EVIDENCE BRIEF

Prisoners

Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress report

www.ecdc.europa.eu

Policy implications

- **There is a need for essential HIV prevention programmes to be as available in prisons as they are in community settings.** In particular, this should include systematic health and drug use assessments on entry and release, harm reduction services for PWID, such as opioid substitution therapy and the provision of sterile injecting equipment, and condoms to all prisoners in need.
- **Implementation of adequate HIV prevention services in prison settings may require legal and regulatory barriers to be addressed.**
- **There is a need for all countries in Europe and Central Asia to recognise that mandatory HIV testing in prison settings cannot be justified from a public health perspective.** Routine offering of HIV testing in prison settings with appropriate provision of test information may result in better acceptance and greater engagement with the health system.
- **There is an opportunity for countries not currently providing drug substitution therapy in their prisons, mainly non EU/EFTA countries, to emulate countries that do provide this service.**
- **Countries not currently providing sterile injecting equipment to PWID in their prisons should emulate the few countries that are demonstrating leadership in this area.**

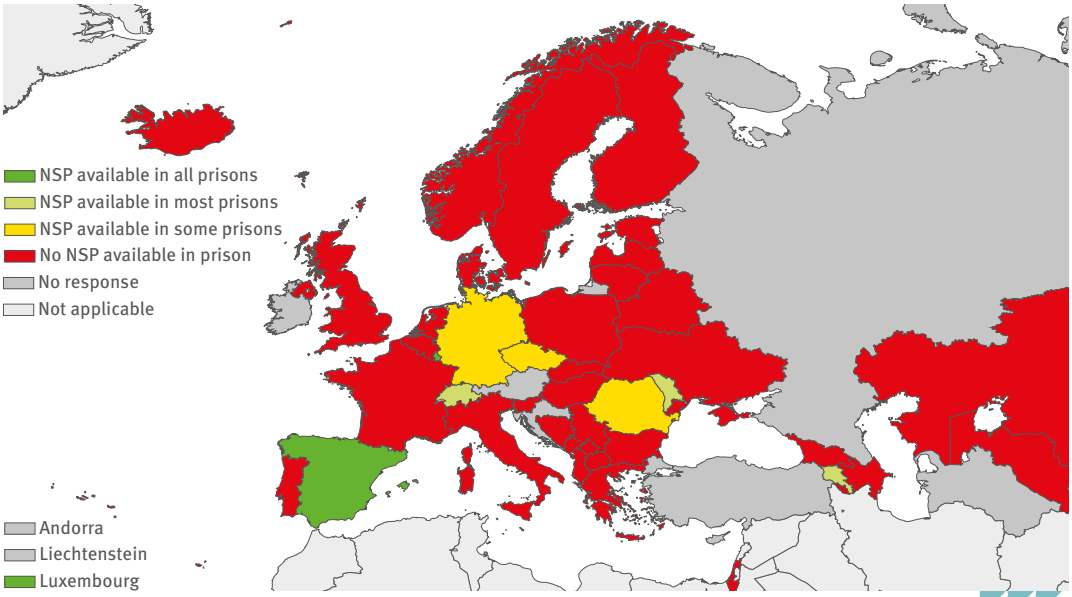
It is important that prisons and other places of detention are included in the response to HIV in Europe and Central Asia

Key populations at increased risk of HIV infection, such as people who inject drugs (PWID), often spend time in the prison. In addition, there is a risk of HIV transmission in prisons through unprotected sex and, for PWID, through the sharing of contaminated injecting equipment.

In countries with significant HIV epidemics among people who inject drugs HIV prevalence is high in prisons

Rates of HIV prevalence among PWID in prisons largely reflect HIV prevalence among PWID in a country. In prison the rate of persons having ever injected drugs is high compared to community populations outside of prison. A number of countries report HIV

Figure 1: Reported availability of needle and syringe programmes in prisons, Europe and Central Asia

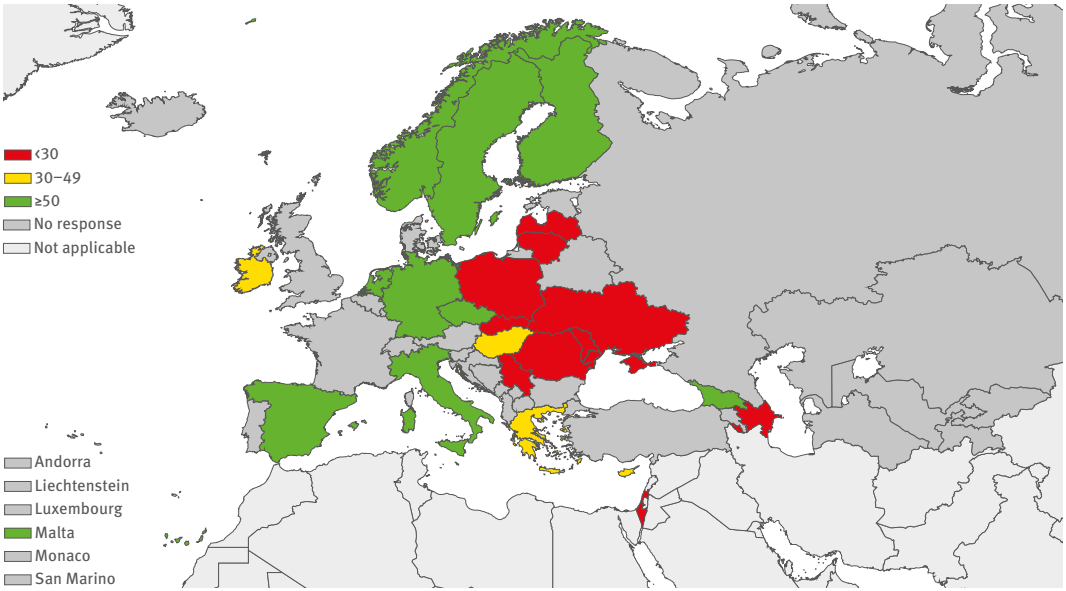


prevalence among prisoners of more than 5%. All these countries have significant HIV epidemics among PWID. In countries with decreasing HIV prevalence among PWID, such as Spain, prevalence among prisoners is also falling

In most countries, HIV prevention and care services are not as widely available in prisons as in the community

In principle, prison systems should aim to provide HIV services equivalent to those available in the community, particularly for PWID. These should include information and education, provision of confidential access to clean needles and syringes, drug dependence treatment, in particular opioid substitution therapy (OST), condoms, HIV testing and counselling, diagnosis and treatment of STI and other infections and antiretroviral treatment. Needle and syringe provision and OST have proven effective at reducing HIV risk in prison environments.

Figure 2: Reported availability of opioid substitution therapy in prisons, Europe and Central Asia



Some countries, such as Norway, Spain and Switzerland, have made considerable efforts to ensure that services are as widely available in prisons as in the community. However, in most countries in the region there is a significant disparity in service availability. For example, very few countries provide sterile injecting equipment to prisoners who inject drugs and there is little difference between EU/EFTA and non-EU/EFTA countries in this respect. However, there are some exceptions including EU/EFTA countries such as Luxembourg and Spain and countries outside the EU/EFTA such as Armenia and Moldova (see Figure 1). There has been no increase in the number of countries reporting that they provide these services since the 2010 reporting round. Free condoms are available in prisons in less than three quarters of the countries in the region, although there is some evidence that the situation has improved since 2010. Legal and regulatory barriers, separate health systems for prisons, limited financial resources and challenges in engaging NGOs to deliver services to prisons are among the reasons for services being less available in prisons than in the community.

Opioid substitution therapy is available in prisons in most EU/EFTA countries, but is much less available in prisons in non-EU/EFTA countries

Opioid substitution therapy (OST) is available in at least some prisons in 84% of EU/EFTA countries, but in only 42% of non-EU/EFTA countries in the region (see Figure 2). However, a number of countries reporting that OST was unavailable in prisons in 2010 indicated that it was now available in at least some prisons. These countries included Armenia, Bulgaria, Greece, Israel and Malta. A number of EU/EFTA countries, including Denmark, Estonia, France and Portugal, also reported that the availability of OST in prisons had improved.

However, the scale and coverage of OST provision in prisons varies markedly between countries in the region. For example, more than 20% of the prison population receive OST in Luxembourg compared to less than 1% in other countries. Coverage is high in EU countries such as Denmark, Ireland, Luxembourg, Slovenia, Spain and the United Kingdom. Unsurprisingly, coverage is lower in countries with newer programmes and countries that restrict provision of OST to those who had started it prior to imprisonment.

The number of countries reporting mandatory HIV testing in prisons has increased

Although prisons provide an important setting for HIV testing, mandatory HIV testing in prisons is not justified based on public health principles. In 2012, 11 countries, including six EU countries, reported this practice, an increase since the previous round of reporting.

In most countries of the region antiretroviral therapy is available in prisons, however barriers to treatment access remain

Most respondents from both government and civil society in most countries reported that ART was readily available for people who need it in prisons. A number of countries have also implemented initiatives to improve the delivery of antiretroviral therapy in prison settings. Obstacles identified included the existence of a separate health system for prisons in some countries and lack of funding for prison health services.

Testing and treatment for hepatitis C is reported to be available in some prisons in almost all EU/EFTA countries but this is not the case in most non-EU/EFTA countries

Testing and treatment for hepatitis C was reported to be available in at least some prisons by 96% of EU/EFTA countries that reported in 2012. However, several of these countries highlighted difficulties in providing treatment for hepatitis C in prisons, for example, because of lack of funding or because of treatment only being available to those with health insurance. Testing and treatment for hepatitis C in prison is not so readily available in prisons in non-EU/EFTA countries – only 50% reported testing being offered in prisons and 27% reported treatment being offered in prisons.

About this series

The Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, adopted in 2004, was the first in a series of regional declarations which emphasise HIV as an important political priority for Europe and Central Asia.

Monitoring progress in implementing this declaration began in 2007 with financial support from the German Ministry of Health. This resulted in a publication by the WHO Regional Office for Europe, UNAIDS and civil society organisations in August 2008.

In late 2007, the European Commission requested that ECDC monitor implementation of the declaration on a more systematic basis and ECDC set up an advisory group comprising 15 countries and various international partners, including EMCDDA, UNAIDS, WHO, UNICEF, and produced its first major country-driven, indicator-based progress report in 2010.

In 2012, the process of reporting was further harmonised with EMCDDA, UNAIDS, WHO, UNICEF, as well as with the EU Commission Communication and Action Plan on HIV/AIDS 2009–2013. The objective was to reduce the number of indicators, focus on reporting that was relevant in the European and Central Asian context and minimise the reporting burden for countries by making better use of existing country reported data. Responses were received from 51 of 55 countries (93%).

In this round, instead of producing one overall report, information provided by countries has been analysed to produce ten thematic reports and this series of eight evidence briefs.

Other reports in the series can be found on the ECDC website at www.ecdc.europa.eu under the health topic HIV/AIDS.

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