

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.

Femdoms 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.