inmates refuse to undergo screening tests following such proposal because they may underestimate their exposure to risk or because the shock of entering detention may not be an appropriate time to understand or adhere to the proposed health offer and the individual and collective interest it incurs. Several authorities and guides recommend that the screening offer be renewed throughout the incarceration period.

There are several recommendations to renew the screening proposal during the incarceration period. There is no data on its implementation, but it is very likely that it is not being done. It is a difficult process to set up on the initiative of USMPs and according to a few criteria: notion of risk-taking according to which identification process, how long ago the last screening test was, if it was at the person's request. The 2017-2030 National Sexual Health Strategy (Framework for Public Action on HIV, Viral Hepatitis, and STIs) provides in its measure No. 64 to “offer HIV, hepatitis and STI testing as well as HBV vaccination upon entry, during detention and upon release”.

According to the PREVACAR survey, only half of USMPs renewed their testing offer during the detention period (52% for HIV and 51% for hepatitis). Most often, an inmate

may request to be screened at the Health Unit even though promiscuity and the way the movement of persons in detention is organised typically prevent this procedure from remaining confidential. The decree of August 1 2016, detailing the conditions for carrying out rapid diagnostic orientation tests for infections with human immunodeficiency viruses (HIV 1 and 2) and hepatitis C virus (HCV) in a medical-social or associative environment authorises, the use of HIV and HCV rapid diagnostic orientation tests in prison by USMP carers as well as authorised NGOs, Reception and Support Centres for Drug-User Harm Reduction (centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues – CAARUD) and Addiction Care, Support and Prevention Centres (centres de soins, d'accompagnement et de prévention en addictologie – CSAPA).

The benefits of rapid diagnostic orientation tests is that they are easy to perform and produce immediate results that can help increase the number of screening opportunities throughout the incarceration period, constituting a complementary offer to blood screenings offered in the USMPs. HIV self-tests must supplement available testing offers and be provided to inmates under the provisions of the decree regarding their distribution. No data is available regarding the distribution of HIV self-tests.

There are many unscheduled releases from prison, as well as a flagrant lack of coordination between USMPs, the Penitentiary Integration and Probation Departments (services pénitentiaires d'insertion et de probation SPIP) and courts administration services, which hinder preparation for release and the continuity of rights and care. It is essential to ensure that inmates benefit from their social rights and affiliation to social security in detention to avoid disrupted care pathways.

According to the regional inventory of HIV, hepatitis and STI care in Île-de-France, all USMP respondents have set up a transmission protocol for medical follow-up and declare issuing medical certificates that give access to various social rights: long-term illness, disabled adult allowance, residence permit for universal supplementary health coverage.

Screening must be systematically offered during the regulatory release consultation for convicted persons. However, these consultations do not always take place, particularly in the case of unscheduled releases.

Other issues in prisons

PLHIV are placed in cells together with other inmates. However, due to the organisation of care in detention, with infectious disease specialists being on call on fixed dates, or the storage of ARVs in cells, can largely compromise medical confidentiality. Other inmates may become aware of one of their peers' HIV status and in the event of discrimination, threats or violence; the prison administration may then decide to place the person in solitary confinement to ensure their safety. There is similar practice for people with viral hepatitis infection.

In case of a suspicion of transmissible tuberculosis implies an isolation maintained up to a treatment duration of at least fifteen days.

The methodological guide on inmates' healthcare states, "specialised consultations are to be organised within the prison establishment". The goal is to provide as many specialised consultations as possible on location to limit the movement of inmates on the outside, which requires security staff. The table detailing these specialised consultations was created

according to the needs identified and the organisational material capabilities”.

According to the PREVACAR survey, 52% of prisons benefit from specialised HIV counselling, and a vast majority (82%) among establishments with over 500 inmates.

The same approach applies to inmates with viral hepatitis. According to the PREVACAR survey, 57% of prison sites possess hepatology clinics. These are more widespread in institutions with over 500 inmates (83%) compared to institutions with less than 150 inmates (39%). The same is true when a CeGIDD is involved (69% versus 53%)

The circular of June 2007 on tuberculosis control details the modalities for screening and treatment. Screening is to be systematically offered upon entry in detention. If a case of tuberculosis is suspected, the inmate is placed in isolation in an individual cell and separated from the other prisoners for showering and walking in the yard to prevent any risk of contamination. The isolation lasts 15 days until the result is received. If the test is positive, the inmate must be referred to a hospital for treatment in a UHSI during the 2-to-3-week-long contagious period, or put in a secure cell in a referral hospital. The inmate can then continue their treatment in detention under the supervision of the

USMP with consultation after three months. In 2010 the Contrôleur général des lieux de privation de liberté issued a statement drawing attention to the “medical care of transsexual inmates” and the difficulties they face. They face numerous challenges in accessing appropriate medical care, endocrinology consultations and hormone treatments. Requests for hormones must be made in writing to the USMP, which adds

yet another obstacle for foreign trans individuals, who have little or no command of the French language.

Furthermore, trans-individuals detained in prisons regularly report that they are prohibited from wearing women's clothing, from buying beauty products in prison and from being placed in normal detention. They are most often confined in isolation wards and can only access certain activities at specific and often restricted times, outside opening hours, to avoid any contact with other inmates to ensure their safety.

Moreover, incarceration in a male or female quarter is theoretically based on the individual's civil gender status. As a result, trans women who have not undergone sex reassignment process or surgery are typically held in the men's ward. The prison administration is currently working on a “National Policy for the Management of Transgender Inmates”, a national procedure intended to be implemented in the prisons concerned.

Issues on HIV/AIDS and hepatitis for prison staff are addressed in a module on initial and continuous training regarding communicable diseases among prison guards.

Medical and prison staff must respect professional secrecy and confidentiality of care, as defined by the French Public Health Code (Code de la santé publique) and the 2009 French Prison Act (loi pénitentiaire).

The USMP must be equipped with secure premises, and medical records must only be accessed by caregivers. Confidentiality of data must be guaranteed, no matter the information medium, particularly for computer media and medical files.

Medical consultations within the USMP must be held without the presence of prison staff. For consultations in hospitals and depending on the level of supervision required, the escorting prison staff may attend, while the inmate may or may not be hampered. Escort personnel are subject to professional secrecy regarding medical information brought to their attention during consultations.

However, the relevance of shackles and the almost systematic presence of prison staff regardless of the inmate's health must be questioned, as security logic takes precedence over patients' rights and dignity. All USMPs are linked to a referral hospital.

Specialised consultations with an infectious disease specialist for instance can be carried out in the USMPs. Depending on the needs and in case of insufficient technical support, the consultation may take place in a health centre or at the UHSI, but this barely applies or even not at all to HIV consultations.

Consultations with a nutritionist are available per request to the USMP, which is in charge of somatic and psychiatric health. However, difficulties in recruiting exacerbate care deficiencies, and there can sometimes be several months of waiting between an appointment request and the consultation.

According to the 2010 PREVACAR survey, 95% of teams offer vaccination against hepatitis B during the consultation upon entry in detention.

According to the PREVACAR survey, a specialised consultation in hepatology is available in 57% of health units. Consultations are more frequent in institutions with over 500 inmates (83%).

Very strong regional disparity. Access to direct-acting antiviral (DAA) treatment is low but steadily increasing. The 2015 National Practice Survey revealed that 65% of USMPs had initiated at least one DAA treatment in a context where prescribing conditions were more restrictive. Since the June 2016 decree, inmates can receive treatment regardless of their degree of fibrosis, covered at 100% by social security.

A referral to the French National AIDS Council is planned in 2020 in order to review the situation of DAA treatment in detention and issue guidelines on ways to improve screening and treatment strategies.

According to the 2010 PREVACAR survey, only a quarter of prisons provide support to sick inmates; however, NGOs are involved in 38% of the prisons with over 500 inmates.

Agreements between the French Directorate of Penitentiary Administration, the French Directorate-General for Health and NGOs known as "network leaders" such as AIDES have been signed. Stakeholders can provide individual support in visiting rooms or in USMPs if the premises preserve the inmate's confidentiality. Stakeholders may also support inmates living with HIV or other chronic conditions who have been granted medical discharge from prison.

NGOs such as AIDES most often intervene for prevention, health education, harm reduction and sexual health actions in the framework of individual or collective actions, offering rapid diagnostic orientation tests for HIV and HCV, provided that the context preserves confidentiality

Pre-trial detention statistics

As of April 1st, 2019 monthly statistics on the inmate population estimate the number

of people in pre-trial detention at 20,336, equating to 28.8% of the 70,519 inmates. There is no official data or estimate of prevalence of communicable diseases or mental illness in pre-trial detentions.

The suicide rate is 7 times higher than in the general population. The suicide mortality rate among detained persons is 25 per 10,000. Defendants commit suicide twice as often as convicted inmates do. The suicide mortality rate is lower among individuals serving sentences of less than one year, and increases with the length of the sentence. 72% of suicides occur during the first year of detention.

Access in pre-trial detention

Similar to people in prison, people in pre-trial detention must have access to the same quality and continuity of care as the general population, according to the principles of the law of January 18th, 1994. Therefore, there is no separate screening policy for persons in pre-trial detention and access to care is similar to those in prison.

As such, data on access to testing and treatment in detention for convicted prisoners can be transposed to the section on people in pre-trial detention. To our knowledge, no specific data is available regarding the health status of defendants and their conditions of access to care, more specifically concerning HIV/AIDS and hepatitis.

One of the main challenges identified is the lack of preparation for release from prison, as commutation of sentences can lead to sudden releases, and in turn negatively impact people's care pathways and access to rights.

Policies vs practice in pre-trial detention

See the answers given in the relevant section for people in prison.

Other issues in pre-trial detention

See the answers given in the relevant section for people in prison.

People in custody

In police custody, criminal investigation takes precedence over public health. Police custody is a measure of deprivation of liberty taken against a suspect during a criminal investigation. It is a tool available to criminal police officers in the framework of their investigations. Police custody is supervised and has a limited duration.

The Code of Criminal Procedure provides for several legal regimes for police custody depending on the age and nature of the offences. In principle, it lasts 24 hours, but can be shortened or extended (96 hours, 144 hours). In this regard, police custody is not intended as a space where public health actions can be carried out. The right to a medical examination is rarely applied.

However, individuals placed in police custody have rights (Articles 63 to 65 of the Code of Criminal Procedure). The dignity, integrity, and health of individuals must be safeguarded. This includes the right to be examined by a doctor and to have access to and knowledge of the medical certificate issued by the doctor.

This right must be notified as soon as the individual is taken into police custody and must be recorded in the police report. Thus, Article 63-3 of the Code of Criminal Procedure states that "any person in police

custody may, at their request, be examined by a doctor appointed by the public prosecutor or the criminal police officer. If the period of custody is extended, the person may request a second doctor examination". Pursuant to Article 63-3 of the Code of Criminal Procedure, a family member may also make such request. Then it is up to criminal police officers to guarantee the consent of the person in police custody, who has the right to refuse.

With the exception of overwhelming circumstances, the medical examination must be carried out within 3 hours of the start of detention if the request has been made by the person in police custody. Medical examination is compulsory for minors under 16 years of age (Article 4 of Order (ordonnance) No. 45-174 of February 2nd 1945, as amended).

The doctor's primary mission is to check whether the person's health is compatible with detention in police custody. The doctor must therefore assess whether the conditions in which the police custody is conducted, in light of the person's overall state of health (physical and psychological), allow the police custody to continue. At the end of their examination, the doctor gives criminal police officers a certificate that decides whether the person's state of health is compatible with the continuation of police custody. This medical certificate is both a medical document and a document of probative legal value. Part of the certificate is given to the authorities. The other is only accessible to the person in police custody, their legal counsel, and the judge.

The doctor is fully independent and subject to professional secrecy. They must inform the person in custody of the information that is to be transmitted to the authorities and the information that remains subject to medical confidentiality. The doctor must

obtain the informed consent of the person in police custody in light of this information. The examination shall be carried out, if possible, on the premises of the police custody, and be conducted in such a way that confidentiality is respected (i.e. in a dedicated room compliant with the necessary health and safety conditions).

In practice, this right to a medical examination is rarely applied because of the conditions of detention, and because this right is rarely signified to people in police custody. Furthermore, there is little access to interpreters, which does not allow people to exercise their rights. Finally, it is difficult to guarantee confidentiality and an examination framework that ensures professional secrecy and privacy.

In theory there is legal obligation to ensure continuity of care, as stated in 2009 in the Guide for Good Practices on the Intervention of Doctors in Police Custody (Guide de bonnes pratiques relatif à l'intervention du médecin en garde à vue) of the French Directorate of Criminal Affairs and Pardons (Direction des affaires criminelles et des grâces). The medical examination should allow hearing the person's complaints; to look for possible pathologies; to guarantee the continuity of care: the principle of urgency to pursue on-going care must guide the doctor's actions; and to provide relevant therapeutic care.

Persons in police custody are under the protection of criminal police officers (Article R. 434-17 of the National Police Code of Ethics (Code de déontologie de la police nationale)). They must do everything in their power to ensure that the person has access to their medical treatment. For instance, they may contact their relatives or personal doctor to obtain their treatment or buy it at the pharmacy. The drugs prescribed during police custody are covered by social

security if the person is covered by social security. For people receiving state medical assistance or without health coverage, access to medicines is often not provided.

The activity reports of the Contrôleur général des lieux de privation de liberté regularly highlight shortcomings in terms of access to a lawyer and a doctor in police custody. These shortcomings can lead to treatment interruptions that can be highly damaging (for instance in the case of substitution treatment), as well as failures to issue valuable medical certificates. These shortcomings are largely due to a lack of resources, degraded or even unsanitary conditions of detention, and the fact that security logic takes precedence over everything else. The French Human Rights Defender and the Contrôleur général des lieux de privation de liberté regularly highlight some of the challenges in enforcing medical secrecy and guaranteeing confidentiality.

Since police custody is not a place where people typically receive treatment, the release process from police custody does not take medical aspects into consideration. Police stations and customs authorities are required to issue a booklet stating the rights of persons in police custody. Yet, this obligation is not fully respected. There are wide discrepancies in terms of practices.

PLHIV placed in police custody are held in the same cells as everybody else. However, they can sometimes be stigmatised by criminal police officers. For instance, one person living with HIV reported that they had been subjected to disagreeable comments from criminal police officers who had affixed a post-it note on their belongings that read "Attention sida" (Warning: AIDS). Often, conditions for enforcing confidentiality and privacy are not met and

can lead to situations where people's fundamental rights are not respected.

In theory, people with viral hepatitis placed in police custody are held in the same cells as everybody else. Often, conditions for enforcing confidentiality and privacy are not met and can lead to situations where people's fundamental rights are not respected.

When a person is infected with tuberculosis, precautions must be taken (e.g. wearing a mask) to avoid contamination. However, the conditions of detention can limit the respect of medical secrecy and contribute to isolate the person.

The doctor involved in the medical examination is appointed by the judge or the criminal police officer. Doctors contacted are often generalists rather than specialists in these disease areas.

In theory, non-binary and trans individuals should be placed in cells with people of the same gender and not according to their sex assigned at birth. However, this is often not the case. Hormone therapy is not considered an emergency response treatment and therefore not considered a priority.

There is no training on HIV or other infectious diseases available for police custody staff.

People's dignity, integrity, and health must be safeguarded and preserved during police custody. The police and customs authorities must do everything in their power to preserve medical secrecy and guarantee confidentiality. In reality however, the lack of resources and unsanitary police cells make it very difficult to guarantee these fundamental rights.

Victim support organisations are the most present in police stations, over health and community organisations, even if as part of their activities they may support a victim in filing their complaint.

Centres for refugees and migrants statistics

The size (or estimate size) of population in administrative detention centres was 14,260 in 1999 and the same figure increased to 45,851 in 2017 (data from the 2018 Cimade Report on Detention Centres and Facilities).

There is no data available for the prevalence of communicable diseases or mental health issues in centres for refugees and migrants. However, several studies¹⁰ highlighted that migrant populations are highly vulnerable to HIV. Some of the infections takes place after arrival in France. In France, according to data from Santé publique France, migrant populations account for 50% of new HIV cases every year. For women, this proportion is 75%.

The prevalence of hepatitis B is 5.25% among people aged 18-80 living in mainland France and born in Sub-Saharan Africa: eight times higher than in the general population.

The risk of being in contact with hepatitis C is three to four times higher for migrants than for the rest of the population. Anti-HCV antibodies are found in 3.12% of foreign-born individuals compared to 0.73% of French-born individuals.

The incidence of tuberculosis among people born outside of France is ten times higher than for French natives, i.e. 35/100,000 (data from the 2019-2022

tuberculosis roadmap of the French Ministry for Solidarity and Health).

A study by Santé publique France from July 2017 revealed that the prevalence of serious psychological disorders among migrants stood at 16.6%. Two thirds of these disorders are psycho-traumatic syndromes. The same study by the French national Public Health agency (Santé publique France) highlighted that over a quarter of respondents had had suicidal thoughts.

The Rapport précarité, pauvreté et santé of July 20th, 2017 by the Académie nationale de médecine as well as the 2017-2020 National Sexual Health Strategy from the Ministry for Social Affairs and Health underscored the high vulnerability of migrants especially women to STIs.

Access in centres for refugees and migrants

Regarding the increased security considerations in a context of tightening asylum and immigration policies the Controller General of Places of Deprivation of Liberty issued a statement on December 17th 2018, expressing concerns about the conditions of detention and access to rights and health care of imprisoned persons. In particular, it points out that security and anti-immigration logics are taking precedence over the respect of detained persons' fundamental rights.

While in 1981 (date of creation of administrative detention centres) detention could last a maximum of 7 days, following the adoption of the Asylum and Immigration Act of 2018, detention can now reach up to 90 days. This logic of extensive confinement has a direct impact on the health care of detained migrants, particularly as this specific population

combines several vulnerability factors (administrative, social, economic, medical and social precariousness) that expose them to various diseases (HIV, HBV, HCV, psychiatric disorders, diabetes).

It is worth noting that persons who are confined in detention centres are not the objects of any criminal conviction. Persons are confined in detention centres because they are in an irregular situation. Their profiles are extremely diverse: men and women who have been living in France for decades, people seeking asylum and who have been denied, people who have not been able to obtain or renew their residence permit, people who have served a prison sentence, children, etc.

A medical interview must be carried out upon entry into an administrative detention centre. Its purpose is to open a file, learn the person's medical history and current pathologies or even to detect them, and to check current treatments. In practice, there are noticeable differences from one administrative detention centre to the next. Some medical units use an "entry questionnaire", others do not. In some centres, this check-up is conducted within 24 hours, while in others, it only occurs upon request from the person in detention.

It is also possible for some detention centres to arbitrarily - on suspicion alone - select a person when they are placed in detention. The duty to inform detained persons is still not respected, often hampered, or even inaccessible due to the challenges in using interpretation services.

There is no screening or prevention policy.

There are disparities from one administrative detention centre to the next. Not all medical units are equipped to perform blood tests and provide screening.

Screening is not mandatory, but carried out at the request of persons in detention. However, the Controller General of Places of Deprivation of Liberty noted that some medical teams have strong reserves when it comes to performing these screening tests. Some consider that they do not have the means to offer a follow up, and that initiating treatment in detention is not convenient. At times, test results come back when the person is no longer in the administrative detention centre. The issues of vaccination and prevention are not considered a priority by the medical units of administrative detention centres.

It is essential to highlight that those detained must benefit from the fundamental right to health, namely equal access to care, continuity of care and health security. However, in practice, respect for this right is not guaranteed due to the inadequacy of the medical units present in each administrative detention centres, the consequences of a longer detention period, and undignified detention conditions. In a place where security and control logic take precedence over everything else, it can be difficult for detained persons to claim patient status. An administrative detention centre is not a place of care. In some centres, one cannot freely access the medical unit but - depending on the premises' layout, relationships between the medical team and police officers - under the control of the police, which poses multiple problems: self-censorship by individuals, control logic to the detriment of health care, disregard for medical secrecy and privacy.

Furthermore, material and living conditions of persons in detention are very precarious, at times unsanitary in numerous centres (lack of hygiene, insalubrity, promiscuity, etc.), making it impossible to respect the integrity of detained persons and their right to health.

Twenty-one NGOs have written to the French Minister of the Interior to denounce this policy of imprisonment, abusive detention, and massive violations of individual rights. One of these NGOs, La Cimade, announced that it would cease its operations in an administrative detention centre in the Paris region to protest against the impossibility of supporting people under these conditions.

The challenge in accessing interpretation services throughout the detention period can have a direct impact on health care. Police officers tend to play down the health condition of detained persons by doubting the pathologies they face. According to them, detained persons supposedly exaggerate their health condition in order to be released from detention because of health concerns. This depicting contrasts dramatically with facts on the field. Violations of inmates' rights are regularly reported by the French Human Rights Defender¹¹ and the Controller General of Places of Deprivation of Liberty as well as by numerous NGOs¹³

Many testimonies attest to breaks in treatment follow-up. For instance, an HIV-positive person placed in an administrative detention centre in the Paris region reported that they had been unable to receive their treatment for two weeks.

Solitary confinement rooms should only be used in specific situations, namely "in the event of a disturbance of public order or a threat to the safety of other foreigners" (Bylaw of May 2nd 2006 pursuant to Article 4 of Decree No. 2005-617 of May 30th 2005 on administrative detention). This confinement regime deprives the person of any contact with the outside world. In practice, these solitary confinement rooms are misappropriated for other purposes, in

particular to isolate people with serious pathological disorders. However, it is essential to note that these rooms are in no way suitable for people in need of care. As a result, they are left without care.

The act of monitoring the compatibility of a person's health status with confinement is highly uncommon. However, article R. 553-13 of the code of entry and residence of foreigners and right of asylum (code de l'entrée et du séjour des étrangers et du droit d'asile CESEDA) provides that persons placed in administrative detention centres may request an evaluation of their "state of vulnerability" by a doctor from their centre's medical unit. In practice, this practice is very uncommon.

Furthermore, there are significant disparities from one administrative detention centre to the next. In addition, whenever incompatibility certificates are issued, they are rarely acted upon by the prefectural authority. Protection against expulsion is rarely enforced and has become more difficult to implement.

A sick foreigner detained in an administrative detention centre may indeed request protection against expulsion if they reside in France and their "state of health requires medical care, the lack of which could have exceptionally serious consequences for them and if, in view of the available care and health system in their country of return, they could not realistically benefit from appropriate treatment over there." The medical unit doctor can issue a medical certificate, which is sent to the doctor of the French Office for Immigration and Integration. Once again, the Controller General of Places of Deprivation of Liberty and many NGOs within the Observatory on migrants' right to health have highlighted major disparities in practices, imprecise

applicable laws, and a hardening of practices.

Preparation for exit from detention is erratic, with numerous disparities from one administrative detention centre to the next. Some medical units have implemented exit procedures, others have not. The lack of communication and transmission of information between police officers and health professionals does not promote anticipation. These practices have significant impacts on people's health: non-transmission of medical records, people leaving without medical treatment, etc.

Other issues in centres for refugees and migrants

PLHIV and people with viral hepatitis are not separated from other people. However, the conditions necessary to ensure confidentiality and privacy are not met and can lead to situations where people's fundamental rights are not respected. These people can be bullied and stigmatised by others as well as institutions. People with tuberculosis can be isolated for health reasons.

Medical units of administrative detention centres can request specialised advice and consultations may be requested from their reference hospitals for all communicable diseases but this rarely happens in practice. In theory, non-binary and trans-individuals should be placed in spaces with people of

the same gender and not according to the gender assigned at birth. However, this is often not the case. Hormone therapy is not considered an emergency response treatment and therefore access to it is not considered a priority.

Young people

In France, minors can go to prison from the age of 13. As of August 1st 2019, the Ministry of Justice's monthly statistics on prison population indicate that 845 minors were in detention, about 1% of the total prison population.

They are typically incarcerated in juvenile quarters (quartiers pour mineurs - QPM), which is a space reserved for minors in prisons that mostly accommodate adults, or in one of the country's six juvenile prisons (établissements pénitentiaires pour mineurs - EPM). Created in 2002, these small structures (with a capacity of around sixty inmates) exclusively accommodate minors.

There are also closed educational centres with a capacity of 1,500 people, but this system is not considered a detention facility.

The 2018 Cimade report on Detention Centres and Facilities revealed that 1,221 minors in Mayotte and 114 families with 208 children in mainland France were detained, in addition to 339 unaccompanied minors. These are serious violations of fundamental rights.

Germany

Country statistics

Germany has a population of 82.8 million. Germany has been very close to reaching the first 90 of the UNAIDS treatment targets: the estimated number of all people living with HIV is around 86,000, by the end of 2017, 74,800 people have been diagnosed; and have already reached the second and third 90 targets: 68,800 were on treatment and 65,500 had an undetectable viral load.

The number of new diagnosis in 2017 was 3,300, which has been stable and showed a slight decrease in the last few years due to effective prevention programmes and the upscale of treatment. In the future, further decrease is expected due to the national rollout of PrEP in Germany.

Access in the general population

The general public has access to most prevention tools and methods, since September 2019, PrEP is also reimbursed through the mandatory health insurance. There is vaccination for HAV/HBV and disinfectants and information leaflets and posters regarding prevention are accessible for the public.

In Germany treatment for HIV, HBV, HCV, and TB are available.

Definition of closed setting – closed settings relevant in the national context

In Germany closed settings include prisons; pre-trial detention; police custody (after arrest); centres for refugees and migrants; and forensic clinics.

Funding for prevention and health interventions in closed settings

Healthcare of inmates in Germany is funded by the Ministries of Justice of the different federal states (Länder). There are differences from federal state to federal state in regulations and legislation that apply to prisons.

Prison statistics

The prison population of Germany is around 60 thousand. The estimate HIV prevalence is at 0.08%. The prevalence for HBV and HCV is 1% and 14-20% respectively.

The suicide rate is 12 people / 10 thousand detained.

Access and policies vs practice in prisons

Testing for HIV, viral hepatitis and TB are offered on an opt-in basis in Germany. Systematic screening for infectious diseases in prisoners is not implemented across the board.

Test strategies for HIV and HCV differ in the federal states (BL) and in some cases from prison to prison, ranging from a compulsory test at the start of imprisonment to a test offered only at the prisoner's own request or in the event of clinical symptoms.

There are issues with confidentiality of test results and medical results in prisons, many prison staff know about test results.

People in prison have access to prevention and treatment services similar to the general population, however, NSP is not available in all prisons across the country.

Other issues in prisons

PLHIV and people with viral hepatitis are detained together with other inmates. TB patients are separated for the period of infectiousness.

In general, all kind of health care is provided by the prison doctors. In case it is needed, they contact and consult specialists. TB check-ups are regularly done by prison doctors.

Training on HIV for prison staff is offered by the local AIDS organizations (Aidshilfen), they also provide consultations, seminars, support services, information materials, and condoms for people in prison.

Besides the services provided by NGOs, there are social and psychosocial services provided in prisons, however, they are only available in around 40% of the prisons in Germany.

Pre-trial detention statistics

The size of population in pre-trial detention was 12,679.

There is no data available on prevalence of communicable diseases or mental illnesses in pre-trial detention in Germany.

Access and policies vs practice in pre-trial detention

People in pre-trial detention have access to condoms and lubricants and OST. Treatment for HIV, HBV, and TB are also available.

Other issues in pre-trial detention

There are single cells in pre-trial detention regardless of their health status or condition. When needed, they are transported to specialist for check-ups and examinations.

HIV specific trainings for staff is offered by AIDS organizations (Aidshilfen) and staff has shown great interest in participating in these trainings.

Consultations, seminars, and information materials are offered to people in pre-trial detention by AIDS organizations.

Forensic clinics statistics

The number of people in forensic clinics is 10,875 people in Germany.

There is no official data available on prevalence of communicable diseases in these settings.

Access and policies vs practice in forensic clinics

There is mandatory testing for TB in forensic clinics and Germany, however, inmates are not screened or offered testing for other communicable diseases.

There is access to hepatitis A and B vaccination and access to treatment of HIV, HBV and TB.

Other issues in forensic clinics

OST is offered in some of the forensic clinics and AIDS service organizations offer some services but this very much differs by the federal state and there is a general issue with lack of data regarding forensic clinics.

Centres for refugees and migrants statistics

In 2019 there were a total of 165,938 asylum applications, including 142,509 initial (first-time) applications in Germany. There is no data accessible of the current number of population that are in centres for refugees and migrants.

There is no data available for prevalence on communicable diseases, mental health issues or suicide rate as Robert Koch Institute (the national CDC) collects data based on migration background, which includes all people in Germany with a migration background.

Similar to other European countries, reception centres for refugees and migrants in Germany are not closed settings in the traditional sense of the definition as people

staying in these institutions are free to leave during the day and only required to return for the nights. Still, they are listed here, as due to their set up, function and conditions are similar to other closed settings when it comes to the needs, issues, and barriers regarding accessing HIV-, viral hepatitis-, and TB-services.

Access in centres for refugees and migrants and policies vs practice in centres for refugees and migrants

There is mandatory testing for TB in the reception centres and in one federal state (Bavaria), there is mandatory testing for HIV for refugees.

People in the centres can access vaccination for hepatitis A and B and treatment for HIV and TB.

Other issues in centres for refugees and migrants

Refugees need to organize their medical check-ups and transport to the health care provider. Specialist do not visit the centres. In some federal states, there are separate centres for queer refugees due to safety considerations.

Hormonal therapy for trans individuals is not covered by the asylum seekers law.

Greece

Country statistics

The population of the country was 10,816,286¹⁴.

The HIV prevalence was 6% in 2018 while HBV prevalence was around 2.5-3%, and HCV prevalence around 1.5-2%, according to the Greek national CDC.

There are approx. 600 TB cases reported each year.

The estimated number of high-risk drug users is around 16,500 according to EKTEPN.

4.7% of the general population are depressed¹⁵.

There were 1,586 reported cases of STIs in the period of 2012-2016, according to the national CDC.

Access in the general population

The public has access to condoms, lubricants; PrEP and PEP are also available. NSP and OST are available for people who use drugs and so is Naloxone. There is vaccination for HAV/HBV. Disinfectants and also information leaflets and posters regarding prevention are accessible for the public.

In Greece treatment for HIV, HBV, HCV, and TB are available.

Definition of closed setting – closed settings relevant in the national context

In Greece the definition of 'detention' from the handbook of UNHCR¹⁶ is used. "It is the deprivation of liberty or the confinement in a confined space, where the asylum seeker cannot depart at will. In this context are included prisons and centres or facilities of detention as well as closed reception centres."

In Greece closed settings include prisons; pre-trial detention; police custody (after arrest); centres for refugees and migrants; and pre-deportation centres (ΠΡΟΚΕΚΑ)

Difference of prevalence in closed settings vs general population

There is no data available for prevalence in closed settings.

Funding for prevention and health interventions in closed settings

Prisons, police custody, and pre-trial detention facilities are under the authority of the Ministry of Public Order (citizen's protection in Greek) and the ministry is responsible for the funding of health interventions from its budget.

Pre-deportation centres for migrants/asylum seekers are also under the authority of the Ministry of Public Order.

Centres for refugees and migrants were under the Ministry of Migration until July 2019 when it was taken over by the Ministry of Public Order for the period of July-December 2019. From January 2020 the Ministry of Migration is in charge again. They are using bilateral agreements (contracts) with non-governmental organizations for the provision of health interventions.

Prison statistics

According to the data released monthly by the Ministry of Justice there are places for 9,935 prisoners in Greece and on the 31st of October 2019 there were 10,495 people detained in prisons and there were 206 people detained in the main psychiatric prison in Greece.

The last research on suicide rate in prisons was carried out covering the period 1977 - 2000 and the rate was identified at 110.1 per 100.000 detained people. It is worth mentioning that the rate outside of the prisons at the same period was 3.68 per 100.000. Two thirds of the victims took out their life in pre-trial settings and one third of the victims did that in the main psychiatric prison.

Access and policies vs practice in prisons

People in prison have limited access to prevention tools and methods compared to the general population. There is access to PEP, OST and vaccination for HBV but other tools for preventing HIV or HCV infections is not accessible or available in prisons in Greece. Information leaflets on prevention are also accessible.

When it comes to treatment, HIV, HBV and TB are covered but HCV not in prisons.

Testing and screening are done on an opt-in basis; there is no difference between policies and practice.

Other issues in prisons

PLHIV are detained separated from other detainees. They are in Agios Pavlos prison hospital.

TB patients are also detained in hospitals outside prisons.

HIV and viral hepatitis specialists visit patients in the prison hospitals. TB specialist also visit prisons but if there is a need for treatment, the patient is transported to the relevant hospital where they can receive the treatment.

Trans individuals are detained according to the sex they have in their ID or other official document. There is no access to hormonal therapy.

Training on HIV is not officially available for prison staff. NGOs sometimes provide seminars for staff in prisons.

Confidentiality in the case of PLHIV is non-existent as they are all detained in a certain ward of the prison hospital, so everybody knows they are living with HIV.

PLHIV have officially access to social services and medical support.

Peer support and psychological support are offered by some NGOs for PLHIV. During these sessions that some NGOs have on a weekly or monthly basis with PLHIV they also provide support with leaflets and information for those who have or had also HCV.

Pre-trial detention statistics

The size of population in pre-trial detention was 1,447 (November 2019)

There is no data available on prevalence of communicable diseases or mental illnesses in pre-trial detention in Greece.

The last research on suicide rate in prisons was carried out covering the period 1977 - 2000 and the rate was identified at 110.1 per 100.000 detained people. It is worth mentioning that the rate outside of the prisons at the same period of time was 3.68 per 100.000. Two thirds of the victims took out their life in pre-trial settings and one third of the victims did that in the main psychiatric prison.

Access and policies vs practice in pre-trial detention

Testing and screening are offered on an opt-in basis, there is no difference between policies and practice. HIV, HBV, HCV testing in practice are provided 'when and if necessary'. TB screening is provided if the person has cough symptoms. This information was provided by the prisoners themselves as the prison administration did not provide an official reply to this inquiry.

In pre-trial detention, detainees have access to OST and disinfectants as prevention methods, and information leaflets and posters are accessible.

In pre-trial detention treatment for HIV and TB are available.

Other issues in pre-trial detention

Regardless of the detainees' detention status, they are always transported to the prison hospital if they are living with HIV.

Hepatitis patients are detained together with others while TB patients are transported to hospitals for the period of being infectious.

Specialist doctors for all 3 communicable diseases visit patients in pre-trial detention or the prison ward of the hospitals

Trans individuals are detained according to the sex indicated in their ID or other official document, there is no access to hormonal therapy.

There is no information on STIs.

Police custody statistics

There is no official data available on police custody.

Access and policies vs practice in police custody

There are no testing policies in police custody settings and there is only access to disinfectants (e.g. for hands). There is no information available on the availability of treatment for any diseases or conditions, which is problematic for the continuity of treatment in police custody.

Other issues in police custody

In police custody NGOs provide psychosocial and rarely legal support.

Centres for refugees and migrants statistics

The size of population in centres for refugees and migrants in Greece is 35,000. There is no data available for prevalence on communicable diseases, mental health issues, or suicide rate.

Access in centres for refugees and migrants and policies vs practice in centres for refugees and migrants

Testing in these centres are offered on an opt-in basis. Access to PEP is provided. There are no other means of prevention or provision of treatment in these settings.

Other issues in centres for refugees and migrants

PLHIV and people with viral hepatitis are together with other people in these facilities. In best case, they are transferred to the mainland to be linked to treatment and care in relevant hospitals.

There are no specialist doctors in these centres but general physicians.

Until recently trans individuals and non-binary people were considered as vulnerable cases and they were transported in safer spaces in the mainland. There is no hormonal therapy provided in the centres.

There is no training on HIV available for the staff of the centres for refugees and migrants.

In some cases NGOs provide psychological, social and legal services for people in the centres.

Centres for refugees and migrants are not exactly considered closed settings. In Greece in the islands of east Aegean Sea, people have to register upon arrival and apply for asylum and then he/she is free to go in and out of the camp but must not leave the island.

Young people

Young people are detained in youth prisons in Greece. Apart from youth prisons recently being highly overcrowded in comparison to adults' prisons, there are no particular differences concerning access to different health services as explored in the case of adults.

Italy

Country statistics

Italy has a population of 60.391.000 (the Italian Institute of National Statistics (ISTAT) report, January 2019).

The estimated number of PLHIV is 130.000 (120.000-150.000)¹⁷.

There is no official data regarding the prevalence of viral hepatitis, unofficial estimates are around 2% for HBV and 2-3% for HCV.

In 2017 there were 3,944 TB cases (6.5 per 100.000) in Italy¹⁸.

The estimated number of drug users is around 4.000.000 drug users¹⁹. The study IPSAD 2017 estimates that 10.6% of the resident population between 15 and 64 years of age used illicit drugs at least once during the course of 2017.

In the course of 2017, 851.189 people were in charge of the National Health System for mental health problems²⁰. In 2017, ISTAT conducted an investigation on data referred to 2015, finding that in 2015 3.935 suicides were reported (6.5% per 100.000).

In 2013, the Italian surveillance system reported 6.251 new cases of STIs²¹.

Access in the general population

In Italy in theory most tools to prevent blood-borne infections are available for the general public. However, when it comes to reality,

there are several issues that affect access to some of the prevention tools:

Femidoms are generally unknown to the general population and while PrEP has been approved in the European Union in 2015, it is still not yet reimbursed by the National Health System.

In addition, needle and syringe exchange programmes (NSP) have very limited coverage.

Vaccination for HBV was introduced as a mandatory vaccine for all new-borns from 1991, so the older population is not immunized properly against hepatitis B.

Information leaflets and prevention campaigns are totally insufficient; government investments into prevention are almost non-existent.

Treatment for all infectious diseases is available through and is covered by the National Health System. However, Italy has regional health systems, which means that in practice there might be differences in accessing health care services, especially for migrants in irregular situations, who should have free access to (testing, care and) treatment of these communicable diseases in Italy²².

Definition of closed setting – closed settings relevant in the national context

Closed settings are places, normally under the direct administration of the State/Ministry of Justice, in which people

are deprived of their personal freedoms and detained usually as the consequence of having been sentenced guilty of crimes that by law are punished with detention. Detention occurs after a trial that ends with a sentence determining the timespan for the deprivation of freedom.

Some individuals might also be detained for different reasons. There are different types of closed settings/prisons, according to different situations.

In Italy the following types of closed settings were identified and covered in this report: prisons; pre-trial detention prisons; identification and expulsion centres for undocumented migrants; other closed settings, which include alternative settings to detention (e.g. therapeutic and rehabilitation centres).

Difference of prevalence in closed settings vs general population

Various regional studies (no national studies) indicate that there is higher prevalence for communicable diseases in prisons, if compared to the general population.

In Italy, closed settings are often described as “concentrators of diseases”. This is partly due to the fact that some of the most affected populations are criminalized and end up in prison (e.g. people who use drugs, sex workers, migrants). A much bigger issue regarding higher prevalence of communicable diseases in prisons is the precarious conditions of many Italian prisons, often rated as insalubrious and harmful by many agencies and NGOs. This rating is partly due to the absence of necessary preventive interventions (e.g. NSP, condom distribution) despite the high presence of inmates detained for drug related crimes (25.3%) and the high rate of

consensual or non-consensual sex acts between same sex partners.

Chronic overcrowding also represents a huge risk factor, together with the lack of products for personal hygiene and hygiene more in general. In 2018, 60.439 people were detained in 190 Italian prisons, almost 10.000 more than the 50.511 official available places. The official crowding rate reaches nearly 120%.

For all the above reasons, the prevalence of HIV, HCV, and HBV is higher than in the general population. The estimated prevalence of HCV might be 10 times higher due to the high number of detainees who use drugs and originate from high prevalence countries (e.g. Egypt or Pakistan).

Funding for prevention and health interventions in closed settings

In 2008 Prison Health was transferred from the Prison Administration (Ministry of Justice) to the National Health System. The implementation of this reform, which should guarantee standards of care similar to those in place for the general population, has encountered many difficulties and resistances, and shows many regional differences.

Proper protocols formalizing the relationship between the Regional Health System and prisons exist only in some regions. Since 2008, national data on the health of detainees are no longer available. Surveillance is managed by local infectious disease hospitals and this complicates the monitoring of infectious diseases in prisons.

Screening and treatment for HIV, hepatitis, TB and STIs should be ensured by protocols, but where protocols have not been established yet there are persisting difficulties. Access to screening for the

mentioned diseases is proposed on an opt-out basis when people access prisons.

Continuity of care is ensured when detainees stay in the same prison; problems sometimes arise in case they are transferred to other prisons or at the time of their release from prison.

Prison statistics

The size (or rather estimated size) of detained population was 60.771 in Italian prisons as of July 15, 2019²³.

There is no official data available on the prevalence (or estimated prevalence) of communicable diseases.

Unofficial estimates indicate around 5.000 PLHIV in prison; half of them are undiagnosed or did not report to have HIV to the penitentiary health departments²⁴.

According to a study conducted in 2017 among 3.100 people detained in a prison in Tuscany, HIV prevalence was 1.6% in males and 0.9% in females²⁵. The same study showed that HBV prevalence was 12.6% in males and 5.3% in females, while HCV prevalence was 11.0% in males and 5.1% in females. Other unofficial sources indicate a prevalence of 6% for HBV and 10-30% for HCV. In the same study, TB prevalence rate was 5.5% in males and 3.0% in females, while other unofficial sources indicate a prevalence of 0.1%.

There is no official data available for the prevalence of mental illnesses in prisons. However, in its XV Report, 2019, Antigone (a relevant national NGO) indicated that of 60.439 detainees present at the time of data collection, 28.7% were prescribed psychiatric therapies by the penitentiary health departments.

According to the Penitentiary Administration, in 2018 61 cases of suicide were reported, for a rate of 10.4 suicides per 10.000 detainees. Other unofficial estimates indicate an average of 100 cases of suicide per year in the last years.

There is also no official data available on STI prevalence; unofficial data report 6-7% syphilis rate.

Access in prisons

Opioid Substitution Therapy (OST) is widely available in Italian prisons, while vaccination for HAV and HBV, Post-Exposure Prophylaxis (PEP), and information leaflets are available only in a few prisons.

In Italy, people in prisons have access to treatment for HIV, HBV, HCV, and TB.

Policies vs practice in prisons

Guidelines for HIV screening are in place: HIV screening is offered upon entering prison on an opt-out basis; however, implementation is very inhomogeneous in Italian prisons and the rate of detainees tested remains low.

Screening for HCV started with the availability of DAA, in the absence of specific guidelines. The main reasons for the absence of consistent screening for infectious diseases lie in structural problems and lack of healthcare staff. Screening is mostly offered to detainees with final sentences. No official data on tests performed in prisons are available.

During detention, unless some research study or other requests for data collection arise, detainees are not periodically offered to undertake tests.

No indications, nor guidelines are in place requiring a full screening for infectious diseases upon release.

Other issues in prisons

In Italian prisons, PLHIV are generally detained together with the other detainees, although LILA Milano is aware of a few cases when they were detained in separate spaces. Prisoners with viral hepatitis are also detained together with the other detainees, while those with TB infection are transferred to specific clinical departments. When it comes to medical check-ups, HIV specialists should visit patients in prison. In the absence of specific protocols or in the case of severe complications, detainees might be transported to hospitals. The same applies for viral hepatitis specialists and TB specialists.

No information was available on areas/departments where trans and non-binary people are detained during incarceration. In general, there is no access to hormonal therapy in prisons except for the prisons of Como and Florence, where it is available.

Training is available only in very few prisons, even if training activities are recommended by the National AIDS Plan. Where available, they are well attended.

Policies to secure confidentiality exist but in very many cases they are disregarded; privacy is not guaranteed in most cases.

Additional support to PLHIV or people with viral hepatitis or TB is very limited in most prisons. Psychological support is offered in very few prisons as well.

NGOs are present in a few prisons, they mostly offer information, support and orientation services.

Pre-trial detention statistics

As of December 2018, the number of detainees in pre-trial detention was 19.565 (32.8% of the total people detained in Italy)²⁶.

There is no data available on prevalence or estimates of communicable diseases or mental illness in pre-trial detentions in Italy. According to the Penitentiary Administration, out of the 48 suicides reported in 2017 (the Observatory 'Ristretti Orizzonti' counted 52 suicides in the same period), 29, i.e. 60.4% of the total, were committed by detainees who were waiting for a final sentence - and were therefore presumed innocent²⁷.

Access in pre-trial detention

Guidelines for HIV screening are in place: screening is offered on an opt-out basis upon entering pre-trial detention.

Similar to the situation in prisons, OST is available in pre-trial detention, while access to vaccination for HAV and HBV, PEP is very limited.

In Italy, people in pre-trial detention have access to treatment for HIV, HBV, HCV, and TB.

Policies vs practice in pre-trial detention

There are no specific guidelines, nor specific data, for people in pre-trial detention. Italian trials and justice system are slow and delayed and detainees might wait for a final sentence for many years, and meanwhile be transferred many times, without receiving any screening in some cases.

In general, detainees in pre-trial detention receive even less and worse testing, treatment and care services than the other detainees.

Other issues in pre-trial detention

For other conditions in pre-trial detention, please see section on "Other issues in prisons".

Centres for refugees and migrants statistics

As of Jul 31, 2018, Italy hosted a total of 160,458 migrants in different types of reception centres²⁸. Only a few of these centres are 'identification and expulsion centres', i.e. closed settings depriving migrants of their freedom. Similar to other European countries, reception centres for refugees and migrants in Italy are not closed settings in the traditional sense of the definition as people staying in these institutions are free to leave during the day and only required to return for the nights. Still, they are listed here, as due to their set up, function and conditions are similar to other closed settings when it comes to the needs, issues, and barriers regarding accessing HIV-, viral hepatitis-, and TB-services.

At present, no specific, separate data are available for such closed settings.

No official data are available on prevalence or estimates of communicable diseases or mental illness in Italian centres for refugees and migrants.

Access in centres for refugees and migrants

Condoms and information materials are available in centres for refugees and migrants only where NGOs collaborate with dedicated projects. PEP is present only if there is an efficient connection with hospitals or the National Health System.

TB screening is compulsory while HIV, HBV, and HCV are offered on opt out basis. People in centres for refugees and migrants have access to HIV, HBV and TB treatment.

Policies vs practice in centres for refugees and migrants

It is difficult to identify people and therefore no official documentation is maintained; turnover in the centres for refugees and migrants is extremely high.

Health interventions are very difficult to deliver since no protocols are in place with the National Health System. The administrations of reception centres often do not follow procedures and migrants do not trust healthcare staff and very often do not understand what they are requested to undertake.

Italian legislation allows access to testing, treatment and care for HIV and other severe health threats and conditions to undocumented migrants; nevertheless, a lot of structural, cultural, linguistic barriers and stigma still represent huge barriers.

Recent changes in the legislation related to security (Decreto Sicurezza and Decreto Sicurezza Bis) created additional obstacles for accessing the fundamental right to health granted by the Italian Constitution.

Other issues in centres for refugees and migrants

Other conditions and issues in centres for refugees and migrants are similar to prisons and pre-trial detention. Patients with TB in the infectious stages are transferred to hospital wards. Information, support, and orientation services for PLHIV and people with TB are present in centres for refugees and migrants only where NGOs are present

and are allowed to deliver these interventions.

Other closed settings statistic

The last data reported by the Ministry of Justice, relative to the first semester of 2018, indicates that during the said period of time 19.073 people benefited from alternative measures to detention.

According to the XV Report, 2019, of the NGO Antigone, in the same period 44.287 people benefited from alternative measures to detention.

As of December 31 2017, 3,146 detainees who committed drug related crimes had benefited from alternative measures to detention and were hosted in therapeutic communities for rehabilitation.

In Italy no data are available on prevalence or estimates of communicable diseases or mental illness in these institutions.

Access in other closed settings

HIV testing is offered on opt out basis in settings, which host people benefiting from alternative measures to detention.

There is limited access to condoms, Naloxone and information leaflets; they are available only in few therapeutic communities. PEP and HAV/HBV vaccines are available only if protocols with the National Health System are in place.

Policies vs practice in other closed settings

No data or information are available on differences between policies and their implementation.

Other issues in other closed settings

Similarly to the situation experienced in other Italian closed settings, PLHIV and people living with hepatitis share common living spaces with the other guests, while TB patients, when infectious, are transferred to hospitals.

Limited training on HIV issues is available for staff.

In theory policies are in place to secure confidentiality, but a lot of problems related to privacy are reported.

Other services, such as psychological support, general support, information and orientation services are limited to those communities where NGOs offer these programmes.

Young people

Young people in Italy are either detained in youth prisons or, if of foreign origin and undocumented, in the centres for refugee and migrant youth.

Minors can only access testing services if they receive the consent from their parents or legal tutors. They can access information about prevention of HIV and STIs.

North Macedonia

Country statistics

The population of the country was estimated at 2,077,132 in 2018²⁹.

There have been a cumulative number of 404 HIV diagnosis in North Macedonia between 1987 and 2018; estimated number of PLHIV in 2017: 402³⁰.

HBV prevalence in the country in 2018: 88 new cases (incidence 4.1/100,000), 22.2% more than in 2017.

HCV prevalence in the country in 2018: 35 new cases (incidence 1.7/100,000), 20.7% more than in 2017.

TB prevalence in the country: prevalence 11.4 on 100,000 citizens, with 217 new cases in 2018.

The estimated number of drug users was 6500³¹, 8.9% of the citizens aged 15-64 had experience with using drugs³².

There is no data available of prevalence of mental health issues in the general population.

The prevalence of STIs in 2018: 271 new cases (incidence 13.1/100,000)³³.

Access in the general population

The general population has access to condoms and lubricants. OST and Naloxone are also available in the country. The population also has access to vaccination for HAV and HBV.

When it comes to treatment options for the general population, HBV treatment is outdated with only lamivudine being available under national health insurance. HCV treatment is limited with DAAs not being made regularly available to patients – medicines are neither included in the positive list, nor is there a special treatment program (as is the case with HIV and TB treatments, which are provided through the national HIV and TB programs respectively of the Ministry of Health).

DAAs have been provided in a couple of ad-hoc situations, based on donation or small extraordinary state procurement. However, HIV patients co-infected with HCV (very few such cases) were offered treatment in 2017 as a matter of priority.

Definition of closed setting – closed settings relevant in the national context

There is no nationally used definition of closed settings in North Macedonia.

The types of settings covered in this report are prisons; pre-trial detention; centres for refugees and migrants; and closed units of psychiatric clinics. There is one juvenile prison and public institution for care of children with educational and social problems and disturbed behaviour in Skopje.

Difference of prevalence in closed settings vs general population

There is significant difference in HIV prevalence in the general population and people in closed settings. Although people convicted to prison sentence are identified as key population in the National Program for protection of the population from HIV/AIDS, the number of PLHIV in prison (the ones with diagnosed HIV) is very low (only 2 cases)³⁴.

A very significant difference between prevalence in the general population and people in closed settings worth mentioning is the prevalence of viral hepatitis. This is due to the fact that people who inject drugs very often have HBV and/or HCV and at the same time, due to the criminalization of possession of drugs for personal use, a lot of people who inject drugs are serving prison sentences.

In the prisons, pre-trial detention and police custody there is no access to clean needles and syringes. All of this contributes to the significant difference in prevalence.

Funding for prevention and health interventions in closed settings

The financing of the healthcare of the people in prison, pre-trial detention and police custody and underage young people sent to disciplinary measure in an educational-correctional institution, is provided by the Budget of the Republic of North Macedonia.

According to the Law on Healthcare and Law on Health Insurance, people in these closed settings are granted with health insurance organized by the Fund for Health Insurance and their healthcare is provided by the Budget of the Republic of North Macedonia. According to the Law on Health

Insurance, the Directorate for execution of sanctions, which is a body of the Ministry of Justice is responsible for the calculation and payment of the contributions for health insurance for people in these closed settings.

According to the Macedonian legislation, a person with status of accepted refugee or person under subsidiary protection will be ensured with the mandatory state health insurance and therefore granted state-funded healthcare, but will be individually responsible for payment of the contributions for mandatory health insurance.

However, the Commission for human rights and freedoms of the Parliament of the country in a recent report on the state of human rights and freedoms in the penal-correctional institutions in the country stated that almost every penal-correctional institution is in great debts. This leads to the omission of payment of contribution for the health insurance of people in these settings. In the public debate regarding the report, the penal-correctional institutions recognized this fact and asked the Government to extend their budgets, because otherwise they would not be able to fulfil their obligations in near future.

Prison statistics

There are 2,200 people annually on average (according to the Ministry of Internal Affairs of N. Macedonia) detained in prisons in North Macedonia. The number in 2017 was 2,845.

On a stratified sample of 200, there were no cases of HIV in prisons.³⁵ Currently there are 2 PLHIV who are in prisons in the country.³⁶

There is no data on the prevalence (or estimated prevalence) for HBV.

On stratified sample of 200, there were 51 cases of HCV positive imprisoned people or prevalence of 25.5% of the stratified sample³⁷

There is no data on prevalence (or estimate prevalence) for TB; there were 4 registered cases in 2019³⁸

There is no data on the prevalence of mental illnesses or suicide rates in prisons.

Regarding the prevalence of STIs, there is data available on syphilis: 1/200, or prevalence of 0.5% (in the beginning of 2018).

Access and policies vs practice in prisons

The situation differs greatly from one prison institution to another. There are eleven prison institutions in the country and the practices among them are very different. On one hand, they all report to have privacy policies and trained prison officials, but the Helsinki Committee of Human Rights in Skopje reported that in some institutions policies do not even exist and in some, they exist, but are not implemented.

From the answers of the prison officials to the requests for information of public interest (i.e. freedom of information applications) by Stronger Together, they expect support from the civil sector for HIV testing, and in four out of eleven institutions such support was available, for VCT for HIV, as well as educational sessions on HIV. A great barrier is confidentiality. Having in mind the stigma around HIV, it is a barrier for people to even ask for an HIV test, which will make them suspicious and in risk of stigmatization.

The prison institutions report that the convicted people can ask for testing in any

time during their stay in the institution and that the service is immediately made available to them.

Still the issues and barriers described in the previous section are identical for this situation as well.

In prisons there is access to condoms and OST, vaccinations against viral hepatitis are also accessible.

The treatment is theoretically available to all, but some irregularities occur from time to time, which show that people in need are in risk of not getting the treatment they need.

First issue here is the risk to lose the mandatory health insurance without which getting the treatment is problematic because of financial burden on the person. People in prisons are a group at risk because they are almost without financial means during their stay in prison. The obligation for calculation and payment of the contributions for health insurance for the people in prison is with the Directorate for execution of sanctions. Unfortunately, the latest findings of the Parliamentary Commission on the state with human rights in prisons³⁹ in the Republic of North Macedonia shows that the prisons have great financial losses and due to that fact they cannot pay the contributions for the health insurance for the convicted people.

Other issues in prisons

In two institutions where PLHIV are detained at the moment, they are detained together with others. Other nine institutions, when asked, answered they do not have PLHIV in their facilities, but if they would, they would have detained them together with others.

Unfortunately, the prison institution from Struga, answered that if they had detained

people living with HIV, with viral hepatitis or TB, they would have detained them separately from the other people in the institution, which is a grave and worrying fact.

In all eleven prisons in the country, hepatitis patients are detained together with others, except in prison Struga, which reported that they did not have this type of patients for a long time, but if they had, they would have detained them separately.

In all eleven prisons, TB patients are detained together with others, after the contagious phase passes, except in prison Struga, which reported that they did not have this type of patients for a long time, but they would detain them separately.

PLHIV are transported to their medical check-ups (at the University Clinic for Infectious Diseases and Febrile Conditions in Skopje), people with viral hepatitis or TB are also transported to specialists for their medical check-ups.

From the visits of the Helsinki Committee in Skopje, there was no record of non-binary and trans individuals who are detained in prisons. The present legislative framework does not provide appropriate treatment of trans people, including access to hormonal therapy.

HIV-specific trainings are generally available, but not taken up regularly by prison staff and it mainly depends on the will of the prison institutions.

The data gathered through requests for access to information of public character sent to all eleven prisons in the country, it could be concluded that in nine out of eleven prisons, there is a confidentiality policy, which is followed. However, the findings of the Helsinki Committee, who had their members to research on field, conclude that

a few prison institutions actually have confidentiality policies and the ones that have one do not follow the policies properly.

Services specially tailored for PLHIV are not available in the prisons. Some prisons report that have employed a psychologist within the institution, but the psychological support specifically tailored for the needs of PLHIV is only available at the Clinic for Infectious and Febrile Conditions and only during the time when patients are taken from the prison to the Clinic for a medical check-up.

In 2018, HERA – Health Education and Research Association Skopje visited 4 prisons and conducted 83 voluntary HIV-tests, including related counselling, among the people in the prisons. Beside this, condoms, lubricants, and educational materials were also provided.

So far, in 2019, the NGOs succeeded to cover only two prisons, the prison in Veles, where the HIV testing was conducted by HERA Skopje with the support of the Red Cross of North Macedonia and in Struga, where the testing was conducted by HERA Skopje with support of the NGO “Option” Ohrid.

The HIV testing is organized through the Program for the protection of the population against HIV infection (National HIV Program), which is funded as part of the budget of the Ministry of Health. HIV testing is delivered by 13 NGOs that participate as implementers of the National HIV Program. With the new Program for 2019, the funds budgeted for convicted people for educational sessions on HIV and HIV testing and counselling, were increased from 2,000€ to 3,000€.

Pre-trial detention statistics

In North Macedonia, the conditions in pre-trial detention do not differ from the ones in police custody. According to a reportage⁴⁰ of the Media Informative Agency in 2018, bad hygiene, substandard conditions, minimum medical care, are just part of the inhumane treatment of the people in pre-trial detention. Some of the detainees stated that it is better to be in prison than in pre-trial detention.

The circumstances with people in these conditions who are at the same time HIV, hepatitis, or TB patients are even worse. There is no data available on the size of population or prevalence.

Access and policies vs practice in pre-trial detention

The issues and barriers are the same as the one existing in the prisons. The conditions are just worse.

Other issues in pre-trial detention

The conditions of detention for PLHIV, hepatitis, and TB patients in pre-trial detention do not differ from the ones in prisons.

Centres for refugees and migrants statistics

There is no official number for the size of the population of people in centres for refugees and migrants.

In the period from June 2015 until March 2016, the police registered and issued a certificate for filing a request for asylum to 477.856 people⁴¹, but international organizations estimate the number of

refugees who passed the Balkan route up to 1 million.⁴²

There is no prevalence (or estimate prevalence) data available.

Access and policies vs practice in centres for refugees and migrants

There is opt in basis for testing upon arrival and during stay in centres for refugees and migrants and there is no testing policy upon release. Condoms are generally available at these centres and there is treatment available for HIV, viral hepatitis and TB.

Other issues in centres for refugees and migrants

There is no reported PLHIV (migrant/refugee) in the Clinic of infectious Diseases and Febrile Conditions in R.N. Macedonia, similar to people with viral hepatitis or TB.

According to legislation and by law, the PLHIV or people with viral hepatitis or TB (refugees and migrants) would have the right to treatment and care equally as if they were citizens of the country and free of charge. If there was a case, the patient would be transported to the Clinic, but there was no HIV case recorded.

Young people

There are three types of institutions, which can be considered as closed settings in the country, which are part of the penal system for underage youth. According to the law, young people are detained separately from adults until they reach 23 years of age.

Public institution for children's care with disciplinary-social problems and disturbed

behaviour, in Skopje is an institution with two facilities. In the first facility, children with disciplinary-social problems aged 7 to 18 years or until the moment of finishing high school, are taken care of. The children stay not longer than 3 years continuously in the facility. Passer-by children also stay in this facility, but no longer than 7 days. This facility also accommodates underage children who have received the measure "sending to centre for underage children" enacted by a court.

In the second facility of this institution, underage offenders are sent to stay. In both facilities, the institution is obliged to take care, educate, observe, diagnose, define corrective treatments for work, regularly communicate with the courts etc. In the facility, formal basic education for children from 10 to 18 years is organized. High school education is organized in appropriate educational institutions.

Educational-correctional institution for underage youth (at the moment functioning within the prison in the town of Ohrid) is an institution where young male people aged 14 – 23 are sent after being sentenced to the sanction referred to as "sending to educational-correctional institution" by a court. In 2016, the Ombudsman issued a report⁴³ on children's rights for the children staying in this institution and published the following conclusions. The children in the institution do not have access to regular

health care, instead of that a doctor is occasionally called from the city to come when they are available. There are no psychologists and pedagogues who would work with the children; although it is a legal obligation, the institution does not provide basic formal education for the children. The Ombudsman noted that the children have access to condoms, but the Ombudsman expresses concerns because it is suspected that sexual abuse is present among peers in the institution. In addition, no formal education regarding infectious diseases (including HIV and others) is available.

The Prison for underage youth in the town of Ohrid is an institution that accommodates young people (both male and female, but detained separately) aged 14 – 23, who are sentenced to sanction: "sending to prison for underage youth" by court.

The Ombudsman reported that there are a lot of complaints from the young people detained in the prison to the Ombudsman, mainly of the conditions of living which are sub-standard, but also about abuse from the prison officials.

As for the young migrants and refugees, they are kept together with adults in the refugee centers. There are some educational programs for the minors offered by NGOs, but not systematically and on very short term.

Spain

Country statistics

The population of the country was 46,658,447 in 2017.

The HIV prevalence in the country was 0.3% (2017); HBV prevalence was 0.6% (2017); HCV prevalence was 1.2% (2017) and TB prevalence was 0.009% (2017).

The estimated number of drug users was 286,629.

The prevalence of people who are suffering from mental illness was 0.6%.

The suicide rate was 7.89 per 100,000 habitants (2017).

The prevalence of STIs was 0.05% (2017)

Access in the general population

The general population has good access to all tools and methods of prevention and they have access to treatment of HIV, HBV, HCV, and TB.

Definition of closed setting – closed settings relevant in the national context

There is no nationally used definition of closed settings.

These settings include prisons; pre-trial detention; police custody (after arrest); centres for refugees and migrants and other facilities.

These include 1. National police stations and other custody facilities. 2. Spanish military police headquarters and other custody facilities. 3. Local police custody facilities and detainees deposits. 4. Autonomous police stations. 5. Jail in court buildings. 6. First aid and detention centres for migrants. (Local Police) 7. First aid and detention complementary installations for migrants. 8. Salas de inadmitidos y de solicitantes de asilo en puestos fronterizos (Rejected and asylum seekers halls at border crossing points) (Policía Nacional). 9. Detention centres for migrants 10. Prisons. 11. Social Integration Centres. 12. Penitentiary Psychiatric hospitals. 13. Health centres where people with mental illness are hospitalized involuntarily. 14. Repatriation services. (FRONTEX) 15. Transfer Services between detention centres for migrants. 16. Custody Hospital Units.

Difference of prevalence in closed settings vs general population

There is a significant difference between prevalence in the general population and people in prison. Women in penitentiary establishments are also much more vulnerable to HIV than the rest of the population. This is all due to issue of drug use and addiction that people bring into prison from the outside and the risk practices that they continue inside prisons, especially unprotected sex and drug use.

Although Spain has managed to reduce HIV cases in prisons in recent years (by more than 90%), the infection rate remains 'much higher' within prisons compared to the general population, which is currently at 0.3%. These results are not only due to the introduction of high-efficient ARV therapy for HIV (treatment as prevention), but also to the extensive development of harm reduction programs in Spain.

Funding for prevention and health interventions in closed settings

The penitentiary system is government funded and it depends on the Interior Ministry, and not on the health systems of each autonomous community. In two of the autonomous communities, Euskadi and Catalunya, which are having the best results, health in prisons depends on the health systems. The CIEs health system is private, contracted by the Interior Ministry.

Prison statistics

The size (or estimate size) of population was 50,461 in 2017.

The prevalence of HIV was 5.1% (2017); HBV was 2.6% (0.23–4.9); HCV was 16.7% (2017); and TB was 0.09% (2017)

There is no data on prevalence of mental illnesses in prisons, the suicide rate was 5.7% per 10.000 (2017).

There is no data on prevalence of STIs.

Access and policies vs practice in prisons

The shortage of sanitary personnel in Spanish prisons prevents the periodic repetition of the Mantoux.

The lack of health professionals in state prisons also prevents recurring testing and screening programmes.

The reality of the Spanish penitentiary system makes it difficult to know when and if the inmate is going to be released or removed from prison.

There is treatment available for HIV, HBV, HCV, and TB in prisons.

Condoms are freely available while femidoms have very limited availability and lubricants are not available or very limited. PrEP is not yet available in prisons; there is no clear information about its realization. However, PEP is available.

When it comes to harm reduction for people who use drugs, NSPs are available in theory but in practice they are not available in all prisons), but there is OST and Naloxone are available for all who need it.

Vaccination for HAV and HBV are available but there are some practical barriers due to shortage of medical staff in prisons. Disinfectants are also available in theory.

NGOs provide information leaflets for inmates.

There are programmes for drug users in most prisons.

Other issues in prisons

PLHIV and viral hepatitis patients are detained together with other inmates. TB patients are only separated if the medical services consider they can be contagious and only until this possibility is dismissed.

There are four care systems: PLHIV and hepatitis or TB patients are transported to the hospital; or the specialist visits the

prison; or the prison's doctor is a specialist; or they use telemedicine services.

Trans individuals can access hormonal therapy if prescribed. There are cases of punishment consisting in denying the access to HT.

Training on HIV is available for prison staff but the lack of doctors and funds destined to these kind of programs implies it is not covered.

Policies to ensure confidentiality are in place but in practice, confidentiality in prison still leaves much to be desired.

Peer support and consultation with nutrition specialists are available in some establishments but psychological support is only available through NGOs.

Health education training, health mediators, support programs for ex-convicts, therapeutic accompaniment for ex-convicts and leisure and free time activities are available for all prisoners.

Special problems are found in the management of associated comorbidities, especially hepatitis C and mental health.

There are recurrent problems with the transport of inmates to hospitals or other specialist medical consultations, they often miss doctor's appointments. This is due to lack of coordination and/or resources.

Centres for refugees and migrants statistics

The size of population in centres for refugees and migrants were 7,855 (2018) and 8,814 (2017).

There is no data available on prevalence of communicable diseases or mental health issues, including suicide in these centres.

Access in centres for refugees and migrants and policies vs practice in centres for refugees and migrants

Although it is mandatory for the private health system contracted out by the Interior Ministry to propose measures to prevent epidemics, this is hardly ever done. These measures require a proposal to the Director and the proposal had to be decided by the Coordination Board.

There is not a mandatory policy for testing or screening, although the Ombudsperson and the Control Courts insist on requiring the systematic practice of screening tests of possible infectious diseases at the time of entry into this centres (CIE).

According to information from NGOs who are able to access these centres, there are not any prevention services.

Other issues in centres for refugees and migrants

PLHIV, viral hepatitis patients, and TB patients are together with other people in these centres.

There are no specialists visiting the centres. Any proposal for the inmate to visit a specialist had to be raised to the centre's director by the centre's doctor, or, if present, by the NGO doctor to both and, in case of being ignored, to the Control Court.

The policy is that trans persons can decide where to stay. If there was a women's facility they could decide to go there. However, there are bullying and discriminatory attitudes between the inmates so they would probably hide their condition. The centres do not provide hormonal therapy.

The policy is to follow the European legislation about protection of medical data. Confidentiality is not followed in practice due to the absence of interpreters. Malpractice about storage of medical information has been reported.

NGOs are not able to offer or ensure any regular services. They are only allowed to access the centres occasionally and arbitrarily.

There is no testing, diagnosis and therefore there is no treatment for these communicable diseases in the CIES. There can be cases in which a doctor from an NGO will go to the centre and present the situation to the Control Judge who will be the one to make the final decision about the treatment.

In other cases, there is information that people bring their own treatment or try to get it from their visitor. An HIV case has been reported in which the NGO doctor talked directly with the centre's doctor, who arranged the treatment for the person living with HIV in the centre. Any proposal for therapy made by the centre's doctor had to be raised to the centre's director.

Health care in these centres is very limited. NGOs are concerned about the deficiencies of health care provided in the CIE, outsourced by the Ministry of Interior to the private company Clínica Madrid. In these centres there is no chance personalized medical attention. Based on information obtained from NGOs, the private health services hardly ever do anything but a very superficial initial medical examination and supply painkillers and anxiolytics or sedative drugs. There is no other psychological or psychiatric attention for regardless the large

number of people in these centres who suffered episodes of anxiety or insomnia derived from transit and their personal situation.

In most cases the lack of response to situations of health that place inmates in a particularly vulnerable situation is the responsibility of the CIEs directors, and not of the centre's doctors.

NGOs try to attend people with diseases or injuries whose treatment exceeds the possibilities of the medical services of the CIE. Sometimes medical reports are not provided to the people in the centres. There are cases in which there are minors in these centres, due to the difficulties in establishing a protocol to determine their age. There are centres in which the right to privacy of the inmates is not preserved either in the showers or in the toilets.

Young people

Closed settings for young people in Spain include detention facilities for young offenders (closed centres, open-prison or semi-open; therapeutic treatment centres; police units: detention centres of the State and the Autonomous Community; police detention centres at border crossings, for the detention of persons of migrant origin: asylum seekers, migrants in an irregular situation; and protection and guardianship centres for unaccompanied foreign minors.

Young people are from 14 to 18 years old, with exceptional decision of the judge, can be raised up to 20 years, based on the personal circumstances and the degree of maturity of the author, and the nature and severity of the facts.

Ukraine

Country statistics

As of January 1, 2018, the population of Ukraine, excluding the temporarily occupied territory and the Autonomous Republic of Crimea and the city of Sevastopol, was 42,386,403 people.

There were 142,061 PLHIV looked after in health care facilities in Ukraine (335 per 100,000 population) (January 1, 2019).

1,449 acute HBV were reported (3.4 per 100,000 population according to the official response to request for public information) (January 1, 2019).

32,018 cases of HCV (123.7 per 100,000 population) were recorded as of January 1, of 2019; in 2019 477 acute HCV cases were reported.

As of January 1, 2019, 31,221 cases of TB were reported (73 per 100,000 population according to the official response to request for public information) (January 1, 2019).

There were 39,724 persons with mental and behavioural disorders as a result of opioid use being monitored according to the official response to request for public information (January 1, 2019).

The prevalence of people who are suffering of mental illness and suicide rate was 614 per 100 000 population (January 1, 2017).

According to the official response to request for public information as of January 1, 2019 in Ukraine there were 19,902 cases of dermatophytosis, trichophytosis, microsporia; 40,831 cases of mycosis, 7,438 cases of scabies.

Access in the general population

The general population has access to most prevention methods and tools, including educational training in schools and promotion of HIV testing. Condoms, femidoms, and lubricants are generally available. There is access to PrEP and PEP. For people who use drugs, there are NSP and OST programmes and Naloxone is available.

There is access to vaccination for viral hepatitis and disinfectants (e.g. for hands, tattoos and piercings) are also accessible.

Treatment for HIV, HBV, HCV, and TB are available and accessible to the general population.

Definition of closed setting – closed settings relevant in the national context

In Ukraine the definition of OPCAT (Optional Protocol to the Convention Against Torture) is used for closed settings.

Closed settings include prisons, pre-trial detention, police custody (after arrest); and centres for refugees and migrants.

Difference of prevalence in closed settings vs general population

Penitentiary institutions (correctional colonies, pre-trial detentions) are the places with high prevalence of HIV, TB, and viral hepatitis.

The incidence of HIV among prisoners is 20 times higher than among the general population, and the prevalence of AIDS among people in prison is four times more frequent. There are several reasons for this higher prevalence. State policy that promotes the concentration of injecting drug users in penitentiary facilities. They are a vulnerable group for these diseases. There are territorial limitations and the accumulation of large numbers of people in penitentiary institutions contribute to the spread of infectious diseases. Behaviour of people in prisons that increases the risk of contracting HIV, viral hepatitis: single-needle drug use, unprotected sex, tattoos, unhealthy lifestyles. In addition, when serving a sentence, the person has the opportunity to learn about their health.

Almost 90% of prisoners are tested for HIV today. There is no such coverage in the general population, so some of the metrics may be related to this. In other closed settings, the incidence of HIV, TB, and viral hepatitis is approximately the same as in the general population.

Funding for prevention and health interventions in closed settings

Migrant Centres are managed and funded by the State Migration Service of Ukraine, in cooperation with the Ministry of Health of Ukraine: joint orders, regulations comply with the general medical standards.

Police custodies are managed and funded by the Ministry of Internal Affairs of Ukraine.

As a rule, individuals are referred for treatment to public healthcare facilities; they are called an ambulance if necessary. They are regulated based on the provision of general medical care.

Penitentiary facilities (correctional colonies and pre-trial detention) are managed and funded by the Ministry of Justice of Ukraine. Within the structure of the Ministry of Justice there is the Public Institution 'Health care centre of the State Criminal-Executive Service.' It is a budget non-profit health care institution, created to fulfil the tasks of the prison service to provide quality medical services to prisoners and persons taken into pre-trial centres. Thus, as of January 2018, a new "demilitarized" vertical of providing medical assistance to convicts and prisoners have started operating.

132 medical units provide medical care in the pre-trial detention centres and correctional colonies, including 31 medical units in pre-trial detention; 3 medical units in juvenile correctional colonies; 17 hospitals (including 7 tuberculosis; 9 multidisciplinary; one health care facility for disabled people); one medical institution of psychiatric profile; 2 orphanages. The rest are medical units in the correctional colonies.

The Public Institution 'Health care centre of the State Criminal-Executive Service' cooperates with the general health care system in the following areas. The Ministry of Health of Ukraine grants a license to provide medical care to the units; the basics of general medical legislation should be reflected in the normative legal acts of the Ministry of Justice of Ukraine; there are common legal acts, for example, on the continuity of treatment of HIV, TB. In practice, although the interaction within the structural organs is well established, however, a person may be lost and interrupt treatment after release.

Prison statistics

The size (or estimate size) of population of persons in penitentiary facilities was 54,186 (pre-trial detention – 19,584, correctional colonies, arrested houses, 34,488)

The prevalence (or estimate prevalence) of HIV as of January 1, 2019, was 3,860 cases. There is no data for viral hepatitis in the institutions.

The prevalence (or estimate prevalence) of TB as of January 1, 2018, was 1,284 cases. There is no data available for mental health illnesses.

There is no data available for STIs.

Access in prisons

In prisons there is access to condoms; femidoms; lubricants; PrEP and PEP; OST; and information leaflets, promoting testing. Treatment for HIV and TB are also available in prison settings.

Policies vs practice in prisons

HIV testing in correctional colonies is provided to newcomers in the first days with their consent. For this, they conduct a preliminary conversation, which is often formal. However, every person has the opportunity to get tested for HIV.

The lack of testing for viral hepatitis is a significant problem today - but the State started to provide such a service from 2019. So finally, now testing is possible not only at the expense of non-governmental organizations but also by state funding.

Tuberculosis testing is mandatory, usually fluorography or sputum analysis: the high level of TB patients in the past has led to mandatory testing for this disease.

The policy determines that the convicted person undergoes a medical examination every year, within which they are tested for TB. They may optionally undergo HIV testing. If there are rapid tests for viral hepatitis, then they will be offered as well.

In early 2019, the Ministry of Justice of Ukraine purchased 60,000 rapid tests to determine viral hepatitis. Testing of prisoners is currently ongoing to determine the incidence rate. The sentenced person may also seek medical assistance or be willing to take an HIV test within the period of their sentence.

Before the release the person undergoes a medical examination that includes mandatory testing for TB and optional testing for HIV. Screening for viral hepatitis is not provided.

Problems with the practice include formality, the conscientiousness of the proper specialists, lack of motivation for testing and treatment. Currently, 360 people diagnosed with HIV voluntarily refuse antiretroviral therapy in penitentiary facilities.

Other issues in prisons

PLHIV and hepatitis patients are detained together with others.

TB patients detained separately, after the detection of TB, are kept isolated in medical units and then sent to specialized correctional colonies for serving their sentence and receiving specialized treatment.

If rapid tests are available, then testing for HIV and viral hepatitis is performed by the medical staff of the prison. Treatment and care for HIV is received from an HIV-specialist. Treatment and care for hepatitis is not provided in prisons at all, but changes are expected in this regard as well.

As a rule, the physicians work in the medical unit of the prison, so TB testing is conducted in prison. If there is no doctor in accordance with a joint order of the Ministry of Justice and the Ministry of Health, the appropriate specialist comes to the prison.

As a general rule, staff training is not provided. However, trainings and seminars are conducted with the assistance of NGOs as well as in-service training courses. Staff provided with methodological information regarding HIV, TB, and viral hepatitis.

Only in 2016, the Penitentiary Code of Ukraine received a norm that to some extent regulated the issue of medical information. Part 6 of Art. 116 of the Penitentiary Code of Ukraine establishes that for the disclosure of medical secrecy, medical professionals and other persons of the penitentiary institution shall bear civil, administrative, or criminal liability in accordance with the law. Only medical staff may be present during the medical examination, except when the doctor considers that exceptional circumstances exist, or when the doctor asks the staff of the penitentiary to be present for security reasons or when the sentenced person requests it.

HIV testing results are confidential and considered medical secret; information about the results of the examinations can only be provided to legal representatives of health care institutions, investigations, inquiries, and courts. Documents containing information about the health of the convicted person and the medical care they provide must be kept in a manner that

guarantees the confidentiality of that information, medical examinations of prisoners are conducted out of the hearing and (if the health worker does not want the other in each case) out of sight of non-medical staff. However, there are cases of such disclosure due to human factors or the inability to provide confidentiality. These incidents are not systemic, although most of all prisoners and staff know who is ill with HIV.

The state guarantees a basic set of services for HIV: testing, treatment, counselling, and psychological counselling. Sometimes the services may be poorly provided or absent. Testing for viral hepatitis for the state fund began only in 2019. However, the cost of treating patients with hepatitis is only covered for those infected with HIV.

The state guarantees a basic set of services for TB: testing, treatment, counselling, and psychological counselling. Sometimes the services may be poorly provided or absent. Today, with the financial support of non-governmental organizations, HIV testing, purchase of ART therapy, training, condoms, lubricants and other means; social support after release, legal and psychological assistance are available.

All types of testing and treatment for viral hepatitis occur at the expense of non-governmental organizations in correctional colonies. Non-governmental assistance is not systematic and covers individual regions involved in the projects - so they cannot replace government policy in this direction. There is already a European Court of Justice ruling⁴⁴ on the absence of viral hepatitis C testing in the evaporation colony.

Non-governmental organizations provide TB prevention, diagnostics, medicines, educational activities, and psychological and legal assistance. In addition to providing medicines, training medical

professionals, advising on treatment regimens, protecting the rights of convicts, providing legal and psychological assistance.

For the last three years, penitentiary medicine has been in a state of reform. As a result, convicts received unsatisfactory services or not receiving them at all. In the previous three years, many disorders have been identified, such as interruption of HIV and TB treatment, inadequate diagnosis, lack of medication, and lack of staff. All of this has an impact on the high incidence of socially dangerous diseases among convicts. To date, there are decisions of the European Court of Justice on this⁴⁵.

Pre-trial detention statistics

As of July 1, 2019, the total number of persons in penitentiary facilities is - 54 186 (pre-trial detention – 19 584, correctional colonies, arrested houses – 34 488).

As of January 1, 2019, 3,860 PLHIV were in pre-trial detention.

There is no data available for other communicable disease or mental health issues.

Access in pre-trial detention

In Ukraine, people in pre-trial detention have access to condoms, femidoms, lubricants, PrEP and PEP, OST and information leaflets, posters. They also access treatment for HIV and TB.

Policies vs practice in pre-trial detention
Conditions for pre-trial detentions and correctional colonies (prisons) are under the direction of the Ministry of Justice of Ukraine.

In the pre-trial detention, testing may be conducted in two cases: once a year during

the preventive medical examination for all, as well as in the case of a convicted person lodging a health complaint to the doctor of the pre-trial detention centre or the administration of the pre-trial detention centre.

The main problem in pre-trial detention are poor detention conditions: absence of the medical units of the pre-trial detention centre a license to conduct medical practice; inconsistent facilities for medical examinations of international standards and legislative requirements Ukraine. These issues in closed settings were outlined in the 2018 Ombudsman's report⁴⁶.

All persons who are released from jail, pass a medical examination of the conduct of examination fluorography (those in transit when the x-ray was carried out over 12 months ago). At the end of the examination, a conclusion is made regarding the health status of each outgoing person who is entered in the medical record of the outpatient. The examining medical officer signs their signature on an open personal identification file of the person leaving the remand prison.

Patients in the acute stage of a disease, patients with infectious and sexually transmitted diseases, affected by pediculosis, scabies, who have not passed the established course of treatment are not allowed to transportation. An exception is patients with active tuberculosis and sexually transmitted diseases, whose sentences have become valid. Such patients are referred for treatment to specialized hospitals of DPTs in isolation. Transport of persons with tuberculosis to medical establishments, courts, for carrying out investigative actions is carried out by specialized transport with observance of sanitary and hygienic norms.

Other issues in pre-trial detention

PLHIV and hepatitis patients are detained together with others.

TB patients detained separately, after the detection of TB, are kept isolated in medical units and then sent to specialized correctional colonies further serving punishment and specialized treatment.

Pre-trial detention centres provide the position of an infectious disease physician who consults, prescribes treatment. In the absence of such a doctor, testing may be performed by a therapist or paramedic or the doctor may come from local hospitals. Rapid tests for hepatitis conducted regular medical staff.

The training of workers is the same as that of correctional colonies.

In the beginning of 2017, medical examinations (surveys) of persons taken into custody are conducted outside the hearing and (unless the health care provider wishes otherwise on a case-by-case basis) outside the visibility of non-medical personnel. Sometimes this rule is broken due to the absence of specially equipped medical offices.

People in police custody statistics

As of January 1, 2018, there were 149 places of police custody (in Ukraine - temporary detention facilities), which held 81,908 persons during 2017.

According to a response to a request for public information from the National Police of Ukraine, people are not tested for HIV or other communicable diseases when they get to a temporary detention centre, and statistics on the prevalence of HIV are not maintained.

Access for people in police custody

In police custody there is access to OST programmes and HIV treatment.

Policies vs practice for people in police custody statistics

A temporary detention facility provides for short-term detention (this explains the large number of people per year compared to the smaller number of places). The longest term of confinement is an administrative arrest of 15 days. Two hundred fifty-two individuals completed this type of administrative charge in 2018.

There are no medical units in the temporary detention centres and no medical staff. Persons undergo a primary medical examination at the health care facilities of the Ministry of Health of Ukraine before being delivered to the temporary detention facility.

Persons, placed in a temporary detention facility, are interviewed by the person responsible for the detention, of their health status, examined for the presence of pediculosis or scabies. If such a person complains of poor health or has symptoms of a disease, an officer is obliged to call an ambulance team immediately.

Persons who are coughing should be screened for the probability of tuberculosis disease by conduction sputum smear microscopy. If according to the conclusion of the ambulance crew the ambulance and according to the opinion of a medical officer of the ambulance team, the person requires inpatient treatment, they are sent under guard to the appropriate institution of local health authorities.

It is not allowed to hold patients with mental and infectious diseases in a temporary detention facility.

The law does not provide for testing and treatment in a temporary detention facility.

Other issues for people in police custody

PLHIV detained together with others, there is no information on individuals with viral hepatitis.

TB patients are not detained in police custody. If TB was detected during the stay, the persons are isolated and sent to the nearest hospital.

Non-governmental organizations provide ongoing training for police officers⁴⁷.

Non-governmental organizations also provide legal assistance and legal advice services, and provide guidance on the rights of prisoners. They control the legality of the actions of police representatives.

The regulations only provide for substitution therapy and antiretroviral therapy for persons who received such services before being admitted to the police custody. Each detainee is legally entitled to receive free ART therapy and must notify the need on time during the registration of another temporary detention facility. The officer in charge must make a journal entry and inform the management of the isolation ward and the nearest medical institution of the need to consult an infectious disease physician.

When transferring a detainee to another facility, management should inform them of the need for treatment and, if released, notify the nearest healthcare facility. The law obliges regular isolation workers to inform management and the nearest

healthcare facility about the need for therapy latest within 3 hours.

Before going to the detainee, the narcologist examines where by whom and when substitution therapy was prescribed, what drug and at what dosage and when they were last received by the detainee. In its turn, the detention centre is obliged, upon the appointment of a narcologist, to transport the detainee to receive substitute supportive therapy or to carry out detoxification to a nearby medical facility.

Centres for refugees and migrants statistics

In Ukraine, there are 3 points of temporary residence of foreigners and stateless persons (the statutory limit is 469, the number of persons in 2018 was 1,281) and 3 refugee temporary accommodation points (normative limit is 421 persons, number of persons staying in 2018 was 262).

In response to formal request for public information, the State Migration Service stated that as of 01.01.2019, there were no HIV patients, tuberculosis, hepatitis C, hepatitis B, or people with drug addiction among the persons accommodated in the facilities of the State Migration Service.

Access in centres for refugees and migrants and policies vs practice in centres for refugees and migrants

Persons who are in refugee centres have the opportunity to apply to health facilities outside to conduct testing for HIV, tuberculosis, hepatitis C, and B.

Persons who are in points of temporary residence of foreigners and stateless persons undergo a primary medical

examination to identify who pose an epidemic threat to the environment or require immediate medical attention. Points of temporary residence of foreigners and stateless persons may refuse to accommodate foreigners and stateless persons when they find infectious diseases that are incompatible with their stay with others. Fluorography examination performed at health care facilities to prevent the spreading of tuberculosis. Testing for HIV conducts with the consent of a foreigner or a stateless person. If necessary, additional laboratory tests, which cannot be carried out at the PTPI health centre, should be performed at health facilities. PTI, drugs provide the provision of medicines and medical products to foreigners and stateless persons, and pharmaceutical products can be purchased by non-governmental organizations and at the patient's expense with his consent.

When a person located in a refugee centre is detected with a disease, including communicable diseases, they are provided by a health care worker to a health centre and transported to a health care facility if necessary by an emergency (ambulance) medical team. If necessary, additional laboratory tests, which cannot be carried out at the health centre of the foreigners' centres, should be performed in a healthcare facility.

According to the procedure of interaction, in case of detection in persons who are in refugee centre, symptoms requiring mandatory examination for tuberculosis according to the results of clinical screening (productive cough with secretion of sputum lasting more than 2 weeks, weight loss, increase body temperature, sweating at night, haemoptysis, chest pain), arrange delivery to health facilities.

Other issues in centres for refugees and migrants

PLHIV can be housed with other people if they do not need special medical care. If a person is ill with infectious disease and needs inpatient treatment, then they will stay in health care facilities.

Persons with TB are not placed in detention centres for foreigners and refugees. According to the procedure of interaction, in case of detection in persons who are in PTRB or PTPI, symptoms requiring mandatory examination for tuberculosis according to the results of clinical screening (productive cough with secretion of sputum lasting more than 2 weeks, weight loss, increase body temperature, sweating at night, haemoptysis, chest pain), arrange delivery to health facilities.

PLHIV and people with viral hepatitis are transported to medical facilities for their necessary check-ups. TB patients are not held in refugee centres

NGOs offer legal support and can arrange purchase of treatment for people in refugee centres.

Refugees accommodated in specialized centres for up to 6 months. In Ukraine, the number of asylum seekers who are held in temporary centres is relatively small but is still increasing from year to year.

According to law, the right of refugees to health care and treatment at the expense of the state is enshrined. The new state medical reform has negative consequences for asylum seekers. Although only Ukrainian citizens and recognized refugees have the right to free medical care in Ukraine, the new medical reform deprives asylum seekers of the right to any free medical services, including emergency care and primary care, which is a cause for grave concern. UNHCR

and partners are pushing for the Department of Health to review changes to a health law that deprives asylum seekers of free basic care.

Young people

Young people are detained in juvenile correctional colonies; centres for refugee and migrant youth; and other institutions such as orphanages, boarding schools for orphans, and children deprived of parental care, centres for social rehabilitation of disabled children, centres for social and psychological rehabilitation.

Minors in Ukraine are considered under 18 years of age.

As of July 1, 2018, there were 106,700 children in boarding schools in Ukraine.

As of July 1, 2019, there are 114 people in 2 juvenile colonies HIV testing for persons 14 years of age and older conduct voluntarily, with the informed consent of the individual, obtained after giving her prior advice on features of testing, its results and possible consequences, compliance with the privacy

requirements of personal data that is the number of data on a person's health.

Testing children under 14 is conducted on the request of their parents or legal representatives and with informed consent. Parents and legal representatives have the right to be present during such testing, get to know its results, and are obliged to ensure the confidentiality of the data on the HIV status of the persons whose interests they represent.

In the juvenile correctional colonies, a preventive examination is carried out twice a year. According to the results of the full medical review, the medical unit physician recruits minors who, for health reasons, require wellness regimen, medical supervision, and enhanced nutrition, into wellness groups, which are created at inpatient medical units.

Non-governmental organizations pay special attention to minors in closed institutions and, as a rule, such minors fully provided with the diagnosis and treatment of socially dangerous diseases. Basic statistics on the stay of children in closed settings is provided in a report⁴⁸.

United Kingdom

Country statistics

The population of the country is 67,666,301. In 2018 the HIV prevalence was 103,800; the HBV prevalence was estimated at 180,000 chronic stage and 0.68 per 100,000 acute (2018). The HCV prevalence in the country was 143,000 and TB prevalence (for England only) was 8.3 per 100,000.

In 2018, 9.4% of adults between the age of 16-59 reported taking drugs in England and Wales; 37% of people in drug treatment services had injected (2018)

There were 11.2 deaths per 100,000 people (2018) by suicide. The prevalence of mental illness due to variability in definitions is difficult to estimate.

In 2018, there were 447,694 diagnoses of sexually transmitted infections (STIs) made in England.

Access in the general population

In the general population there is theoretical access to prevention services, methods and tools, but in practice service availability is limited.

Treatment is available for HIV, HBV, HCV, and TB.

Definition of closed setting – closed settings relevant in the national context

There is no definition for closed settings in the UK but they include prisons; pre-trial detention; police custody (after arrest); immigration detention centres where migrants are detained prior to deportation; and other settings including secure facilities for children and young people, and police and court Liaison and Diversion services

Difference of prevalence in closed settings vs general population

The estimated prevalence of HIV and other blood borne viruses (BBVs) is higher in closed settings as there is higher prevalence of other linked behaviours, particularly injecting drug use.

Funding for prevention and health interventions in closed settings

In England, NHS England Health and Justice is responsible for commissioning healthcare for children, young people and adults across secure and detained settings, which includes prisons, secure facilities for children and young people, police and court Liaison and Diversion services and immigration removal centres. It is also responsible for sexual abuse/assault services.

The Health and Justice services are commissioned via 10 Health and Justice teams across 4 regions (North, Midlands, London and South). Central Government (Department for Health and Social Care) funds NHS England.

In Wales, Local Health Boards (LHBs) commission healthcare services in public sector prisons (including clinical drug treatment services), and are responsible for commissioning mainstream healthcare services which offenders in the community will access.

In Scotland, the responsibility for healthcare in the Scottish Prison Service (SPS) sits with local health boards. The commissioning guidelines place responsibility for healthcare costs on the health board of residence, not the situation of the prison. For the first six months of their custodial sentence, prisoners are considered to be resident in the area where they were ordinarily resident before they were sentenced, or the area in which the offence was committed if their ordinary residence cannot be determined. After a period of six months following conviction, a person held in prison is to be treated as ordinarily resident at the place where that person is held.

In Northern Ireland, Prisoner Health Services are delivered within the three prison establishments of Maghaberry, Hydebank Wood College, and Magilligan and are managed by the South Eastern Health and Social Care Trust, which is the local HSCB (Health and Social Care Board).

People in prison across the UK are entitled to the same level of healthcare as those in the community. This is called 'equivalence of care'.

Prison statistics

The size of prison population was 83,430 in England and Wales (end of May 2018); 7,595 in Scotland (end of June 2018); and 1,475 in Northern Ireland (end of March 2018).

In the most recent estimates, approximately 1% of women and 0.3% of men in prison were living with HIV, but it is not clear when these estimates are from (they are from before 2017).

There are no official estimates for HBV prevalence; however, there are indicators that it is higher than among the general population.

13% of women prisoners and 7% of men are estimated to have HCV in prisons (pre 2017).

There are no official estimates of TB in prisons but it is considered to be higher than in the general population.

The prevalence of mental illness is unknown; there are indicators that it is higher than among the general population. The suicide rate was 1.1 per 1,000 prisoners in 2018. Suicide accounted for 92 of 325 deaths.

The prevalence of STIs is unknown in prisons.

Access and policies vs practice in prisons

Hepatitis vaccinations, information on BBVs and HIV, and prevention measures such as condoms and lubricants, Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis, and needle and syringe exchange, opioid

substitution therapy and Naloxone are theoretically available, but in practice access is limited and highly variable between prisons.

BBV testing is supposed to be opt-out but in reality some prisons are better than others at implementing this policy. 34% of new arrivals in prison were tested for HIV in 2018. Rates of take up from BBV testing indicate that it is in fact opt-in in a lot of prisons and some have not implemented the policy fully at all. There are pressures on time but also communications - i.e. actually asking people to opt-in.

Access to healthcare should be equivalent to in the community but in reality we know that people struggle to access sexual health services and testing. There is not always clear information on how to access testing. Health checks and wider healthcare support is often inadequate.

Other issues in prisons

PLHIV, people with viral hepatitis and TB patients are detained together with the other detainees.

There is mixed practice whether HIV, viral hepatitis and TB specialists visit patients in the prison or whether they are transported to the specialist clinic or offices. The necessary transportation usually takes place, but not always.

Trans people can access hormonal therapy in theory but NAT (National AIDS Trust) is aware of issues with access in prisons.

Training for prison staff happens on an ad hoc basis, and rarely rather than regularly.

Medical information should always be confidential; however, there can be issues with prison staff sharing information if they learn about someone's status.

Other services for PLHIV are rarely available, and usually only if the specialist HIV clinic is able to provide them. Other services for patients with viral hepatitis or TB depend on the institution but are usually low level and not comprehensive.

Some of these services are sometimes provided by NGOs but also on a very ad hoc basis.

Pre-trial detention statistics

The pre-trial population was 9145 in June 2019. People are detained prior to their trials in the same facilities as those who have been sentenced. The data for those in pre-trial detention cannot be separated from that for prisons. Therefore, the following data is for the entire prison population, not just for those in pre-trial detention. In most recent estimates, approximately 1% of women and 0.3% of men in prison were diagnosed with HIV, but it is not clear when these data were collected (pre 2017). The prevalence of HBV is unknown, but there are indicators that it is much higher than among the general population. The prevalence of HCV is 13% of women prisoners and 7% of men (pre 2017 estimates). TB prevalence is unknown, but there are indicators that it is higher than among the general population.

The prevalence of mental illness is unknown. The suicide rate is 1.1 per 1,000 prisoners in 2018. The prevalence of STIs is unknown.

Access and policies vs practice in pre-trial detention

PLHIV, patients with viral hepatitis and TB are held together with the general prison population, therefore the information below describes prisons in general, rather than pre-trial detention specifically.

There is access to prevention tools and methods in theory, but in reality, there is limited access or none at all.

Treatment services for HIV, HBV, HCV, and TB are available.

BBV testing is supposed to be opt-out but in reality, some prisons are better than others at implementing this policy. Rates of take up indicated that it is in fact opt-in in a lot of prisons and some have not implemented the policy fully at all. There are pressures on time but also communications - i.e. actually asking people to opt-in. Some prisons are better than others at implementation of the opt-out policy.

Other issues in pre-trial detention

For specialist check-ups, people held in prisons are usually transported to the relevant specialist clinics.

NGOs are present in some of the facilities but they do not provide a standardised service, rather provision is on an ad hoc basis.

People in police custody statistics

There is no data available on police custody.

Access and policies vs practice for people in police custody

Treatment is available but there are no policies for testing and screening activities in police custody.

Testing tends only to be considered in police custody following incidents where there are concerns for officer safety. A law was considered to allow forced testing in these circumstances, which NAT successfully challenged.

If someone says, they need access to medication then the police should help them to access it but in reality, NAT is aware that people often go without while in custody. There are some better-informed custody nurses but experiences are very mixed.

Other issues for people in police custody

PLHIV, patients with viral hepatitis and TB are held together with other detained people.

In general, people can only be held in police custody for 24 hours. This is not long enough to be visited by specialists or to be transported to a specialist facility for their HIV, viral hepatitis or TB care and treatment. NGOs are present in some of the facilities but it is not a standardised service they provide, rather on an ad hoc basis.

Centres for refugees and migrants statistics

People who are subject to immigration controls can be held in immigration removal centres (IRCs) prior to deportation. There are no detention centres for those who have successfully claimed refugee status, but some people who have been detained may make an asylum claim. The size of the IRC population was 2,226 as at the end of June 2018; over the course of 2018, 27,348 entered these facilities.

Prevalence of communicable diseases or mental illnesses in IRCs is unknown.

36% of deaths in immigration detention were the result of suicide for the period of 2010-2015.

Access and policies vs practice in centres for refugees and migrants

In theory, the 'equivalence of care' principle extends to immigration detention. Therefore, anyone detained in an IRC should receive the same standard of care that is available to the general community.

Prevention tools and methods are theoretically available, but they are not commonly or universally available.

There is access to treatment. However, there are barriers to healthcare for individuals in immigration detention. Everyone should be able to access testing in immigration removal centres but in reality, there are many barriers in access to healthcare for people in IRCs

Other issues in centres for refugees and migrants

PLHIV, patients with viral hepatitis and TB are held together with other people in the centres.

For specialist check-ups, they are usually transported to the relevant specialist clinics, but there is good evidence that people miss appointments because of transport being unavailable

NGOs are present in some of the facilities but they do not provide a standardised service, rather their service provision is on an ad hoc basis and will vary.

Young people

Closed settings for young people include youth prison and correction (training) centres for young offenders in the UK.

The policy around opt-out BBV testing does not apply to youth detention settings. Young people in detained settings should have access to equivalence of care and should have condoms and other prevention tools made available. This is likely to vary between settings.

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