



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

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Mapping Report - Italy



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

Mapping Report Italy

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I. INTRODUCTION

1. Background/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 the Harm Reduction International website (www.ihra.net).

The current report, written by Alessio Scandurra, Dr. Sandro Libianchi and Grazia Parisi, presents the mapping situation in Italy.

Italy's prisons have a high number of prisoners who have drug problems and related issues with infections.

This report, drawing on research in the Italian prison system, will discuss the current situation in Italian prisons regarding the implementation of harm reduction materials and treatments available to prisoners.

The negative health effects arising from imprisonment include, in addition to the impact on mental health and the risk of suicide and self-harm; the risk of drug overdose on release, the risk of acquiring blood-borne-infections and the harm resulting from inappropriate imprisonment of people requiring facilities unavailable in prison or in overcrowded prisons.

Guidelines developed by the World Health Organization (WHO) Health in Prisons Project and the Pompidou Group of the Council of Europe principles for the provision of healthcare services in prisons (2001) state that there should be health services in prisons which are broadly equivalent to health services in the wider community (WHO Europe 2001¹). They also recommend that services are based on clearly assessed needs of prisoners, who are often from socially deprived groups and present additional problems. This will include identifying problematic drug users and those with diseases such as HIV and hepatitis who need additional support as well as healthcare.

A key element of this process should be to consult with prisoners themselves and allow them to take some responsibility in planning their treatment. These guidelines are not only in place to assist prisoners but also the prison and healthcare services on a wider scale by preventing the spread of infections, promoting healthy lifestyles and reducing the personal and environmental harm resulting from high-risk behaviours.

However, this study into healthcare services in the Italian prison system reveals that this level of care is often difficult to achieve, despite the implications for the human rights of prisoners. Prisons generally do not have a rehabilitative effect because the range of action for implementing remedial measures in prisons is very limited. Prisons

may exacerbate harms caused by drug use, and these harms may then be translated to the community outside of prisons.

It is imperative to provide adequate and equivalent beneficial services that meet the needs of prisoners and are based on their abilities and resources. The prevention, care, treatment and support measures taken must be balanced with the requirements for security and good order, and be consistent with human rights norms and standards. The goals pursued should also be pragmatic, not only with respect to the prison system but also with respect to the prisoners. Therefore, the reduction of harmful drug use and risk behaviours should be the guiding philosophy behind the measures.

However, the successful implementation of harm reduction programmes in Italian prisons is still quite varied. The coverage, availability and accessibility of harm reduction services changes significantly within the country from region to region and it is most concentrated in the largest cities.

3. Methodology and methodological challenges

A review of national and international literature on harm reduction measures in prisons was carried out in order to set the foundation for an evidence-based approach. Basic data were collected, also through contact to national experts in the field, to describe prevention, treatment and harm reduction services in prisons. Special emphasis was put on the evidence of the prevalence of HIV, HBV, HCV, and TB and risk behaviours in prisons. Published studies concerning the topics mentioned above were identified through manual and computerised searches.

This research has some limitations: (i) only publications in Italian and English were included, as well as some in French, Spanish and other languages were not included; (ii) not all papers could be obtained within the time limit.

II. NATIONAL CONTEXT

1. Political and policy context

Since 2 June 1946, when the monarchy was abolished by popular referendum, Italy has been a parliamentary, democratic republic with a multi-party political system based on the 1948 Constitution. The Parliament is bicameral (there is a Chamber of Deputies and a Senate), and its members are directly elected for five years through a public vote. The President of the Republic is elected for seven years by a joint session of the two chambers and is the formal head of the state. The Prime Minister is usually the leader of the party that has the largest representation in the Chamber of Deputies. He must be endorsed by, and have the confidence of, both parliamentary houses. The judiciary system is independent and is ruled by a self-government authority, the High Council of the Judiciary.

Since the beginning of the Republic, Italian politics have been characterized by high levels of instability and government turnover. This was especially true during the early 1990s, when persistent government wavering, mounting economic pressure and especially a series of corruption scandals implicating all parties in illegal financing prompted a profound political crisis. Many political leaders were under criminal prosecution (known as the 'Mani Pulite' investigation) by the courts and the whole power structure faltered. After a period of transition, the so-called Second Republic began. New political forces and new coalitions emerged, while at the same time a major turnover in the new parliament took place. The new parties developed around two poles: the centre-left and the centre-right. For nearly 15 years, governments tended to alternate between these two poles, until the political crisis of November 2011 following the resignation of then-Prime Minister Silvio Berlusconi. A technocratic government led by former EU Commissioner Mario Monti steered the administration for 18 months before elections were held in early 2013. Italy was then governed by a grand coalition government led by Enrico Letta, and after his resignation in early 2014, Italy's current prime minister is the leader of the centre-left Democratic Party, Matteo Renzi.

2. Economic context

Italy has the fourth-largest² national economy in Europe and the 12th-largest³ by Gross Domestic Product (GDP) in the world. It is also a founding member of the EU as well as a member of major multilateral economic organizations such as the Group of Seven Industrialized Countries (G-7), the Group of Eight (G-8), OECD, the World Trade Organization (WTO) and the International Monetary Fund (IMF). Its annual GDP accounts for 11.7%⁴ of the European Union's total GDP. Nevertheless, per capita income is nearly 20% lower than the average among European Union countries.

Since the end of the Second World War, Italy's economic structure has completely changed from being agriculturally based to industrially based, thus the industrial

complex has been restructured to meet the challenges posed by the new context.

From 1992, after learning that Italy might not qualify to join the European Economic and Monetary Union, authorities made a significant effort to address the most pressing economic issues. Economic policies were launched to tackle the fiscal and monetary imbalances that had developed over the previous years; aiming to re-establish an environment of sound finance, a stable currency and low interest rates. The government adopted fairly strict budgets, ended its highly inflationary wage indexing system, and started to reduce its social welfare programmes, specifically focusing on pension and health-care benefits. The success of the corrective action undertaken during the 1990s led Italy to adopt the common European currency, the Euro (€), on 1 January 1999.

Economic prosperity or crisis?

Since the beginning of the 2000s, the Italian economic situation has been characterized by stagnating growth rates and very high levels of government debt, factors which left it vulnerable to the economic crisis that started in 2008 and the euro-area sovereign debt crisis that followed from 2010. These crises led financial markets to become concerned about debt sustainability. Although Italy is still the third-largest economy in the Eurozone, it remains vulnerable to sudden changes in market valuations.

Italy was among those Euro-area countries which have been particularly struck by the financial and economic crisis in 2008/09. For this reason, Italy's economic and political situation recently gained widespread attention. Italy's debt levels were the highest in Europe in the 2000s, increased between 2011 and 2012, and still remain very high. This is attributed largely to lower-than-expected growth, notably in domestic demand. Since 2011 the country, which faces substantial refinancing needs, experienced a marked increase of the BTP-Bund spreads on financial markets and a substantial downgrade of its credit rating.

After Silvio Berlusconi was forced to resign in November 2011 and Mario Monti took the Prime Minister office, backed by wide political and popular support, a broad reform agenda with the objective to address the country's troubled public finances and structural problems of the economy was set out. The reform era was inaugurated by harsh austerity measures in December 2011, with new taxes and cuts in social and health services (mainly provided by regional or local bodies), accompanied by a reform of the pension system and liberalization measures in January 2012. Then, in July 2012, the reform of the labour market and the spending review were approved, whose effects are still undefined. Amongst the expenditure reductions are cuts in healthcare and education, reduction in public sector employees and reorganization of local governments. As for the labour market reform, a number of changes were made to how it operates; intending to make the exit from jobs more flexible, to disincentivise the use of temporary and atypical contracts and there is a plan to make a more comprehensive insurance-based system of unemployment benefits to become operational from 2017.

However, the social welfare system is not well placed to deal with the impact of the crisis or the impact of the austerity measures. In particular, Italy does not have a nationwide minimum income system in place leaving some people, such as workers on temporary contracts, with no safety net if they lose their jobs. The European Commission has also acknowledged that economic decline pointed to further deterioration in household disposable income, which the social protection system is not well-equipped to address. Recognising the need for a universal measure to combat poverty, public and private organisations are continuing to seek the introduction of a minimum income system, which was not provided for in the Finance Act 2014 despite a prior commitment.

Italy's growth prospects are not good, as the country officially re-entered recession in the second half of 2011. The current government led by Matteo Renzi is also undertaking comprehensive reforms which address a wide range of structural weaknesses, yet economic recession and political factors both at a national and European level make the outlook uncertain. In addition, a number of issues remain high on the agenda, notably the weakness of the justice system, inefficiency in public administration and corruption, which hinder Italy's economic growth. Although steps have been taken to address these issues, more courage is needed to address these weakening factors.

Has there been an impact on vulnerable groups?

The economic crisis in Italy has sharpened the dynamics of impoverishment and of social vulnerability. Now that several years have passed, some qualitative and quantitative trends seem particularly alarming:

- a) the number of people experiencing economic difficulties is consistently increasing;
- b) the middle class and the social groups traditionally unrelated to social distress are now equally involved in the economic vulnerability;
- c) social services and other social welfare bodies take care of fewer users than the past years.

These major socio-economic transformations have generated new risks and needs that exacerbated some of the main limits of the Italian welfare system.

Poverty in Italy remains a problem. The economic and financial crisis made some situations of weakness worse or created new ones, most of them due to major losses of jobs, which reached very high levels compared to the European average. For the first time in 16 years, poverty rates have risen, along with the general jobless and youth unemployment rates. Italy remains hopeful to see results of newly implemented policies and move on from past adversities, but the very high increase in youth unemployment within the past year is a worrying feature of the social situation. Particularly as it is associated with many young people neither in employment nor education or training (NEETs), and with the associated long-term risks of exclusion for this generation.

There are also signs of a worsening of poverty, with significant increases in the risk-of-poverty or social exclusion rate and the rate for severe material deprivation. The sharp reduction in resources for social programmes has exacerbated the fragility of welfare services and impacted negatively especially on low-income families, children, and on people aged over 65 due to the de-indexation of the pensions to the cost of living.

It is clear that cuts in public services have hit poorer people hardest, as they do not have the incomes to compensate for these cuts. For this reason there is an urgent need to develop integrated strategies to protect people from poverty and to make access to quality services affordable.

And on prisoners in particular?

Prisons reflect society and the current economic crisis. Punitive criminal policies and a judicial system that expose vulnerable groups (namely drug users, migrants, homeless) to severe convictions have, as a result, had a growing number of imprisonments. An overuse of pre-trial detentions, as well as a shortage of social protection services in the community, continue to contribute to the rapid growth of the prison population. Overcrowding is a key concern in almost all prisons and is the root cause of many human rights violations that occur in prisons. It also highlights the political failure over policies regarding the provision of resources for the prison service, with the demands on the system now completely outstripping the resources provided to meet them. The lack of resources leads to chronic staff shortages, both of prison officers and social workers (such as psychologists, teachers, educators, interpreters). Due to this, most prisoners cannot rely on education or entertainment for stimulation, and spend most of their days locked up on restricted regimes with little to do.

It is widely known that most inmates have a history of social exclusion. Coming with this are traditionally higher levels of family, educational or health disadvantages, as well as poor prospects in the labour market. So, if the number of poor people rises outside prisons, poor people entering prisons likewise increase, with growing levels of poverty and distress in almost every penitentiary institution. Then, when released, these former prisoners are often left with no prospects for employment and are again subject to socio-economic exclusion. This leaves these individuals vulnerable to an endless cycle of poverty, marginalisation, criminality and imprisonment. Thus, imprisonment contributes directly to the impoverishment of the prisoners, of their families (with a significant cross-generational effect) and of society by creating future victims and reducing future potential economic performance.

3. Health context

The Italian National Health Service (*Servizio Sanitario Nazionale* – SSN) was established in 1978 to grant universal access, irrespective of income, to a uniform level of care throughout Italy, free at the point of use, financed by general taxation. It established that human dignity, health needs and solidarity as the guiding principles of the system.

The Ministry of Health fulfils the function of the overall steward of the health system and defines the basic level of care (*livelli essenziali di assistenza* – LEA) to be delivered across the country. It has an internal authority with technical and consultative tasks, the National Health Council (Consiglio Superiore di Sanità – CSS), which gathers scientists, physicians and other recognized experts who propose scientific investigations and studies on relevant public health issues. The Ministry is supported in its functions by several permanent government agencies, such as the National Institute of Health (*Istituto Superiore di Sanità* – ISS), AGENAS (National Agency for Regional Health Services) and AIFA (National Authority for Pharmaceutical Regulation).

Beyond this, Italy's 19 regions and 2 autonomous provinces are responsible for the planning and delivery of services. They have considerable legislative, executive and evaluative functions to fulfil this role. Important partners are the network of Local Health Authorities (*Aziende Sanitarie Locali* – ASL) and public and private hospital trusts (*Aziende Ospedaliere* – AO) within each region and autonomous province, to whom executive functions are largely delegated. Regional and local bodies provide technical support and performance management.

Articulation between the central government and regional governments is expressed in the so-called “Pact for Health,” a plan that is agreed jointly every three years and, since 2001, has become the main instrument for the planning and organization of public health care in Italy. In 1983 the State-Regions Conference was also established to provide a permanent interface for consultation and communication between the state and the regions in the domains of public policy where their mandates overlap.

The various reforms set out over the past few decades led to the creation of 21 distinct health-care systems. In fact, different regions have made different choices on how to exercise their increasing autonomy. Because of these regional differences, a divide exists in the extent and the quality of policy and financing strategies between regions of excellence, which are mainly placed in the northern part of the country, and areas where self-directed initiatives are scant. There are also markedly divergent patterns of care and outcomes across regions, giving rise to a trend of patients crossing regions in search of quality health care.

Health expenditure planning

As previously mentioned, the National Health Service is largely funded through national and regional taxes, and only minimally by private health insurance. Since the early 2000s it has been undergoing a process of fiscal devolution from the central government to the regions. Although most funding is pooled at national level and redistributed to regions, there are substantial differences in funding between regions, resulting in a significant regional variation in tax rates.

Furthermore, in recent years, many regional health budgets ran into substantial deficit, leading central authorities to imposing recovery plans on many of them. Regions are

forced to comply with specific terms of these plans to improve their financial balances within given deadlines. Such regions are regularly monitored by national government agencies and can be sanctioned if they fail to comply with their recovery plan's terms. Sanctions include the possible appointment of a national commissioner to temporarily oversee the management of the region's health-care system, temporary suspension of the region's workforce turnover, or mandated tax increases. The details of these conditions have been regularly redefined over the years, and more recently incentives were introduced for regions that introduced improved budget management measures.

These plans also signalled the introduction of a dominant new player in national health care policy, the Ministry of Finance. Although the Ministry of Health maintained its primary role, the Ministry of Finance became actively involved in designing and approving health care delivery, directly monitoring health-care expenditure and has powers over regions that overrun their budgets.

This process, then, sets out a new collaborative agenda between the national government and the respective regions. It has also enabled increased central government interference in the regions' autonomy to fund and plan health-care services.

In Italy, as in most countries, health expenditure has steadily increased over time, making its efficient expenditure a major issue for governments. However, it is noteworthy that public health-care expenditure has remained virtually unchanged in recent years. In July 2014, a new Pact for Health was agreed between the central government and the regional administrations. The budget set out for 2014 is €109.9 billion, while the fixed expenditure for 2015 and 2016 is, respectively, €112 and €115.4 billion. The plan contains measures to standardise the cost of medicines across the regions and guidelines for the reinvestment of funds saved as the result of an internal spending review. The purpose of this Pact is to deal with the concerns that are being raised on the sustainability of the system during Italy's continued economic and financial crisis. These measures are expected to have a marked impact on health care in the years to come, possibly reducing inequalities in access to care, with special attention to the most vulnerable groups of the population, and softening existing differences in the quality of care among regions.

Health of the population and prison health

In spite of cost avoidance measures, Italy's statistics of health system outcomes are uniformly impressive. A range of indicators shows that the health of the population has hugely improved over the last decades. Average life expectancy reached 80 years for men and 85 years for women in 2012 and 2013, according to the WHO data⁵. It is the second highest in Europe after Switzerland. These results can be attributed to multiple factors; such as improved standards of living, more widespread education, better-quality health care and increased access to health services. However, a substantial gender difference in life expectancy and a high variability among regions are observed.

Under-five mortality rate (per 1,000 live births) for both sexes has constantly decreased over the last decades and now is 4%, while the adult mortality rate (probability of dying between 15 and 60 years per 1,000 people) is 70% for men and 39% for women. The numbers are quite impressive if compared to the European average of 12%, 79% and 80% respectively.

The most frequent causes of death are Ischemic Heart Diseases (IHD) with 75,098 cases, Cerebrovascular Diseases (61,255) and other Heart Diseases (48,384). Cancer also has emerged as one of the main causes of death, together with Alzheimer's and other types of dementia.

Nonetheless, these trends indicate that Italy faces a growing ageing population and a rising burden of chronic conditions, which are likely to result in higher health care costs. The management of chronic conditions requires a coordinated response from a wide range of professionals, and the fragmentation of the system undermines the continuity of care for chronic diseases. This is especially true with the integration between actors of social care (municipalities) and health care (ASLs) varies across the country and is mostly incomplete.

Italy has made significant progress in improving the quality of health care in recent decades. Quality monitoring and improvements have not been priorities, however, due to the economic crises. To address the challenges these health needs involve, Italy must urgently prioritise the quality of its health care services alongside economic sustainability. Regional differences must be lessened, in part by giving central authorities a greater role in supporting regional monitoring of local performance.

Since 2008, the provision of health care in prisons has come under the responsibility of the Ministry of Health and the responsibility for the delivery of medical services has been given to the SSN, inspired by the principle of universality and of the same health care as free people. In 2001, the SSN was regionalised and as a consequence the provision of health care varies very much depending on the region where the prison is located.

Equal treatment is ensured to non-national prisoners as well: the law establishes that all prisoners, including irregular non-nationals, within the limits of the period of their detention shall be registered in the National Healthcare System.

The 2008 reform has been a milestone for prisoners' health protection and a major breakthrough toward a positive relationship between prisons and society. Despite the improvements resultant from this reform, the medical situation in some Italian prisons remains poor. Medical, surgical and psychiatric services are often insufficient. In some institutions, especially the smaller ones, the service does not provide any guarantees of a continuous medical presence (of a doctor) over a 24 hour period. There is a substantial lack of preventive medicine as well as issues of malfunction and deficiency of sanitary tools.

Information regarding infections is quite scant. A penitentiary rule states that sick prisoners who need special treatment should be moved to specialized institutions or to city hospitals when the required treatment is not available in prison. However, visits in external hospitals are often delayed, mainly due to long waiting lists and the lack of police staff required to supervise the transfers.

Prisoners also report difficulties in obtaining a visit from an external doctor they trust, due to bureaucracy and the resultant extended waiting times. The opportunity for a prisoner to choose a doctor they trust is a right acknowledged by the constitutional value of health as a fundamental human right. In this perspective, the national system should actively work to protect the health of everyone, irrespective of the social or economic conditions of each person. This highlights a problem of “denied access” to quality healthcare for inmates, which deny the possibility of fully recognizing the principles of universality, equal access to treatment, efficiency and quality of services.

The problems affecting the prison health system cannot and must not be contained inside the world of confinement; this would be a partial and simplistic view of the problem. Rather, a look at the wider context is needed. It is important to remember that these health issues do not remain confined to prisons: the high level of mobility between prisons and the community means that the health of prisoners should be a fundamental issue of public health concern. Diseases transmitted or exacerbated in prison inevitably become public health issues when prisoners return to their communities. It is time to acknowledge that prisoners’ health is a priority not only for the inmates, but for society as well.

4. Criminal justice and prison context

The Italian prison system is ruled by a law issued in 1975, the Penitentiary Act, and its Regulation on Enforcement. Although they have changed in severity in response to real or claimed emergencies, these acts remain the basic legislation regulating prison administration.

The law is guided by the principle of penitentiary treatment leaning toward re-education, based on article 27 of the Italian Constitution, which states that “Punishments shall not consist of treatments against the sense of humanity and shall be aimed at the re-education of the sentenced person,” thus stressing the principle of the rehabilitative purposes of punishments.

Therefore, an observation of the personality of each prisoner is needed in order to identify the best individual path to re-integrate the detainee into society. The punishment can be flexible; it can be reduced if the prisoner behaves according to prison and treatment rules. Prison staff are responsible for both treatment and security.

The warden is responsible for security and for treatment issues, as well as for the budget. The prison police are responsible for inner security and for prisoners’ transfers

outside the jail. Each section of the prison has a chief police officer, who is accountable for his or her actions and decisions to the warden. Educators and social assistants are responsible for social issues and re-education. Educators work within the prison. Social assistants work outside the prison and are in charge of the relationships between prisoners and their families in addition to the wider territorial community. Wardens, police staff, educators and social assistants are employed by the Ministry of Justice, while doctors, nursery staff and healthcare assistants work for the National Health System., Psychologists are employed either by the Ministry of Justice or by the Ministry of Health. School teachers work for the Ministry of Education, all other operators are occasional workers employed by local authorities or by cooperative societies.

Prisons and prisoners in Italy

According to the last official data, released by the Ministry of Justice Department of Prison Administration (DAP) and dated 31 January 2015, there are 206 prisons in Italy. They are either *case circondariali* or *case di reclusione*; unsentenced people, people who have a total maximum sentence of five years or people who have less than five years of imprisonment left to serve are appointed to the former facilities; inmates sentenced to a period of imprisonment longer than five years are placed in the latter.

Some of these prisons are located in historical buildings (old fortresses or monasteries) and some others are in more recent buildings. The most recent prisons were built in the late 1980s. In March 2010, the Italian authorities implemented a Prison Plan, which aimed to create and make available new prisons or places of detention. The plan followed the declaration of the state of emergency on prisons' overcrowding by the Italian Government, but was modified soon after that situation. The Ministry of Justice aimed to accommodate 80,000 prisoners in places of detention by the end of May 2014. Around 350,000,000 Euros were made available for the construction of 4 new prisons and 16 new wings in existing prisons. At the time of writing this report, almost no progress towards accomplishing these goals has been made. On the contrary, some facilities and many prison sections were recently closed due to lack of funds for their maintenance or because they are in need of structural renovation as a result of their age and lack of proper maintenance.

The total number of prisoners hosted in all prison establishments is 53,889, while the standard capacity is 49,943, which means 108 detainees for 100 available places. Approximately 17,500 detainees (32% of the prison population) are foreign nationals, mainly from Morocco, Romania, Albania and Tunisia. If compared to the previous statistics, this number is decreasing, but still there are almost 4,000 prisoners more than the whole system can accommodate. The calculation of the estimated capacity is usually based on the 9m² for a single prisoner and 5m² for others criterion. But, in its statistics, the DAP states that the capacity data does not take into account the possible instances when given values temporarily deviate from the norm.

When Italy was condemned by the European Court of Human Rights for violation of Article 3 ECHR (in the pilot sentence *Torreggiani and Others v. Italy*, 2013) there were almost 68,000 detainees, whilst the official capacity was 45,000 places⁶. There has since been a decrease in the number of detainees and an increase in capacity, as some progress has been made to ease overcrowding. However, the variance between the two figures remains significant.

The DAP also publishes the data of prisoners disaggregated by types of crimes. The most recent figures are from 31 December 2014, and report that imprisoned people for drug law offences are 18,946 (18,157 men and 789 women), but none of these are for drug use or possession.

Italy's drug laws

Historically, the Italian legislation in the field of drugs has been based on the principle of the non-criminalization of the consumption of drugs.

The law adopted in December 1975 confirmed this principle, but affirmed the unlawfulness of possessing a controlled drug. Two criteria were introduced in this law to regulate prosecution for offences pertaining to this legislation, notably relating to personal use and the quantity of the drugs possessed. This act was strongly criticized, because the mechanism of the decriminalisation related to the possession of small quantities caused strong divergences in the application of the law.

In response to these criticisms, a new consolidated law was adopted revising and concentrating the previous regulations regarding drug sale, use and possession in 1990. This law provided the legal framework for licit trade, treatment and prevention, prohibition and punishment of illicit activities. For the first time in Italy the use of drugs and all conduct related to it, such as possession, acquisition, transportation, were prohibited. The offenders would be punished by administrative sanctions (fines or suspension of driving and gun licences, passports and equivalent documents). Regarding the use of drugs, a system of fixed quantities was introduced as the threshold definitions determining the difference between use and traffic.

Once again strong criticisms and a lively debate among the public opinion accompanied this text, and provoked a major change in the new law. A referendum took place three years later and amended the provision in the law regarding the prohibition of drug use. The prohibition of personal use was abrogated as well as the reference to the daily average quantities, the intervention by a penal judge, and the concept of a fixed threshold to divide between users and traffickers.

The 1990 law, abrogated by the referendum in 1993, was in effect for about 10 years. The government led by Silvio Berlusconi launched a campaign against the referendum's outcome and announced a government bill that would fill the legislative void resulting from the previous abolition of the daily average quantities. The bill was named after

then-Vice Premier Gianfranco Fini and the Minister of Relations with Parliament Carlo Giovanardi. In their opinion, the abrogation achieved with the referendum conferred too many discretionary powers to the judges, who had to decide about the end use of the drugs held by the defendant, which determined the type and severity of sentence. The law was approved by the Parliament in 2006 and represented a return to the hard line policies of the 1990s. It removed the distinction between “soft drugs” (such as marijuana and hash) and “hard drugs” (such as heroin, ecstasy and cocaine), and exacerbated punishments for soft drug users. It also reintroduced the quantitative threshold to distinguish between personal use and traffic, however, personal ownership now carried a penal punishment. The argument for this change was that amounts of drugs held for personal use could not be unlimited.

This change brought back the old policy which allowed possession of drugs to be prosecuted as intent to traffic. Cannabis and heroin consumption were equalised and identically punished with detention from 6 to 20 years, with mitigation from 1 to 6 years for modest-degree violations. As a consequence of these proscriptive policies a large increase in drug-related crimes was recorded, with about 120,000 arrests in 7 years. Additionally, the number of drug addicts in prison rose alarmingly, leading prisoners’ rights organisations to claim that these harsh laws created a booming prison population in a system that was already overcrowded.

In February 2014, the Constitutional Court ruled that the Fini-Giovanardi Bill was improperly approved, and abrogated the law. As a consequence of the declaration of unconstitutionality of the law and of the re-determination of the sentences, many detainees convicted for offences related to “soft” drugs were released, contributing to reduce prisons’ overcrowding.

Since then, drug use is no longer mentioned (at least as an offence) in Italian law. Possession, acquisition, and import for personal consumption remain prohibited, receiving administrative sanctions only. No more fixed quantities are applied as limits determining the difference between use and traffic. It is left to the judicial authorities to assess the objective of the illegal act and to define the threshold to distinguish illicit activities to be punished either by administrative measures or by penal sanctions.

Controlled substances are classified in five lists and illicit activities related to drugs are punished differently according to the list to which the drug belongs: lists II and IV are less severely punished than lists I and III.

When a person is found in possession of drugs for personal use, the person will be summoned for an interview with the Prefect of Police or his representative. Someone summoned may voluntarily request a treatment or rehabilitation service (as defined in the law). Proceedings are then suspended whilst the user is referred to the Services for Treatments (Ser.T) for an assessment, which must be completed within a set period of time. If an individual misses two programmed meetings or fails to complete the treatment on two occasions without a valid excuse, he or she is subject to additional

punitive measures. These can range from house arrest, to community service, and, in the case of non-Italians, the suspension of a residence permit. These may be imposed for a period of 3 to 8 months in the case of table I and III drugs and for a period of 2 to 4 months in the case of drugs in tables II and IV.

The penalties for production and/or trafficking at an individual level are imprisonment and a fine according to the quantities and the types of drugs involved (again, more severe for drugs in table I and III, less severe for table II and IV drugs).

There has been increasing involvement of the Ser.T and of the socio-rehabilitative services within the prison system, especially since the number of prisoners with drug-related problems started to rise as a result of the firm application of the Fini-Giovanardi law.

On 31 December 2013 (the date of the last count made by the DAP), there were 14,879 drug users in prison, 23.8% of the entire prison population. At the moment, both absolute and per cent values are gradually decreasing. This is also due to the opportunity for imprisoned drug users to start or to re-start treatment and subsequently apply for an alternative measure instead of the prison sentence to complete the treatment in a therapeutic community or environment. The treatment service must provide the court with a declaration explaining the treatment proposed and its suitability for the client. The court must be convinced of the client's commitment to undertake the treatment programme.

Alternative measures are available for all offenders where they meet the criteria defined in the law. For drug using offenders, the focus is specifically on treatment and rehabilitation measures which address both criminal behaviour and, equally as important, the drug-using behaviour which may have been an important factor in offending.

Italy's sex work laws

On 31 January 2015, the DAP counted 840 people (737 men and 103 women) in prison for crimes related to prostitution. The higher number of men compared to women is explained by the law, which states that prostitution (the exchange of sexual services for money) is legal, but organized prostitution indoors, in brothels or controlled by third parties is prohibited. Pimping, i.e. the procurement and living on the earnings of a woman in prostitution, is also illegal.

The Merlin Law became effective in 1958. This law, still in force today with few changes, superceded the previous regulations which were established in 1861, the year of Italy's unification. It closed the *case chiuse* and introduced the offence of exploitation of prostitution with the express aim to punish pimping. Specifically, it provides penalties for any person who in any way promotes or exploits the prostitution of others; lists places where prostitution is prohibited, such as houses, hotels, dance halls, entertainment

clubs or other areas open to the public; prohibits solicitation in a public place or place open to the public; or solicits in a scandalous or disturbing manner.

It is a classic abolitionist law, prohibiting not only trafficking and exploitation, but also all forms of aiding and abetting of prostitution with or without the intent of financial gain. Therefore it allows only street prostitution or independent prostitution by workers in their own house. The decision to close brothels and liberate women deprived of many of their civil rights by being obliged to reside in those closed houses was promoted and greeted as a measure of liberation in the spirit of equality. In reality the law never ceased to be an object of intense public debate over the ten years it took to pass. This debate still continues today, periodically emerging in the national media with articles, books, campaigns, and proposals for new laws.

Meanwhile, prostitutes began to organise themselves. In 1983, a Committee for Prostitutes' Civil Rights was founded in Pordenone, following a protest against violence towards the street workers. The Committee's goal is not the official recognition of prostitution as a profession, but rather the decriminalisation of the aiding and abetting without the intent to profit, and the achievement of the right to exercise prostitution indoors. This would render the work easier, less subjected to police surveillance and oppression, and, perhaps less stigmatised. In fact, prostitution is still so stigmatised that many Italians think it is illegal.

A number of reform bills addressing those requests were discussed in the national Parliament, but no reforms were approved. Some local authorities did take steps to address these requests and began to order traffic police to target clients of prostitution. These clients were fined for disturbing traffic and a copy of the fine, including the specific violation, was sent to their homes so that their families would be informed. Clients also risked being charged with aiding and abetting prostitution if they returned the women to their spot on the streets and their cars were confiscated as "instruments for committing a crime." The criminalisation of clients was stopped in 2000 by a sentence of the Tribunal of Perugia, declaring that aiding and abetting must apply only to third parties and not to clients.

Despite these debates, no major change in the structure of the abolitionist law occurred. While the abolitionist principles have been upheld at the national level, more restrictive measures were taken at the local level. At this level some towns started to withdraw residence permits from foreign women working in the streets and to deport those without a valid residence permit. In fact, street prostitution became much more visible with increasing migratory waves.

Among these migrants were women who joined the sex trade with little or no choice, some enduring coercion and debt bondage, including under-aged girls. These issues of foreign nationals, coerced sex work and under-aged workers have reshaped the debate in Italy as elsewhere in recent years, shifting focus to human trafficking and male violence. The ministries in charge announced increasing penalties for recruiting,

exploitation and trafficking, as well as new rules to protect victims of trafficking and those who renounced prostitution.

Then a new prohibitionist wave took place: although there were no laws against street prostitution, other laws concerning public order and decency could be used to criminalise outdoor work. In 2008, a bill outlawing street prostitution was introduced by Mara Carfagna, the then Minister for Equal Opportunities, which was approved by the government. The bill is framed as an amendment to the Merlin Law and provides penalties for:

- acts of prostitution, solicitation or availing oneself of sexual services in a place open to the public;
- recruiting, inducing, promoting, using, managing, organizing, controlling, or profiting from the sexual services of a person under 18, or for those promising any kind reward for a sexual act with a person between 14 and 18;
- repatriation of foreign minors engaging in prostitution;
- organised crime - penalising conspiracy to exploit prostitution, prohibiting solicitation and harassment, with punishments of up to 15 days imprisonment.

However, after approval by the government, the bill was never brought to Parliament so it never became a law.

Recently the problem was in the press when Rome's mayor approved a plan for a red light district where prostitution will be officially tolerated. The proposal would allow prostitution in a non-residential area from April, with the aim of reducing the impact of a trade currently conducted on more than 20 streets in the district. Police will be ordered to impose fines up to €500 on sex workers caught outside the permitted area, which will be supervised. Local residents campaigned for the change, while objections to the initiative have been raised by the centre-right opposition on Rome's municipal council, church personalities as well as some representatives within the mayor's party (PD). The opponents hope it is simply a bizarre idea to draw attention to the problem, arguing that it would lead to unacceptable prostitutes' ghettos, but the fight shows this is still an active topic of debate.

5. The bill for a criminal justice reform

On 23 December 2014, the Government presented a wide bill of reform of the Criminal Code, the Code of Criminal Procedure and of the Penitentiary Act. Among other things, it includes rules to reduce the length of criminal proceedings, provides more severe sanctions for bribery and corruption offences, reforms the statute of limitations, enables the Government to make a revision of the legislation on preventive measures and on court records, and amends the rule on the suspension of the proceeding if the defendant is found mentally unfit to stand the trial. However, no specific mention is made about a reform of the laws pertaining to drugs and sex work.

In the penitentiary field this reform enables the Government to adopt legislative decrees to modify the whole Penitentiary Act (PA). Since the PA became law it has been amended so many times that its coherence and consistency have been jeopardized. During time the punitive efficacy of the penitentiary rule prevailed on its re-educational and rehabilitative remits. However, the bill declares the principles that should guide the Government in its reformatory action. These principles concern the simplification of procedures for the surveillance tribunals and judges, the review of the requirements to concede alternative measures of detention, the modification of the rules on penitentiary work (both intramural and external), the right to intimacy, and new rules for juveniles.

Before its takes effect there will be a long and complicated discussion in the Parliament's commissions. Nonetheless, some inconsistencies can already be noticed. Foremost of which is the broad recourse to voluntary work of prisoners and to provision of services that go beyond the classical contractual relationships. The jurisprudence of the Constitutional Court aims to equalize the penitentiary work with the work of free people. So stakeholders should supervise whether the implementation decrees of the mandate go as intended or decline towards a greater differentiation in the treatment of prisoners.

III. HIV, HCV AND TB IN PRISONS

1. Legal and policy context

There is a large amount of Italian legislation regarding infections with more than 170 texts including laws, decrees, regulations, guidelines and other official documents (see appendix below for references). In particular they address: diseases in general, HIV and AIDS, protection of personal data and privacy, places and access to work, disability, home care assistance, infections in childhood, transfusions and organ donations, etc. The specific legislation adopted in the penitentiary field mostly concerns the transfer of responsibility for health from the Ministry of Justice to the Ministry of Health, through Local Health Authorities.

Data on HIV, HCV and TB

After the above-mentioned transfer, each region became responsible for data collection, but some regions have yet to gather data systematically. When data is collected by a regional authority, it is not given over to Ministry of Justice or to the Ministry of Health, and a unified personal medical record for detainees in every region has not yet been arranged.

The last official data available are those recorded by the Ministry of Justice in 2009. According to the survey undertaken by the DAP (Department of Penitentiary Administration) at that time, 48% of Italian prisoners had an infection, about 2% were HIV positive, and only 28.2% underwent infections screening on admission. Unfortunately however, these data are now obsolete.

More recently, an interesting multi-centric study⁷ conducted in 9 Italian prisons and performed through peer-to-peer consultation, followed by a month of blood sampling on a voluntary basis, shows that the percentage of detainees who consent to infectious disease screening is highly varied between prisons (37.3% to 95.2%). These numbers, however, are definitely higher than the 28.2% of those screened in 2009 with the traditional procedure of screening on admission. This suggests that the health care systems inside prisons do not have the same standards and should be uniformly improved in each prison.

The last available data were recorded in 58 penal facilities spread over 6 Italian regions, and collected by the Ministry of Health and the Regional Health Agency of Tuscany (ARS Toscana). They were published on 10 April 2015, and are very reliable. It should be noted that only data on prevalence of diseases are provided, while the data of the incidence of infections inside prisons are still unknown. Of 15,751 patients tested, 7.4% were diagnosed with hepatitis C virus (HCV), 2% with hepatitis B (HBV), 2% with HIV and 0.6% with tuberculosis (TB). If compared with the data observed in the general population, the gap is evident, especially with respect to the rate of HCV, which is 3 times higher among prisoners than among the rest of society.

Data analysis

Data until 2009 have been disaggregated only by sex and nationality (Italian/non-Italian). The last survey, however, includes information on sexual identity, age and ethnic group. For example, it identifies transgendered prisoners as the most affected by both HCV and HBV (12.8% and 6.4%, respectively). Analysing distribution by age group reveals a higher prevalence of both HCV and HBV in patients aged between 30 and 49, but also shows that HBV affects an alarming 17.2% of under-30s. Infections in young age groups seem to be related mainly to a drug addiction, affecting 61.7% of patients who tested positive to HCV and 43.8% of those with HBV.

Among ethnic groups, the most vulnerable to HBV are Eastern Europeans (3.3%, with 2% as the national average rate). HCV infection, on the other hand, affects Italians the most (11.2%), followed by Eastern Europeans (3.8%) and North Africans (3.4%).

With respect to HIV infection rates, Italy is in line with other Western European countries. The rate registered in the prison population tested is around 2%. Again, transgendered prisoners are the most affected with 34% being HIV positive, whereas the age group most at risk is between 40 and 59 years. There is a surprisingly low prevalence of HIV in prisoners from both North Africa and Eastern Europe. That could be related to the fact that they usually do not inject, preferring other methods of drug use.

In general, it could be said that the rate of detainees affected by an infectious disease has grown. It seems likely that this is due to a combination of factors, namely the improvement and the expansion of screening programmes and the increase of life expectancy for patients with AIDS.

Harm reduction context

The Italian prison healthcare system implements some harm reduction strategies through the Services for Treatment (Ser.T). These services receive public funding, which is permanent, secure, and established every year by law. 80% of prison facilities have signed permanent agreements with these services, while the rest work “on demand,” if requested by medical staff, for a previous patient now in prison or depending on the presence of specific categories (mafia, elderly people, etc.).

The aim of these services is to treat patients with a drug dependence and related diseases. For this reason they use mostly methadone, buprenorphine and other opioid-based medicines that prevent or reduce withdrawal symptoms. The policy for methadone treatment in prison is, as a general rule, either for substitution treatment or dosage reduction. The methadone treatment that is available depends on each prison. In particular, opioid substitution treatment (OST) is a very effective option for prisoners because it aims at reducing illicit opioid use, injecting and associated risks while in prison, and potentially minimizes the likelihood of overdose on release. Nonetheless, its provision in prison is not as widespread as it should be due to negative perception

among policy makers and prison administrators. Equally, there are currently no overdose prevention programs being implemented upon release from prison.

Overdose still remains one of the major causes of death in prison and during the first two weeks after release. According to the report “*Morire in carcere*” by Ristretti Orizzonti⁸, 31 people died from overdose between 2002 to July 2015.

Needle, syringe and condom distribution programs, despite being deemed a successful harm reduction measure and considered best practice at the international level, are not implemented in any Italian prison.

There is unfortunately no data available to confirm any change in rates of infections in prison related to the implementation of harm reduction programs.

Of course the prevention of overcrowding is a critical factor in preventing and controlling the spread of diseases in prison, along with delays in diagnosis, limited access to water, soap, clean sheets and underwear. Besides, there is no law providing for the distribution of harm reduction supplies (condoms, injection equipment, etc.).

In Italy, the most common thinking is that admitting the need for prison services to implement a harm reduction strategy is an acknowledgement of the failure of the treatment and programmes available for drug users. In general, this is also reflected in the current community policy on harm reduction.

This leaves the lack of a supportive legal and policy framework as the greatest obstacle to the acceptance, introduction and maintenance of harm reduction programmes in prisons. For example, the free distribution of syringes to inmates who inject drugs is impeded by the fact that while drug use is not a crime, the transfer of drugs is. The distribution of syringes might, therefore, be considered as a form of complicity with whoever has unlawfully provided drugs to the inmates. In addition, although there is no evidence to support this view, there is still a concern that syringes may be used as weapons or to self-harm.

IV. HUMAN RIGHTS MONITORING IN PRISON AND HIV, HCV, TB

1. Prisoners health: legal and policy frameworks

Since 2008, the provision of health care in prisons has been the responsibility of the Ministry of Health and the delivery of medical services has been handed over to the SSN (the National Health Service) through the Local Health Authorities.

The Penitentiary Act (Law 354/1975) and its implementation regulation (DPR 2000/230) define the standards upon which the monitoring bodies should base their activities. They deal with the general conditions of detention, such as the hygiene and lighting of the premises, medical assistance, clothes and equipment, and diet. In other words, they handle every aspect related to the prison regime and internal life. Additionally, a decree of the Ministry of Health (5/7/1975) defines the standards – which are the same for private buildings – to regulate cell conditions and capacity.

2. Human Rights Monitoring Mechanisms

National monitoring mechanisms

a. Ombudsman

The law 10/2014 established a National Authority for the Rights of People Detained or Deprived of their Personal Liberty (*Garante dei Detenuti*), but its designation has not yet occurred. Since 2003, some regions, provinces and municipalities have been appointing local and regional prison Ombudsmen. However, their overall number is not high. They have visiting powers (limited to the prisons of their region or municipality) and they can arrange interviews with the detainees without prior authorisation. As of May 2014, 12 regions (out of 20) have established their regional authority. In 2008, a National Conference of Regional Ombudsmen was organised to plan initiatives of national importance in order to address organically the problems related to the protection of the fundamental rights of prisoners, to the execution of the punishment and to their social rehabilitation. The above mentioned law n. 10 February 2014 also established the National Authority as the coordinating mechanism for the Local Authorities working on the rights of people deprived of their liberty at regional and municipal level. The whole system will constitute the National Preventive Mechanism (NPM).

Among the discussions on the establishment of a National Human Rights Institution, it was initially suggested that Italy's NPM be included in the new institution. The establishment of a National Commission for the Promotion of Human Rights was therefore proposed, which included a sub-unit called "Defender of Rights of People Deprived of their Liberty." This unit was granted the mandate to monitor places of detention, acting as the NPM. In 2010, Italy declared its intention to ratify the OPCAT

once the NPM is established, “in connection with the establishment of a National Human Rights Institution”.⁹ In addition, Italy indicated that the adoption of the legislation establishing the National Human Rights Institution was forthcoming. The government initially considered designating the future Human Rights Commission as a body coordinating the regional independent authorities, specifying that the appointment would happen only when all of the 20 regions established their own authority. However, this proposal did not reach consensus among civil society debates. Thus, in 2014, the Parliament adopted the law introducing an independent authority (*Garante dei Detenuti*) which is meant to be the National Human Right Institution.

Local/regional Ombudsmen perform their role independently, but they have to give the Mayor/Governor and the other local government bodies an account of their activities, their initiatives, any unsolved problems, and present an annual report. Ombudsmen monitor and promote respect for the rights of people deprived of their liberty in the areas under their responsibility. The rights they have to protect are those stated in the Constitution¹⁰, but they can only perform the tasks defined by the terms of the documents which created their posts, so their basis for intervention can vary from place to place.. For instance, they can intervene on matters related to the health system but none of them have any power on security issues. Their goal is to protect prisoners’ rights and monitor whether the rules stated in the Penitentiary Act and its Regulation are respected. Ombudsmen can perform surprise visits and are allowed to have direct contact with prisoners. They receive complaints about the lack of respect of the prison rules, the infringement or the partial fulfilment of prisoners’ rights, and address warnings toward the authority in charge. They are allowed to request explanations or clarifications from authorities and can recommend actions needed to reverse the situation. Ombudsmen often cooperate with external experts (in addition to their own staff) who are able to provide specialist advice, such as legal experts, social and cultural professionals and health professionals.

b. Parliamentarians

National and regional parliamentarians can visit all prisons without restrictions. Their independence is assured by the constitution. In particular, national parliamentarians have the right and the duty to make inspections in every place of detention within the national territory whenever they want, and without authorisation, as provided by art. 67 of the Penitentiary Act. The same power is given to regional council members, but they are limited to their own districts. All are required to assess whether detention conditions are congruent with national laws and Constitutional principles and respectful to the sense of humanity and the dignity of the person. They are empowered to inspect prison conditions, can perform surprise visits and are allowed to have direct contact with prisoners. At the institutional level, art. 67 of the Penitentiary Act states that during prison inspections, parliamentarians can be accompanied by people chosen at each visit. These “collaborators” could be human rights experts, health professionals or right to health experts, but usually they are not. As they can talk directly with prisoners and receive complaints from them, they are able to collect information on health, human

rights and diseases issues. However, as the results of their visits are not published, we do not know if they actually collect this kind of data.

c. Surveillance judges

Surveillance judges have a visiting mandate, they can talk with prisoners and also receive complaints from them. However, traditionally, surveillance judges have not fully accomplished their mission of prison supervision because of the many other tasks the law assigns them (to evaluate the possibility of admission to alternative measures, to authorize volunteers to enter prisons, to evaluate the request of sending a prisoner to an external hospital, etc.). Like parliamentarians, their independence is assured by the Constitution. According to art. 69 of the PA, they must monitor the overall organisation of prisons and report needs and requirements to the Ministry of Justice, with special attention to education. Same as parliamentarians, judges are required to assess whether detention conditions are congruent with national laws and Constitutional principles and respectful to the sense of humanity and the dignity of the person. They can perform surprise visits and are allowed to have direct contact with prisoners, so they can receive individual complaints. The procedure to address a complaint toward a surveillance judge is the only one settled by the law (PA articles 35 and 60).

After the Torreggiani sentence, judges' decisions about health protection in prisons are binding. Each surveillance judge has an office made up of chancellery and administrative personnel, but half of the surveillance court is composed by professionals, whose areas of expertise are specified in art. 70 of the PA. An expert's presence is related to the role that surveillance courts are required to perform. They, in fact, have to assess the chances of a future rehabilitation of prisoners and the risk they pose to themselves, others and society. To do so, they make use of specific competencies. For instance, when it comes time to take decisions related to the health status of the prisoner, a doctor is called on to provide an interpretation of medical records and certifications.

d. Antigone

The NGO Antigone, focusing on observations of detention and prison conditions, is authorized year by year by the Ministry of Justice to visit prisons with more limited powers than those given by the law to the parliamentarians. The NGO states its independence in article 1 of its foundation charter, which says that "the association is non-profit, independent and not related to political parties or institutionally represented groups". Antigone has a prison observatory status and since 1998 has been authorised to visit every prison facility. At the end of each visit a short report is drafted and published on Antigone's web site. Additionally, since 2007, Antigone produces an annual report on prison conditions in Italy. It is currently in its 11th iteration. Antigone's purpose as a civil society organization is to study and investigate in order to make society aware about rights, justice and fair punishments. Antigone's observers have to plan visits with the prison warden and they cannot talk with prisoners. As they are empowered to monitor prison conditions, they use a form that is not sent, but filled during visits and interviews

with the prison staff. Forms are structured to learn about the main problems observed in eight areas of the penitentiary service from interviewees: security, safety, order, healthcare, prisoners' activities, justice, conditions and management. This system allows observers to elaborate indicators on the quality of the service.

With concern to healthcare, Antigone's observations aim to assess for each prison the number of doctors and nurses, how the service is organized, how prisoners with disabilities and mental diseases are treated, if the collaboration with Ser.T works properly and if there is access to specialists' advice. Antigone's observers have the capacity to collect information on health and human rights issues, but often the satisfactory outcome of their job depends on the discretionary power of the Penitentiary Administration, which is not always willing to provide data on these subjects. As mentioned above, Antigone's observers cannot talk with prisoners but there is a network of volunteer lawyers to which people deprived of their freedom (and their relatives, friends, lawyers, etc.) can address complaints by post, email or phone about their detention conditions and failure to respect their rights. These lawyers solicit the penitentiary administration and the surveillance courts to take action. Among Antigone's experts there are some physicians, but they can only give fiduciary advice in the cases they are directed to.

All these monitoring bodies use the collected information to denounce violations of human rights in prisons. The actions taken are very useful, given the current situation, but institutional feedback is not often given. Political will is also lacking, despite the strong pressure aimed to solicit policies of real change. Aside from these factors, it is worth reiterating that only surveillance judges' warrants are legally binding. This means that claims addressed to judges during visits or in any different way can result in decisions that penitentiary administrations must implement.

In all the cases, the data collected, not usually disaggregated, focus on the most important issues, namely reporting ill-treatment, gaps in policies, regulations, and practices, as well as the appropriateness of conditions under which inmates are living, reflecting systematic lack of protection of the rights of inmates. Data collectors also note and file good practices for systematic analysis. None of the data focus on the availability, accessibility, acceptability or quality of prison health facilities, goods and services. Rather, questions and observations about healthcare services in prisons generally aim to assess the maintenance of prisoners' psychophysical well-being, with special attention to drug users and HIV positive people. Specific questions about harm reduction services are not included.

Finally, art. 11 of the Penitentiary Act outlines the role of the provincial doctor. The doctor will visit prisons at least twice a year to assess the hygienic and sanitary conditions of the facility, the cells and the health of prisoners, as well as the adequacy of the preventative measures planned by the national healthcare service against infections. They report the outcomes of visits to the Ministry of Health, to the Ministry of Justice, and informs regional offices, surveillance judges and wardens, suggesting measures to be taken to improve the situation. However, the provincial doctor is not a human rights-based monitoring

mechanism and is only qualified to warn about critical situations and suggest immediate interventions needed. In many districts the role has been abolished and replaced by ASL functionaries.

Regional and international monitoring mechanisms

Italy signed the OPCAT in 2003 and ratified the treaty in April 2013.

The Sub-Committee on the Prevention of Torture (SPT) has never visited the country, while the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment (CPT) has made 10 visits so far, the last in May 2012.

The CPT encouraged the Italian authorities to adopt a comprehensive preventive programme in all the establishments visited to reduce the spread of transmissible diseases inside prison. It was recommended that this programme should also address the risks of HIV or hepatitis B/C infection through sexual contact and intravenous drug use. No specific mention was made about harm reduction services in prisons¹¹.

The Director General for Prisoners and Treatment of the Department of Penitentiary Administration cooperates and supports initiatives aiming at encouraging the prison population to take care of their health, as well as those of local bodies or scientific associations.¹² Prevention programmes against transmissible diseases are already taking place in some prisons, according to local programmes. For example, there has been a planned intervention involving 19 prisons throughout the national territory. The Permanent Committee on Health in Prison of the Ministry of Health is considering promoting a national general framework on the subject.

The situation has slightly improved since these recommendations were made. For instance, the medical service at Palermo-Ucciardone Prison developed an initiative to provide all newly-arrived prisoners with relevant information on the prevention of transmissible diseases. For this purpose, prisoners received a specific brochure as well as oral explanations by the nursing staff. The Committee welcomed the project and encouraged the relevant health authorities (including the Ser.T) to promote awareness-raising activities for the prevention of transmissible diseases in all Italian prisons.¹³

Right to health protection in prison and case law

National judges must deal with at least three systems of protecting fundamental rights such as right to health, interacting with each other: (i) the one ruled by the Constitution and the domestic laws, such as the Criminal Code and subsequent laws, (ii) the EU law and (iii) the European Court of Human Rights' (ECtHR) jurisprudence. Their coordination cannot be described in terms of hierarchy of sources or powers among different levels and different institutions, but presents forms of mutual influence.

The European Prison Rules of 1987, and then the Recommendation Rec (2006)² assess that prison management must emphasize the ethical obligation to treat all detainees humanely and to respect the dignity of every human being. The staff must have a clear idea of the objective pursued by the prison system and management shall indicate the way to effectively reach this goal. The right to health is therefore an absolute individual right, also provided for prisoners from national and international sources. It is a right that every prisoner has, and its exercise is not left only to the discretion of the administrative authority but its protection is entrusted also to the surveillance judges.

In cases of serious illness the punishment should be applied differently from the one ordinarily provided for healthy inmates. The legislature has confirmed this trend, for instance in relation to HIV, dictating a specific discipline by Law 12 July 1999 n. 231 (Provisions on the application of punishments, security measures and custodial measures for people suffering from full-blown AIDS or serious immune deficiency or other particularly serious illness).

The legal system provides judges with several possibilities of protecting the right to health:

- i. the postponement of sentence under articles 146 (mandatory postponement) and 147 (discretionary postponement) of the Criminal Code, which can also be ordered by the surveillance judge as a matter of urgency under art. 684 of the Criminal Procedure Code, resulting in the release of the prisoner in the case of serious illness or when some specific conditions occur, such as suicide risk, psychological damage or additional suffering caused by the detention condition. The institution of postponement meets the need to protect the health of the prisoner and the need to ensure the right to assistance from their relatives during the illness;
- ii. alternative measures to detention (custody to social services, home detention) is usually ordered by the proceeding judge, but in case of serious and irreparable damage resulting from detention may be ordered as a precautionary measure by the surveillance judge. The law provides that a similar mechanism can be applied to prisoners with drugs or alcohol addictions sentenced to up to six years of imprisonment, except for the most serious crimes.

Considering that prisons are not good places to treat addictions, this kind of prisoner can be transferred to a therapeutic community. However, the use of this alternative measure is still limited over the Italian territory because of the lack of synergy between local public services and prisons;

- iii. the complaint that the prisoner can file before the surveillance judge under Articles 35 and 69 of the PA to denounce the violation of the right to health. These proceedings can only be instigated when the violation has already occurred and the judge has to ascertain whether there was infringement or not.

It is possible to outline an evolution in the interpretation given by the Supreme Court about

the compatibility assessment under articles 146 and 147 CC, identifying three moments:

i. until the 1990s, the criterion set out by the Constitutional Court in its judgment 114/79 was prevalent. According to the Court, the serious physical infirmity relevant to the application of art.147 CC was the one “not susceptible to healing through the medical care available in the place of detention.” However, in some following sentences, the same Supreme Court stated that the postponement had to be related to the possibility of regression of the disease because of the effects of treatments practiced in the state of freedom, or to the existence of the risk of death. For example: “It is necessary a prognosis quoad vitam or that the person needs care and essential treatments that cannot be practiced in detention neither through admission to civilian hospitals or other places of intramural treatment under article 11 PA”¹⁴.

ii. however, it is also stated that the principle according to which

“even the general mandatory nature of the execution of the sentence cannot overtake when the condition of serious illness of the subject end up constituting a treatment contrary to the sense of humanity, thus losing the goal of rehabilitation. In the sentences the judges must provide reasons for their choices, balancing the constitutional principle of equality (Art. 3 of the Constitution) with those of health protection (Art. 32 of the Constitution) and the sense of humanity (Art. 27 of the Constitution) that must characterize the sense of the punishment”¹⁵.

iii. Recently, more conditions are required for granting the postponement. The judicial path outlined by the Supreme Court in recent years is largely guided by subtext and not the overt word or structure of relevant laws and policies. In a decision of 2011¹⁶ we highlight two important principles:

“In terms of discretionary postponement of the sentence, in accordance with art. 147 CC, there is a duty for the judge to take into account, independently of the compatibility or not of the illness with the chances of assistance and care provided by the prison system, the need not to compromise the fundamental right to health and the prohibition of treatments contrary to human dignity, as provided by Articles 32 and 27 of the Constitution.”¹⁷

It would seem, therefore, that the reference to “medical treatments available,” that is to say, the possibility of being treated in prison or through art. 11 of the PA, does not represent only the discriminating criterion anymore. If it did, treatment would need to still be assessed if, in case of serious illness, the length of stay in prison (even if the necessary care is provided) does not constitute an additional suffering “that comes from the deprivation of liberty per se, in consequence of which the sentence may be incompatible with the right to health and to the prohibition of treatment contrary to human dignity.”

V. CONCLUSIONS AND RECOMMENDATIONS

In Italy there is a clear need for prisons to provide education and information about HIV, HCV and TB in a way that both engages prisoners and also meets the needs of non-Italian speakers. Most Italian prisons have many prisoners who come from other countries and the majority of professionals are aware that they may be excluded because of language barriers.

Moreover, it appears that the few prevention and harm-reduction measures that are in place are geared only towards those prisoners identified as known drug users. This tends to ignore the rest of the prison population who may either be ignorant of what constitutes risk behaviour, or may be engaging in risk behaviour (tattooing, sexual contact or injecting drugs) but receive no information about infections and harm reduction.

This is not to say that there are no prevention and harm-reduction initiatives operating in Italian prisons for some groups of prisoners. In some prisons a range of staff provides useful information to prisoners about prevention and harm reduction. However, there is a tendency to focus on the specific needs of identified prisoners, particularly those identified as engaging in high-risk activities. The result is that there are no formal central policies or written strategies for the implementation of prevention initiatives in prisons. Prevention is done in an *ad hoc* way for individual prisoners, who either asked for information or who were known to be involved in risk behaviours (for example, intravenous drug users) prior to coming into prison.

This demonstrates that prisoners want this chance to learn more about prevention and harm reduction. The fact is, in Italy, the prevention strategy is focused on changing behaviour to minimise risk.

There is also the problem of overcrowding. In some prison facilities basic hygiene is a serious problem and it is understandable when considering that there are nearly 2,000 prisoners in a prison built for 800. In this situation, prevention and harm reduction is an idea and not a reality. Due to a lack of staff it is also considered problematic to deal with the everyday problems with little attention being paid to harm reduction and prevention programmes. Overcrowding places strains on staff, reduces the amount of constructive activities available to prisoners, and thereby limits the effective implementation of policies for diseases.

The lack of written strategies is one factor that can hinder implementation of policies across the prison system. The make-up of the prison population, which currently has a high number of foreign nationals, raises barriers to successful implementation of harm reduction and drug treatment programmes due to language difficulties. The DAP in conjunction with the Ministry of Health should develop clear guidelines and implementation mechanisms across the prison service to ensure that, as far as is

possible, the treatment of people with infections in the prison system reflects practice outside and works towards equivalence and the realisation of human rights.

Italy needs to develop stronger standards for monitoring and documentation of infections in prisons. The healthcare services available in prison should be coordinated and integrated towards common actions and the monitoring mechanisms above mentioned should work more frequently and better together to share information in order to collect and analyse harmonised, good quality data leading to more effective treatment and harm reduction initiatives.

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