

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

Authors: Cristina Fernández Bessa, Gemma Nicolás Lazo and Gerard Viader Sauret

**Mapping Report -
Catalonia (Spain)**



Report by

**OSPDH - Observatory of the Penal System and
Human Rights (University of Barcelona)**

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

Mapping Report Catalonia (Spain)

Cristina Fernández Bessa, Gemma Nicolás Lazo and Gerard Viader Sauret

© 2015 OSPDH- Observatori del Sistema Penal i els Drets Humans (Universitat de Barcelona)

Editor: Jeff Marks
Designer: Mark Joyce

Published by
OSPDH - Observatori del Sistema Penal i els Drets Humans (Universitat de Barcelona)
Av. Diagonal 684
08034-Barcelona



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



This project is co-funded by the European Union under the Criminal Justice Programme. The contents of this publication are the sole responsibility of the authors and can in no way be taken to reflect the views of the European Commission.



CONTENTS

I.	Introduction	7
	1. Background and justification	7
	2. About this report	7
	3. Methodology and methodological challenges	8
II.	National context	9
	1. Overall political context	9
	2. Economic context	11
	3. Health context	13
	4. Criminal Justice and prison context	19
	Relevant legal frameworks	19
	Prison system	20
III.	HIV, HCV and TB in prisons	24
	1. Legal and policy context	24
	2. Data and analysis of data	27
	3. Harm reduction policies and services in prison	37
IV.	Human Rights Monitoring in prison and HIV, HCV, TB	39
	1. Prisoners health: legal and policy frameworks	39
	2. Human Rights Monitoring Mechanisms	42
	National monitoring mechanisms	42
	Regional/International monitoring mechanisms	46
V.	Conclusions and recommendations	48
	References	51
	Abbreviations list	52
	Annexes	53



I. INTRODUCTION

1. Background and justification

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

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

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

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

2. About this report

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

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

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

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

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

The current report, written by Gemma Nicolás Lazo, Cristina Fernández Bessa and Gerard Viader presents the mapping situation in Catalonia (Spain).

3. Methodology and methodological challenges

This report is based on an extant desk research and some field work.

The desk research comprised the following data:

- The Spanish and Catalan laws and other regulation on prisons, health and monitoring systems.
- Secondary data on imprisonment rates, health and social index, etc.
- Scientific journals on the field.

The national experts interviewed were:

- Dr. Andrés Marco: Penitentiary doctor. Responsible of the VIH and Hepatitis programmes of Male's Prisons of Barcelona (La Model). Coordinator of the infectious diseases group of the Spanish Society of Penitentiary Healthcare.
- Dr. Elisabet Turu: Director of the Penitentiary Health programme of the Catalan Health Institute.
- Mr. Rafael Guerrero: Expert of the Penitentiary Health programme of the Catalan Health Institute. Responsible of Health of the Catalan Penitentiary Administration (from 2005 to 2014).
- Ms. Mar Torrecillas: Consultant of the Catalan Ombudsman.

Methodological challenges of this report came when deciphering complex or technical medical terminology and translating it to actionable information from a Human Rights standpoint.

II. NATIONAL CONTEXT

1. Overall political context

Spain is composed entirely of 17 Autonomous Communities and two autonomous cities. In reality the autonomy of these cities and communities is varied. This is due to the fact that the Spanish Constitution does not formally state that the country is a federation (nor a unitary state), causing varying grades of decentralization of power and influence depending on specific issues. These range from the quasi-confederal status of tax management in Navarre and the Basque Country to the total centralization of Criminal law.

The Central Government of Spain does have exclusive jurisdiction on some matters, such as penal and penitentiary laws (art. 149.6 Spanish Constitution). Autonomous communities have jurisdiction on issues regarding their own laws, but always require the approval of the Central Government.

In relation to our research, Catalonia has the jurisdiction, called a 'competence', to execute penitentiary laws and to manage prisons (art. 11.1 Catalan Autonomy Law). Catalonia is the only Autonomous Community in Spain that has competence on prisons.

The Spanish government is led by the conservative party "Partido Popular" (PP). PP won the elections in 2011, and the current President is the right-wing Mariano Rajoy.

In Catalonia the party in power is the Catalan nationalistic and conservative party "Convergència i Unió". This party, always having good relations with Spain and with PP, turned to more extreme separatist positions starting in 2012. The President, Artur Mas, has been in power since 2010.

The history of Spain is hardy and marked by the Civil War (1936-1939) and the Francoist Dictatorship (1939-1975)¹. The Francoists took control of Spain through a comprehensive and methodical war of attrition. This involved the imprisonment and executions of Spaniards found guilty of supporting the values promoted (at least in theory) by the Republic - regional autonomy, liberal or social democracy, free elections and human rights (especially women's rights).

The consistent points in Francoism included authoritarianism, Spanish nationalism, National Catholicism, militarism, conservatism, anti-communism and anti-liberalism, as well as a frontal rejection of Freemasonry.. After 40 years of dictatorship, the

¹ It was a civil war fought from 1936 to 1939 between the Republicans, who were loyal to the democratic Spanish Republic, which had led interesting and progressive advances on Human Rights, and the Nationalists, a rebel fascist group led by General Francisco Franco. The Nationalists fascist won, and Franco ruled Spain for the next 36 years, from 1939 until his death in 1975.

Spanish transitioned to democracy, which began with Franco's death (20th November 1975). This was when Spain moved from a dictatorship to a democracy in the form of a constitutional monarchy. The transition to democracy, which faced political and economic crises at the time, was one of the factors that allowed Spain to join the European Economic Community and NATO.

The first democratic elections were held on 15 June 1977, and confirmed the existence of four important political forces at the national level: Union of the Democratic Centre (UCD), Spanish Socialist Workers' Party, Communist Party of Spain and the Popular Alliance (AP, *Alianza Popular*). At the same time, with the success of the Basque Nationalist Party (PNV) and the Democratic Pact for Catalonia (PDC) in their respective regions, nationalist parties also began to show their political strength.

The Constituent Cortes (elected Spanish parliament) began to draft a constitution in the middle of 1977. Finished in 1798, the Spanish Constitution went on to be approved in a referendum on 6 December 1978. It is the current supreme law of the Kingdom of Spain. The separation of powers is implicitly stated throughout the Constitution, which states that all people have the right to decide the representatives who will occupy the *Cortes Generales*, consisting of the Congress of Deputies and the Senate; both of which share the legislative power. The Government, whose president is appointed by the Congress of Deputies, directs executive power. Judicial power relies on judges and the Constitutional Court which ensures that all laws follow the Constitution.

The Constitution is based on the indivisible unity of the Spanish Nation; it recognizes and guarantees the right to self-government of the nationalities and regions of which it is composed and the solidarity among them all. The Spanish Constitution is one of the few Bills of Rights that has legal provisions for social rights, including the definition of Spain itself as a "Social and Democratic State, subject to the rule of law". However, those rights do not offer equal protection as the individual rights contained in articles 14 to 28, since those social rights are considered principles and directives of economic policy, but never full rights of the citizens to be claimed before a court or tribunal.

Other constitutional provisions recognize the right to adequate housing, employment, social welfare provision, health protection and pensions. According to the Constitution, Spaniards have the right to State intervention in private companies in the public interest and the facilitation of access by workers to ownership of the means of production were also enshrined in the Constitution. The Government respects the human rights of its citizens; although there are problems in some areas.

Of these we can identify the following:

- Allegations that a few members of the security forces abused detainees and mistreated foreigners and illegal immigrants. According to Amnesty International (AI), government investigations of such alleged abuses are often lengthy and punishments were light (CPT reports).

- Occasional lengthy pre-trial detention and delays in trials.
- Violence against women was a problem, which the Government took steps to address.
- Trafficking of women and teenage girls for the purpose of prostitution was a problem, which the Government also took steps to address.
- Under a new health law introduced in 2012, immigrants without proper residence permits are to be refused medical care. Illegal immigrants older than 18 will only be entitled to free treatment within Spain's healthcare system in cases of emergency, a pregnancy or birth.

As examined in next chapter the recent financial crisis is worsening some endemic problems in Spain: unemployment, difficulties in accessing housing, social exclusion, poverty, etc.

The Spanish economic crisis was caused by high financial exposure to the property sector, resulting in its GDP falling by 0.9% in 2008 and trending negatively since 2009. In response, in 2012, the Spanish Government requested financial assistance from the EFSF for the recapitalisation of its financial institutions. The Eurogroup approved this support and established an 18-month programme that aimed for Spain to adopt reforms in several fields, including the financial sector and labour market (Freixes and Lladós, 2015). Concerns have been raised regarding some of the austerity measures adopted by the Government. Cuts in social, health and educational budgets have led to a worrying increase in family poverty, negatively impacting the realisation of fundamental rights, including the right to education, to healthcare and to housing, among others (Freixes and Lladós, 2015).

2. Economic context

After the global recession of the early 1990s and during the 2000s, the Spanish economy has experienced a period of prosperity and expansion. However, since 2008, the economic and financial crisis, and specifically the collapse of the Spanish construction boom and the indebtedness of the families, has ended in a recession that had a deep impact on labour, politics and social lives. Between 2008 and 2012, the economic boom of the 2000s was reversed, contracting the Spanish economy and leaving a large amount of Spain's workforce unemployed². The unemployment of many families, who had acquired property in the form of overpriced houses during the prosperous period, made them stop paying the mortgages contracted with the banks, which usually contained abusive contract terms and clauses. The Spanish Mortgage Law - qualified as excessive and against the European Directives, according to a statement of 14th March 2014 of the European Union Court of Justice - caused 79,043 evictions from 2007 to 2013, a rate of about 30 per day. 70% of the evicted families were unemployed and also had difficulties covering their basic needs (food, water, energy, etc.).

² In Catalonia the unemployment rate rose from 6.5 % of the population in 2006 to 24.5% in the first semester of 2013. In the third semester of 2015 the rate fell to 17.5% (while in the whole of Spain it was 21.2%) (Source: Idescat. Available at: <http://www.idescat.cat/economia/inec?tc=5&id=0608&cp=04&x=12&y=10&lang=en>).

According to a report by the Department of Health of the Government of Catalonia entitled “The effects of the economic crisis in the health of Catalan Population”, the risk of poverty has increased from 17.2% in 2006 to 20.1% in 2012. From 2008 to 2013, the homeless population increased by 31,2% (Generalitat de Catalunya. Agència de Qualitat i Avaluació Sanitàries de Catalunya 2014). The crisis culminated in budget cuts in the most vulnerable sectors; health, education, social aid and justice administration, which effectively reduced the welfare state, public services and social benefits.

Another consequence of the crisis, according to the report of the Department of Health of the Catalan Government, has been the growth of the drug use of the population, above all among long term unemployed and economic poor people (Generalitat de Catalunya, 2014).

Inequality has also increased. The GINI index of Spain rose from 31.9 in 2007 to 34.7 in 2014. While in many European countries the crisis implied a reduction of inequalities (for instance in Portugal or UK), in Spain, poor people became poorest³.

The economic and financial crises and the increase in inequality are having a great impact on vulnerable groups. The general precarious labour conditions have especially affected women, who have more part time jobs than men. According to the ISOCAT report (2015) the salary gap among men and women has increased. The regression of social policies moved many care-works, previously covered by the welfare system, to the households and this too has especially affected women.

Young people and children were also affected by the economic crisis and budgetary cuts. On one side, the young persons’ labour market is characterised by a high index of unemployment (higher than the 45% in people younger than 25 years in the last trimester of 2014) and temporality (higher than the 55%). On the other side, the labour conditions of parents are a determining factor of children’s poverty in Catalonia. According to the statistics regarding the personal income and poverty risk in 2011, the 26.4% of Catalan minors under the age of 16 were at risk of poverty (Idescat). In the last two decades, the before-mentioned difficulties of access to appropriate housing conditions became notable among socially disadvantaged populations. Families with dependent children are particularly represented in the groups with unsafe or inadequate housing situations (Ombudsman, 2010).

Elderly people are not apparently affected by the crisis, as they continue receiving their retirement benefits; however, they are suffering some of its consequences. The escalation of power and water fees or the help that they provided to sustain their families (usually adult children) have a weakening impact on their already weak domestic economies. Nowadays elderly people, usually seen as economically dependents, became a cushion of the hard consequences of the crisis for the youngest generations. They attenuated the difficulties of most families for obtaining basic services, becoming

³ Source: Eurostat Available at: <http://ec.europa.eu/eurostat/tgm/table.do?tab=table&plugin=1&language=en&pcode=tessi190>

an unavoidable care and support network.

Another vulnerable group that is suffering the consequences of the crisis is migrant people. Many migrant families decided to return to their country of origin or to start a new migration, but those who decided to remain in Catalonia are suffering the aforementioned effects of the crisis and the cuts in a higher proportion than the rest of the Catalan population. Specifically undocumented migrants are hit hardest by the unemployment, evictions and as we will see in the next section, the exclusion from health care.

The crisis has also affected prisons and prisoners. According to Brandariz Garcia and Castro Linares,

“...the Great Recession has constituted a remarkable turning point for the Spanish criminal justice system. Though the Spanish prison system has experienced almost constant growth since the end of the autocratic period, the deepening of the economic downturn has finally curbed the rise of punitiveness.” (2014:5)

Some authors (Forero and Jiménez, 2013, Rodríguez and Larrauri, 2012) argue that the reduction of prison populations may be partially explained by the reduction in crime rates since the beginning of the crisis, the legal reform that attenuated penalties for drug trafficking in 2010, and by the rise in the number of foreigners sentenced to deportation instead of imprisonment.

In general terms the scarcity of resources and the adaptation of the prisons to the “crisis frame” have affected prisoners’ rights and caused a significant tightening of the conditions of life in prison. As much as the demographic decline has improved the situation of overcrowding, budgetary cuts affected health services of some prisons as well as the already scarce penitentiary legal aid services (Forero Cuéllar & Jiménez Franco, 2014). There are surely many other aspects of prison life affected by these cuts; there is evidence, for example that food for prisoners got worse in terms of quantity and quality (Brandariz, in press).

3. Health context

Under Chapter III of the 1978 Spanish Constitution, all Spanish citizens have the right to life and to physical and moral integrity and they are beneficiaries of public health services. It specifically establishes:

- Article 15: Everyone has the right to life and to physical and moral integrity, and may under no circumstances be subjected to torture or to inhuman or degrading punishment or treatment.
- Article 39: Public authorities shall ensure the social, economic and legal protection of the family.
- Article 43: The right to health protection is recognized.

It is the duty of public authorities to organise and safeguard public health by means of preventive measures and the necessary benefits and services. The Law shall establish the rights and duties of all concerned in this respect. Public authorities shall promote health education, physical education and sports.

- Article 49: Public authorities shall carry out a policy of preventive care, treatment, rehabilitation and integration of the physically, sensorial and mentally handicapped who shall be given the specialised care that they require, and be afforded them special protection in order to recognize the rights conferred by this Title to all citizens.

The **Spanish National Health System** (SNS) is the grouping of public health services that has existed in Spain since it was established through and structured by the *Ley General de Sanidad* (the “General Health Law”) of 1986. Management of these services has been progressively transferred to the distinct autonomous communities of Spain, while some continue to be operated by the National Institute of Health Management (INGESA) of the Ministry of Health and Social Policy. The activity of these services is mediated by the Interterritorial Council of the Spanish National Health Service (*Consejo Interterritorial del Servicio Nacional de Salud de España*, CISNS) in order to give cohesion to the system and to guarantee the rights of citizens throughout Spain.

Article 46 of the *Ley General de Sanidad* establishes the fundamental characteristics of the SNS:

- a. Extension of services to the entire population.
- b. Adequate organization to provide comprehensive health care, including promotion of health, prevention of disease, treatment and rehabilitation.
- c. Coordination and, as needed, integration of all public health resources into a single system.
- d. Financing will be offered by resources of public administration, contributions and fees for the provision of certain services.
- e. The provision of a comprehensive health care system, seeking high, properly evaluated and controlled standards.

The General Health Law of 1986 (*Ley 14/1986 General de Sanidad*) was formulated on two bases. First, it carries out a mandate of the Spanish Constitution, whose articles 43 and 49 establish the right of all citizens to protection of their health. The law recognizes a right to health services for all citizens and for foreigners resident in Spain (until 2012).

Second, Title VIII of the Constitution confers to the autonomous communities broad purview in matters of health and health care. The autonomous communities have first-order importance in this area, and the law permits devolution of these functions from the central government to the autonomous communities in order to provide a health care system sufficient for the needs of their respective jurisdictions. Article 149.1.16 of the Constitution, a further foundation for the present law, establishes substantive

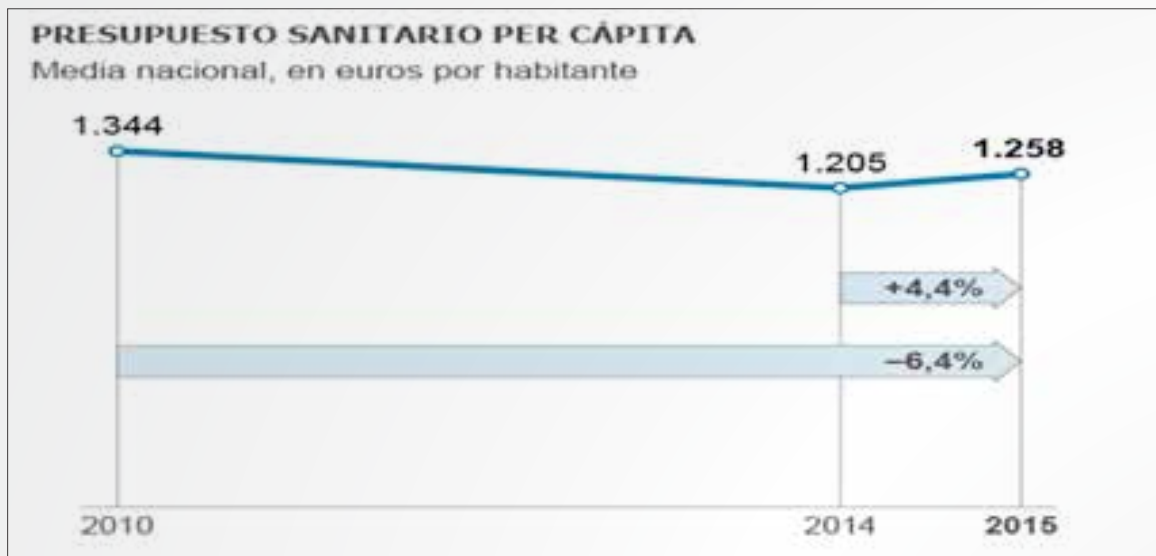
principles and criteria that allow general and common characteristics to be consistent throughout the new system, providing a common basis for health services throughout Spanish territory.

The National Health System is conceived as the properly coordinated set of health services of the Autonomous Communities. Thus, the various health services fall under the responsibility of the respective autonomous communities, but are also under basic direction and coordination by the central state. The respective health services of the autonomous communities would gradually see a transfer of health resources from the central government to the autonomous communities over time.

The Catalan health model was established in 1990 with the Law of Health Order of Catalonia (LOSC) which created the Catalan Service of Health, a mixture of public and private health centres. The main supplier of public health in Catalonia is Catalan Institute of Health (Institut Català de la Salut-ICS). It is a public company with a staff formed by 8,677 professionals providing health services to 6 million of people (75% of Catalan people).

The budget for public health system is huge. Nevertheless, the financial and economic crisis has had a negative impact. Since the beginning of the crisis, health expenditure growth declined, and even became negative in real terms, in 2010 and 2011. This reduction has been mainly due to a reduction in pharmaceutical expenditure. Nonetheless, it also affected healthcare resources, i.e. reductions in the number of doctors and nurses and their wages, a decrease in the number of hospital beds, and a rise in co-payments for medical prescriptions. Austerity measures also introduced the limitation of the status of the insured person - no longer providing coverage for undocumented migrants.

Between 2010 and 2013, the budget per person of Spanish health system reduced by 11%. In 2015, the budget per capita is €1,258, 4% more than in 2014 (2015 is an electoral year) (Federación de Asociaciones de Defensa de la Sanidad Pública, El País 11/12/2014).

Graph 1: Budget per person. National average, Euros per resident.

Source: Federación de Asociaciones en defensa de la Sanidad Pública (FADSP). (Retrieved from El País 11/12/2014)

According to the “Federación de Asociaciones de Defensa de la Sanidad Pública” the Catalan budget per person in 2015 was €1,133 (El País 11/12/2014). Catalonia has a budget of €8,290,590 (2015) for the public health system with coverage for 7.5 million inhabitants (Idescat). Almost a quarter of this budget is assigned to private health centres which offer public services to the population. Catalonia has always promoted the public-private collaboration, which is called “privatisation of public health system,” although since the crisis and cutbacks it has increased (Federación de Asociaciones para la Defensa de la Sanidad Pública, 2011).

The health of the population

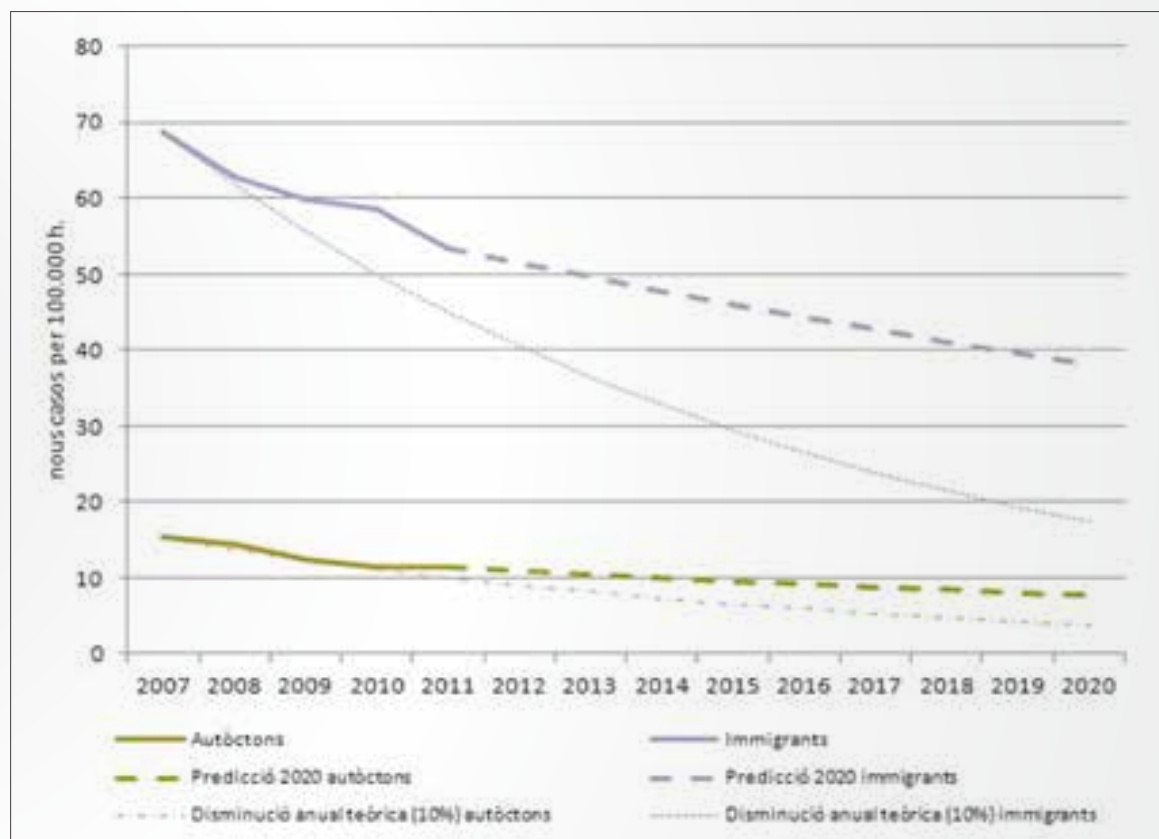
The 80.3% of Catalans older than 15 consider themselves as healthy: 85.2% of men and 75.5% of women. Catalonia heads up the ranking of perceptions of good health within the European Union, after Ireland (Agència, 2014). At 15.4%, Catalonia also has a larger percentage of elderly people than most other European countries. That is to say, 15.4 out of 100 people are between 65 and 84 years old. The percentage of elderly women (18.3%) is higher than men (11.4%). Recently this gap has slightly reduced. The life expectancy in Catalonia is 82.7 years (2012); 79.8 years old for men and 85.4 years for women (Observatori del Sistema de Salut de Catalunya, website). Addiction to tobacco is higher than the European average, like in other southern European countries. Catalonia follows the median rate for obesity, below Spain and Greece and above France and Italy. The tendency in all the countries is increasing (Agència, 2014).

The number of general medical professionals is low in relation to other countries. However, the number of staff in hospitals is quite high and contrasts with the personnel of nursing. Catalonia has fewer beds for intensive care patients and more beds for extended stay (Agència, 2014).

Tuberculosis:

In 2011, 1,353 cases of tuberculosis (TB) have been reported in Catalonia, which corresponds to an incidence rate of 17.9 cases per 100,000 inhabitants. The incidence of tuberculosis in Catalonia is higher than the European average (14.6) and Spain (14.6) and much higher than other neighbouring countries, such as Germany (5.3), Italy (5.5), France (7.9) and the UK (13.7). The population born abroad present a rate almost five times higher compared to the native, which can explain why Catalonia has higher incidence of Tuberculosis than the rest of Spain (Agència Catalana de Salut Pública, website).

Graph 2: Evolution of the TB incidence rate (per 100,000 inhabitants), by country of origin. Native (autòctons)/ Immigrants (Immigrants)



Source: TB register, 2007/2011. Catalan Agency of Public Health. Health Department.

HIV:

In 2013, there were 754 reported cases of HIV, representing an overall rate of 10.4 cases per 100,000 inhabitants, the same as in 2001. 87% of the cases were male and 13% female, with rates of 18.3 and 2.7 cases per 100,000 inhabitants, respectively. The male: female ratio was 7:1 (Centre, 2014).

Aids:

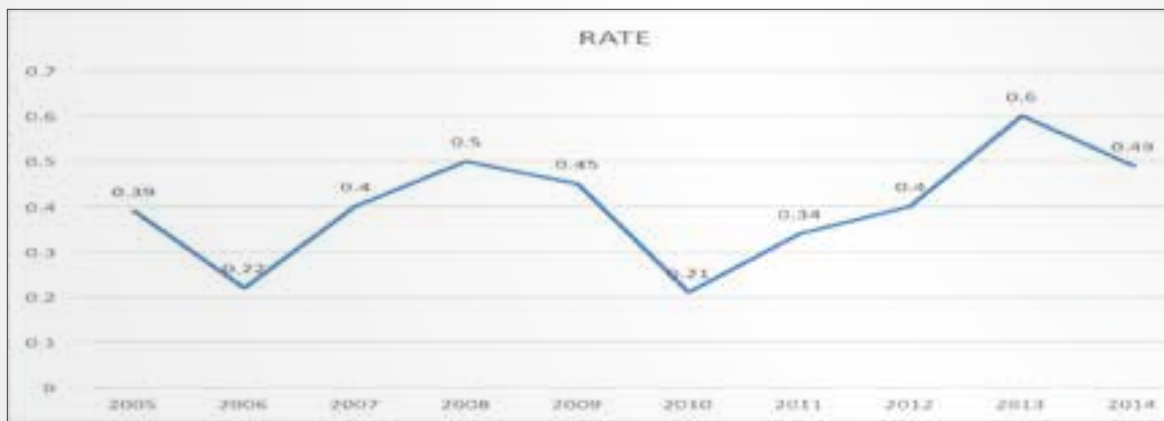
The declared total number of AIDS cases in 2013 was 139, which represents an overall rate of 1.9 cases per 100,000 inhabitants. 83% of cases were men and 17% women, the rates being 3.2 and 0.6 cases per 100,000 inhabitants, respectively. The ratio of male: female is 5:1 (Centre, 2014).

The total number of AIDS cases reported from 1981 to 31 December 2013 is 17,293. Since the diagnosis of the first case of AIDS in 1981, the annual incidence rate increased gradually, from 0.8 cases per 100,000 inhabitants in 1983 to reach 26.0 cases per 100,000 population per year 1994, coinciding with the expansion of epidemiological case definition of AIDS. Between 1996 and 1998 there was a sharp fall in the number of cases (1,359 and 694 cases, respectively), representing a decrease of 49% AIDS notifications in two years. Since then, the annual decrease in the number of AIDS cases is smaller and more gradual, reflecting the stabilizing effect of new therapies in the incidence of AIDS cases (Centre, 2014).

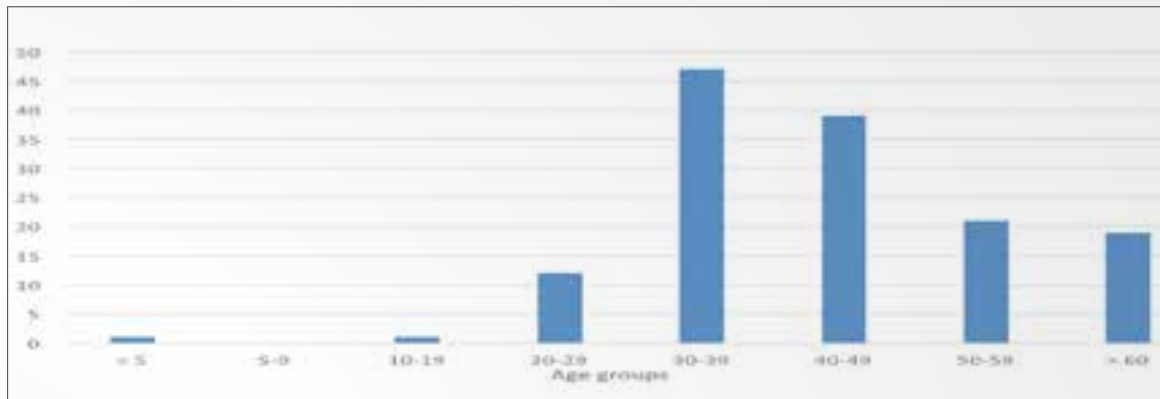
Hepatitis C:

From 2005-2014, the incidence rate of hepatitis C ranged between 0.21 to 0.62 per 100,000 inhabitants affected per year. In 2014, 37 cases were reported, keeping the rate the same at 0.49 per 100,000 (Agència Catalana de Salut Pública, website).

Graph 3: Hepatitis C Incidence rates. Catalonia, 2005-2014



Source: Sub-department of Surveillance and Answer to Public Health Emergencies. ASCPAT

Graph 4: Hepatitis C Cases, by age groups. Catalonia, 2011-2014

Source: Sub-department of Surveillance and Answer to Public Health Emergencies. ASPCAT

4. Criminal Justice and prison context

Relevant legal frameworks

Drug use is not a crime, neither is sex work, even if they are criminalised by administrative laws. Only drug dealing and other linked activities are crimes according to the Spanish Penal Code (PC) and could imply a sentence of prison. Here presumptions regarding use or dealing are very important. Jurisprudence establishes possession amounts for drugs as suitable for either personal use or sale. Drug use in public space is considered as an administrative offence, so personal fines may be issued.

Drug-related offenses are some of the most prevalent causes of incarceration in the Spanish and Catalan penal systems. The geopolitical situation and social reality of Spain as a port of entry of many drugs from Africa (hash, marijuana) and from the Americas (cocaine, heroin) have heavily impacted the PC. The Spanish Penal Code issues harsh penalties for drug dealing. For example, a person who carries bags of cocaine in their stomach (usually known as “Mule”) can be sentenced to 6 years of imprisonment (9 years before the Legal Reform passed in 2010). These people, mostly women, usually have greater difficulty getting penitentiary benefits because of the problem of not being settled down in Spain. Sentences for crimes related to drugs committed inside prison have been hardened as well.

There is a very strong relationship between drug addiction and crime (the type of crime which is prosecuted), especially in crimes against property and incidences of drug trafficking.

In 1988, the old PC was modified to increase penalties and increase the rate of penal intervention on these crimes specifically. The new PC of 1995 did not change this direction, although it introduced rehabilitative mechanisms such as conditional suspension of penalties and the development of different programs that help drug users to give up drugs. In 2003, the Popular Party (PP) government pushed a legal reform on

the Penal Code, targeting some of these crimes. In 2010 there was an important legal reform that significantly reduced imprisonment for trafficking drugs from 9 to 6 years down to 6 to 3 years. A new penal reform has been passed on March 2015, the Organic Law 1/2015, however it does not affect drug or sex work regulations.

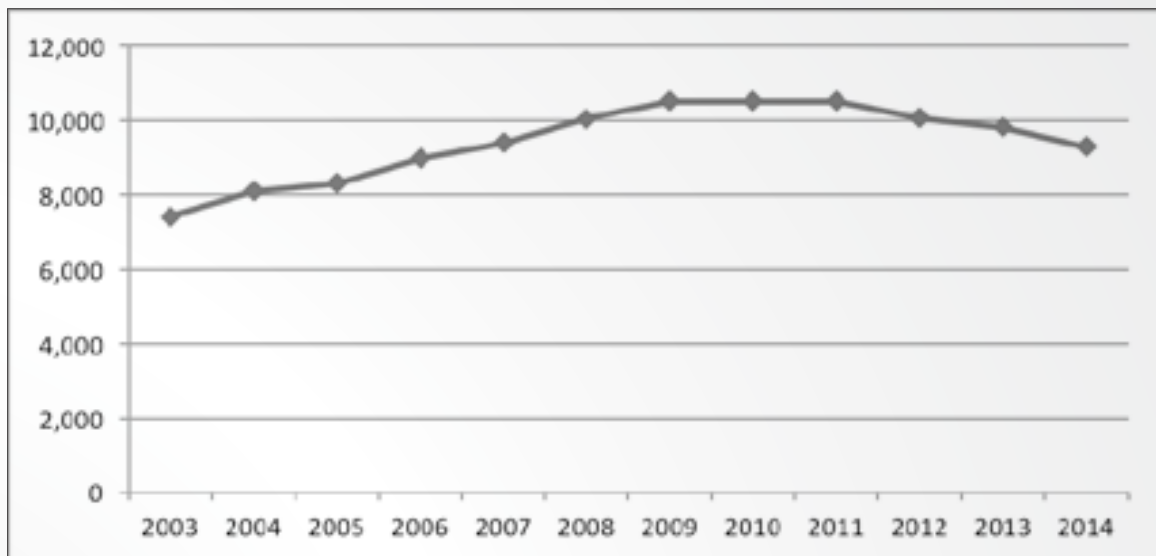
Prison system

Currently, in Catalonia, there are 11 prisons and one penitentiary hospital pavilion. They are distributed in the following municipalities of the territory:

Table 1: Catalan prisons and location

Prisons	Location
Centre Penitenciari Brians 1	Sant Esteve Sesrovires
Centre Penitenciari Brians 2	Sant Esteve Sesrovires
Centre Penitenciari d'Homes de Barcelona (Model)	Barcelona
Centre Penitenciari de Dones de Barcelona (Wad-Ras)	Barcelona
Centre Penitenciari Obert de Girona	Girona
Centre Penitenciari de Joves	La Roca del Vallès
Centre Penitenciari de Tarragona	Tarragona
Centre Penitenciari Lledoners	Sant Joan de Vilatorrada
Centre Penitenciari Ponent	Lleida
Centre Penitenciari Puig de les Basses	Figueres
Centre Penitenciari Quatre Camins	La Roca del Vallès
Pavelló Hospitalari Penitenciari de Terrassa	Terrassa

The prison population as of 31 December 2014 was 9,294 inmates (93.2% - 8,660 - men and 6.8% - 634 - women). After reaching its peak in 2009 (with 10,525 people in prison), the Prison Population in Catalonia started to decrease slightly, as shown in the graph below.

Graph 5: Prison population (last day of the year), Catalonia, 2003-2014

Source: Own elaboration. Data retrieved from: http://justicia.gencat.cat/ca/departament/Estadistiques/serveis_penitenciaris

Of these 9,294 inmates, 56.2% were Spanish and 43.8 % were foreigners. As we can see below, the number of foreigners in Catalan prisons reached its peak in 2011 and then started to diminish.

Table 2: Inmates in Catalan Prisons, by nationality (Spanish/Foreigners), 2003-2014

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Spanish	5.209	5.469	5.462	5.609	5.626	5.853	5.955	5.874	5.695	5.508	5.467	5.221
Foreigners	2.207	2.625	2.843	3.361	3.769	4.198	4.570	4.646	4.818	4.554	4.351	4.073
% Spanish	70,2	67,6	65,8	62,5	59,9	58,2	56,6	55,8	54,2	54,7	55,7	56,2
% Foreigners	29,8	32,4	34,2	37,5	40,1	41,8	43,4	44,2	45,8	45,3	44,3	43,8

Source: http://justicia.gencat.cat/ca/departament/Estadistiques/serveis_penitenciaris

Regarding the criminal/procedural situation of inmates, 84.43% are sentenced and 15.57% are in pre-trial detention. During 2014, 1,071 inmates were on parole.

If we look at the rate of prisoners per capita compared with nearby countries, in 2014, Catalonia had a rate of 123 prisoners per 100,000 inhabitants, a lower rate than the rest of Spain, which was 141.

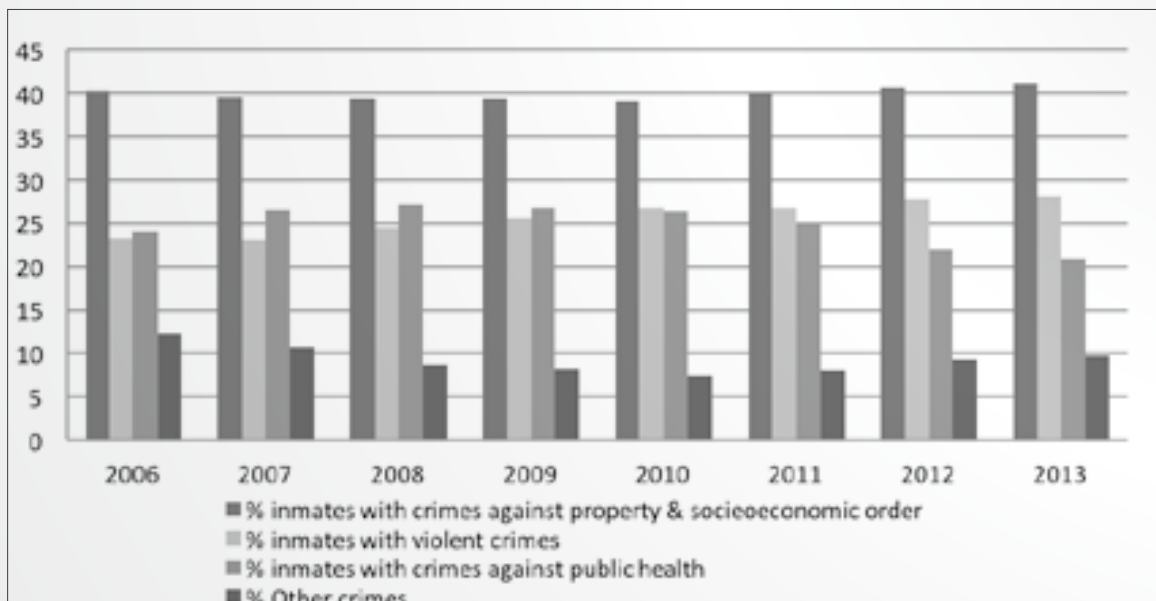
Table 3: Rate of prisoners per capita, different European countries, 2014

Country	Rate of prisoners per capita
Sweden	57
Denmark	67
Netherlands	75
Germany	81
Italy	88
France	102
Catalonia	123
Portugal	136
Spain	141
England and Wales	149

Source: http://justicia.gencat.cat/ca/departament/Estadistiques/serveis_penitenciaris

41.17% of imprisoned people in Catalonia during 2013 committed a crime against property or of some other socioeconomic nature. 28.08% committed a violent crime and 20.02% were imprisoned for committing a crime against public health (drug trafficking). Nobody could have been imprisoned for drug use or sex work, because, as mentioned before, they are not criminally punishable behaviours.

As shown in the following graph, from 2006 to 2013, people imprisoned for crimes related to drug dealing represented between 20% and 27% of the overall number of imprisonments.

Graph 6: Prison population by crime, Catalonia, 2006-2013

Source: Own elaboration. Data retrieved from: http://justicia.gencat.cat/ca/departament/Estadistiques/serveis_penitenciaris

Drug use in prison

Drugs are part of prison life and play a role in keeping the prison population quiet, especially in the stressful environments of overcrowded prisons. We have no data about the number of people who use drugs while in prison. According to the Spanish Observatory on Drugs, the consumption of drugs in Spanish Prisons (including Catalonia) is lower than the consumption rates in the community, although significant and potentially dangerous to prisoners' health due to the proportion of risk behaviours related to infectious diseases - like injecting and sharing injection tools - in a population characterized by a high prevalence of these diseases (OED 2007 and 2012).

The psychoactive substances (not taking into account tobacco) most frequently used by the prisoners when they are free, in order of importance are: alcohol, cannabis, cocaine, heroin and tranquilizers. This is very similar to the general population. The profile of substances used once people enter prison changes and the most important are cannabis, tranquillizers and heroin respectively (OED 2007 and 2012).

III. HIV, HCV AND TB IN PRISONS

1. Legal and policy context

The Organic General Penitentiary Law (1979), which was introduced before the implementation of the public health system in Spain, includes a chapter for health assistance (arts. 36-40). The Penitentiary Rules (1996) develop these articles including specific regulations (arts. 207-220). These norms can be considered as national standards.

Each prison must offer an infirmary, a psychiatric and drugs unit, and a unit for contagious diseases (art. 37 OGPL). Prisoners have the right to medical assistance and healthcare (art. 40 OGPL). All the inmates without exception will receive health care equivalent to the general population. They will also have the right to the pharmaceutical benefits (art. 208 PR).

Health care has to be comprehensive and will be targeted toward the prevention, healing and rehabilitation of the individual. Particular attention is paid to the prevention of communicable diseases (art. 207 PR).

Healthcare prison staff must be composed, at minimum, of a general practitioner, a nurse and an assistant nurse. There will also always be a dentist and a psychiatrist. Centres for Women also have the services of a gynaecologist and, when children live together with their mothers, a paediatrician (art. 209 PR).

Specialized assistance is preferably ensured through the National Health System. Efforts will be made to attend to the most common health demands inside the prisons, in order to avoid the release of inmates. Inmates can also go to the hospitals designated by the health authority and, in case of emergency, to any hospital near the prison (art. 209.2 PR). In order to allow proper monitoring of the incidence and prevalence of communicable diseases in prisons, the Prison Service and Health Administrations should implement plans and programs of action on the most prevalent diseases.

Art. 219 establishes that any outbreak of a communicable disease detected in a prison will be immediately communicated to the competent health authorities. Moreover, appropriate measures will be initiated to prevent the spread of the outbreak and to treat those affected. In accordance with the provisions of the General Health Law, when an inmate with an infectious disease is released from prison, the Prison Administration will inform the relevant health authorities. In prisons, there is a very high early detection of infectious diseases and universal access to medicines. Each prison has its own expert in infectious diseases.

Since the 80's, penitentiary health system has paid special attention to infectious diseases, mostly related to drug use and AIDS. Prisons have always had, even before

the Spanish Constitution of 1978, a component of public health because they have to take care of people who are inside an enclosed institution. Since the appearance of intravenous drug users and AIDS, the current health system in prisons started to be developed. There were so many patients with AIDS and other infectious diseases related to intravenous drug use that ordinary hospitals could not assist them. So prisons started to do it by themselves. Now when a prisoner enters in prison he/she is offered voluntary medical tests, called “screening”, to detect AIDS, Hepatitis B, C and Tuberculosis early. In 2014, 92 % of the prison population was tested for AIDS, Hepatitis B, C and Tuberculosis. If the test is positive, the treatment begins. If the test is negative, it is repeated in 6 months.

The Penitentiary Health Service was attached to the Department of Justice from the 80’s until 2014. In November of 2014, Catalonia transferred the jurisdiction of health provision on prisons from the Department of Justice to the Department of Health.

Catalonia is the only Community in Spain which has followed the order of the Law of Cohesion and Quality of Spanish Health System of May of 2003, which established an 18 month term to transfer health competence in prisons to health departments of each Autonomous Community.

Now the health system of prisons is wholly integrated within the Catalan public health system. This change in the management of the health in prisons has real and symbolic consequences. This change does not seem to have impacted the prevention or treatment of infectious diseases. The main advantages have been to what has been called “the continuum in health assistance”.

Moreover, this has allowed for a common medical history for people when outside or inside prison, creating this continuum in health assistance. In order to have access to the public health system, everybody needs a health identification number, called a CIP. In Spain, natives and foreigners who have residence permits and are registered have a CIP. Foreigners who do not have a residence permit and are illegal do not have a CIP and do not have right to access the health system. However, in prison, because of the special relationship between the State and prisoners, everybody has a CIP and access to healthcare.

The Catalan Health Department is about to implement a new project called “contact nurse”. This nurse will help ill prisoners who are going to be released in touch with health care services outside prison. This ill prisoner, when released, will have appointments with his/her new doctors, with nurses, with hospitals, etc. of the new place of residence and will go out from prison with the necessary medicines to follow the treatment until he/she will receive them outside of prison. It has been demonstrated that some ill prisoners do not follow health treatments when released. The causes are related to social exclusion, drug use and the absence of residence permit for foreigners.

On the other hand, the new management of health in prisons by the Department of

Health will improve the approach to chronic common illnesses, such as diabetes, hypertension, etc.

Finally, it is thought that health education will be strengthened, especially for young offenders. Prisons for young offenders will include educational activities related to health (skincare, healthcare related to sport, sexual and reproductive health, etc.).

Policies on infectious diseases

The Catalan Agency for Public Health is a public company dependant of the Department of Health. Its aim is to improve individual and collective health by implementing health policies including the promotion of health, the protection and vigilance of health and food security.

Periodically, this Agency creates an Interdepartmental Plan for Public Health. Among its many areas of influence are interventions on the promotion of health. These are oriented to promote health among the population and use strategies of information, awareness raising and education on health, to promote healthy lifestyles. The interventions on the prevention of illnesses are directed to prevent specific problems through immunizations, counselling, screenings and early treatment and monitoring. One of the most important preventive activities is vaccination.

Another area of influence includes targeting drug use. It purports to develop strategies and interventions to reduce drug use, minimising the associated risks and negative consequences, both individually and collectively. In Catalonia, an information system is responsible for monitoring the specialised services on drug use, in order to offer data on epidemiologic surveillance, planning and evaluation of health services.

One of the most common treatment programmes offered for heroin drug users is the substitution treatment with methadone, which combines services of medical, social and legal assistance for users.

The programme called “alternative to administrative sanctions” offers an educational measure as an alternative to an administrative sanction. This programme is especially directed at minors who have had an administrative sanction imposed for having drugs or taking drugs in a public place.

Harm reduction programmes aim at decreasing the negative consequences of drug use, both in relation to active users and in relation to the community. The main programmes in the community are:

- a. **Syringe interchange programme:** this programme distributes syringes and other necessary sterile equipment for intravenous drug use. The programme includes an element of education, promoting the less risky behaviours in the use of drugs. The programme works in concert with more than 600 services in Catalonia (health, food, social assistance, legal and labour aid). In 2014, 850,000

syringes were distributed (Catalan Agency for Public Health, website).

- b. Overdose prevention programme:** this programme aims at preventing overdoses by offering information on overdose prevention and providing training and tools to react against an overdose (cardio pulmonary resuscitation practices and distribution of naloxone, an antidote against some overdoses).

Another area of work is the surveillance of public health and the rapid response in case of emergency. It includes the collection, analysis, interpretation and dissemination of information related to the state of the health of the population and the factors which can influence it. Its aim is to be the base for monitoring and improving public health, in order to best respond to emergencies. It systematically monitors illnesses and other determinants of health.

There is a special programme of prevention and control for tuberculosis with the aim of decreasing the incidence of this illness in Catalonia and to avoid the appearance of resistant forms of tuberculosis. This programme also studies the incidence of tuberculosis and its determinants in Catalonia. There are also similar programmes for hepatitis.

Finally, in relation to the prevention and control of HIV and other sexual transmitted diseases, there are special programmes to prevent these infections and to secure easy access to health, psychological and social assistance for people living with HIV/AIDS. Other programmes are directed to promote constructive social responses and to avoid marginalisation.

2. Data and analysis of data

The Department of Justice of the Government of Catalonia (*Generalitat de Catalunya*) periodically reports the main statistical indicators of population and prison health on its website⁴. According to Dr. Andrés Marco, Director of the Spanish Journal of Prison Health, official data on infectious diseases available online in Catalonia are highly reliable, as after the AIDS epidemic that impacted heavily Spanish prisons, in recent decades a massive investment has been made in prison health in Catalonia and Spain.

The Epidemiological Bulletin of Catalonia (BEC) publishes monthly data about the epidemiological situation in the whole population of the country on the website for the Department of Health⁵. There are monographic bulletins on various specific themes⁶.

When someone is sentenced to prison there is a medical consultation in the first 24 hours and, if the person voluntarily accepts, it also includes a screening of viral pathologies

4 http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/12_pob.html

5 http://canalsalut.gencat.cat/ca/home_ciutadania/actualitat/llista_butlletins/salut_publica/butlleti_epidemiologic_de_catalunya/

6 In March 2015, last BEC related to infectious diseases were: Hepatitis C, reference year 2010 (Generalitat de Catalunya, December 2010); Mortality, reference year 2012 (Generalitat de Catalunya, May 2014a); HIV-AIDS & STI, reference year 2013 (Generalitat de Catalunya, August 2014b); Tuberculosis, reference year 2013 (Generalitat de Catalunya, September 2014c).

(HIV, HCV, HBV)⁷ and a TB screening. If any of the aforementioned infectious diseases is detected, the inmate immediately begins treatment. If the screening doesn't detect any pathology, the inmate would be invited to voluntarily take the tests again in six months (retest) and every six months thereafter, until he or she is released. The treated patients will also have this option (interview, Dr. Elisabeth Turu, head of prison health area in the Catalan Institute of Health, ICS).

The official statistics of HIV and HCV published online are updated every three months. The analysed population never reaches 100% of the imprisoned population at the time, because the screening is not done among inmates in pre-trial detention, who were 14.3% of imprisoned people in 2014. The number of inmates who refuse the screening is “minimal” (interview, Dr. Elisabeth Turu). So, the coverage of prison population screened for HIV in the last quarter of 2014 was 84.4%⁸. Regarding HCV, the coverage was 81.2%⁹. According to Dr. Turu, the percentage of the population studied is very high. Since the disclosure of screenings began, it has always recorded slightly higher levels of coverage for HIV than for other diseases; the reason could be the high awareness of this topic among the inmates.

In order to test the adherence of the data, we seek to triangulate official information by consulting other sources in scientific literature. In general, we find that the data converge and they provide evidence of reliability¹⁰.

The website of the Department of Justice of the Government of Catalonia offers quarterly data from 2011 onwards about the absolute number of cases of HIV, AIDS and HCV and the respective instantaneous prevalence rates.

7 According Dr. Turu, the ICS is pending to include tests for STIs, that it seems, have increased in the whole of the Catalan population (Generalitat de Catalunya, 2014b).

8 http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/VIH.htm

9 http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/hepatitis.htm

10 For example: the PREVALHEP project, a cross-sectional and multicentre study held in June 2008 to measure the prevalence of infection with hepatotropic virus, HIV and M. tuberculosis on inmates in 18 Spanish prisons (including Catalan prisons), found very similar levels of HIV & HCV prevalence of the numbers recorded in official sources. Specifically, rates found in the study on HIV prevalence (10.8%) and HCV (22.7%) were very close to that officially published in Catalonia in 2011: 9.01% HIV; HCV 21.11% (see Table 2).

Table 4: Total number of inmates suffering from infectious diseases per year¹¹ – Prisons of Catalonia, 2011-2014

	2011	2012	2013	2014
HCV	1,802	1,610	1,590	1,427
HIV	802	715	687	596
AIDS	181	151	124	113

Source: Own elaboration. Data: Justice Department of the Catalan Government.
 Available at: http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/VIH.htm;
http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/SIDA.htm;
http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/hepatitis.htm.

Table 5: Prevalence rates (%) for infectious diseases per year – Prisons of Catalonia, 2011-2014

	2011	2012	2013	2014
HCV Rate ¹²	21.11%	19.60%	19.21%	18.90%
HIV Rate ¹³	9.01%	8.34%	8.01%	7.60%
AIDS Rate	1.69%	1.50%	1.26%	1.22%

Source: Own elaboration. Data: Justice Department of the Catalan Government.
 Available at: http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/VIH.htm;
http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/SIDA.htm;
http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/hepatitis.htm

Since 2002, official statistics also show annual data concerning new cases of AIDS and Tuberculosis discovered throughout the year, as well as deaths from AIDS and other causes. However, the Administration does not use the absolute numbers to calculate the rates.

Table 6: Total number of new cases of AIDS and Tuberculosis by year – Prisons of Catalonia, 2002-2014

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
AIDS (new cases)	43	27	31	32	30	25	32	19	17	9	14	17	7
TB (affected)	44	28	28	25	20	29	26	23	16	21	21	24	22

Source: Own elaboration. Data: Justice Department of the Catalan Government.
 Available at: http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/SIDA.htm
http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/tuberculosi.htm

¹¹ Data relating to the 4th quarter of each year.

¹² Proportion based on the prison population analysed: between 79.9% and 84.3%.

¹³ Proportion based on the prison population analysed: between 84.7% and 87.4%.

Table 7: Total number of deaths of inmates¹⁴, caused by AIDS or by other causes – Prisons of Catalonia, 2002-2014

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
AIDS (deaths)	13	9	9	9	7	7	6	5	1	2	2	2	1
Other causes (death)	50	56	52	65	45	59	51	53	52	53	42	60	49
Total deaths	63	65	61	74	52	66	57	58	53	55	44	62	50

Source: Own elaboration. Data: Justice Department of the Catalan Government.
Available at: http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/10_SANITARIS/defuncions.htm.

Calculation of the rates of AIDS and TB is possible by using the statistics on the number of inmates who entered prisons over a year (as showed in **Graph 5**). Statistics of the prison population are provided on the last day of each month and the annual average of these monthly measurements is also provided¹⁵.

Table 8: Incidence rates (per 100,000 inmates) of AIDS and Tuberculosis by year – Prisons of Catalonia, 2003-2014

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
AIDS Rate (new cases)	212.8	230.3	236.2	213.2	166.5	196.2	110.4	95.0	50.3	79.7	101.5	43.9
TB Rate	220.7	208.0	184.5	142.1	193.1	159.4	133.7	89.4	117.5	119.5	143.2	137.8

Source: Own elaboration (using population data about the number of different inmates who pass through the Catalan prisons each year, see Annex 1).

In order to understand the meaning of these figures it would be useful to compare the prevalence of the diseases in prisons with the data regarding the whole population of Catalonia.

Official data on **HCV** regarding the Catalan population refers to cases on treatment (new or pre-existing). These data are not directly comparable to the statistics on monthly prevalence of HCV in prison. In fact, the last time that an epidemiological study measured the HCV prevalence rate in Catalonia used sample data from 1994-96 (Solá et al., 2002)¹⁶. The study estimated that 2.64% of the population were infected by HCV at that time. According to BEC, this study is supposed to correspond to 100,000 people, approximately (Generalitat de Catalunya, 2010). So, if we consider the latest available HCV prevalence data (2.64% in the general population and 18.90% on prison), despite the temporal gap, these would present a risk of disease 7.2 times higher among prisoners.

¹⁴ It includes deaths of people serving sentences, either in prison, hospital, health centre, with family, on probation, etc.

¹⁵ See also annex 1.

¹⁶ Currently, the Catalan Society of Digestology (SCD) is conducting a new study with a sample of 4,500 people over 18 years. Beside prevalence rates, this study will update the risk factors, given the enormous social changes in the last years. See also in: <http://www.lavanguardia.com/salud/20150128/54424064619/plan-conocer-presencia-real-hepatitis-catalunya.html>

HIV data in the general population as periodically reported refers to the incidence of new cases (Generalitat de Catalunya, 2014b). These data are not directly comparable to the monthly prevalence of HIV in prison. In Spain there is no universal HIV screening. Indirect methods estimate that the number of people infected by the HIV is between 100,000 and 150,000. It represents a prevalence of infection of 2.7 to 3.7 cases per 1,000 inhabitants [0.27-0.37%] (Marco Mouriño et al., 2012). These data show that the risk of disease in Catalan prisons is 20-28 times overrepresented (7.6% in 2014).

Concerning the incidence of **AIDS**, in the year 2013, 139 cases were reported in Catalonia. This represented an overall rate of 1.9 cases per 100,000 inhabitants (Generalitat de Catalunya, 2014b). The same year, the incidence rate in prison was, according our own calculations, 43.9. This means that despite the great reduction in incidence rates generally, incidence rate on inmates was 23 times higher than in the general population.

According to the official data, 1,164 cases of **TB** were reported in Catalonia in 2013. 95.5% of these cases (1,112) were new patients who had never been treated with anti-tuberculosis drugs for more than one month. This corresponded to a TB incidence rate of 14.7 new cases per 100,000 inhabitants (Generalitat de Catalunya, 2014c). If we compare this rate (14.7) and the incidence rate of TB among prison population in 2013 (143.2), we realize that the risk of disease is nearly 10 times higher in prison.

There is no available official data regarding Latent Tuberculosis Infection (**LTBI**) and Hepatitis B virus (**HBV**). In order to obtain this information it is necessary to resort to scientific research. The LTBI is the precondition for developing TB and its highly effective treatment prevents the evolution from infection to disease. Garcia-Guerrero et al. (2010) found a LTBI rate of 50.4% in a sample of 378 inmates from 18 Spanish prisons (including some Catalan prisons) in June 2008. This means that one in two inmates would have been in contact with the M. Tuberculosis bacteria. However, Dr. Marco, who also participated in this research, believes that nowadays the comparison parameter with the general population is 25% (personal interview). Consequently, this would mean that if the LTBI rate for prisons continues at the same rate with the risk of coming in contact with the M. Tuberculosis bacteria in prison being twice that of the general Spanish population.

In another study Marco Mouriño et al. (2012) estimated that the prevalence of **HBV** in Spanish prisons was 2.6%. Regarding the prevalence in Catalonia, Solà et al. (2002) showed a HBV rate of 1.69% for the period 1994 to 1996. Dr. Marco updated this data affirming that on average the HBV rate in prisons nowadays is double than the national standard (0.7-1.7%) (personal interview).

Regarding mortality rates, in 2012 there were 63,284 deaths in Catalonia, a crude mortality rate (CMR) of 8.32 deaths per 1,000 inhabitants (in 2011, the rate was 8.01). (Generalitat de Catalunya, 2014a). If we compare this rate with the annual crude mortality rate of Catalan prisons, in the table below, we can surmise that for 2012, the

CMR was much lower (4.25) than the general population CMR.

Table 9: Crude mortality rate (CMR) and specific mortality rates (SMR) from AIDS and other causes (per 1,000 inmates) – Prisons of Catalonia, 2003-2014

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
AIDS SMR	0.71	0.67	0.66	0.50	0.47	0.37	0.29	0.06	0.11	0.11	0.12	0.06
Other causes SMR	7.55	6.42	7.83	5.02	6.28	5.07	5.04	4.94	5.04	4.17	6.11	5.27
CMR	8.97	7.75	8.95	5.90	7.11	5.82	5.60	4.93	5.14	4.25	6.19	5.14

Source: Own elaboration (using annual population average, see Annex 1).

Disaggregation and specific vulnerabilities

Published official statistics do not contain disaggregated data by socio-demographic profile of prisoners. To get this kind of information it is necessary to resort to scientific literature. Relevant data from some of these studies regarding different infectious diseases are as follows:

- HIV:** The multicentre study of Marco Mouriño et al. (2012) found that 90% of inmates infected by HIV were Spanish – who are usually more likely to be injecting drug users (IDU) than foreign prisoners. 85% of the sample were IDU and only 16.1% of those who once had been IDU had not acquired the infection. In addition, most of them were over 40 years old and they knew about their infection for 8 years, but it is possible that a significant percentage of them were infected years before knowing it. These data suggest that there is a decreasing degree of young people choosing to inject drugs and infections in the IDU group have been significantly reduced (Marco Mouriño et al., 2012).

85% of those infected with HIV were co-infected with HCV and 12.5% with HBV and HCV together, as these viruses are efficiently transmitted by injection. Multivariate analysis confirmed the association between being infected by HIV+ and: a) having ≥ 40 years; b) being UDI; c) being infected by HCV; d) being infected by HBV (Marco Mouriño et al, 2012).

- HIV and adherence to antiretroviral treatment:** Herraiz, Villamarín & Chamarro (2008) studied adherence to antiretroviral therapy in 163 HIV positive inmates of Centro Penitenciario de Hombres de Barcelona (CPHB) between 2003 and 2005. The socio-demographic and criminal-prison profile of the sample is as follows: the average age was 36.4 years, 61.3% were single, 1.3% was illiterate, 34.75% attended primary school, 42.7% went to secondary school and 1.3% attended university. 86.7% were convicted. The most common crimes committed were theft (66.2%) and offenses against public health (10.8%). 94.7% were recidivist. 97.3% were serving sentences under ordinary regime (see Annex 2).

Regarding the clinical characteristics and treatment (see Annex 3), 73.4% of inmates had been infected by HIV through needle exchange, as they were IDU. 66.7% of the sample did not have AIDS. The mean time from diagnosis of HIV infection until the interview was 149 months. According to the authors, these data are similar to those reported by other research with inmate populations (Herraiz, Villamarín & Chamarro, 2008).

- HCV treatment adherence:** Marco Mouriño et al. (2010) studied the compliance to treatment for Chronic Hepatitis C (CHC) drug user patients, between 2003 and 2007 in four prisons of the province of Barcelona. The profile of their sample was the following: there were 162 patients in prison treated for CHC with a history of illegal drug use. Their average age was 34.9 years, 97.5% were male and 95.7% were Spaniards. 82.7% of patients were IDU; 100% of women and 75.9% of men. IDU prevalence was higher among prisoners with Spanish nationality than the others (83.2% vs 57.1%; $p < 0.001$). 20.5% were included in Methadone Treatment (MT) during the entire treatment time¹⁷.

33.1% of patients reported having used heroin and/or cocaine during or after treatment, (21.9% nasally and/or smoked, 6.6% intravenous and 4.6% in both ways. See Annex 5). MT patients had lower consumption of drugs, but it was not statistically significant (75.6% of non-users vs 68.2%; $p=0.49$). Otherwise, there were differences in the use of intravenous drugs (2.4% where performed MT vs 12.7% in those without; $p=0.04$). 12 patients admitted having shared injecting equipment, of which 10 of them while they were in prison (Marco Mouriño et al., 2010).

Multivariate analysis confirmed the link between the interruption of the treatment and intravenous drug use inside and outside prison, while it is rejected any association with the other variables included in the research (Marco Mouriño et al., 2010).

HCV: According Major & Guerrero (2014), the distribution of different genotypes of HCV among infected inmates of Catalan prisons is the following: genotype 1 (54%), genotype 2 (2%), genotype 3 (27%), genotype 4 (16%) and 1% for other serotypes. This distribution has not suffered significant changes in recent years and it does not differ from the distribution that we can find in the rest of Spain or from non-imprisoned IDU.

LTBI: Garcia Guerrero et al. (2010) state that factors commonly associated with LTBI (or ITL) are: a) age, because the longer exposure time means a greater chance of infection; b) physical proximity, sometimes due to prison overcrowding. Among all the studied factors, these two were independently associated with LTBI. The logistic regression model confirmed the independent association of the LTBI with: a) age > 40 years; and b) term > 5 years in prison. This high prevalence may be due to the poor socioeconomic conditions of a great proportion of prison

¹⁷ Other descriptive characteristics of the study population are shown in Annex 4.

population which is also classically associated with the risk of LTBI.

- **LTBI:** Solé et al. (2012) analysed a sample of 152 immigrant men imprisoned in the CPHB in June 2009, to study the prevalence of LTB. The profile of their sample was: average age: 31.9 years. 37.3% were consumer of heroin and/or cocaine and 7.5% were IDU. Multivariate analysis only confirmed the association with age.

Unlike the native population, where there is often a relationship between the LTBI and HIV infection rates, this linkage was not observed in the immigrant population, which had the same LTBI rates but had lower HIV rates. The key would be that foreign inmates were generally less likely to be intravenous drug users (Solé et al., 2012).

- **TB:** According Dr. Andrés Marco “the number of TB cases is five times higher in foreign inmates than in Spanish” (interview).
- **HBV** - In the interview, Dr. Marco explained that years ago Catalan public health vaccinated various risk groups, including inmates and prison officers. He considered that it was a successful strategy at that time, so today the prevalence rate between national inmates (1.5%) would be similar to the general population (0.7-1.7%). However, at the time of the vaccinations, the presence of foreigners in prison was much lower. Today they represent nearly one in two inmates (43% in 2014), in Catalonia. So, the HBV risk among foreign prisoners now is 3.5 times higher, since they arrived with the new flows of international migration and they were not subjected to vaccination in the past.

Trends on rates of infectious disease in the last years

Trends in prisons

Time series show a sustained downward trend in prison health indicators. The best descriptions and interpretations of trends, again, are found in the available scientific literature. Although generally this covers the prison-epidemiological transition in the whole of Spain, this can be considered as applicable to the Catalan prison situation as well.

Hernández & Arroyo (2010) analysed the trends of infectious diseases in Spanish prisons. According to these authors, “the prevalence of HIV infection shows a clear downward trend in recent years, with the prevalence observed in 2008, 3.5 times lower than that observed ten years ago” (see Annex 6) .

These authors also show the evolution of the incidence of tuberculosis and AIDS in Spanish prisons (see Annex 7). Both diseases have a decreasing trend with almost parallel curves, which also indicates the important relationship between tuberculosis

and AIDS. Between 1994 and 2008 there has been a decline in AIDS cases of 93.7%. In the case of tuberculosis the descent began in 1996, and from this year to 2008 it decreased by 85% (Hernandez & Arroyo, 2010).

Regarding the evolution of the prevalence of infection with HCV in Spanish prisons, with a high prevalence in 1998, in the last 10 years it has halved (**see Annex 8**) (Hernandez & Arroyo, 2010).

The prevalence of HCV in Catalan prisons followed the same path. According to data from the Health Area of the Department of Justice – DGSP- HCV prevalence rate has reduced from 43.6% in 2004 to 19.2% today (Major & Guerrero, 2014).

Hernandez & Arroyo (2010) observed that the evolution of the incidence of HIV and HCV infections transmitted in prison (seroconversion) has also decreased in Spanish prisons. This indicator measures the effectiveness of prevention and control programs for these diseases in prison. Seroconversion rates in both infections have declined in the last 8 years (years for which data are available), 85% in seroconversions to HIV and 71% in HCV seroconversions (**See Annex 9**).

Regarding the overall mortality rate in prison, Marco Mouriño (2011) states that “the number of deaths in prison has decreased considerably in recent years. The crude mortality rate, which once was far superior to that of the general population, currently is lower than that of non-incarcerated population”.

Trends in the general Catalan population

It is possible to find equally favourable trends for TB and AIDS trends in general population and, to a lesser extent, also for HCV. In the last twenty years **TB** has been declining very significantly in the general population. The incidence rate of TB per 100,000 inhabitants was 48.5 in 1995; 41.9 in 1996 and 22.2 in 2008. In 2013, it stood at 15.4 (Generalitat de Catalunya, 2014c). These figures represent a cumulative reduction of 68.2% in the period.

In the same years, the number of **AIDS** patients in Catalonia also dropped, passing from 1,323 cases in 1996 to 139 in 2013, a reduction of 89%. Unfortunately, we cannot say the same about the **HIV** incidence, due to a very slow decreasing trend, since this statistic was started. In 2001, the first year of the time series, 741 new HIV cases were reported, representing a rate of 11.7 cases per 100,000 inhabitants. In 2009, these figures were 722 new cases and a rate of 10.2, which represents a cumulative reduction in the HIV incidence rate of 12.8% over 8 years. But in the last five years (2009-2013), the total number of reported cases has remained stable. Thus, in 2013 there were 754 new cases and a rate of 10.4 (18.3 for men and 2.7 for women) (Generalitat de Catalunya, 2014a).

It was not possible to find trend analysis in the sources consulted for **Hepatitis C**,

although it was reported that the incidence of new cases of **CHC** treatment per 100,000 inhabitants in Catalonia was 28.83 in 2006; 24.17 in 2007; 30.44 in 2008; 24.8 in 2009 and 22.8 in 2010 (Generalitat de Catalunya, 2009; 2010). These data imply a reduction of 21.9% in the short period considered (2006-2010). The number of new cases of patients being treated ranged from a maximum of 2,242 in 2008 and a minimum of 1,721 in 2010. So, the incidence of HCC patients who are treated for the first time showed a “slightly down” tendency (Generalitat de Catalunya, 2009; 2010).

We can conclude this data analysis with the following from Rafael Guerrero, who affirmed that “prison is a reflection of society. Everything that happens in society also happens in jail. All actions that have been made in the community benefit us. Everything we’ve done in prison, also benefits us” (interview)

In fact, the important epidemiological transition in Catalan and Spanish prisons in the last fifteen years can be explained not only by a set of sanitary measures, but also by important sociological changes in the profile of prisoners throughout the years.

In general two relevant sociological factors should be noted:

1) There is an overall reduction of Spanish prisoners who use drugs and, among drug users, there is a change in the consumption pattern observed, with less IDU¹⁸.

2) The percentage of foreign prisoners grew enormously in Spain and in Catalonia. Foreigners in 1996 represented 17% of inmates, while in 2013 this segment represented 44% in Catalan prisons and 29% in the rest of the state (32% for all Spain)¹⁹. Among these prisoners there are generally fewer drug users, especially IDU (Marco Mouriño et al, 2010; 2012; Solé, 2012). So, it seems that the increased presence of migrant populations has contributed somehow to reduce HIV and HCV on prison, but, on the other hand these people come from poorer countries with greater exposure to TB (Solé et al., 2012).

Health system reform in the Catalan population has also contributed to the fact that among the new inmates entering prison, proportionally we find fewer sick people. Key statistics, as seroconversions in prison, seem to show that in this period the performance of health professionals in prison was very effective. This would show that the prison health managers took advantage of the window of opportunity represented by having a population at risk concentrated in a single institution. So, it can be concluded that the control of infectious diseases in prison has also contributed to a substantial improvement of epidemiological tables in the whole population.

The decline of the crude mortality rate has occurred mainly because of the improvement in living conditions and survival rates of people infected with HIV, as a consequence

¹⁸ According to Dr, Turu, in the first medical consultation offered to the inmate on admission to prison, information about drug use and consumption pathways are also collected. By this source, which is not published, it's been observed a progressive decrease of the IDU population in prison.

¹⁹ Own elaboration based on data available in the Statistical Yearbook of the Ministry of Interior of Spain - 2013

of the introduction of HAART (Highly Active Antiretroviral Therapy), in late 1996 (Marco Mouriño, 2011). Thanks to the availability of antiretroviral drugs, mortality from this cause today represents less than 10% of all deaths in prison (Garcia Guerrero et al., 2011), transforming HIV in a chronic disease (Herraiz, Villamarín & Chamorro, 2008).

It should also be noted that the increase of health provision in prisons allowed inmates to make more use of medical services than if they were out of prison, which facilitates the early detection of health problems that might otherwise be unnoticed (Garcia Guerrero et al., 2011).

Concerning mortality in prison, all the implemented programs (reduction of damage associated with drug use, suicide prevention, prevention and control of infectious diseases etc.) have shown remarkable success so they will continue as they are necessary for this population (Marco Mouriño, 2011).

3. Harm reduction policies and services in prison

Harm reduction programmes in prison have been developed since the eighties, when drug users came into prisons and AIDS and infections related to drug use through intravenous injection started to be a problem.

In the eighties, the first programmes in prisons were drug free programmes, education, and awareness raising. Brochures about how to safely inject drugs, with recommendations about not sharing syringes or other equipment, and teaching how to clean them were made available to prisoners. Hygienic packs were distributed with brushes, blades, and bleach. Later, harm reduction programmes started to be offered in prisons.

The most important harm reduction programme is substitution treatment and maintenance with methadone, which combines services of medical, social and legal assistance for users. It was very controversial when it started to be implemented in prisons in 1993, where it had been widely available outside prisons for some time. Many addicts in prisons were reluctant. They were afraid about the effects of tacking another drug, such as methadone for the risk of overdose, etc. (interview to ICS).

Luckily, the programme was widely expanded and now it is offered in all Catalan prisons. It is a low threshold programme, which means that access to this programme is easy and few conditions are required. It prevents infections and it is secure.

Recently, however, the number of persons following this programme is decreasing. In 2014, 1,300 prisoners were registered in the methadone maintenance programme of which 200 were new patients (interview to ICS). The cause of this decrease is due to the general reduction of IDU.. Luckily, in 2014, only 7% of new prisoners affirm use or have used drugs by this method (interview to ICS).

The Syringe Interchange Programme distributes syringes and other necessary equipment for the safe use of drugs intravenously. Outside of prisons, the pack contains: syringes, water, towels and a bowl.

This programme arrived very late in prisons and it has been implemented with many difficulties. Currently it is offered in all Catalan prisons except in “Centre Penitenciari d’Homes de Barcelona” (known as “La Model”), where there are mainly prisoners in pre-trial detention. Most nurses and doctors believe that it should be offered there too.

There are different perspectives on the needle exchange programme. From a public health objective standpoint, where supporters believe it should be offered always and everywhere. From the point of view of those who understand the programme as a way of change of behaviour and a treatment for drug use and support a restricted use of the programme. Finally, we find those who consider that this kind of programme is incompatible with the idea of a prison, because it challenges its safety (interview to ICS). Spain implemented this programme before than Catalonia. Catalonia faced the opposition of penitentiary worker unions who considered that syringes in prison were very dangerous.

Members of prison health care staff are responsible for the exchange of syringes. Other options were considered but in the end, syringes are exchanged only in the nursery. Anonymity is required. A prisoner is supposed to go to the nursery without having to say why she/he is going. Having a syringe inside a cell is a severe infraction except if the person who has the syringe is registered in the syringe interchange programme. It is in this instance when anonymity could be broken. Also of note is the fact that the pack that is delivered in prisons is not complete. The bowl is not included, as it is considered dangerous. These factors could explain the limited use of this programme. Only 5-6 % of IDU in prisons are following the syringe interchange programme.

In 2010-2011 a pilot harm reduction programme for safe tattooing was introduced, addressed to young offenders, who usually practice tattooing. The programme offered the availability of a professional to those who wanted to get a tattoo and provided education about how to practice safe tattooing. However, this programme did not fit with the programme of detection of gangs. Many motifs and drawings, which could be associated to gangs, were forbidden. At the end of the pilot, few young offenders wanted to get a tattoo within the programme and the programme was discontinued.

Finally, condoms are generously distributed within the ordinary hygienic pack (towels, shampoo, hygienic paper, etc.), when prisoners have “vis a vis” visits, or when they want. The number of items in the hygienic pack has decreased since the crisis and the cuts (interview to Mar Torrecillas, Catalan Ombudsman).

IV. HUMAN RIGHTS MONITORING IN PRISON AND INFECTIOUS DISEASES

1. Prisoners health: legal and policy frameworks

As previously mentioned, articles 15 and 43 of the Spanish Constitution guarantee the right to life, to physical and moral integrity, and the right to health protection. As they are fundamental rights they cannot be limited by any judicial pronouncement or any sentence.

According to the article 3.4 of the Organic General Penitentiary Law and article 4.2 of the Penitentiary Rules, imprisoned people have the right to a safe life guaranteed by the Administration, including physical and moral integrity in addition to health.

The health of prisoners is provided according the national standards given by the National Health System and the Penitentiary Law and Rules. Until last year in Catalonia the Penitentiary Health Service was dependant on the Department of Justice, but in November of 2014, Catalonia transferred the responsibility of health care in prisons from the Department of Justice to the Department of Health.

The deprivation of freedom of a citizen though imprisonment binds the prisoners and the Administration together, establishing a “special relation[ship] of subjection” (Sentence of the Constitutional Court 74/1985, 2/1987, 120/1990 y 57/1994, among others). This special relationship gives the Administration an autonomous and greater administrative responsibility towards a prisoner than towards a common citizen. Exercising this power is under strict observation of the law and is limited by the original purpose of the relationship, the prison sentence, (article 1 Organic General Penitentiary Law) and by the preferential value of the fundamental rights of the prisoner which are specially recognized by article 25.2 of the Spanish Constitution.

This “relation[ship] of special subjection” allows the Penitentiary Administration to limit some fundamental rights of the prisoners due to the deprivation of freedom itself, but at the same time it imposes the protection and facilitation of the exercise of the other rights which are not necessarily limited (Sentence of the Tribunal Court 2/1987). In our case, the Penitentiary Administration has to protect and facilitate the right to health protection. Therefore the responsible party for ensuring the health of prisoners is the Penitentiary Administration which fulfils its duty through the common Catalan and Public health system, as the health system of prisons is wholly integrated within it.

There are no special laws or polices governing the monitoring of health in prison, so we must refer to laws outlining the supervision of general oversight and practices of the Administration. As the Penitentiary Administration and the Public Health System are subsidiary departments of the Catalan Government, the institution that protects and defends the rights and freedoms of the citizens is the Catalan Ombudsman, or, “*Síndic*

de Greuges". The Catalan Ombudsman is regulated by the articles 78 and 79 of the Statute of Autonomy of Catalonia (2006). Article 78.1 describe its functions as follows:

The Ombudsman has the function of protecting and defending the rights and freedoms recognised in the Constitution and in this *Estatut*. To this end, he or she oversees, exclusively, the activity of the Administration of the *Generalitat*, that of any public or private related bodies that are associated with or answerable to it, that of private companies that manage public services or that carry out activities of general or universal interest, or equivalent activities in a publicly-subsidised or indirect way, and that of other persons with a contractual relationship with the Administration of the *Generalitat* and with the public bodies which are answerable to it. He or she also oversees the activity of the local administration in Catalonia and that of the private or public bodies which are associated with or answerable to it.

Its regulation is further developed in the ACT 24/2009, of December 23, on the *Síndic de Greuges* (Official Bulletin of the Generalitat of Catalonia number 5536 of 12 30 2009).

The institution that defends the fundamental rights of prisoners and monitors the Spanish Administration is the Spanish Ombudsman, or, "*Defensor del Pueblo*". According to the Spanish Constitution (article 54), "he or she is the high commissioner of the *Cortes Generales*, appointed to defend fundamental rights; for this purpose he or she may supervise the activity of the Administration and report [back] to the *Cortes Generales*." This institution is regulated by the Organic Act 3/1981, of 6 April 1981 and is further amended by Organic Act 2/1992, of 5 March 1992 and Organic Act 1/2009, of 3 November 2009 (Official State Gazette 266, of 4 November 2009).

Following ratification by the Spanish State of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment adopted by the United Nations General Assembly in New York on 18 December 2002, and ratified by Spain on 3 March 2006, the Spanish Parliament attributed the functions of the National Preventive Mechanism against Torture (NPM) in Spain to the "*Defensor del Pueblo*" in late 2009.

By way of Organic Law 1/2009 of 3 November 2009, the Spanish Parliament vested the "*Defensor del Pueblo*" with the authorities inherent to Spain's National Preventive Mechanism. In its role as NPM the "*Defensor*" started conducting visits into places of detention in March of 2010. The "*Defensor*" as NPM can visit places of detention over all Spanish territory, which includes Catalan Prisons and the health of their prisoners. The NPM submits an Annual Report to the Spanish Parliament and to the United Nations Subcommittee on Prevention of Torture headquartered in Geneva.

In Catalonia, the ACT 24/2009 on the "*Síndic de Greuges*" includes a Title regarding the prevention of torture and other cruel, inhuman, or degrading treatments (Title VIII).

It states:

“by virtue of the optional protocol to the United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatments, (...) the Catalan Ombudsman is granted the status of Catalan Authority for the Prevention of Torture and other Cruel, Inhuman or Degrading Punishment, with the character of an independent national body, pursuant to Article 17 of the Protocol (article 68)”.

Article 69 continues to establish that:

“the Catalan Ombudsman shall act as Catalan Authority for the Prevention of Torture and other Cruel, Inhuman or Degrading Punishment in any place where there are persons deprived of freedom, be they centres or facilities located in Catalonia, or transports travelling through Catalonia, if said places are dependent on the administrations, bodies, companies and persons referred to in [the above mentioned] article 78.1 of the Statute.”

When this Catalan ACT was passed, the “*Defensor del Pueblo*,” the Spanish Ombudsman, appealed it before the Constitutional Court. On 5 March 2015, the Constitutional Court found that Title VIII of ACT 24/2009 was unconstitutional. Specifically, the Court stated that the Catalan Ombudsman cannot be internationally recognised as Catalan Authority, but he or she can be the Catalan Mechanism for the Prevention of Torture. That means that the Catalan Ombudsman, the task force and the Advisors Council created for the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment can continue with their duties, but without the international recognition of the institution. Currently the “*Síndic de Greuges*” and the “*Defensor del Pueblo*” are working on an agreement to regulate the collaboration among the institutions.

To sum up, the “*Síndic de Greuges*” as Catalan Ombudsman has the duty to monitor the Catalan public health system and the Catalan Prison Administration, by extension this means that he or she is responsible for monitoring health in prisons. The “*Defensor del Pueblo*” as the Authority of the Spanish National Preventive Mechanism against Torture has the duty to verify that in the detention centres within all Spanish public Administrations the authorities as well as their staff act in accordance with the criteria laid down by Spanish and International standards for provision of care. They must also ensure that their administrations and facilities are not conducive to mistreatment or torture. The “*Síndic de Greuges*” as the Catalan Mechanism for the Prevention of Torture has the same duties but only in Catalonian detention centres, making both institutions responsible for monitoring the health of inmates in Catalan prisons.

On 26 November 1987, Spain ratified the Council of Europe’s “European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment,” which came into effect in 1989, which established the European Committee for the

Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The Committee shall, through inspection visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment. According to the CPT standards, health care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate. Therefore, the CPT can also visit Catalan Prisons to ensure that prisoners receive appropriate healthcare.

2. Human Rights Monitoring Mechanisms

National monitoring mechanisms

The national bodies with the mandate to monitor health in Catalan prisons are the “*Sindic de greuges*”, (the Catalan Ombudsman), the Catalan Preventive Mechanism and the “*Defensor del Pueblo*,” the National (Spanish) Preventive Mechanism.

The Sindic the Greuges:

The Catalan Ombudsman shall exercise his/her competencies with impartiality, objectivity and independence (article 2 ACT 24/2009). He or she is elected by a majority vote (three fifths) of the Catalan Parliament for a nine-year term. The *Sindic* is not subject to any government body, is politically independent and acts with objectivity, freedom of criteria and independence.

The *Sindic's* power resides in persuasion. The *Sindic's* decisions contain the recommendations and warnings considered prudent for the various administrations to correct an irregular situation. The *Sindic* can also recommend the introduction of changes or legal modifications in the rules if s/he observes an infringement of persons' rights. The *Sindic* does not impose, penalize, or sentence, but his or her decisions are unappealable.

Every year, the *Sindic* informs the Parliament on his or her work in a plenary session. S/he also presents special reports on any specific issues deemed especially important or urgent.

As Catalan Ombudsman, the *Sindic's* role is to handle the complaints of anyone who is left unprotected by an administrations' actions or omissions. She seeks to ensure the proper administration of the Catalan Government (Generalitat) and local administrations, such as local councils, provincial governments or county councils. Thus, s/he works as a supervisor and collaborator with the Catalan Administration, with the aim of improving its operation.

The *Sindic* intervenes after receiving a complaint or on his/her own initiative (“*ex-officio*”), when s/he observes that administrations (autonomous government, ministries, county councils, provincial governments, peripheral Spanish administrations) or the

companies that provide services of public interest in Catalonia may have infringed the rights of a person or group.

Based on the complaints received, or *ex-officio*, the *Síndic* undertakes the actions and investigations necessary to detect possible rights infringements and to find solutions, making this role a reactive mechanism. If affairs have already been settled or are pending a judicial sentencing, the *Síndic* cannot intervene. The *Síndic* serves also a patient's Ombudsman, and he has the mission of guaranteeing the rights of all the users of the Catalan Health System.

The Catalan Ombudsman receives queries and complaints from people detained in penitentiary centres, as they are permitted to address the *Síndic*. In order to collect information to investigate their cases, the *Síndic* solicits the necessary data from the regional administration, s/he visits the prisons facilities and interviews the authorities responsible for the penitentiary centres, staff and prisoners. When the Catalan Ombudsman, as *Síndic the Greuges*, goes to a prison s/he usually announces the visit and the name of the person that they want to interview, but if they wanted they can also perform "surprise visits". They announce the visit for organizational reasons and to guarantee that they can see the requested inmate, but once they are in the prison they can also interview other inmates without prior notice, penitentiary doctors, social workers, etc. After the *Síndic's* intervention they send a questionnaire to assess his or her work and to know the results of their actions.

As the Catalan Preventive Mechanism, according to Title VIII of the ACT 24/2009, the Catalan Ombudsman, as the Catalan Preventive Mechanism (before the Constitutional Court decision: the Catalan Authority for the Prevention of Torture and other Cruel, Inhuman or Degrading Punishment), may:

- a. Regularly visit the places where persons deprived of freedom are held.
- b. Make recommendations to the competent authorities.
- c. Make proposals and observations to the draft bills on this subject matter.
- d. Exercise any other duty attributed by the optional protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment.

The Catalan Preventive Mechanism (CPM) has access to the information on the number and location of any place where there are persons deprived of freedom, on the number of persons deprived of freedom, on the treatment these persons receive and on the conditions of their detention or internment. S/he also may have access to medical record information only if it is related with the duties exercised by the institution in this field, and must adhere, in all cases, to the obligation of confidentiality (article 72 ACT 24/2009).

The CPM may interview the persons deprived of freedom, without witnesses, and with the assistance of an interpreter if necessary, and any other person who could provide relevant information, on the premises deemed appropriate of the places where the

persons deprived of freedom are held (article 73 ACT 24/2009).

The Catalan Ombudsman's task force for the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment is made up of the Catalan Ombudsman or Ombudswoman and five professionals. Among them are human rights and health experts, specifically, there is a psychiatrist (from 2014) and a doctor (from 2015). The staff have the capacity to monitor and collect information on health and human rights issues, and in particular infectious diseases in prisons but they do not record these as they are not taking this issue into account in their inspections.

To monitor prisons they do not send questionnaires, but they perform "surprise visits" to inspect prison conditions. They mainly collect qualitative information, so the data is not disaggregated. The activities conducted as the Catalan Preventive Mechanism are annually presented by a monographic report to Parliament.

The "*Defensor del Pueblo*," as the National Preventive Mechanism:

As part of the broad duties devolved to the *Defensor del Pueblo* for the defence and protection of fundamental rights by article 54 of the Spanish Constitution and by the Organic Act 3/1981 of 6 April 1981 regulating the aforementioned Institution, the specific role of the National Preventive Mechanism is to ensure compliance with article 15 (right to life) and article 17 (right to liberty and security) of the Spanish Constitution.

The *Defensor del Pueblo* as the National Preventive Mechanism against Torture makes preventive inspection visits to detention centres to verify the fulfilment of Spanish and International standards for these establishments and ensures that their operation and facilities are not conducive to mistreatment or torture.

To this end, the NPM may carry out – freely and without restrictions – visual, documental or any other kind of inspections of the places and centres of deprivation of freedom under the jurisdiction of the Spanish authorities.

The *Defensor* as NPM may obtain from the Spanish authorities any documents and reports it deems necessary. The authorities shall provide the Ombudsman with all such relevant documents, and shall act in full collaboration with this Institution.

The preventive actions of the National Preventive Mechanism consist of:

- Carrying out regular, unannounced inspection visits to deprivation of liberty centres in accordance with what has been set out in articles 1 and 19 a) of the Optional Protocol.
- Carrying out Records of Inspection and Reports in accordance with what has been set out in article 23 of the Optional Protocol.
- Making recommendations to the Authorities in accordance with what has been set out in article 19 b) of the Optional Protocol.

- Making proposals and observations about the legislation in effect or as is relates to bills regulating those matters in accordance with what has been set out in article 19 c) of the Optional Protocol.

The status of Ombudsman is incompatible with any representative mandate, with any political post or political propaganda activity. , It is also not compatible with affiliation to a political party or the performance of management duties in a political party or in a trade union, association or foundation and with employment in the pay thereof. It cannot conflict with judicial or financial employees of the state or with any professional, liberal, commercial or labour activity.

The “*Defensor del Pueblo*,” in his or her role as NPM draws up a public annual report which gives an account of its activity and submits it to the Spanish Parliament and the United Nations Organisation Subcommittee on the Prevention of Torture.

The different monitoring mechanisms use similar tools and follow similar processes, but they are not the same. The *Sindic the Greuges*, as the Catalan ombudsman, is a reactive mechanism; so, when they go to a prison to interview a prisoner or to inspect the conditions they announce the visit. The *Sindic* and the *Defensor* as the Catalan and National Preventive Mechanisms respectively, are preventive, so they do not schedule their visits.

The Catalan and National Preventive Mechanisms have different methodologies to carry out inspections to detention centres, but they follow similar guidelines of standards to query and observe during their visits. For instance, the NPM publish quantitative data and pictures in their reports, while the Catalan PM doesn't. The Catalan and National Preventive Mechanisms do not work together and they do not coordinate their visits. They do not compare or share the information they gather and report on. In fact, it is possible that they visit the same prison for the same case without knowing about the work conducted by the other institution.

The NGO's and associations that are part of the Spanish Coordinator for the Prevention of Torture regret that the NPM is not effective, independent, transparent and swift to act as it could be. They regret that instead of creating a truly independent new mechanism, driven and managed by the civil society, the Spanish Government decided to obey the OPCAT by designing the Ombudsman as the NPM. They make similar criticisms for the Catalan situation; despite the goodwill of the institution, there are not enough formal procedures to ensure participation by institutions they inspect.

The Courts in Spain are empowered to consider health rights and also health rights of prisoners, but if the affair has already been settled or is pending judicial sentencing, the NPMs cannot intervene. This aspect is also critiqued by the Coordinator for the Prevention of Torture as an obstacle to truly eradicate torture and ill-treatment.

Regional/International monitoring mechanisms

The Special Rapporteur on the question of torture, Theo van Boven, visited Spain from 5 to 10 October 2003. The report of the visit was published on 6 February 2004 (E/CN.4/2004/56/Add.2), and contains a study of the legal and factual aspects regarding allegations of torture or ill-treatment, in particular as it pertains to detainees held in connection to counter-terrorism measures. The Special Rapporteur concluded that torture or ill-treatment was not systematic in Spain, but that the system as it operates allows torture or ill-treatment to occur, particularly with regard to persons detained incommunicado in connection with terrorist-related activities. Accordingly, he recommended a number of measures to be adopted by the Government in order to comply with its commitment to prevent and suppress acts of torture and other forms of ill-treatment. The report did not include any recommendations relevant to infectious diseases and harm reduction services in prisons.

The European Committee for the Prevention of Torture and Inhuman and Degrading Treatment (CPT) has also visited Spain many times. The results of the visits can be found in the following reports:

1. Report to the Spanish Government on the visit to Spain carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 14 to 18 July 2014.
2. Report to the Spanish Government on the visit to Spain carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 19 to 22 June 2012.
3. Report to the Spanish Government on the visit to Spain carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 31 May to 13 June 2011.
4. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit to Spain from 14 and 15 January 2007.
5. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit to Spain from 12 to 19 December 2005.
6. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit to Spain from 22 July to 1 August 2003.
7. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit from 22 to 26 July 2001.
8. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit from 22 November to 4 December 1998.
9. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit on 17 and 18 January 1997

10. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit from 21 to 28 April 1997.
11. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit from 10 to 14 June 1994.
12. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit from 110 to 22 April 1994.
13. Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its visit from 1 to 12 April 1991

According to the CPT Standards, the spread of transmissible diseases, in particular of Tuberculosis, Hepatitis and HIV/AIDS in prison is an issue of serious concern to the CPT because of the inadequacy of the measures adopted in some European countries to tackle this problem. This is not the case of Spain, however, as in recent years there are no relevant recommendations regarding infectious diseases in prison.

V. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The Catalan and Spanish health systems are well-regarded due to their wide coverage, but the privatization trends and the situation after the economic crisis brought a reduction in budget which affected the access to health care for the entire population.

The Catalan and Spanish penitentiary systems present one of the higher population ratios of the European countries. After an exponential rise in population that took place until 2009, the population has since stagnated and even slightly diminished in some areas. Living conditions in Catalan prisons have worsened slightly in recent years, a consequence of the economic crisis and budgetary cuts.

The prevalence rates of infectious diseases (HIV, Hepatitis and Tuberculosis) in Catalonia and in Spain are higher than in surrounding countries. Prevalence rates in prisoners, in spite of reductions in the recent years, are still high. The prevalence of infectious diseases in Catalan prisons is overrepresented, compared to the general population.

In general terms, in Catalonia there are good health policies regarding detection of infection diseases in prisons, and so detection rates are high. Currently when each prisoner enters prison they are offered a medical test, called a “screening,” to detect AIDS, Hepatitis B, C and Tuberculosis. This test is voluntary. In 2014, 92% of the prison population was tested. If the test is positive, treatment begins. If the test is negative, it is repeated again in 6 months.

We can find the origin of testing policies in the 1980s, when the vast majority of the imprisoned population were drug users and there was a real epidemic of AIDS, HIV and Hepatitis that caused a great number of deaths in prison. This situation compelled the Penitentiary Administration to develop systems of detection, treatment and prevention of infectious diseases in prison, even if they were not implemented in the Spanish and Catalan societies, for reasons of public safety. This also ensures access to the treatments by inmates that the general population are afforded.

There is a great amount of reliable data about infectious diseases in prison but it is not disaggregated by gender, age or nationality.

The Penitentiary Health Service depended on the Department of Justice since the 1980s until last 2014. In November 2014, Catalonia transferred the responsibilities of health care in prisons from the Department of Justice to the Department of Health. Therefore the current health system in prisons is fully integrated within the common Catalan public health system. This change has not only symbolic consequences, as healthcare is prioritized ahead of security, but also practical ones. The main

advantages are related to what has been called the continuum of health assistance and the approach to chronic common illnesses.

Harm reduction programmes have been present in prison since the 1980s, when drug users came into prisons and AIDS and other infections related to intravenous drug use were widespread. The most important programme in the context of harm reduction was the treatment of drug addiction with methadone, which combined medical, social and legal assistance services for drug users. Administration and Prison workers, have had difficulties in adapting to this preventive health approach of these harm reduction programmes. From the beginning, many stakeholders in prisons were reluctant to enact these kind of programmes, making their implementation difficult.

The Syringe Interchange Programme distributes syringes and other necessary elements for the safe intravenous use of drugs. This programme arrived late to prisons, even more so in Catalonia where it faced the opposition of prison worker unions, who believed that syringes in prison were dangerous. It has been implemented with much difficulty especially in securing the anonymity of drug users and the tools given to these users. Currently the programme is offered in all Catalan prisons except in “Centre Penitenciari d’Homes de Barcelona” where there are mainly prisoners under preventive detention. Only 5-6% of intravenous drug users in prisons are participating in the Syringe Interchange Programme.

As far as monitoring systems are concerned, the national bodies with the mandate to monitor health provision in Catalan prisons are the “*Sindic de greuges*,” as the Catalan Ombudsman, and as the Catalan Preventive Mechanism, and the “*Defensor del Pueblo*” as the National (Spanish) Preventive Mechanism. The Catalan and National (Spanish) Preventive Mechanisms have different methodologies when carrying out inspections to places of detention, but they follow similar guidelines of questions to ask and what to look for during the visits. Their staff has the capacity to monitor and collect information on health and human rights issues, in particular about infectious diseases in prisons, but they do not record this as they are not taking this issue into during their inspection visits as there is a lack of resource for monitoring these specific issues. The main issue is that they do not work together and do not coordinate their visits. They do not compare, nor do they share the information they gather. Despite the goodwill of the institutions, NGOs and associations regret that these monitoring systems are not “really independent,” and regarding the NPM specifically, they regret that it is not as effective, transparent and swift acting as it could be.

The Special Rapporteurs on the question of torture, of the United Nations and the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment (CPT) have visited Spain many times but they did not make any relevant recommendations regarding infectious diseases or harm reduction services in prisons.

Recommendations

We recommend increasing the investment on public health systems, which will have a positive effect on infectious diseases in general and in prisons in particular. Additionally, restrictions in the access to public health care for migrants without residence permits should be removed.

We think that more effort should be given to have almost 100% of the imprisoned population screened for viral pathologies (HIV, HCV, HBV and TB). The initial and consecutive screenings offered to prisoners should be also offered to pre-trial detainees.

In relation to harm reduction programmes, we consider that greater effort should be made by the authorities to support health priorities to prioritise health care before security. We hope that the change of department responsible for health care in prisons in Catalonia would help in this prioritization. To aid in this goal, the Syringe Interchange Programme should be offered in all prisons, including the pre-trial detention centres, and with comparable equipment to that offered in the wider community (including the bowl). Other aspects of the programme relating to the anonymity and the easy access to the syringes and kit by prisoners should be developed. The success of the programme will be achieved when almost 100% of intravenous drug users in prison follow it.

Data about infectious diseases in prison should be disaggregated by gender, age or nationality.

The Catalan Ombudsman "*Síndic de Greuges*" as the Catalan Preventive Mechanism, and the "*Defensor del Pueblo*" as the National (Spanish) Preventive Mechanism should coordinate, cooperate, share information and work together to provide more comprehensive and cohesive monitoring systems. There is a need to develop mechanisms to monitor infectious diseases in prison. The Catalan and Spanish Ombudsmen should use these when they examine prisons. These mechanisms should also be available to doctors in prison, in order to take them into account when they treat inmates.

NGO and civil society groups which advocate for human rights in situations of deprivation of liberty should be aware of these mechanisms to be able to pressure authorities and monitoring institutions. NGO and civil society groups should also have access to deprivation of liberty centres to promote the proper application of these.

Finally, it would be useful if protocols for infectious diseases in prisons could be applied to other centres of detention, especially centres for migrants without a residence permit (CIE), where some cases of infection of Tuberculosis have appeared recently (CIE of Barcelona, 2015). Moreover, special attention must be paid to HIV and AIDS. In 2013, a woman died in the CIE in Madrid because nobody informed health services that she suffered from AIDS (this case is currently in trial).

REFERENCES

- Agència de Salut Pública de Catalunya (2014) Central de Resultats. MONOGRÀFICS 8. La salut de la població de Catalunya en el context europeu. Generalitat de Catalunya. Agència de Qualitat i Avaluació Sanitàries de Catalunya.
- Brandariz García, J.A & Castro Liñares, D. (2014) "The 'Great Recession' and criminal justice: the value of scarcity?", The Howard League for Penal Reform. Working Paper 07/2014 (http://www.howardleague.org/local_justice_working_papers/).
- Brandariz García, J.A (press) "La evolución del sistema penitenciario español, 1995-2014: La recepción de nuevos discursos en torno a la penalidad. Nueva justificación y modificación práctica de la realidad penitenciaria" in *Crítica Penal y Poder* (forthcoming)
- Centre d'Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEEISCAT) (2014) Vigilància epidemiològica de la infecció pel VIH i la SIDA a Catalunya. Actualització a 30 de juny de 2014. Badalona: CEEISCAT; 2014
- ECAS (2015) INSOCAT núm. 5| Monogràfic CRISI, GÈNERE I POBRESA: http://acciosocial.org/wp-content/uploads/2015/03/INSOCAT-5_Crisi-genero-pobresa_ECAS.pdf
- Forero, Alejandro and Daniel Jimenez (2014) La cárcel española en (la) crisis. Mano dura y escasez; ¿hacia la esquizofrenia punitiva?, in *Revista de derecho Penal y Criminología*, ISSN 0034-7914, N.º. 5, 2014, p. 27-52
- Freixes, Teresa and Júlia Lladós Vila (2015), Study: The impact of the crisis on fundamental rights across Member States of the EU. Country Report on Spain. <http://www.europarl.europa.eu/studies>
- García-Guerrero, J. et al. (2010). Estudio multicéntrico de prevalencia de infección tuberculosa latente en los internados en prisiones españolas. *Rev. esp. sanid. penit.* [online], vol.12, no.3, p.79-85.
- García-Guerrero, Julio, Vera-Remartínez, Enrique J. and Planelles Ramos, Manuel V. (2011) Causas y tendencia de la mortalidad en una prisión española (1994-2009). *Rev. Esp. Salud Pública* [online], vol.85, no.3, p.245-255.
- Generalitat de Catalunya, Departament de Salut (2009). Anàlisi de casos de d'Hepatitis C crònica tractats a Catalunya durant el període 2006-2008. *Butlletí epidemiològic de Catalunya*. Vol. XXX, maig 2009, n.º 1.
- Generalitat de Catalunya, Departament de Salut (2010). Anàlisi de casos de d'Hepatitis C crònica tractats a Catalunya durant el període 2009-2010. *Butlletí epidemiològic de Catalunya*. Vol. XXXI, desembre 2010, n.º 12.
- Generalitat de Catalunya, Departament de Salut (2014a). Anàlisi de la Mortalitat a Catalunya, 2012. Resum de resultats. *Butlletí epidemiològic de Catalunya*. Vol. XXXV, maig 2014, n.º 05.
- Generalitat de Catalunya, Departament de Salut (2014b). Vigilància epidemiològica de la infecció pel VIH i la sida i de les infeccions de transmissió sexual a Catalunya. Situació fins al 31 de desembre de 2013. *Butlletí epidemiològic de Catalunya*. Vol. XXXV, agost 2014, n.º 08.
- Generalitat de Catalunya, Departament de Salut (2014c). La tuberculosi a Catalunya l'any 2013. *Butlletí epidemiològic de Catalunya*. Vol. XXXV, setembre 2014, n.º 09.
- Generalitat de Catalunya (2014) Determinants socials i econòmics de la salut. Efectes de la crisi econòmica en la salut de la població de Catalunya. Agència de Qualitat i Avaluació Sanitàries de Catalunya (AQuAS). http://observatorisalut.gencat.cat/web/.content/minisite/observatorisalut/contingutsadministratius/observatori_efectes_crisi_salut_document.pdf
- Hernández-Fernández, T. & Arroyo-Cobo, J.M. (2010). Resultados de la experiencia española: una aproximación global al VIH y al VHC en prisiones. *Rev. esp. sanid. penit.* [online], vol.12, no.3, p.86-90.
- Herraz, F., Villamarín, F. & Chamarro, A. (2008). Correlatos psicosociales de la adhesión al tratamiento antirretroviral en el Centro Penitenciario de hombres de Barcelona. *Rev. esp. sanid. penit.* [online], vol.10, no.3, p.23-32.
- Major, Xavier & Guerrero, Rafael (2014). Epidemiologia: Situació de la infecció pel VHC i de la coinfecció del VIH amb el VHC a Catalunya en la població drogodependent. In: *Hepatitis C: Llibre de recomanacions sobre el tractament de l'Hepatitis C i de la coinfecció del VHC amb el VIH en pacients drogodependents*. Generalitat de Catalunya, Agència de Salut Pública de Catalunya: p. 26-30.
- Marco Mouriño, Andrés (2011). Evolución de la mortalidad en población reclusa tras la introducción del tratamiento antirretroviral de gran actividad (TARGA). *Rev. Esp. Salud Pública* [online], vol.85, no.3, p.233-236.
- Marco Mouriño, Andrés et al. (2010). Factores predictivos de cumplimiento del tratamiento de la hepatitis C crónica en personas drogodependientes de cuatro prisiones de Barcelona. *Rev. Esp. Salud Pública* [online], vol.84, no.4, p.423-431.
- Marco Mouriño, Andrés et al. (2012). Estudio multicéntrico de Prevalencia de Infección por el VIH y factores asociados en las prisiones de España. *Rev. esp. sanid. penit.* [online], vol.14, no.1, p.19-27.
- Solà R, Cruz de Castro E, Hombrados, M, Planas R, Coll S, Jardí R, Sunyer J, Covas MI, Marrugat J. (2002). Prevalencia de las hepatitis B y C en diversas comarcas de Cataluña: estudio transversal. *Medicina Clínica*, Volume 119: 90-95
- Solé, N. et al. (2012) Prevalencia de infección tuberculosa latente en población inmigrante que ingresa en prisión. *Rev. esp. sanid. penit.* [online], vol.14, no.1, p.12-18.

ABBREVIATION LIST

AIDS	Acquired Immune Deficiency Syndrome (SIDA in Spanish & Catalan)
BEC	Butlletí Epidemiològic de Catalunya (Epidemiological Bulletin of Catalonia)
CHC	Chronic Hepatitis C (HCC in Spanish & Catalan)
CMR	Crude Mortality Rate (TCM in Spanish & Catalan)
CPHB	Centre Penitenciari d'Hommes de Barcelona (Barcelona Male Penitentiary Center)
DGSP/DJ/GC	Direcció General de serveis penitenciaris/Departament de Justícia/ Generalitat de Catalunya (General Directorate of Penitentiary services /Department of Justice/Government of Catalonia)
HAART	Highly Active Antiretroviral Therapy (TARGA in Spanish & Catalan)
HBV	Hepatitis B Virus (VHB in Spanish & Catalan)
HCV	Hepatitis C Virus (VHC in Spanish & Catalan)
HIV	Human immunodeficiency Virus Infection (VIH in Spanish & Catalan)
HR	Harm Reduction (RD in Spanish & Catalan)
ICS	Institut Català de la Salut (Catalan Health Institute)
IDESCAT	Oficial statistics website of Catalonia, Generalitat de Catalunya, Institut d'Estadística de Catalunya
IDU	Injecting Drug Users (UDI in Spanish & Catalan)
LTBI (or ITL)	Latent Tuberculosis Infection (ITBL o ITL in Spanish & Catalan)
MT	Methadone Treatment (TM in Spanish & Catalan)
NEP	Needle Exchange Program (PIJ in Spanish / PIX in Catalan)
RESP	Revista Española de Sanidad Penitenciaria (Spanish Journal of Prison Health)
STI	Sexually transmitted infections (ITS in Spanish & Catalan)
TB or MTB	active Tuberculosis infection – short for tubercle bacillus (TB o TBC in Spanish & Catalan)

ANNEXES

ANNEX 1

Table 10: Prison population according to various criteria: POP1: different prison inmates who passed through over a year; POP2: inmates at December 31 of each year; POP3 annual average of inmates to the last day of each month – Prisons of Catalonia, 2003-2014

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
POP1	12.689	13.463	13.549	14.070	15.017	16.308	17.209	17.888	17.876	17.575	16.755	15.961
POP2	7.416	8.094	8.305	8.970	9.395	10.051	10.525	10.520	10.513	10.062	9.818	9.294
POP3	7.246	7.867	8.271	8.820	9.283	9.792	10.352	10.741	10.702	10.348	10.009	9.734

Source: DGSP/DJ/GC.

<http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/1_Poblacio_penitenciaria/int_dif_hist.htm>

<http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/1_Poblacio_penitenciaria/1_hist.htm>

<http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/1_Poblacio_penitenciaria/1_mitjana.htm>

ANNEX 2

Table 11: Socio-demographic and criminal-prison characteristics in HIV-positive inmates – Barcelona Male Penitentiary Centre (CPHB), 2003-2005.

	N (%)
Nivel cultural	
Primer nivel instrumental (analfabeto)	(1,3%)
Segundo nivel instrumental (neolector)	11 (14,7%)
Tercer nivel instrumental (certificado)	15 (20%)
Primer nivel graduado (secundaria primer grado)	32 (42,7%)
Segundo nivel post-graduado (secundaria segundo grado)	15 (20%)
Acceso mayores 25 años	1 (1,3%)
Estado civil	
Soltero	46 (61,3%)
Casado/pareja	15 (20%)
Divorciado/separado	14 (18,7%)
Actividades en el centro	
Si	33 (44%)
No	42 (56%)
Situación penal	
Penados	65 (86,7%)
Preventivos	8 (10,7%)
Penado + preventiva	2 (2,6%)
Reincidencia penitenciaria	
Si	71 (94,7%)
No	4 (5,3%)
Régimen de vida	
Ordinario (Segundo grado)	73 (97,3%)
Cerrado (Primer grado)	2 (2,7%)
Tipología delictiva principal	
Robo	49 (66,2%)
Contra la salud pública	8 (10,8%)
Homicidio	5 (6,8%)
Robo con intimidación/violencia	4 (5,4%)
Lesiones	4 (5,4%)
Otros (Hurto, violencia doméstica, falsificación...)	4 (5,4%)
	Media (DS)
Edad (años)	36,4 (5,31)
Condena (días)	1948 (1766,38)
Delitos	2,25 (2,51)

Source: Herraiz, Villamarín & Chamarro, 2008

ANNEX 3

Table 12: Clinical treatment and psychosocial characteristics in HIV-positive inmates – Barcelona Male Penitentiary Centre (CPHB), 2003-2005.

	N (%)
Vía de transmisión	
Contacto heterosexual	15 (23,4%)
Usuario de drogas por vía parenteral	47 (73,4 %)
No sabe	2 (3,2%)
Estado enfermedad	
Sida	24 (32%)
No Sida	50(66,7%)
Tratamiento previo	
Si (no naive)	57 (79,2%)
No (naive)	15 (20,8 %)
Razones interrupción/cambio de tratamiento antirretroviral	
Efectos secundarios medicación	26 (40%)
No mejora	1 (1,5%)
Complejidad tratamiento	5 (7,7%)
Descenso CD4	6 (9,2%)
Recaída en el consumo de drogas	3 (4,6%)
Depresión	2 (3,1%)
Enfermedad	6 (9,2%)
Aumento de carga viral	3 (4,6%)
Olvido	1 (1,5%)
Otros	12 (18,6%)
Ingesta otro tipo de medicación	
Psicotrópicos	28 (49,1%)
General	16 (28,1%)
Psicotrópicos + general	13 (22,8%)
	Media (DS)
Tiempo transcurrido desde el diagnóstico (meses)	149 (66,07)
Nº de pastillas de antirretrovirales prescritas al día	4,67 (2,67)
Variables psicosociales	
Apoyo social	5,07 (3,32)
Cuidados personal médico y sanitario	5,15 (1,87)
Barreras percibidas para seguir el tratamiento	2,16 (1,06)
Beneficios del tratamiento	14,58 (3,81)
Severidad enfermedad	2,04 (1,11)
Norma subjetiva	4,60 (2,44)
Autoeficacia manejo medicación	7,16 (1,92)
Autoeficacia comunicación	6,51 (2,52)
Estado de ánimo	107,88 (9,69)

Source: Herraiz, Villamarín & Chamarro, 2008

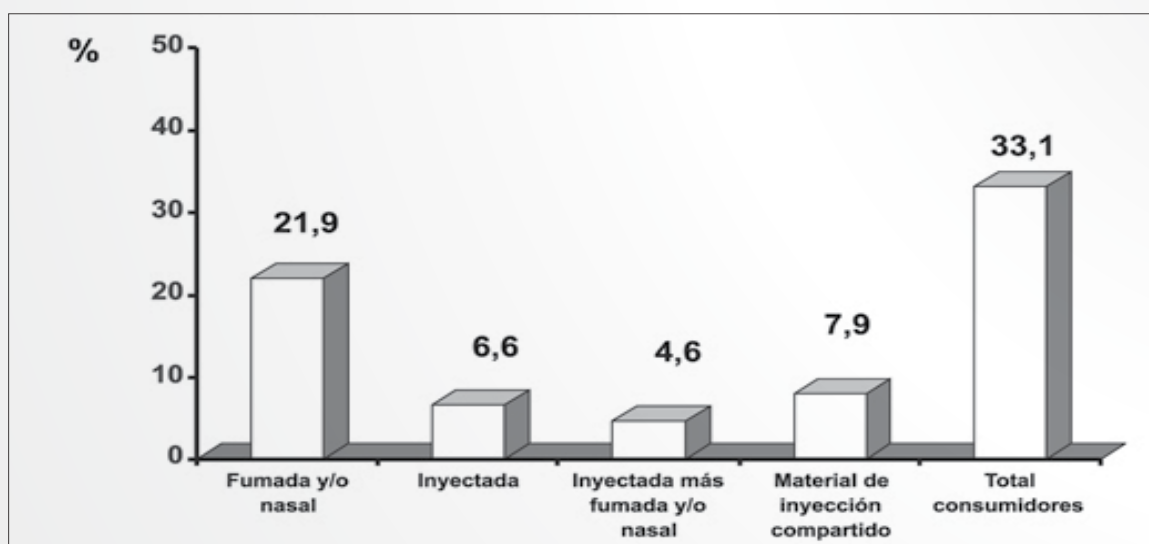
ANNEX 4

Table 13: Characteristics of drug users inmates with CHC – Catalonia, four prisons, 2003-2007.

Variable		N	(%)
Sexo	Hombre	158	97,5
	Mujer	4	2,5
UDI	Sí	134	82,7
	No	28	17,3
Españoles	Sí	155	95,7
	No	7	4,3
Estudios básicos completados	Sí	128	79
	No	34	21
Ingresos en prisión; n	1	14	8,6
	>1	138	91,4
HIV coinfección	Sí	35	21,6
	No	127	78,4
Genotipo 1 ó 4	Sí	80	49,4
	No	82	50,1
RNA viral basal [*] 500.000 IU	Sí	116	71,6
	No	46	28,4
Duración del tratamiento	24 semanas	65	40,1
	48 semanas	97	59,9

Source: Marco Mourinho et al. (2010, 424)

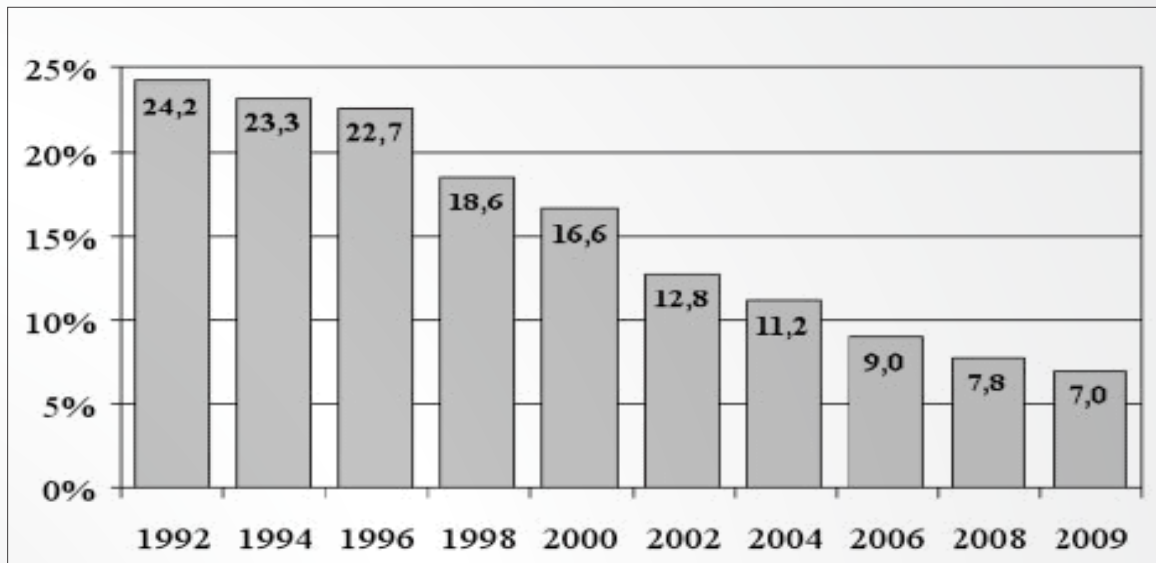
ANNEX 5

Graph 7: Proportion of drug users inmates with CHC according to way of consumption and use of shared injection equipment – Catalonia, four prisons, 2003-2007.

Source: Marco Mourinho et al. (2010, p 429)

ANNEX 6

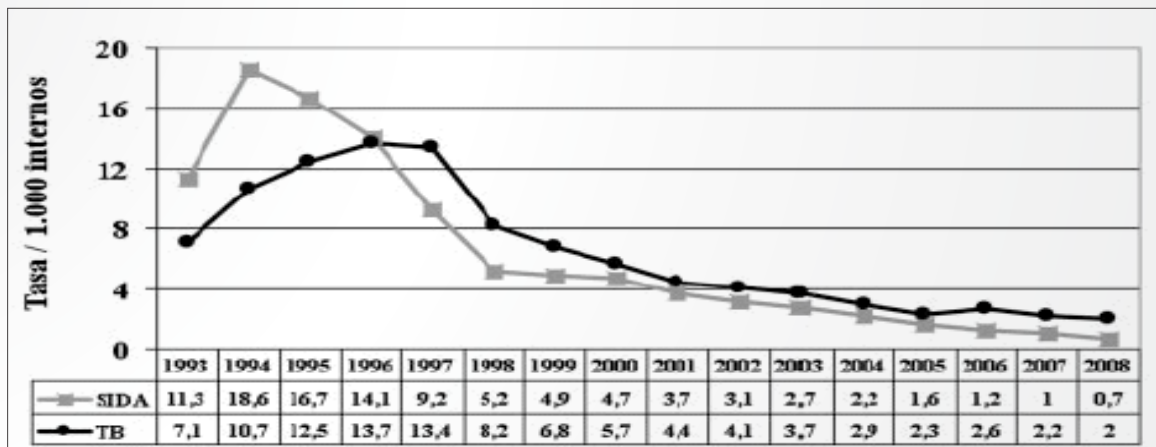
Graph 8: Prevalence of HIV infection among inmates per year – Spain (except Catalonia), 1992-2009.



Source: Hernández & Arroyo (2010, 42)

ANNEX 7

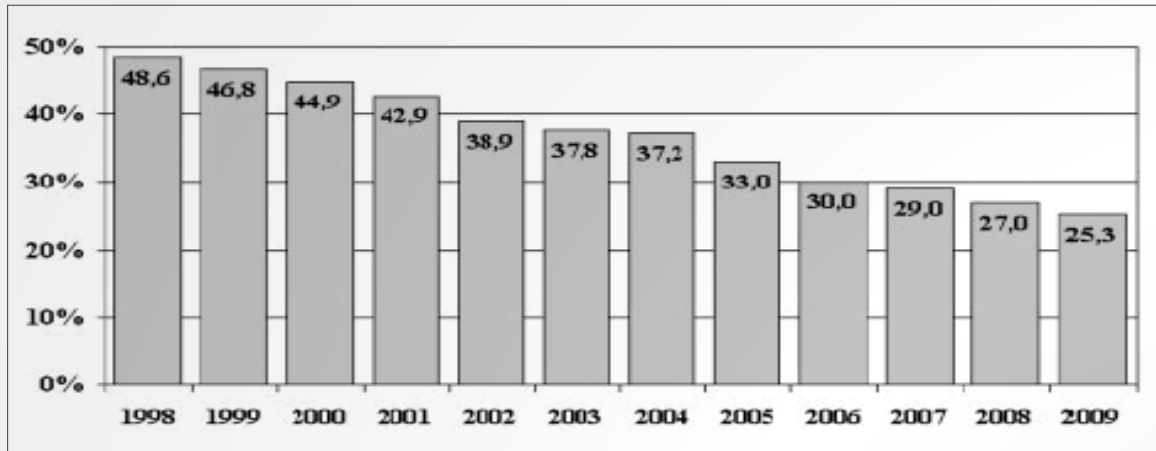
Graph 9: Temporal series with the incidence of AIDS and Tuberculosis in the prison population – Spain (except Catalonia), 1992-2008.



Source: Hernández & Arroyo (2010)

ANNEX 8

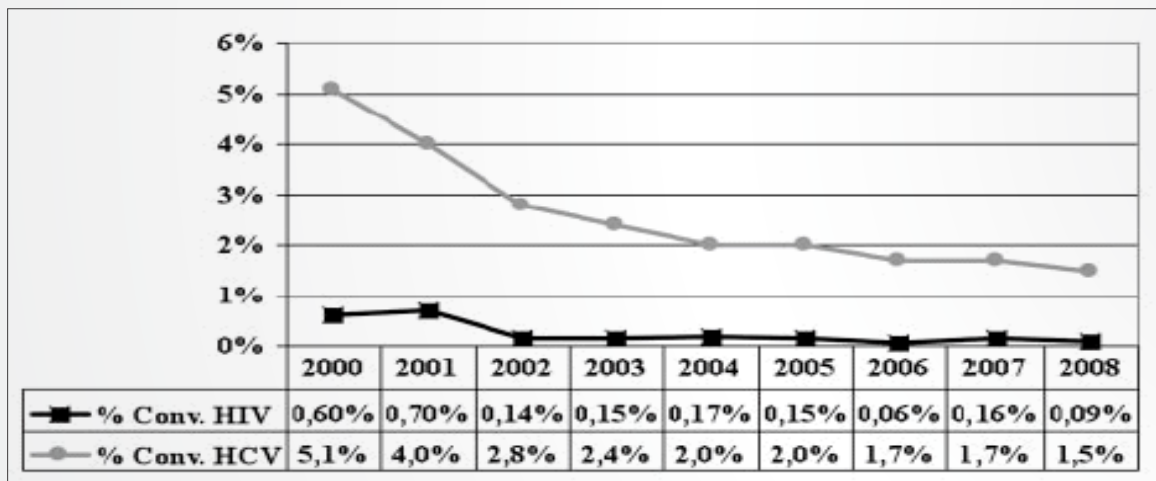
Graph 10: Prevalence of HCV among inmates per year– Spain (except Catalonia), 1992-2009.



Source & elaboration: Hernández & Arroyo (2010, 43)

ANNEX 9

Graph 11: Incidence of HIV and HCV infections transmitted in prison (seroconversion) – Spain (except Catalonia), 2000-2008.



Source & elaboration: Hernández & Arroyo (2010,43)

OSPDH
Observatori del Sistema Penal i els Drets Humans
(Universitat de Barcelona)
Av. Diagonal 684
08034-Barcelona

**Report by OSPDH - Observatory of the
Penal System and Human Rights
(University of Barcelona)**



This Project is co-funded
by the **European Union**