SPECIAL REPORT

Thematic report: Prisoners

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

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Monitoring implementation of the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia: 2012 Progress Report

This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori and Anastasia Pharris, Programme for STIs, including HIV/AIDS and blood-borne infections.

This report is one in a series of thematic reports based on information submitted by reporting countries in 2012 on monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS. Other reports in the series can be found on the ECDC website at: http://www.ecdc.europa.eu/ under the health topic HIV/AIDS. ECDC gratefully acknowledges technical input and review of this thematic report by experts at the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) including Lucas George Wiessing, Dagmar Hedrich, Julian Vicente, Roland Simon, Ilze Jekabsone, Linda Montanari, Andre Noor, Klaudia Palczak and Alessandro Pirona.

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Abbreviations

ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
EU/EFTA	European Union/European Free Trade Association
GARP	Global AIDS Response Progress Reporting
NCPI	National Commitments and Policies Instruments
NGO	Non-governmental organisation
OST	Opioid substitution therapy
PWID	People who inject drugs
UNAIDS	Joint United Nations programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

Executive summary

Key messages

HIV prevalence among people who inject drugs (PWID) in prisons largely reflects the rate of HIV prevalence among PWID in any given country. In most countries within Europe and Central Asia, HIV prevention services are not as widely available in prisons as in the community.

Very few countries in the region make sterile injecting equipment available to prisoners and there has been no increase in the number of countries reporting doing so since the last round of Dublin reporting in 2010.

Overall, the scale and coverage of opioid substitution therapy (OST) provision in prisons varies markedly across Europe. OST is available in at least some prisons in many EU/EFTA countries. However, OST is much less available in prisons in non-EU/EFTA countries. In this round of reporting, a number of countries indicated that OST was now available in prisons where it had not been available previously.

Although the number of countries reporting the availability of free condoms in prisons has improved since the last round of Dublin reporting, a significant number still do not distribute free condoms in prisons. Although prisons provide an important setting for voluntary HIV testing, mandatory HIV testing in prisons is not justified. Yet the number of countries reporting this practice increased between 2010 and 2012.

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.

There are a range of reasons explaining why HIV prevention services are not as widely available in prisons as in the community. These include legal and regulatory barriers to the provision of services in prisons; the existence of a separate health system for prisons in some countries; limited financial resources for the provision of health services in prisons and challenges in engaging NGOs to provide services in prisons.

Background

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 the countries of Europe and Central Asia.

Monitoring of progress in implementing this declaration began in 2007 with financial support from the German Ministry of Health. This resulted in the publication of a first progress report by the WHO Regional Office for Europe, UNAIDS and civil society organisations in August 2008. In late 2007, the European Commission requested ECDC to monitor the Dublin Declaration on a more systematic basis. The first country-driven, indicator-based progress report was published in 2010. The objective was to harmonise indicators with existing monitoring frameworks, notably UNGASS and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) indicators, and with the EU Communication and Action Plan[i], using existing data and focusing on reporting that was relevant in the European and Central Asian context, to minimise the reporting burden for countries. In 2012, instead of producing one overall report, information provided by countries has been analysed to produce ten thematic reports.

Method

All 55 countries of the region were requested to submit data regarding their national responses to HIV (see Annex 1 for a list of the 55 countries). For this round of reporting, the process was further harmonised with Global AIDS Response Progress Reporting (formerly known as UNGASS reporting). As a result, countries submitted most of their responses through a joint online reporting tool hosted by UNAIDS. Responses were received from 51 of 55 countries (93%). This response rate was slightly higher than for 2010. More details of methods used are available in the background and methods report.

In general, international reporting processes, such as Global AIDS Response Progress reporting, have had relatively little focus on prisoners as a key population affected by HIV or prisons as a setting in which HIV transmission may occur and where HIV services need to be provided. There are a few questions within the National Commitment and Policies Instrument (NCPI) relating to prisoners as one of a number of key affected populations and/or prisons as a special setting for HIV service provision. Countries were asked to respond to these questions in relation to the situation in most or all of their prisons.

i Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee, and the Committee of the regions. Combating HIV/AIDS in the European Union and neighbouring countries, 2009–2013. Available here: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0569:FIN:EN:PDF

In addition, a number of region-specific indicators were introduced into the UNAIDS reporting tool for Global AIDS Response Progress reporting. These included one indicator related to HIV prevalence among prisoners. Countries were asked to report data on this indicator. In addition, countries were asked to report disaggregated data for prisoners in relation to coverage of antiretroviral therapy and late diagnosis.

A number of questions related to prisons were included in the European supplement to the NCPI. These questions were asked of both government and civil society respondents. They focused on the availability of key services in prisons, such as provision of free condoms; needle and syringe programmes; opioid substitution therapy and testing and treatment for hepatitis C. The question about hepatitis C was included for the first time in this round of Dublin reporting because of the high prevalence of hepatitis C and the significant co-infection of hepatitis C and HIV among PWID, which can complicate HIV treatment. It was also included due to the perception that availability of services for testing and treatment of hepatitis C in the region is limited. As in the previous round, countries were asked about the practice of mandatory HIV testing in prisons. Respondents were offered the opportunity to submit additional data and a number did so, particularly through their narrative reports.

EMCDDA also produced country data sheets for a total of 29 countries based on reports submitted by its network of national drugs focal points (Reitox). These sheets included some data relevant to prisons and prisoners including the availability of key services in prisons, such as provision of free condoms; needle and syringe programmes; opioid substitution therapy and testing and treatment for hepatitis C. The data sheets also provided information about the practice of mandatory HIV testing in prisons[i].

Challenges faced in dealing with this particular population include difficulties in deciding how to quantify availability of key services in prisons. Unsuccessful attempts were made through the advisory group of the Dublin reporting process to identify coverage measures for HIV prevention programmes of relevance to prisons, such as those used for PWID outside prison. Consequently, the report has retained its previous focus – assessing government and civil society perceptions of the policy environment in prisons throughout the region. The EMCDDA does, however, have some data on the scale of HIV prevention programmes in prisons, e.g. the number of prisoners receiving OST and estimates of the proportion of prisoners receiving such treatment. Where available, this data has been used. An underlying problem is limited availability of quantitative data relating to the level of other relevant HIV services in prisons (such as needle and syringe programmes, antiretroviral treatment, and HIV testing).

i The European supplement to the NCPI is not yet fully aligned with the EMCDDA on data related to prisons. In particular, the supplement asks countries to classify availability of services as – not available; available in some prisons; available in most prisons; available in all prisons. EMCDDA asks countries to classify availability as not available; rare; limited; extensive or full.

Introduction

Prisons and other places of detention are significant for the response to HIV in the countries of Europe and Central Asia. Key populations at increased risk of HIV infection, such as PWID, often spend time in prisons. Risks of HIV transmission exist in prisons through the sharing of contaminated injecting equipment and through unprotected sex. As a result, national responses to HIV need to include prison systems. Prison systems should aim to provide HIV services equivalent to those available in the community, in particular for PWID. These services should include information and education; needle and syringe programmes; drug dependence treatment (in particular opioid substitution therapy); provision of condoms; HIV testing and counselling; diagnosis and treatment of STIs and other infections and antiretroviral treatment. Opioid substitution therapy has proved effective in reducing HIV risk behaviour in a wide range of prison environments[i]. Needle and syringe programmes have been introduced in several EU countries without leading to negative consequences for the health of prison staff or prisoners[ii].

This report is divided into two main parts. The first part considers the HIV situation affecting prisoners in Europe and Central Asia. The second part considers the nature of HIV responses for prisoners in the countries of Europe and Central Asia. The report then draws a number of conclusions, considers progress since the last round of Dublin reporting and presents issues identified for further action.

i Hedrich D, Alves P, Farrell M, Stover H, Moller L, Mayet S. The effectiveness of opioid maintenance treatment in prison settings: a systematic review. Addiction 2012;107(3):501–17.

ii EMCDDA. Selected Issue: Prisons and Drugs in Europe: The Problem and Responses. European Monitoring Centre on Drugs and Drug Addiction. Lisbon, 2012.

HIV situation for prisoners in countries of the region

Box 1. HIV prevalence and prevention coverage among prisoners in EU/EFTA countries

HIV prevalence among prisoners is high in those EU/EFTA countries where HIV prevalence among PWID is also high. These countries include Estonia, Latvia, Portugal and Spain.

Increasing HIV prevalence among prisoners in some EU/EFTA countries reflects rising HIV prevalence among PWID in that country. For example, between the two rounds of Dublin reporting, HIV prevalence in prisoners in Bulgaria rose from 0.5% to 1.6%. During the same period, HIV prevalence among PWID rose from 3.4% to 7.1%.

Some EU countries have demonstrated best practice in responding effectively to HIV in prisons. For example, from 1995 to 2011, Spain reported that HIV prevalence among prisoners fell from 22.4% to 6.3%.

Prisons are an important setting for HIV testing across the region. However, it is of concern that a number of EU countries (e.g. Bulgaria, Cyprus, Germany, Latvia, Portugal and Romania) report mandatory HIV testing within their prisons.

Government respondents report that free condoms are available in at least some prisons in just over three quarters (77%) of EU/EFTA countries responding to this question, compared to just under three quarters (71%) in non-EU/EFTA countries. However, civil society respondents report that free condoms are available in at least some prisons in just over half (59%) of EU/EFTA countries responding to this question, compared to three quarters (75%) of non-EU/EFTA countries.

Opioid substitution therapy (OST) is reported to be widely available in prisons in EU/EFTA countries (See Figure 3). There is a marked difference between EU/EFTA and non-EU/EFTA countries on this. Exceptions include Iceland, Latvia and Lithuania which do not provide OST. No data is available from Liechtenstein. Conflicting reports were received from government and civil society respondents in Greece and Slovakia. EU/EFTA countries that reported improved availability of OST in prisons between the two rounds of Dublin reporting included Bulgaria, Denmark, Estonia, France, Greece, Malta, Portugal and Slovakia (see Figure 3).

The scale of OST in prisons in some EU countries is very high (i.e. >10% of the prison population receive OST). These countries, which include Denmark, Ireland, Luxembourg, Slovenia, Spain and the UK, generally have a long history of providing this type of therapy in prisons. For example, in Luxembourg, more than one fifth of all prisoners are reported to receive OST. EU countries that have introduced OST into their prisons more recently usually provide it on a lesser scale. Such countries include the Czech Republic, Estonia and Romania. However, this depends on the proportion of opioid users among prisoners which is likely to differ significantly between countries.

Some EU/EFTA countries restrict OST in prisons to those who were receiving it prior to imprisonment. Government respondents reported this restriction in Bulgaria, the Czech Republic, Estonia, Finland and Greece. Civil society respondents also reported this restriction in Hungary, Portugal and Sweden.

Very few EU/EFTA countries provide sterile injecting equipment to PWID in prisons. There is little difference here between EU/EFTA and non-EU/EFTA countries. EU/EFTA countries that report they do provide sterile injecting equipment to PWID in prisons include Germany, Luxembourg, Romania, Spain and Switzerland.

Almost all EU/EFTA countries report offering testing and treatment for hepatitis C in prisons. The only EU country where the government respondent reported that it does not offer testing for hepatitis C in prisons is Latvia. Civil society respondents from Sweden indicated that testing for hepatitis C was not available in prisons. There are restrictions on availability of treatment for hepatitis C in some EU countries. For example, in Bulgaria and Czech Republic, this treatment requires that the recipient has health insurance which is not the case for prisoners. In Finland, treatment for hepatitis C is available during a long imprisonment. Several countries, including Estonia and Lithuania, reported financial barriers to providing treatment for hepatitis C in prisons.

HIV prevalence is high in prisons in countries with significant HIV epidemics among PWID

A number of countries report HIV prevalence of more than 5% among prisoners, including Azerbaijan, Estonia, Kyrgyzstan, Latvia, Portugal, Spain, Tajikistan and Ukraine (see Annex 2). All these countries have very significant HIV epidemics among PWID. The high prevalence documented in prisons in these countries does not mean that HIV transmission is necessarily occurring in prisons. Rather, it probably reflects the high HIV prevalence among PWID and the likelihood that they spend time in prisons.

Figures for HIV prevalence need to be interpreted with caution as they come from a variety of different sources. In some cases, those already known to be HIV positive are included and in other cases they are excluded from prevalence estimates, causing values to differ across settings. example, in 2011, 1.1% of those tested in Estonian prisons were found to have previously undetected HIV infections, while the overall prevalence in Estonian prisons was estimated at 16%.

Trends in HIV prevalence in prisons reflect broader trends in HIV prevalence among PWID

In countries with declining HIV prevalence among PWID, HIV prevalence among prisoners is also decreasing. For example, in 1995, HIV prevalence in prisons in Spain was 22.4% but, by 2011, this had fallen to 6.3% (see Annex 2). This is likely to be a result of the effective response to the HIV epidemic among PWID in Spain, not only in prisons but also within the broader community, although it may also be explained by the significant reduction in injecting drug use that has occurred in combination with the higher mortality of HIV infected PWID. Conversely, Bulgaria saw HIV prevalence among prisoners rise from 0.5% in 2007 to 1.6% in 2009. Although a relatively modest rise, this probably reflects the increase in HIV prevalence among PWID in Bulgaria. During the same period, HIV prevalence among PWID rose from 3.4% to 7.1%.

HIV responses for prisoners in countries of the region

Several countries reported that HIV services for prisoners are an important part of the national response to HIV

Estonia reported a range of programmes focused on prisoners, including information, education and communication activities; condom distribution and HIV testing. Iceland reported that HIV education for prisoners is part of their national response. In Kosovo (UNSCR 1244), the HIV strategic plan provides for a range of services for prisoners including information, education and communication activities; voluntary counselling and testing and peer education and outreach services.

Countries highlighted achievements in a number of areas:

- Provision of comprehensive HIV services in prisons. For example, in 2010, two Ukrainian NGOs received the Red Ribbon award for their work providing comprehensive services to prisoners in six prisons.
- Provision of condoms in prisons, e.g. in Romania.
- Provision of harm reduction services in prisons, e.g. in Romania. The civil society respondent from Azerbaijan commented that harm reduction has been integrated into the programme of vocational training and educational standards for experts of the penitentiary service at the Ministry of Justice.
- Provision of OST in prisons, e.g. in Armenia and in Georgia where the civil society respondent commented that 'one of the most notable achievements has been the introduction and expansion of OST in several prisons nationwide'.
- Improved access to antiretroviral therapy (ART), e.g. in Portugal.

In many countries HIV prevention services in prisons are not the same as in communities

In general, it is recognised that health and HIV services available in prisons should be equivalent that on offer in the broader community. Some countries, e.g. Norway, Spain and Switzerland, have attempted to do this by ensuring that the same healthcare providers deliver services in both settings. Box 2 presents an example of a Swiss project to bring healthcare in penal institutions in line with that in the community.

Box 2. Attempting to bring healthcare in penal institutions in line with that in the community: the BIG project in Switzerland

In 2008, the Federal Office of Public Health (FOPH), the Federal Office of Justice (FOJ) and the Swiss Conference of Cantonal Justice and Police Directors launched the BIG project. Four areas of activity were defined: gathering data on infectious diseases in prisons; providing information and training to prisoners and staff; prevention, testing and treatment and addressing structural matters, including language barriers.
Key lessons learned from the BIG project include:

- The need to have a consistent national approach and to minimise variations between cantons.
- The importance of dialogue and cooperation between the different players in prison medicine, nursing care and law enforcement.

The BIG project is continuing, with a focus on developing recommendations to harmonise healthcare in Swiss penal institutions which will seek to ensure that agreed norms and standards are applied consistently. Another aim is to establish a centre of excellence for prison health which would have an administrative link with the Swiss Prison Staff Training Centre.

Serbia reported that support from the Global Fund had enabled it to lift prison HIV services to a higher level so that those services available in the community are now available in prisons as well.

However, there is evidence from many countries that the type and scale of HIV services available in prisons is inferior to those in the broader community. This is particularly clear in relation to provision of sterile injecting equipment but is also the case in many countries for substitution therapy and the provision of condoms. For example, the civil society respondent from Belarus commented that integration of harm reduction programmes into prisons had been poor. The reasons for this are complex. One example, reported from Romania, was fear among prisoners regarding use of the services.

Other possible reasons include:

- The absence of non-discriminatory laws and policies that specify protection for prisoners in approximately half of the reporting countries.
- The existence of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for prisoners. For example, in Georgia state regulations and the attitude of prison authorities were considered to be highly restrictive. In Serbia, it was reported that there was a policy precluding the distribution of needles, syringes and condoms in prisons. In Ukraine, the civil society respondent reported that there was no legislative regulation providing for syringe exchange and substitution therapy in prisons.

There may also be issues relating to health and prison systems that result in services being provided at a lower level in prisons than in the community. This may be more likely to occur when the systems for providing services are different in the two settings. This is the case in a number of countries (e.g. Croatia) and it may be particularly problematic in times of economic austerity. For example, since 2009, the funds available for health services in prisons in Latvia have been dramatically reduced and the Latvian Prison Hospital has had to operate on a restricted scale. The civil society respondent from Spain stated that 'prison health should form part of the National Public Health System, in order to avoid treatment interruptions of prisoners while entering/leaving prisons'.

In addition, in countries with highly decentralised system such as Germany and Switzerland (see Box 2), there may be a great deal of variation between the types and scale of HIV services offered in prisons in different regions of the country. For example, in Germany, needles and syringes are provided in only one prison. Germany reported that: 'More progress is needed in the area of prison health. At national level no jurisdiction for the management of prisons exists. Prison health is the responsibility of the federal states leading to the fact that the level of prison health activities varies'. This implies that differing approaches are being used to needle exchange, drug substitution and condom promotion.

Figure 1. Laws, regulations and policies that specify protection or pose obstacles to HIV services in prisons in European and Central Asian countries

Several countries have engaged with civil society organisations to ensure services in prison settings, particularly those that governments find difficult to provide. However, in some countries, e.g. Latvia, it has proved difficult to engage NGOs to work in prisons because there are reported to be only a small number of NGOs with limited capacity.

Another approach mentioned by some countries – e.g. Moldova – is to reduce the number of PWID spending time in prison, for example, by introducing alternative punishments for drug users. In Moldova, there has been a marked shift in drug enforcement strategy since 2004. Since 2008, the possession of drugs for personal use has been regarded as an administrative rather than a criminal offence. As a result, such offences now attract a fine or community service.

Prisons are an important setting for HIV testing in many countries

Prisons are an important setting for HIV testing across the region because key populations at increased risk of HIV infection, such as PWID, who may be difficult to reach in community settings, often spend considerable amounts of time in prison. The prison setting offers an opportunity for service providers to engage PWID in a range of HIV programmes on a voluntary basis. HIV testing can be a key entry point for this engagement (see Box 3).

Box 3. Examples of HIV testing and counselling programmes in prisons

- In Bulgaria, voluntary counselling and testing (VCT) services were first introduced in prisons in 2005 through the work of teams from the VCT centres in Sofia and Stara Zagora. In 2006, these services were expanded to five prisons. Since 2007, as a result of financing from the Global Fund and cooperation between the Ministries of Health and Justice, it has been possible to provide services in all 13 prisons and four pre-trial detention centres in Bulgaria. Services include voluntary and anonymous HIV counselling and testing; individual counselling on safe sex and injecting practices and distribution of condoms and information materials. In 2009, the package of HIV prevention services was complemented by the addition of group health education sessions among prisoners. In 2011, a pilot project was implemented in Sofia Central Prison involving the training of ten peer educators.
- In Croatia, one of ten voluntary counselling and testing centres established with Global Fund financing was located in a prison setting.
- In Georgia, voluntary counselling and testing centres were established in prisons with support from the Global Fund. As a result, approximately 5 600 people received HIV testing and counselling in prison settings.
- In Sweden, between 2002 and 2011, a programme operated in remand prisons in two of the country's largest cities, Stockholm and Gothenburg. Services include HIV testing and counselling and provision of immunisations. Approximately 2 500 PWID received services and a total of 31 new HIV infections were detected.

Although mandatory HIV testing in prison settings violates ethical principles and cannot be justified from a public health perspective, reports from government and civil society sources indicate that it is mandatory in up to 11 countries of the region[i]. These countries include Belarus[bc], Bulgaria[c], Cyprus[a], Estonia[c], Israel[ac], Kazakhstan[abc], Latvia[bc], Portugal[c], Romania[bc], Turkmenistan[a] and Uzbekistan[bc]. It appears that the number of countries conducting mandatory HIV testing in prisons has increased since the previous round of Dublin reporting. However, it could be that there is some confusion over the term 'mandatory'. One country[ii] that reported mandatory HIV testing in prisons in the previous round of Dublin reporting and initially in this round, later clarified that all prisoners are offered an HIV test but they are not mandatory.

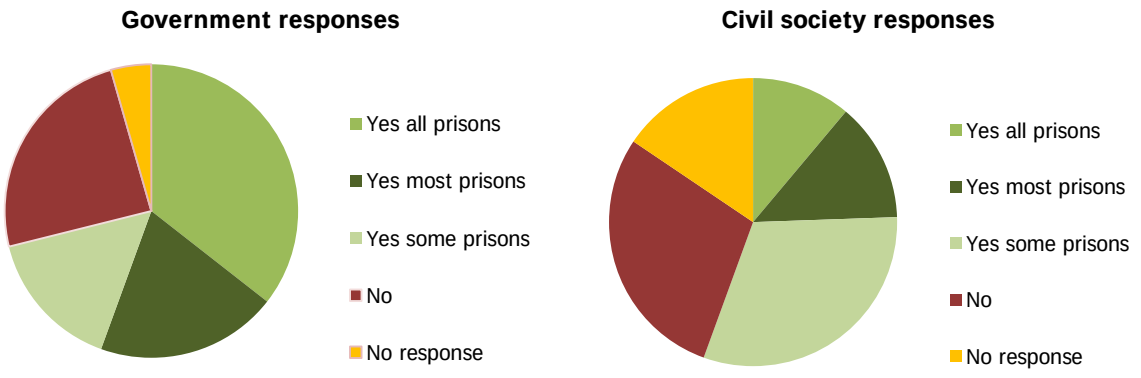
Condoms are not as widely available in prisons as in the community

In general, the availability of condoms in prisons is limited (see Figure 2).

Overall, government respondents reported that free condoms were available in prisons in 32 countries (74%) and unavailable in 11 countries (26%). In the countries where free condoms were reported to be available, they were reported to be available in all prisons in 16 countries (50%), in most prisons in nine countries (28%) and in some prisons in seven countries (22%) (see Figure 2).

[i] List includes five countries that reported mandatory HIV testing in the previous round of Dublin reporting (denoted [a] above). Government respondents from five countries reported mandatory HIV testing in the current round of reporting (denoted [b] above). Civil society respondents from nine countries reported HIV testing in the previous round of reporting (denoted [c] above).
[ii] Germany.

Figure 2. Reported availability of free condoms in prisons in 45 countries of Europe and Central Asia



Country examples

- In Estonia, condoms are available under certain circumstances, for example, in long-term appointment rooms, when requested from the medical department and in the prison shop. From 2004 to 2007, as a result of Global Fund financing, NGOs distributed free condoms in prisons.
- In France, male condoms are available in prisons, mostly through medical units (UCSAs). However, lubricants are only available in half of prison establishments. Access to female condoms in women's prisons is far more limited.
- In Lithuania, condoms are available in prisons but not in all prison settings. In addition, access is reported to be limited.
- In Montenegro, although HIV prevention measures have been introduced to offer information and counselling, condoms are not being provided.
- In Poland, free condoms are not provided in prisons.
- In Slovakia, it is reported that condoms are available for sale in prison shops.

However, civil society respondents presented a more critical picture. They reported that free condoms were available in prisons in 25 countries (66%) and unavailable in 13 countries (34%). In the countries where free condoms were reported to be available, they were reported to be available in all prisons in five countries (20%), most prisons in six countries (24%) and some prisons in 14 countries (56%). In most countries where there was a difference in assessments by government and civil society respondents, it related to the degree of availability of free condoms in prisons. For example, in Azerbaijan, the government respondent reported that free condoms were available in all prisons but the civil society respondent reported that they were only available in some prisons. In Italy, Lithuania, Poland and Slovakia, government respondents reported that free condoms were available in at least some prisons while civil society respondents reported that this was not the case. In four countries, the civil society respondent presented a more positive picture than the government respondent. In the former Yugoslav Republic of Macedonia and Kazakhstan, the government respondents reported that free condoms were available in most prisons while the civil society respondents reported that they were available in all prisons. In Greece and Serbia, the government respondents reported that free condoms were not available in prisons while the civil society respondents reported that they were available in some prisons.

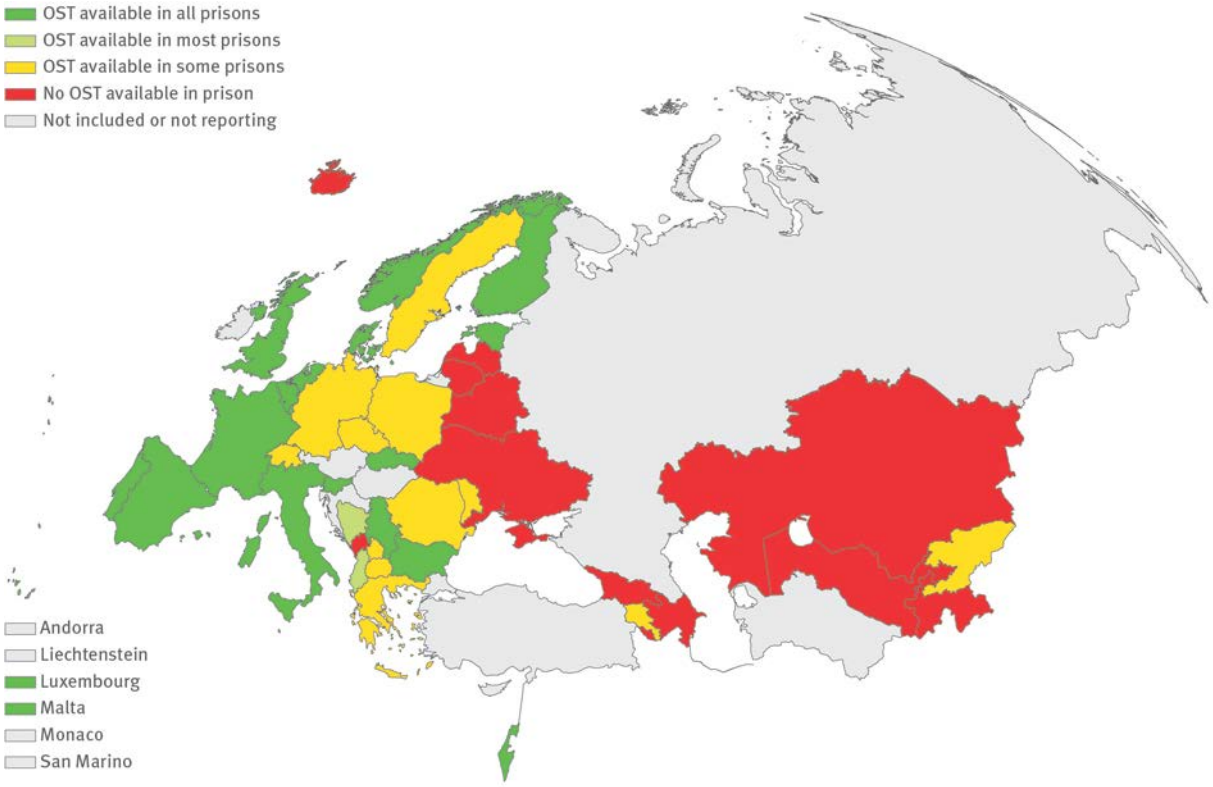
Overall, the picture presented by government respondents was very similar inside and outside of the EU/EFTA. For example, just over three quarters (77%) of countries within the EU/EFTA reported providing free condoms in at least some prisons while just under three quarters of countries (71%) outside the EU/EFTA reported this. However, the proportion of countries reporting that free condoms were available in all prisons was higher (60%) in EU/EFTA countries than in non-EU/EFTA countries (33%). In general, civil society respondents from EU/EFTA countries presented a more critical picture than those in non-EU/EFTA countries. For example, less than two thirds (59%) of civil society respondents from countries within the EU/EFTA reported that the country provided free condoms in at least some prisons while three quarters (75%) of civil society respondents from countries outside the EU/EFTA reported this.

There is some evidence that availability of free condoms in prisons across the region may have increased since the last round of Dublin reporting. The proportion of countries reporting that free condoms are available in at least some prisons rose from 64% to 74%.

OST is not widely available in prisons in all EU/EFTA countries

OST is available in at least some prisons in almost all (84%) of EU/EFTA countries. Exceptions include Iceland, Latvia, and Lithuania. No data is available for Liechtenstein. Government respondents from Greece reported that OST is available as a pilot project funded by EU cohesion funds in two prisons. The Greek civil society respondent indicated that substitution therapy is not available in prisons.

Figure 3. Reported availability of opioid substitution therapy in prisons in Europe and Central Asia



OST is less widely available in prisons outside of the EU/EFTA

Outside of the EU/EFTA only 10 (42%) of countries have reported providing OST. Opioid substitution therapy is not available in Azerbaijan, Georgia, Kazakhstan, Tajikistan, Turkmenistan, Ukraine and Uzbekistan. No report was received on the situation in the Russian Federation. Similarly, substitution therapy is not available in prisons in Montenegro or Turkey. Countries which report substitution therapy being available in at least some prisons include Armenia, Kyrgyzstan and Moldova. The civil society respondent from Kazakhstan identified the lack of substitution therapy in prisons as a challenge for the national response to HIV.

Availability of OST in prisons has improved in a number of countries since the last round of Dublin reporting

A number of countries that reported that substitution therapy was not available in prisons in the last round of Dublin reporting have confirmed that it is now available in at least some prisons. These include Armenia, Bulgaria, Greece, Israel and Malta. Other countries where OST is now more available in prisons include Denmark, Estonia, France and Portugal. Three countries – Poland, Sweden and Switzerland – reported that substitution therapy was now only available in some prisons as compared to all or most prisons in the previous round of reporting. (See Figure 3).

One example of a country that introduced substitution therapy relatively recently is Estonia. Methadone treatment in prisons started in 2008 with treatment being provided to two people. By 2009, 12 people had received withdrawal or substitution treatment with methadone. In 2010, 59 people received withdrawal treatment and 64 received substitution treatment. Methadone treatment was introduced in detention centres under the Ministry of Interior in 2010.

The scale of OST in prisons varies widely across the region

OST has been introduced into prisons in various countries at different times. For example, the Netherlands has been providing this treatment in prisons since 1985. Yet in other countries it has been introduced much more recently: e.g. the Czech Republic (2007), Estonia (2008) and Romania (2008). As a result, and because the number and percentages of problem opioid users differs between countries, it is unsurprising that the scale of substitution therapy in prisons varies markedly across the region.

Although the advisory group of the Dublin monitoring process did not agree on a method for tracking the scale and coverage of OST in prisons, certain countries (e.g. Romania and Ukraine) acknowledged that the scope, magnitude and coverage of their HIV programmes in prisons remained low.

A key problem for tracking the scale of OST in prisons is that the number of problem opioid users within a country's prison system is often unknown. Consequently, EMCDDA tracks data for the proportion of a country's prison population receiving OST in a number of countries[i]. This proportion is:

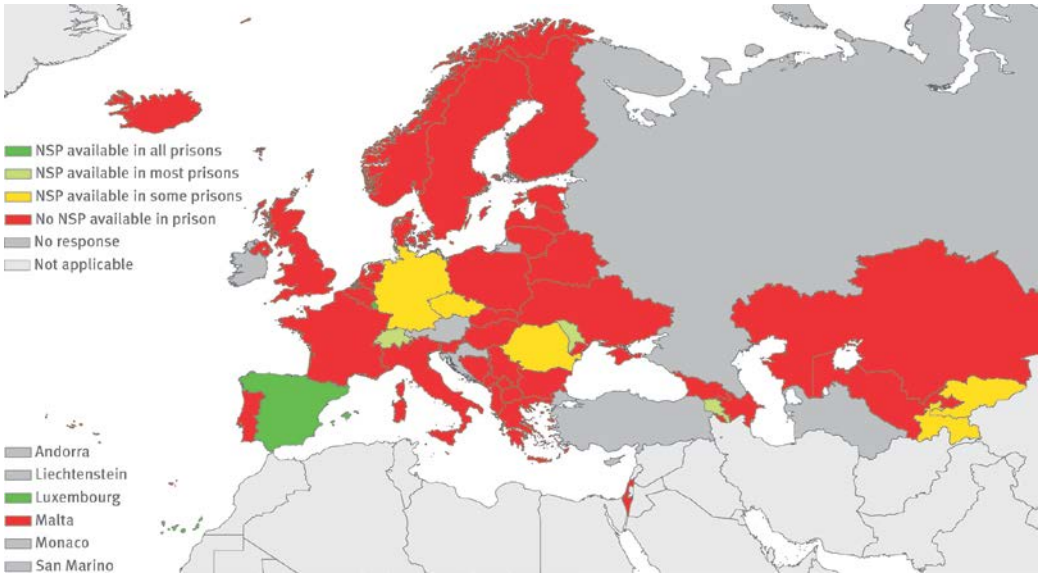
- High (>10%) in Denmark, Ireland, Luxembourg, Slovenia, Spain and the UK[ii]. In Luxembourg, for example, more than one fifth of all prisoners are reported to receive OST
- Moderate (1–10%) in Austria, Belgium, Croatia, Finland, France, Italy, Netherlands, Norway and Portugal
- Low (<1%) in the Czech Republic, Estonia, Germany, Poland, Romania and Sweden
- Unavailable in Cyprus, Greece, Hungary, Latvia, Lithuania, Slovakia and Turkey.

Some countries only provide continuation of OST in prisons for those who received it prior to imprisonment

A number of countries report that, although substitution therapy is available in prisons, there are restrictions on its use. For example, in some countries, prisoners initiate substitution therapy in prison but may continue if they were receiving it prior to imprisonment. Countries where government respondents reported this restriction included Bosnia and Herzegovina, Bulgaria, the Czech Republic, Estonia, Finland, Greece, Serbia and Ukraine. In the case of Finland, the civil society respondent commented that it was possible for prisoners to initiate substitution therapy in prison if they were imprisoned for a long period. In the case of both Poland and Portugal, the countries' most recent reports to EMCDDA indicated that this restriction applied. However, in their responses to this round of Dublin reporting, government respondents indicated that this was not the case. Yet, in the case of Portugal, the civil society respondent commented that it was not possible for people to initiate OST in prison. Similar responses were received from civil society respondents in both Hungary and Sweden.

Sterile injecting equipment remains largely unavailable for PWID in prisons across the region

Figure 4. Reported availability of sterile injecting equipment in prisons in Europe and Central Asia



[i] This data is based on the country sheets provided by EMCDDA for the Dublin reporting process. More up-to-date information is available at http://www.emcdda.europa.eu/stats12/hsrfig4

[ii] Both England and Scotland.

Very few countries report providing sterile injecting equipment in prisons (see Figure 4). Those that do mostly reported having done so in the last round of Dublin reporting, namely Armenia, Germany, Kyrgyzstan, Luxembourg, Moldova, Romania, Spain and Switzerland. A similar situation was reported to EMCDDA by the UK, namely that a limited number of prisoners were able to receive sterile injecting equipment. However, in responding to this round of Dublin reporting, both government and civil society respondents from the UK noted that this was not the case.

Two countries (the Czech Republic and Tajikistan) reported that they were providing needles and syringes in prisons when they had not reported this in the previous round of reporting. However, in the case of the Czech Republic, their latest report to EMCDDA indicated that needle and syringe programmes were not available in prisons. In addition, the civil society respondent stated that these services were not available in prisons. Tajikistan did not submit data on this issue in the previous round of Dublin reporting.

Although government responses to both EMCDDA and this round of Dublin reporting indicate that needle and syringe programmes are not available in prisons in Poland, the civil society respondent indicated that they are available in some prisons.

Several respondents explained that they would like to see needle and syringe programmes available in their prisons. These included civil society respondents from Finland, the former Yugoslav Republic of Macedonia, Germany and Kazakhstan. Some countries explained why needle and syringe programmes are not available in prisons. For example, in Azerbaijan there are regulations concerning the type of items that can and cannot be stored in prisons. These regulations are interpreted as prohibiting the storage of needles and syringes in prisons. As a result, prisoners can be punished if they are found to be in possession of a needle or syringe. There are similar regulations in other countries (e.g. Serbia).

There is little difference between EU and non-EU countries in terms of the provision of sterile injecting equipment in prisons

Based on the data available, just under one quarter (23%) of EU/EFTA countries report providing needle and syringe programmes in at least some prisons. This is the case for one sixth (17%) of non-EU/EFTA countries in the region. Some EU/EFTA countries, such as Luxembourg and Spain, have shown leadership in this area.

There is currently no agreed measure for assessing the scale of needle and syringe programmes in prisons

A variety of qualitative methods have been used to assess the scale of needle and syringe programmes. This report identifies whether programmes are available in some, most or all prisons. Reports to EMCDDA divide the scale of coverage into rare; limited; extensive and full. Reports to EMCDDA also include the number of NSP sites, which vary from three in Romania to 70 in Spain. In its report, Moldova commented that its needle exchange programmes cover nine penitentiary institutions and detention centres, including (from 2010) three prisons on the left bank of the Nistru River. Reports to EMCDDA also include data on the number of syringes distributed but such data was only available for one country: Romania.

Almost all EU/EFTA countries offer testing and treatment for hepatitis C in prisons

Of those EU/EFTA countries replying, almost all (96%) reported offering testing and treatment for hepatitis C in prisons (see Box 4).

In 2010, a survey was conducted on services for HIV and hepatitis in prisons in France and its overseas departments (the PREVACAR study). Almost all of the 146 medical units responding offered screening for HIV and hepatitis B and C on arrival into the prison system. Around half offered such screening again in cases where it had been declined at the time of entry. Free and anonymous testing was available in around one third of jails. Access to hepatitis B vaccination was reported not to be a problem

In 2011, a survey was conducted of hepatitis C services in prisons in England. Responses were received from 110 prisons. The survey found that:

- 41% of responding prisons refer hepatitis C positive prisoners to outpatient hospital appointments for assessment and/or treatment.
- 54% of responding prisons have a specialist hepatitis C ‘in-reach’ service provided by the local National Health Service acute hospital trust.
- 21% of responding prisons provide specialist treatment for hepatitis C infection in-house, overseen by the prison doctor.
- The vast majority of responding prisons (86%) provide follow up for prisoners being discharged into the community.

Box 4. Hepatitis C testing and treatment in prisons in Europe and central Asia

According to government respondents, Latvia is the only EU country that does not provide hepatitis C testing and treatment in its prisons.

However, civil society respondents report that testing for hepatitis C is not available in prisons in Greece or Sweden. The government respondent from Sweden commented that treatment for hepatitis C and HIV is available through the regular health system and, if prescribed while in prison, treatment is monitored by nurses in prison.

Several countries report that although testing for hepatitis C is available in prisons, there are difficulties in providing treatment for hepatitis C in prisons:

- The civil society respondent from Bulgaria indicated that although testing for hepatitis C was available in prisons, treatment for hepatitis C was not. This may be because, as reported by the government respondent, treatment for hepatitis C is only available in Bulgaria for people who have health insurance.
- The same situation applies in the Czech Republic.
- In Finland, treatment is provided for those who need it during a long imprisonment. The civil society representative also commented that people can continue receiving hepatitis C treatment if they were receiving it prior to imprisonment.
- In Lithuania, it was reported that testing is available if hepatitis C is suspected. However, specific treatment for hepatitis C was not fully accessible because of lack of funds for treatment.
- Similarly, the civil society respondent from Estonia commented that access to hepatitis C treatment in prison depends on the number of people needing treatment and the level of funding available to the Ministry of Justice.
- In the Netherlands, hepatitis C testing is not routine but can be performed, depending on the length of stay in prison.

Some countries report that prisoners have the same access to hepatitis C treatment as anyone else:

- In Norway, healthcare in prisons is part of the local municipality healthcare system. As a result, prisoners have the same access to treatment options for hepatitis C as everyone else.
- Similar situations were reported in Spain and Switzerland. In Spain, it is reported that there are currently 365 people within the prison system receiving treatment for hepatitis C.

Some countries reported to EMCDDA whether or not they test for hepatitis C on entry to and release from prison:

Six EU/EFTA countries did not respond to these questions – Austria, Cyprus, Hungary, Ireland, Liechtenstein and Portugal. However, five of these have reported data to EMCDDA on hepatitis C testing on entry to and release from prison. Of these, Austria, Cyprus, Ireland and Portugal report that they do provide testing for hepatitis C on entry to and release from prison. Although Hungary does not carry out testing for hepatitis C upon entry and release there has been, since 2007, an extensive screening programme in prisons for HIV and both hepatitis B and C. The civil society respondents for Hungary and Portugal confirmed that both testing and treatment for hepatitis C are available in prisons.

Few non-EU/EFTA countries offer testing and treatment for hepatitis C in prisons

Of those non-EU/EFTA countries replying, half (50%) offered testing for hepatitis C in prisons while just over a quarter (27%) offered treatment. Only four non-EU/EFTA countries reported offering both testing and treatment – Georgia, Israel, Serbia and Uzbekistan. However, in Georgia, hepatitis C testing is only available in the prison hospital if requested by a doctor. If prisoners test positive, only general, symptomatic treatment for hepatitis C is available unless they are co-infected with HIV.

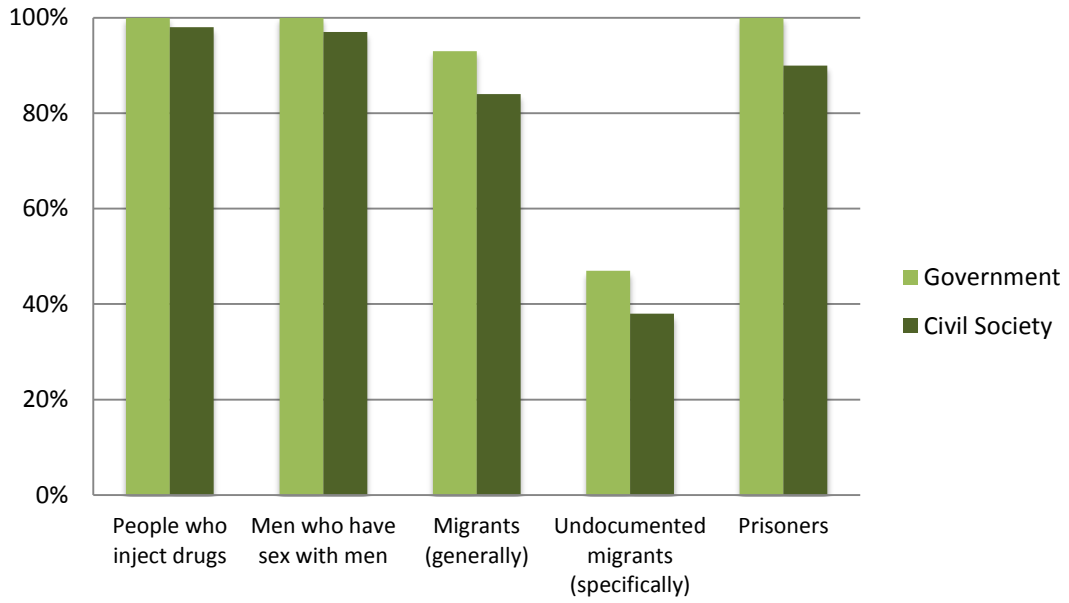
Eight non-EU/EFTA countries specifically reported that they did not provide testing for hepatitis C in prisons. These were Armenia, Belarus, the former Yugoslav Republic of Macedonia, Kazakhstan, Kyrgyzstan, Montenegro, Tajikistan and Ukraine. Three countries – Albania, Azerbaijan and Moldova – reported that they offer testing for hepatitis C in prisons but they do not provide treatment. Both Bosnia and Herzegovina and Kosovo (UNSCR 1244) reported that they provide testing for hepatitis C in prisons but the government respondents did not answer the question on treatment. The civil society respondent for Bosnia and Herzegovina indicated that treatment for hepatitis C is available in prisons.

Antiretroviral therapy for HIV is available in prisons in most countries

Countries identified a number of populations that face difficulties in accessing HIV treatment and care and these included prisoners. Problems for prisoners accessing HIV treatment and care were largely reported by civil society respondents in Belarus, Greece, Lithuania, Serbia and Ukraine. In some countries (e.g. Croatia and Spain) the existence of a separate health system for prisons was identified as an obstacle to delivery of HIV programmes. In Lithuania, there was reported to be poor coordination of ART between prison and community settings. In Georgia, the attitude of prison authorities was identified as an obstacle to service delivery. Ukraine reported that the number of people receiving ART had increased in prisons and that the management of opportunistic infections had improved. The country also reported that a decision had been taken to allow continuation of OST in prisons for those who had been receiving it prior to imprisonment. However, it was also reported that there is a lack of adequate funding for prison health and HIV services in Ukraine. Azerbaijan reported that people living with HIV in prisons were receiving ART. Belarus reported that they provide support to people living with HIV when they leave prison.

Nevertheless, most respondents from both government and civil society concluded that ART is readily available for prisoners (see Figure 5).

Figure 5. Percentage of European and Central Asian countries reporting that ART is readily available for key populations



A number of countries reported initiatives to improve and support delivery of antiretroviral therapy in prison settings. For example, Ukraine reported providing training to staff in prisons. In Belarus, NGOs provide support to people living with HIV in prisons.

Conclusions

HIV prevalence is high throughout the region in prisons that have high rates of HIV infection among PWID. This reflects the fact that PWID may often spend time in prison. Trends in HIV prevalence in prisons tend to reflect wider trends in HIV prevalence among PWID.

Prisons provide an important setting for HIV testing among key populations at increased risk of HIV infection, particularly PWID. Many countries have taken the opportunity of this setting to carry out extensive HIV testing in prisons. However, it is of concern that the number of countries reporting mandatory testing of prisoners has increased since the last round of Dublin reporting. Mandatory HIV testing in prison settings cannot be justified from a public health perspective.

Overall, HIV prevention services are not as widely available in prisons as in the community. According to government respondents, free condoms are available in prisons in less than three quarters (74%) of the countries that responded to this question. According to civil society respondents, the figure is lower (66%). However, there is some evidence that this has improved since the previous round of Dublin reporting.

OST is available in prisons in most EU/EFTA countries although there are a few reported exceptions, such as Iceland, Latvia and Lithuania. However, OST is much less available in prisons in countries outside the EU/EFTA, although there are a few reported exceptions including Armenia, Kyrgyzstan and Moldova. In this round of reporting a number of countries reported OST availability in prisons that did not do so in the previous round. These countries included Armenia, Bulgaria, Greece, Israel and Malta.

The scale and coverage of OST provision in prisons varies markedly. For example, more than 20% of the prison population receive OST in Luxembourg compared to less than 1% in some other countries. In some cases, such as Estonia and Romania, this may reflect the fact that these programmes were only started recently. In some, it may be because of restrictions on practice (e.g. only allowing people to received OST if they were already receiving it prior to entering the prison).

Very few countries make sterile injecting equipment available to prisoners. Exceptions include EU/EFTA countries, such as Luxembourg and Spain, and countries outside the EU/EFTA, such as Armenia and Moldova. There has been no increase in the number of countries reporting provision of such services since the last round of Dublin reporting. There appears to be no difference between EU/EFTA and non-EU/EFTA countries in terms of providing these services. It is difficult to assess the scale of provision for sterile injecting equipment in prisons as there is no agreed measure for this.

Testing and treatment for hepatitis C appears to be available in many prisons in EU/EFTA countries. Latvia was the only EU country reporting that it did not provide HCV testing although some countries, e.g. Estonia and Lithuania did report that there were financial limitations on provision of treatment. In some other countries (e.g. Bulgaria and the Czech Republic), it was reported that treatment for hepatitis C is only available for those with health insurance. In some countries (e.g. Norway, Spain and Switzerland), prisoners have access to the same health system and the same level of services as other citizens. Outside the EU/EFTA, very few countries offer testing and treatment for hepatitis C in prisons.

In summary, HIV prevention services are not as widely available in prisons as in the community. This is particularly relevant for some key services, such as the provision of sterile injecting equipment and opiate substitution treatment for PWID. The reasons, which are complex, include:

- Legal and regulatory barriers to the provision of services in prisons
- The existence of a separate health system for prisons in some countries
- Limited financial resources for the provision of health services in prisons
- Reported challenges in some countries in engaging NGOs to provide services in prisons.

Addressing these causes may require changes in laws, regulations and systems. Some countries, e.g. Moldova, report that they are trying to address this issue by reducing the imprisonment of PWID.

In 2010, the ECDC report on monitoring the implementation of the Dublin Declaration identified a number of key issues needing further action. Progress on addressing these is summarised here:

Issue identified as needing further action in previous report	Progress *(shading indicates the amount of progress since last reporting round; ranked from limited to good)*	Comment
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 harm reduction services for PWID, such as OST and provision of sterile injecting equipment and condoms.	Limited progress / Good progress	Some progress has been made in some countries on some of these services, such as the provision of condoms and OST. Little progress has been made on providing sterile injecting equipment.
There is also a need to ensure equivalence in access to HIV treatment and care services in prison and community settings, including access to tuberculosis diagnosis and treatment.	Limited progress / Good progress	Most government and civil society respondents report that HIV treatment and care services are readily available for prisoners although challenges are reported in a number of countries.
There is an opportunity for countries not currently providing drug substitution therapy in their prisons to emulate EU/EFTA countries that do provide this service.	Limited progress / Good progress	There remains a divide between the EU/EFTA and non-EU/EFTA countries on this matter. OST in prisons is the norm in almost all EU/EFTA countries. This is not the case outside the EU/EFTA.
There is an opportunity for countries not currently providing sterile injecting equipment to PWID in their prisons to emulate the few countries that are demonstrating leadership in this area.	Limited progress / Good progress	There has been very little progress in this area. These services remain largely unavailable in countries of the region.
There is a need for all countries in Europe and Central Asia to recognise that mandatory HIV testing in prison settings violates ethical principles and 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.	Limited progress / Good progress	The number of countries reporting mandatory HIV testing in prisons has increased since the last round of Dublin reporting.

Issues needing further action

- 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 harm reduction services for PWID, such as OST and the provision of sterile injecting equipment and condoms.
- 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.
- There is a need to improve the monitoring of HIV and risk behaviour among prisoners with more comparable data across countries.

Annex 1. Countries included in Dublin Declaration monitoring

Nr	Country	Nr	Country	Nr	Country
1	Albania	20	Greece	39	Poland
2	Andorra	21	Hungary	40	Portugal
3	Armenia	22	Iceland	41	Romania
4	Austria	23	Ireland	42	Russian Federation
5	Azerbaijan	24	Israel	43	San Marino
6	Belarus	25	Italy	44	Serbia
7	Belgium	26	Kazakhstan	45	Slovak Republic
8	Bosnia and Herzegovina	27	Kosovo	46	Slovenia
9	Bulgaria	28	Kyrgyzstan	47	Spain
10	Croatia	29	Latvia	48	Sweden
11	Cyprus	30	Liechtenstein	49	Switzerland
12	Czech Republic	31	Lithuania	50	Tajikistan
13	Denmark	32	Luxembourg	51	Turkey
14	Estonia	33	Malta	52	Turkmenistan
15	Finland	34	Moldova	53	Ukraine
16	the former Yugoslav Republic of Macedonia	35	Monaco	54	United Kingdom
17	France	36	Montenegro	55	Uzbekistan
18	Georgia	37	Netherlands		
19	Germany	38	Norway		

Annex 2. HIV prevalence among prisoners in Europe and Central Asia

Country	Dublin Reporting 2010			Dublin Reporting 2012		
	HIV prevalence	Year	Comment	HIV prevalence	Year	Comment
Albania			No data			No data
Andorra			No data			No data
Armenia			No data	1.2%	2011	Source: GARP reporting 2012: Routine HIV testing with known positives excluded. The rate of HIV prevalence among 1 015 men was 1.2%. The rate among 33 women was 0%.
Austria			No data			No data
Azerbaijan	2.9%	2007/8	29/1000 in epidemiological surveillance[i]	5.8%	2011	Source: GARP reporting 2012: Behavioural surveillance survey. All 400 in the sample were men. The rate of HIV prevalence among 333 >25 was 6.3%. The rate among 67 <25 was 3.0%.
Belarus			No data			No data
Belgium	1.5%	2006	Of 902 prisoners, 269 reported having had an HIV test. Of these, 82.1% reported being negative; 16.4% did not know the result or did not answer; 1.5% reported being positive.			No data
Bosnia and Herzegovina			No data	0%	2011	Source: GARP reporting 2012: Behavioural surveillance survey. No positives among sample of 620. Of these, 581 men and 39 women; 495 >25 and 125 <25.
Bulgaria	0.5%	2007	Data from 2006 available through the national system for second generation HIV sentinel surveillance. Integrated bio-behavioural surveillance has been conducted in 13 prisons in Sofia, Burgas, Pelven, Stara Zagora and Plovdiv. Convenience sample using annual, cross-sectional, venue-based survey. In 2006, 0 of 600 positive. In 2007, 4 of 754 positive. Disaggregated data by age and sex available.	1.6%	2009	Source: GARP reporting 2012: Behavioural surveillance survey. All 1 151 in the sample were men. The rate of HIV prevalence among 895 >25 was 1.2%. The rate among 254 <25 was 2.8%.

i It has been assumed that this was a survey sample rather than diagnostic testing or testing of all prisoners

Country	Dublin Reporting 2010			Dublin Reporting 2012		
	HIV prevalence	Year	Comment	HIV prevalence	Year	Comment
Croatia	0%	2003–9	No such studies conducted in Croatia yet. However, through the prison VCT centre 1 078 tests conducted and no positive cases found.	0%	2010/11	Source: GARP reporting 2012: VCT results
Cyprus			No data			Source: GARP reporting 2012: The total number of prisoners tested is not available, but the number of prisoners testing HIV positive in 2011 was two.
Czech Republic	0%	2009	0 of around 100 mainly PWIDs	0.2%	2010	Source: GARP reporting 2012: Behavioural surveillance survey. All 581 persons in the sample were men. One positive.
Denmark			No data			No data
Estonia	1.8%	2007	This data relates to new HIV diagnoses among prisoners. In 2007, there were 63 new diagnoses in prisons. These accounted for 10% of all new diagnoses and represented 1.8% of all prisoners. Of these, 92% were male.	16%	2011	Source: GARP reporting 2012: In Estonia, all prisons have a well organised HIV testing and counselling system. HIV tests are usually done when prisoners enter the prison and are then repeated after one year or when there are clinical/risk behaviour indications. HIV testing is voluntary and counselling is considered very important. In 2011, 4 364 prisoners were tested for HIV. The number of newly diagnosed cases was 46. In total, 16% of the prisoners are HIV-infected.
Finland			No data	1.0%	2005-7	Source: GARP reporting 2012: Convenience sample. Indicator data collected as part of the 'Health, working capacity and need for treatment of criminal sanction clients' study conducted by the study group of Matti Joukamaa et al. University of Tampere, Tampere School of Public Health; Tampere University Hospital, Division 5 for the Finnish Criminal Sanctions Agency. Reported rates the same among men and women. Overall sample size 410; 309 men; 101 women.
The former Yugoslav Republic of Macedonia			No data	0%	2009-11	Source: GARP reporting 2012: Behavioural surveillance survey. Sample size 200.
France			No data	2.0%	2010	Source: GARP reporting 2012: Cross-sectional single-day study based on a two-stage sampling of prison establishments (PE) and prisons inmates. Reported prevalence rate 2.0% among men and 2.6% among women. Data source – Prevacar Study. Prevalence was not reported but estimated (from the results in medical records).

Country	Dublin Reporting 2010			Dublin Reporting 2012		
	HIV prevalence	Year	Comment	HIV prevalence	Year	Comment
Georgia	1.0%	2009	Using Global Fund money, a survey was conducted in 2009 among 210 prisoners in three prisons in Tbilisi and Kutaisi.	0.3%	2011	Source: GARP reporting 2012: Behavioural surveillance survey. The rate of HIV prevalence among 2 302 men was 0.3%. The rate among 122 women was 0%.
Germany	0.8%	2006/7	1 582 offered testing. 1 515 accepted.	0.86%	2006-7	Source: GARP reporting 2012: Cross-sectional anonymous seroprevalence and behaviour survey among prisoners from six prisons in three (of 16) federal states of Germany. Same results as reported in previous round of Dublin reporting.
Greece	N/A	2008	20 prisoners on antiretroviral therapy			No data
Hungary	<0.1%	2008	As part of a health promotion and counselling programme, 4 800 prisoners, out of total of 15 000 took part in the screening programme. One person was found to be HIV positive.			No data
Iceland			No data			No data
Ireland			No data	0.2%	2001	Source: GARP reporting 2012: Cross-sectional survey among 1 193 inmates, of whom 596 were entrants. Results published in BMJ in 2000 and 2001.
Israel	0.3%	Not stated	All new prisoners are tested for HIV upon incarceration. Of around 30 000 prisoners in Israel, 85 were HIV-infected (~0.3%).			Source: GARP reporting 2012: We do not always know that a person who is HIV positive is also a prisoner. In addition, we only know about the positive results.
Italy	2.5%	2009	In 2009, the total prison population was 65 000. Of these, 35% were screened for HIV. HIV prevalence was 2.5%. However, a study in 2005 found 7.5% of 973 prisoners to be positive.			No data
Kazakhstan	2.4%	2008	Annual sentinel surveillance among 4 470 prisoners found an HIV prevalence of 2.4% and a hepatitis C prevalence of 43%. HIV prevalence among those with hepatitis C is four times higher than among those without hepatitis C.	3.0%	2011	Source: GARP reporting 2012: Behavioural surveillance survey. The rate of HIV prevalence among 3 978 men was 3.0%. The rate among 297 women was 3.0%. The rate of HIV prevalence among 3 333 >25 was 3.6%. The rate among 942 <25 was 0.7%.
Kosovo (UNSCR 1244)			No data			No data

Country	Dublin Reporting 2010			Dublin Reporting 2012		
	HIV prevalence	Year	Comment	HIV prevalence	Year	Comment
Kyrgyzstan	4.8%[i]	2008	Data from epidemiological surveillance for 2008: men under 25 – 25%; women under 25 – 33%; men over 25 – 46.4%; women over 25 – 69.2%	13.7%	2010	Source: GARP reporting 2012: Behavioural surveillance survey. The rate of HIV prevalence among 718 men was 13.9%. The rate among 32 women was 9.4%. The rate of HIV prevalence among 639 >25 was 14.4%. The rate among 111 <25 was 9.2%.
Latvia	9%[ii]	2008	On 1.1.08, there were 621 people with HIV and 103[iii] with AIDS in prisons out of total of 6 873 prisoners. On 1.1.07, there were 570 people with HIV and 97 with AIDS in prisons out of a total of 6 548 prisoners.			No data
Liechtenstein			No data			No data
Lithuania	2.1%[11]	2008	12/570	1.4%	2010	Source: GARP reporting 2012: National HIV surveillance data. 248/18 324
Luxembourg	N/A	2008	In 2008, 12 prisoners tested positive, but of those 10 had been tested before	1.6%	2011	Source: GARP reporting 2012: Convenience sample.
Malta			No data			No data
Moldova	4.2%	2007	Integrated bio-behavioural survey using probability sampling and a two-stage cluster sampling design. Two categories of prisons were used - those with syringe exchange points and those without. Penitentiaries in the Transdniestrian area were not involved. Data disaggregated by age available.	3.4%	2010	Source: GARP reporting 2012: Behavioural surveillance survey. The rate of HIV prevalence among 481 men was 3.1%. The rate among 42 women was 7.1%. The rate of HIV prevalence among 407 >25 was 3.4%. The rate among 114 <25 was 3.5%.
Monaco			No data			No data
Montenegro			No data			Source: GARP reporting 2012: Survey among prisoners will be conducted in 2012
Netherlands			No data	0%	2010	Source: GARP reporting 2012: Seroprevalence survey in one prison in the south of the Netherlands. No HIV infections found among the 300 participants but HIV seronegative, hepatitis B and C seroprevalence in Dutch male prisoners is higher than in general population.

[i] This figure was not provided for the previous round of Dublin reporting but was provided by the government of Kyrgyzstan when commenting on this report.

[ii] Calculated from numbers provided

[iii] For the prevalence rate, it is assumed that this number is a sub-set of those with HIV.

Country	Dublin Reporting 2010			Dublin Reporting 2012		
	HIV prevalence	Year	Comment	HIV prevalence	Year	Comment
Norway			No data			No data
Poland	N/A	2008	In 2008, 3 965 prisoners were tested for HIV. Number of people living with HIV – 281. New cases – 88. As of September 2009, there were 211 prisoners on antiretroviral therapy.	0.4%	2012	Source: GARP reporting 2012: Data from the Central Board of Prison Service: In February 2012 there were 82 985 people in penitentiary centres in Poland (2 591 of them were women). There were 90 cases of AIDS, 305 cases of HIV and 210 people were on ARV treatment. Offenders in detention in Poland: the right to free health services is given to prisoners and foreigners who are under arrest or stay in detention centres. Antiretroviral treatment is provided in penitentiary centres as a continuation of a treatment offered before a person was placed in a penitentiary centre or to people who require such a therapy while imprisoned.
Portugal	7.3%	2008				No data
Romania	2.1%	2007	Data disaggregated by age and sex available	0.2%	2010	Source: GARP reporting 2012: Behavioural surveillance survey. Sample size 644. One positive.
Russia			No data			No data
San Marino			No data			No data
Serbia			No data			No data
Slovakia			No data			Source: GARP reporting 2012: No official data available.
Slovenia			No data			No data
Spain	7.8%	2008	Trends: from 22.4% in 1995 to 8.6% in 2007	6.3%	2011	Source: GARP reporting 2012: Epidemiological surveillance in prisons.
Sweden	4.3%	2006/7	979 interviewed and tested. 969 tested for HIV and 42 positive. Stockholm only.			Source: GARP reporting 2012: The Swedish Prison and Probation Service is a member of the National HIV Council. An example of HIV preventive activities within the Swedish Prison and Probation Service is the ongoing second generation surveillance project 'Svenska Häktesprojektet' directed at PWIDs in remand prisons in Stockholm and Gothenburg.
Switzerland	1–2.4%	2001–5	A study conducted in prisons within the French-speaking area of Switzerland			No data
Tajikistan			No data	8.5%	2010	Source: GARP reporting 2012: Sentinel surveillance. All of the sample (800) were men. The rate of HIV prevalence among 653 >25 was 8.9%. The rate among 147 <25 was 6.8%.

Country	Dublin Reporting 2010			Dublin Reporting 2012		
	HIV prevalence	Year	Comment	HIV prevalence	Year	Comment
Turkey			No data			No data
Turkmenistan			No data			No data
Ukraine	14.5%	2008	In 2008, 20 552 prisoners were tested for HIV. Of these, 2 975 were positive. Figures were 2 700 of 21 068 in 2007 and 2 979 of 21 385 in 2006.	13.6%	2011	Source: GARP reporting 2012: Bio-behavioural study. The rate of HIV prevalence among 1 100 men was 10.1%. The rate among 200 women was 33.0%. The rate of HIV prevalence among 861 >25 was 17.3%. The rate among 436 <25 was 6.4%.
United Kingdom	0.3% men and 1% women	1997/8				No data
Uzbekistan			No data			No data