

EVALUATION OF NATIONAL RESPONSES TO HIV/AIDS IN PRISON SETTINGS IN ESTONIA

Evaluation carried out on behalf of the UNODC Regional project “HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania”

(December 2007 – March 2008)



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Acknowledgements

We would like to acknowledge the assistance provided by Signe Rotberga, Coordinator of UNODC Regional project “HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania”; also Aire Trummal and her colleagues at the National Institute for Health Development; employees of the Ministry of Justice, physicians in the prisons, nurses, social workers, who participated in interviews and discussions; NGO “Convictus” staff members. Also we would like to thank Roger Drew, Anya Sarang, Martin Donoghoe for support and many fruitful discussions.

Heino Stöver, Bremen/Germany, March 2008

Executive Summary

Estonia has the most rapidly expanding HIV/AIDS epidemic, after Ukraine (1.4%) with the second highest reported prevalence of HIV in the European Region (1.3% in the adult population in 2005). The incidence rate of HIV infection is by far the highest in Europe (504.2 per 1,000,000 population in 2006). The epidemic is mainly driven by injection drug use (IDU), a drug using behaviour that is also widespread in Estonian prisons associated with risk behaviour like sharing of needles, injection equipment, tattooing and unprotected sexual contacts. In 2006 about 12–13% of all prisoners in Estonian prisons were infected with HIV. The rate for female prisoners is even higher. On the first of December 2006 there were 638 HIV positive prisoners in all Estonian prisons, out of these 638 HIV-positive prisoners 105 received HAART.

Additional epidemiological data describe Estonian prisons as a setting characterized by multiple health burdens: high spread of blood borne viruses (HIV, HBV/HCV), other infectious diseases (TB, STIs), co-infections, drug addiction, and mental diseases. A substantial number of prisoners are suffering from either of these health damages or more than one. Many data are alarmingly high, which require a massive response to these health challenges.

Studies show that also in Estonian prisons high risk behaviour like injecting drug use, sharing of injection equipment and unprotected sexual contacts are going on. Almost one third of interviewed prisoners reported injecting drugs during imprisonment; two thirds of those reported sharing needles, less than 10% of the drug using inmates had started to use drugs in prison.

According to data from recent studies also unprotected sexual contacts are quite widespread in Estonian prisons. 42% of respondents in prisons had sex with same sex partners. 56% of those with heterosexual, and only 17.4% of men having sex with men used condoms during the last sexual intercourse. Most prisoners have been HIV-infected before imprisonment. According to the data from the Ministry of Justice there have been seven cases of HIV-transmission in prisons.

Drug use and risk behavior is not only confined to the prison setting, it also plays an important role for the police and arrest houses in Estonia. Data indicate the crucial role of police and arrest houses in dealing with drug issues, continuity of treatment and possibly provision of harm reduction measures. Drug users are stopped/arrested for having either clean or used syringes with them. That means that carrying/possessing drug injection equipment is still seen as a crucial indicator for drug criminality by the police and would possibly lead to the fact that drug users would avoid carrying their works with them. This of course increases risks of sharing needles, once drugs but no sterile injection equipment are available.

Although substantial efforts have been made to reduce the number of prisoners (currently 3,400) Estonia still has the highest numbers of citizens per 100,000 population in prisons in the European Union (311), after the Russian Federation and Ukraine the third highest numbers in the Council of Europe Member States. At the same time new prisons have been built or are about to be finalised in the near future (Tartu, Viru in April 2008, new Tallinn prison ready by 2011). These institutions have a better quality of living conditions for prisoners (single cell instead of camp-style prisons) and working conditions for staff. The prison hospital seems to be well equipped with the necessary modern technical devices and organisational procedures (X-rays, electronic health file, TB-ward). However, single cells and improved living and working conditions do not guarantee a more effective drug supply reduction and reduced risk behaviour of inmates. Still demand and harm reduction are key elements within a comprehensive and integrated HIV-prevention, treatment, care and support strategy.

What are the responses to these challenges?

The National HIV and AIDS strategy (2006–2015) on HIV prevention states that “all HIV prevention interventions that have been implemented outside prisons should be equally available also in prisons”.

First of all hostile attitudes and discrimination of HIV-positive prisoners have been reduced significantly by delivering continuing education about HIV. This is due to the integration and work of NGOs in the prisons and due to the efforts undertaken by the medical units to implement HIV/AIDS prevention, treatment and care services. HIV positive inmates now are no longer segregated and live together with other inmates.

HIV testing in the Estonian prison system is completely voluntary and may be performed only upon the person’s informed consent. VCT is provided to all prisoners. About 20–30% of Estonia’s new HIV cases are detected within the prison system.

For several years psychological support groups in all prisons for PLWHA in the prisons have been organised by NGOs.

The efforts to reduce drug use however are mainly abstinence-oriented. And also future plans invest massively in drug free areas. Substitution treatment and needle exchange as the two main, proven, and evidence-based HIV preventions strategies for IDUs have not been implemented yet. This does not meet the ambitious goals of equivalence of healthcare inside and outside of prisons, formulated in the National HIV and AIDS strategy. The major approach in delivering treatment services is abstinence-based, which may provide a good opportunity for those prisoners who wish and are able to change their drug use. However, there is a lack of provision of harm reduction measures for those who are not motivated or able to stop using drugs in a risky way even in prisons.

Regarding the prevention of unprotected sexual contacts condoms seem to be provided by staff in the medical units, via NGOs and in the prison shop, the question remains whether condoms (and lubricants) are really accessible in a discreet way. However, the number of provided condoms decreased over time.

Disinfectants seem to be available (“in the toilet”), but it needs to be said that bleach is absolutely not to be recommended as a safe disinfectant for needles and syringes in prisons (also not as second line strategy) without proper and detailed transfer of knowledge of how to use it.

Apart from HIV/AIDS, TB, Hepatitis B and C are major challenges facing prison’s health care in Estonia. This calls for a comprehensive and multi-disciplinary approach, which needs to be grounded on clear strategies (e.g. drug strategy including harm reduction for prisons) and protocols.

Generally, HIV/AIDS and related issues in all custodial settings (police detention, arrest houses, prisons and also within the probation service) should be more actively addressed in Estonian drugs and HIV/AIDS strategies and more attention and resources should be paid to their implementation.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BBV	Blood Borne Virus
CDC	Centres for Disease Control and Prevention
CSW	Commercial sex worker
DOH	Department of Health
DOTS	Directly Observed Treatment, short course
EHIF	Estonian Health Insurance Fund
ESPO	Estonian Society for Positive People
EU	European Union
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	Highly Active Antiretroviral Therapy
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPI	Health Protection Inspectorate
IDU	Injecting Drug User
IT	Information Technology
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
M+E+S	Monitoring, Evaluation, Supervision
MDR-TB	Multidrug-Resistant Tuberculosis
MoJ	Ministry of Justice
MOSA	Ministry of Social Affairs
MSD	Mental Health and Substance Dependence
MSM	Men who have Sex with Men
N/A	Not Available
NGO	Non-Governmental Organisation
NIHD	National Institute for Health Development
NPHAP	National Programme for HIV and AIDS prevention
NSDP	National Strategy for Drug Prevention
NSEP	Needle and Syringe Exchange Programme
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis

PLWHA	Person Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RDS	Respondent-Driven Sampling
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOR	Terms of Reference
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
Y	Year

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I. Introduction

Estonia has the most rapidly expanding HIV/AIDS epidemic, after Ukraine (1.4%) with the second highest reported prevalence of HIV in the European Region (1.3% in the adult population in 2005)¹. The epidemic is mainly driven by injection drug use (IDU), which is widespread in Estonian prisons associated with risk behaviour like sharing of needles and injection equipment. Although imprisoned drug users are unlikely to be able to use drugs with the same frequency as outside in the community, risk behaviour is more likely to happen, once drug use occurs. Prisons throughout Europe have developed a dual strategy of drug demand and supply reduction, being aware of the fact that it is unrealistic to presume that injection drug use can ever be fully suppressed in prisons by supply reduction strategies only, despite strong and persistent efforts by the prison authorities to prevent drug use by preventing drugs from entering the establishments and through education and treatment of drug users.

There are strong relationships between incarceration and HIV infection that have been analysed manifold (Kang, S.Y., 2005; Wood, E., 2005; Stöver et al., 2007). Evidence from many countries shows that

- prevalence and incidence rates among prisoners in all custodial settings (police detention, arrest houses, prisons) are higher than in the outside society,
- imprisonment is an independent risk factor to acquire HIV (e.g. Iran) and HCV,
- epidemic outbreaks of BBVs infections (such as HIV and HCV) in the closed prison setting occur (e.g. Scotland, Germany, Lithuania)
- prison-concentrated epidemics tend to spread outside prison (e.g. Estonia, Thailand)
- other communicable diseases like TB (especially drug resistant TB) and hepatitis are also disproportional widespread in custodial settings and complicate the picture.
- Communicable diseases like HIV and hepatitis infection are serious problems in juvenile and women's prisons because of the very close association between illicit drug use and imprisonment.

The reasons for these facts were – depending on the social context – identified in the past years, such as a lack of access to preventive methods, lack of information, imprisonment-driven and sub-cultural changes of sexual behaviour, high rates of coercive sexual intercourse, high prevalence rates of (intravenous) drug use, longstanding culture of tattooing and piercing in prisons.

Prisons and more broader custodial settings (including police detention and arrest houses) are a setting in which members of most-vulnerable-groups (IDUs, migrants, ethnic minorities) are overrepresented and are living mostly in overcrowded premises and under poor hygienic conditions.

Estonia has been hardly struck by the spread of TB and HIV/AIDS. High incidence rates in the general population and high prevalence rates in custodial settings indicate a massive HIV/AIDS problem and the need for targeted health interventions that meet the needs of the target groups. HIV infection in prisons is primarily seen among IDU's, the majority of them male, young (between 15 and 25 years old), and Russian speaking heroin/amphetamine users.

1 European Statistics Summary: <http://www.avert.org/eurosum.htm>; accessed 28th of February 2008

The purpose of this work was to evaluate the Estonian response to HIV and AIDS in prison settings and to develop recommendations for further improvement. The guiding idea of this assessment is the principle in the Estonian National HIV and AIDS Strategy (2006–2015), which states: “All the necessary HIV prevention interventions that are implemented outside the prison should be available also in the prison (for example the syringe and needle exchange and methadone substitution maintenance therapy) if this does not contradict the Estonian penal policy. The continuity of the provision of HIV-related health and social services should be ensured in the detention institutions and outside them” (page 22).

This report has been inspired by 4 new key documents released (2007) by WHO, UNAIDS and UNODC only recently in the “Evidence for Action Technical Papers Series”:

- Effectiveness of Interventions to Manage HIV in Prisons – Provision of condoms and other measures to decrease sexual transmission².
- Effectiveness of Interventions to Manage HIV in Prisons – Opioid substitution therapies and other drug dependence treatment³.
- Effectiveness of Interventions to Manage HIV in Prisons – HIV care, treatment and support⁴.
- Effectiveness of Interventions to Manage HIV in Prisons – Needle and syringe programmes and bleach and decontamination strategies⁵.

1 Background of the evaluation

At present, Estonia operates in a framework of the fourth national program/strategy for fighting HIV/AIDS – “National HIV and AIDS Strategy 2006–2015”. Financial resources for implementation of the strategy are mainly provided by the state budget and grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Estonia started its 4-year GFATM program on the 1st October 2003 and finished it on the 30th September 2007. Ending this program is an important turning point in fighting HIV and AIDS in Estonia as GFATM has given big amount of extra resources to increase the scale of Estonia’s response to the epidemic. At this point it is necessary to reassess the national response to HIV/AIDS and to provide practical recommendations for further improvement of the national response.

The National Institute for Health Development (NIHD) has requested UNODC to assist with evaluation of HIV/AIDS interventions in prison settings. The assignment will be performed within the framework of the United Nations Office on Drugs and Crime (UNODC) project “HIV/AIDS prevention and care among injecting drug users and in prison settings in Lithuania, Latvia and Estonia” (XEE/J20). The main objective of the project is to establish a favourable environment in all project countries to better implement HIV/AIDS prevention and care activities among injecting drug users (IDUs) and in prison settings. The project addresses normative policy, capacity building and programmatic aspects of national HIV/AIDS prevention activities.

2 http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20sexual_transmission.pdf

3 http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf

4 http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20hiv_treatment.pdf

5 <http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20NSP.pdf>

1.1 Purpose of consultancy

The purpose of the consultancy is to evaluate the national response to HIV and AIDS in prison settings and to develop recommendations for further improvement. The report will serve as a basis for the revision of the national HIV/AIDS action plan and development of UNODC project work plan for 2008–2010.

1.2 Specific tasks

- Assessment of structures, systems and organizational development:
 - Institutional assessment of key actors involved in management of HIV/AIDS in prison settings;
 - Analysis of national funding plans and resources to address HIV/AIDS in prison settings, including NGO support systems;
 - Assessment of M&E system for responses to HIV/AIDS in prison settings;
 - Development of recommendations to fill in the gaps in the current structures and systems.
- Assessment of coverage and quality of services in prison settings:
 - Compliance with international standards of providing HIV/AIDS treatment and care in prisons;
 - Continuity of services between correctional institutions and jurisdictions, and between the prison and the community;
 - Accessibility to and coverage of the key interventions within the comprehensive package of services for IDUs: HIV prevention, voluntary counseling and testing, professional HIV/AIDS care, treatment and support, drug dependence treatment;
 - Monitoring and evaluation of HIV prevention services in prisons;
 - Capacity building needs for prison staff and service providers;
 - Develop recommendations for improvement and scaling-up of HIV prevention and care in prison settings.

1.3 Timeframe and expected outputs

The site visits have been taking place in January 2008 (mission from 7–11 January 20) by Prof. Dr. Heino Stöver and Signe Rotberga. The consultancy work has been integrated into an assessment carried out parallel by a WHO team of experts conducting the evaluation of fighting HIV/AIDS in Estonia.

Most of the information was obtained during the site visits to prisons in Tallinn and Murru, drug therapy institutions in Narva, contact houses in Kakhli Jähvi, and many interviews with police officers, employees of the Ministry of Interior. The consultant together with Signe Rotberga met with representatives from National Institute for Health Development, medical staff of prisons and prison hospital but not with patients. A desk review of available relevant background documents in English has been carried out until the beginning of January 2008.

1.4 Implementation arrangements

The National Institute for Health Development provided all background documents and organized the meetings in Estonia. Findings and recommendations were discussed with the WHO team of experts conducting the evaluation of fighting HIV/AIDS in Estonia.

1.5 Establishments visited

Two prisons (Tallinn and Murru) and the prison hospital (in Tallinn) have been visited (see II.1.3). Furthermore meetings have taken place with representatives of the Probation Service in Tallinn, Police (Tallinn and Narva) and NGOs (Narva and Tallinn)

We focussed almost exclusively on the HIV/AIDS situation in prisons, the prison hospital and the police arrest houses (see also list of experts met in Annex)

II Background information

1 Prison data

1.1 Situation in Europe¹

More than 600.000 people are incarcerated in the prisons of the 27 European Member States on a given day², with an estimated annual turnover of 860.000 to one million prisoners. Therefore, issues of health in prisons affect directly more than half a million people at an appointed date and around 1 million people annually (table 1).

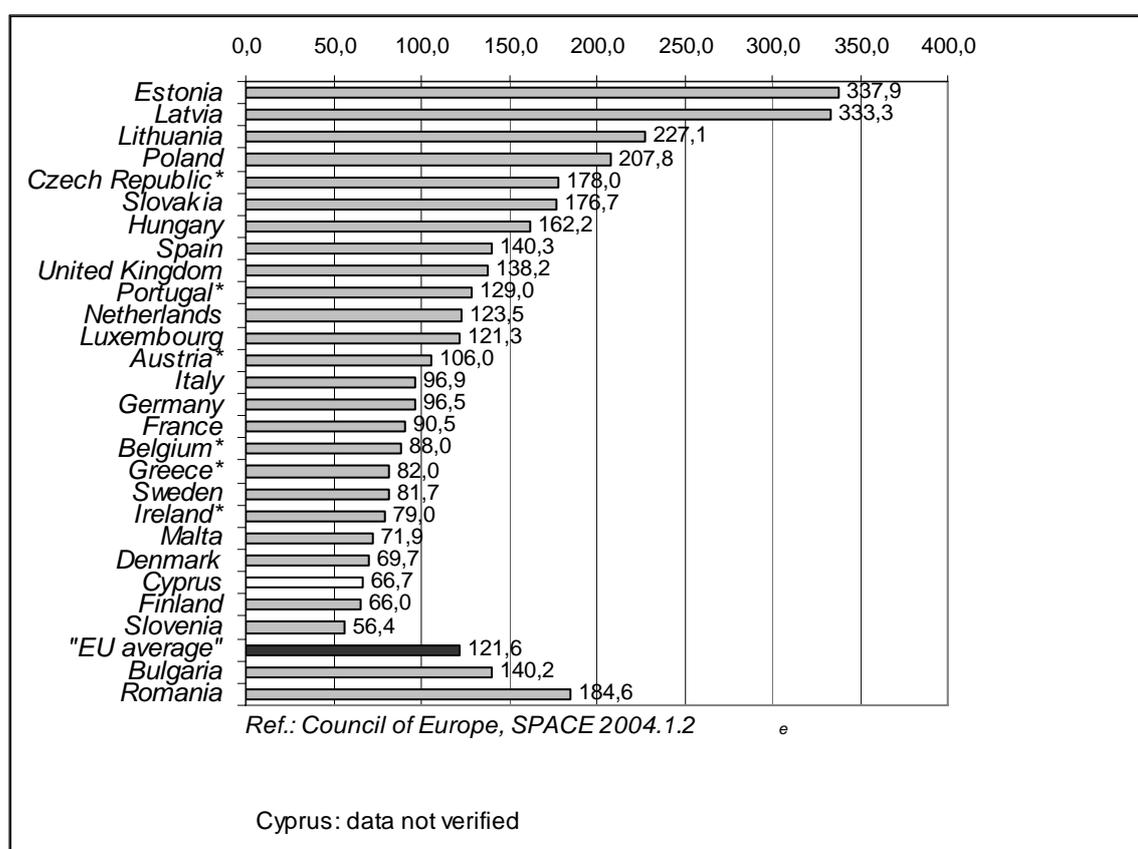


Table 1: Prison population rate per 100,000 inhabitants³

- 1 These figures have been updated by the Council of Europe for the situation in penal institutions on 1st of September 2006. Estonia is after Russian Federation (608.6), Ukraine (355.3) holding the third most prisoners per 100,000 population: 311.6. Latest figures see: http://www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/Statistics_SPACE_I/List_Space_I.asp
- 2 The prison population in the member states of the European Union comprises 558,025 prisoners (including pre-trial prisoners) on 1st September 2004, while 40,085 persons in Romania and 10.935 persons in Bulgaria, were in prison at that time. Source Council of Europe Annual Penal Statistics: SPACE I http://www.coe.int/t/e/legal_affairs/legal_cooperation/prisons_and_alternatives/Statistics_SPACE_I/List_Space_I.asp
- 3 "EU average" used in some of the following figures has been calculated on the basis of the absolute numbers in all member states of the European Union (without Bulgaria and Romania) for which data were available (i.e. not always the 25 member states), and consequently takes into account the demographical weighting of the countries involved. Therefore, the "EU average" is strongly determined by the United Kingdom, Germany, Poland, Spain, France and Italy, which have the biggest prison population numbers

In average, the prison population rate per 100,000 inhabitants in the European Union is 121.6 (with large variations between 56.4 in Slovenia and 337.9 in Estonia, see Table 1). In many countries the number of prisoners has dramatically increased over the last two decades⁴. The Member States with the highest number of prisoners relative to the general population over the period 2003–2005 were the three Baltic States, Estonia and Latvia (both 329 prisoners per 100,000 head of population) and Lithuania (239).

In average, 5% of the prison population are female prisoners.⁵ At the same time there is a wide range of percentages of foreign prisoners, which is first of all indicated by a difference of almost 8 to 35% in a large middle group of 16 member states. Furthermore, the discrepancies in European prisons are expressed by an extreme rate in Luxembourg (74.6%) and very high values in Cyprus, Greece and Belgium (48.4 to 40.9%), while in Latvia, Lithuania, Romania, Poland, Bulgaria, the Slovak Republic and Hungary (0.5 to 3.9 %), detainees from foreign origin are only a small group, compared to the “EU average” of 18.6%. Moreover, with the exception of Estonia⁶, all eastern countries are below this value, which indicate that strong structural differences between European Eastern and Western societies still exist.

1.2 Situation in Estonia

In 1993 the responsibility of the penitentiary system was transferred from the Minister of Interior to the Minister of Justice. On December-1 2000 the new Imprisonment Act entered into force. A lot of main important changes were stipulated. From January-1 2000 the Prison Board has been reorganised into the Department of Prisons and the management and control of the prisons is subjected directly to the Ministry of Justice (Arnadottir et al., 2002).

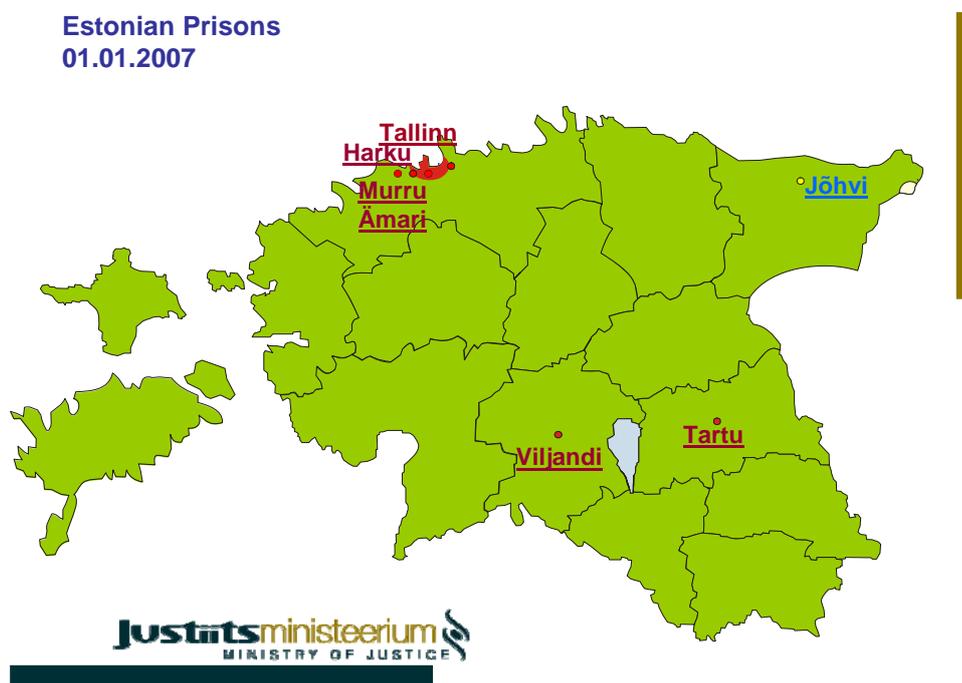


Chart 1: Dislocation of prisons in Estonia

4 Stöver, H.; Weilandt, C. (2007): Drug use and drug services in Prisons. In: Møller, L.; Stöver, H.; Jürgens., R.; Gatherer, A. (ed.; 2007): Promoting health in prisons. The essentials. Copenhagen/Denmark

5 Source: Council of Europe Annual Penal Statistics: SPACE I http://www.coe.int/t/e/legal_affairs/legal_cooperation/prisons_and_alternatives/Statistics_SPACE_I/List_Space_I.asp

6 It is not possible to determine, if the high value for Estonia is caused by the large Russian minority in this country as a result of the Soviet era, a group which can hardly be compared to the ethnic minorities and migrants in western countries. In this case, all eastern states would differ from the western member states.

The Estonian government is building new prisons in order to move the camp-style prisons into single or double cell institutions. The new prison in Viru will be opened in April 2008, Viljandi, Harku and Murru prisons will be integrated into the new Viru prison. The youth institution in Viljandi has already been closed. Our respondent in the prison said that at the same time it is intended to reduce the number of prisoners down to 3,000.

Ministry responsible	Ministry of Justice
Prison administration	Department of Prisons
Contact address	Tõnismägi 5a, EE-15191 TALLINN, Estonia
Telephone / fax / website	tel: +372 6 20 82 29 or 20 82 00 fax: +372 6 20 82 72 url: www.just.ee
Head of prison administration (and title)	Priit Kama Deputy Secretary General
Prison population total (including pre-trial detainees / remand prisoners)	3,490 (110 female, 60 juvenile, 3320 male) at 24.01.2008 (Ministry of Justice)
Prison population rate (per 100,000 of national population)	260
Pre-trial detainees / remand prisoners (percentage of prison population)	23.1% (31.10.2005)
Number of establishments / institutionsv	7 (2005)
Official capacity of prison system	4,366 (2005 – 3,084 places for sentenced prisoners, 1,282 for pre-trial/remand prisoners)
Occupancy level (based on official capacity)	102.2% (31.10.2005)
Recent prison population trend (year, prison population total, prison population rate)	1992 4,778 (306) 1995 4,401 (295) 1998 4,791 (330) 2001 4,803 (351) 2004 4,576 (339)

Table 2: Estonian prison issues at a glance⁷

Table 2 presents official data available (from October 2005). Substantial changes in the number of prisoners have taken place over the last few years, in 2005 the number was **4,463** (31.10.2005), whereas in January 2008 this number has dropped down to 3,490.

Even if in Estonia a person can be imprisoned for illicit drug use, the most common reasons for imprisonment of drug users are crimes against property.

The annual turn-over rate of prisoners is not known (usually about 3 fold in many European countries). Arnadottir et al. (2002) point out that sentences are frequently of short duration, average 3-6 months, and people move in and out of prison. (An update of these figures is missing). This is in contrast to a 2004 survey the mean number of convictions among the surveyed prisoners was 1.9 and the mean time spent in prison was 5.5 years (Trummal & Lõhmus, 2006).

In a study on “HIV/AIDS and drug related knowledge, attitude and behaviour among prisoners” (Lommus/Trummal, 2006), which took place in 2006 data of 807 prisoners (26% of the total number of prisoners) have been analysed. It has been revealed that the prison population consists in the majority of Russian inmates (50%), Estonians were 44. 6% and others 5.4%

⁷ Source: www.prisonstudies.org

<i>Prison</i>	<i>Estonian</i>		<i>Russian</i>		<i>Other nationalities</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Harku	27	29,0	60	64,5	6	6,5
Murru	40	28,4	98	69,5	3	2,1
Pärnu	32	58,2	22	40,0	1	1,8
Tallinn	62	47,7	64	49,2	4	3,1
Tartu	111	67,3	47	28,5	7	4,2
Viljandi	29	48,4	23	38,3	8	13,3
Ämari	38	32,8	66	56,9	12	10,3
TOTAL	339	44,6	380	50,0	41	5,4

Table 3: Nationality of respondents by prisons. (Source: Lommus/Trummal, 2006)

The study also revealed that prisoners in the majority have long prison experiences, especially in the prisons of Murru, Tartu and Ämari.

<i>Prison</i>	<i>No of prison sentences</i>	<i>No of years spent in prison</i>
Harku	1,7	3,2
Murru	2,5	5,9
Pärnu	2,5	4,8
Tallinn	2,3	4,8
Tartu	2,2	6,3
Viljandi	1,6	2,5
Ämari	3,9	8,7

Table 4: Mean number of prison sentences during the life time and the years spent in prison by prisons. (Source: Lommus/Trummal, 2006)

One of the key inventions in Estonian prisons is the system of contact persons, who form a link between prisoners and other staff, such as healthcare and specialist staff and also assist prisoners with administrative tasks such as arranging home leave. An important part of their role is also to build a relationship of trust with prisoners, and observe them in order to be aware of health problems or incidences of bullying. They are valued by prisoners, who felt they were more accessible and available than other specialist staff, and were better equipped to assist them with problems, compared to security staff. This policy has been in place in Estonian prisons for some time and is a well developed concept, which has been adopted in other prison systems (MacDonald et al., 2006).

1.3 Prisons visited

The prisons visited were Tallinn, Murru and the prison hospital near Tallinn.

Tallinn Prison holds male pre-sentenced and sentenced prisoners and also has a small section for (approximately 45) women. At the time of the visit there were approx. 1,100 prisoners in the main prison and 30 in the prison hospital. The prison is overcrowded, as the official capacity of the prison is 650. Estimations reported were that approximately 10% of the prisoners were problematic drug users, and the other 90% had probably tried drugs.

Although 90% of prisoners are transferred from the arrest houses (10% are coming directly from the streets) no cooperation with nurses (or emergency doctors) is implemented. In Estonian's prisons an electronic medical health filing is being used. All five prisons are connected to the system so in case of transferrals other doctors might know if any treatments have been started, which medication has been used etc. Condoms are given out only on request by the medical doctor and in conjugal visit rooms. There is a discussion whether or not condoms should be given out at all as they seem to be often misused for drug smuggling

purposes. The fact that drugs are in the system is highlighted by the occurrence of drug deaths in Tartu prison.

During our visit there was a discussion of how far a cooperation between medical and security services should go. This highlighted the need of implementing structures which keep and guarantee confidentiality in order to get a trustful doctor/nurse-patient-relationship.

Murru prison is a closed male prison, colony-type and holds about the same size of prisoners than Tallinn: At the time of visit (January 2008) 1,200 prisoners. 80% were supposed to be drug addicted according to the medical doctor, 1/3 of them opioid addicted. Prisoners who come from arrest houses (most of the detainees) are actually sober, resp. infrequent drug users. In case of addiction symptoms, bencodiacepines are prescribed for short periods in order to ease withdrawal pain. A key argument brought against Opioid Substitution Treatment was the possibility of prolonging addiction.

Approx. 20% of the prisoners are HIV+ (220 at the time of the visit). 60 prisoners are under ARV treatment – not all prisoners want an ARV treatment, or are not fully convinced of the benefits of such a treatment. There are rumours of sustainable negative side effects. It takes time for prison staff members and the NGO “Convictus” staff to educate prisoners and to improve adherence once they started treatment. According to the MoJ (2008), “antiretroviral therapy, all laboratory analysis is accessible for all inmates who require antiretroviral treatment. Currently 120 prisoners are receiving the treatment”.

Approx. 50% of the prisoners are hepatitis B+C infected. Once a month an infectology specialist medical doctor from the community is visiting the prison and is responsible for dosages, treatment issues etc.

One problem explained by the experts interviewed is the continuation of ARV treatment after release. According to the medical doctor in Murru prison only 50% of those under ARV treatment show up in their communities. According to the MoJ (2008) “all ARV-patients when released from prison got their ARV pills with them for three days and usually the same infectious disease doctors who work in prison, also work in the community. Patients are well informed how to continue ARV treatment”. Obviously there remains a gap in motivating patients and doctors to continue their cooperation.

Prisoners are X-rayed 2 times year, however, the service does not cover 100% of the prisoners, approx. 10% of the prisoners refuse TB-screening.

Condoms are given out by Convictus, whose staff is coming regularly into the prison approx. two times in 3 months. Additionally support prisoners can obtain from a psychologist. Extra food is given to prisoners with HIV and/or hepatitis infections. Sports offers are give as a privilege.

In Murru prison seven doctors and 13 nurses are working.

1.3.1 Findings

The following findings can be derived from the prison visits:

- New prison buildings with better quality of living conditions for prisoners and working conditions for staff either already finished or about to be finished (Tartu, Viru April 2008, new Tallinn prison ready by 2011)
- New prisons and the prison hospital are well equipped with X-ray and other modern technical devices and procedures (electronic health file)
- There are still massive obstacles on the way to introduce substitution treatment in prisons (not a single case yet)
- Needle and syringe exchange schemes are not introduced or debated
- The necessity of the provision of condoms is being debated again

- The provision of bleach (“on the toilet”) to clean syringes and needles is insufficient regarding knowledge and safety of use
- Medical ethics are not yet fully discussed and implemented
- Not all prisoners follow the requested TB-screening
- Aftercare and throughcare seem to be a massive problem in securing a continuation of treatment from the community in prisons and from prisons into the community.

2 Police work, arrest houses and health care service

2.1 Police structure

The structure of Estonian police:



Chart 2: Structure of the Estonian Police (Source: Eesti Politsei⁸)

The Police Board is the central supervisory authority, which manages, directs and coordinates the activities of all the police agencies under its administration. The Estonian police service incorporates two larger independent branches:

- The State Police is responsible for public order and internal security, crime prevention and crime detection, and for carrying out pre-trial criminal investigations.
- The Security Police is responsible for maintaining the state’s constitutional and territorial integrity, protecting state secrets, conducting counter-intelligence, fighting against terrorism and corruption.

8 <http://www.politsei.ee/?id=1572>; accessed 27th of February

The State Police is divided up into 4 prefectures and the Security Police operate in four regional sections. Within the State Police there are two main branches: the Central Criminal Police and the Constabulary. The role of the Criminal Police is to investigate organised crime, drug crimes, economic and IT related crimes and crimes requiring international co-operation. At the operational level the police prefectures maintain public order and ensure internal security in its area, prevent, combat and detect offences and conduct the preliminary investigations. The size of the regional police depends on the level of crime and population of the area (Police Board, 2006).

The police may hold a person suspected of criminal offence for up to 48 hours and, after this, there needs to be an extension made by the courts via the prosecutor. The detainee must be interviewed by a police investigator within 24 hours, starting from the time of deprivation of liberty. If the investigator is not ready to bring charges at the end of the first 48-hour period then police custody can be extended by the order of a judge for up to 10 days. After this, in exceptional cases, police custody can then be extended to a maximum of 30 days. If the detainee has not been charged by the 30-day period then they must be released. Usually the case file will be sent to the court within six months but if the case is complicated then it can be up to 12 months to prepare.

2.2 Arrest houses

Arrest houses are used for those detainees expected to be held for up to 30 days while the formal charge is prepared. When a suspect has been charged they may be remanded in custody by an investigating judge and sent to the remand section of a prison. However, the Imprisonment Act of 2000 has provided the alternative possibility of placing such persons in police arrest houses. In addition, the police investigator may decide that a remand prisoner should be returned to police custody from the remand prison to a police arrest house in cases where it is deemed necessary for the preliminary investigation. The length of time that remand prisoners stay in the police houses in this situation is variable but the CPT delegation (2003) found that there were 'certain cases where remand prisoners were returned to arrest houses for periods up to one month'.

Detainees can also be held in arrest houses for other reasons, such as administrative detention (up to 30 days) for those found guilty of minor offences, or who have been given a short prison sentence (up to three months) and, for sentenced prisoners (up to 14 days) who could provide information about a criminal offence committed by another person on the authorization of a prosecutor. In the majority of countries, detainees are held for only a relatively short time on police premises. However, in Estonia, a person can be held in a police arrest house for prolonged periods, which can reach and, on occasion, exceed three months (MacDonald, 2007).

At the time of our visit 597 detainees (90 in Tallinn) were held in 16 arrest houses. From 1st of January 2008 the arrest houses are given a bigger amount of money (287,000 EEK) in order to improve health care services, links with community health care services and training needs. Medical health care until now has more or less been provided either by general nurses (in bigger institutions; these are also fully equipped) or by the medical emergency service in the community. Other smaller institutions only can provide First Aid by trained officers. The arrestees are seen by policemen and checked on visual injuries. No visits are possible and no NGO is working with the detainees.

There are discussions to put arrest houses administratively under the responsibility of the Ministry of Justice.

According to our respondents information on HIV/AIDS infection is kept in the personal file.

Methadone treatment of drug users entering the arrest houses are interrupted. In the East of Estonia a NGO (“Rehabilitation Centre for Alcoholics and Drug Users” near Narva) provided for a short period of time those prisoners being in a methadone treatment with methadone on a daily basis. But this support has been stopped by officials in 2004 (there are no cooperation between arrest houses and rehabilitation centres. The latter claimed that police is exploiting the situation of drug users especially when they show withdrawal symptoms to get further information). Some leaflets containing health information are given out for drug users by the police. The respondents said that police men would receive training on (i) infectious disease issues, (ii) drug issues) and (iii) needle stick injuries (PEP). Police forces are vaccinated against Hepatitis B.

It was estimated that drug users comprise 5–10% of all arrestees. Unclear remained how the general management of withdrawal symptoms looks like for drug users entering the arrest houses.

Our respondents from the Police Board (Ministry of Interior) expressed their wish to have more resources for immediate treatment for arrestees.

In Narva our respondents from the Narva Police Department informed about the drug problem and the number of cases of drug related stops and arrests in their department. Drug related cases comprise 10% of all cases. In

2004	293 persons were detained for drug related problems 50 of them were <18y
2005	258 43 <18y
2006	333 36 <18y
2007	436 33 <18y

Before 2004 the numbers were much higher. The preferences and availability of drugs changes over time: In 1999 the most widespread drug was heroin and then “China White” (Fentanyl). Today it’s more amphetamines and ecstasy. Drug users under 18 years prefer ephedrine or cannabis.

The police representatives stated that according to their data and experiences the number of injecting drug users decreased. There was a high degree of mortality among IDUs. They stated that methadone was of great help to tackle the problems of opioid users. Apart from drug services (like the rehabilitation centre for alcoholics and drug users near Narva) the improvement of the economic and social situation contributed to a decrease of the drug use and subsequently drug problems.

Police forces receive a special training and are specially equipped with gloves when searching suspicious persons, disinfectants etc.

The police representatives reported from a collaboration with street cleaners, who are giving information on the meeting places of drug users, and they then follow these information.

2.3 Healthcare in police detention⁹

In response to the CPT visit (2003), the Estonian authorities indicated that police prefectures have concluded agreements with local family physicians, in order to provide preliminary health examinations and healthcare services. Full-time medical assistants employed by the police also carry out preliminary medical checks in detention centres. At the moment requirements concerning the provision of medical examinations are fulfilled in five arrest houses; soon other police prefectures will conclude agreements for the provision of health care services (CPT, 2003).

Alcoholics who are experiencing withdrawal in the police houses are sent to the psychiatric clinic and people with problematic drug use are given some pills for withdrawal to reduce the pain. If there are major problems they send the problematic drug user more quickly to prison. The emergency services will be called if there is a problem and will examine the arrestee in the arrest house. Currently, the police houses do not provide any drug treatment and do not liaise with community drug treatment services (MacDonald et al 2007, 85f).

Since 8th of January 2008 a new order is out – also financial means are allocated to this budget – highlighting (amongst other issues) three new developments:

- A continuation of treatment started in the community in arrest houses.
- Medical staff will be employed in order to secure improved health care services and medical checks in arrest houses.
- Questionnaires (one self administrating, one administered by health care staff) have been elaborated to assess the health status and needs of arrestees¹⁰.

In the past the continuation of Opioid Substitution Treatment was lacking personnel to control the intake and other treatment issues. The new order (see above) is supposed to solve this problem in that all forms of medical treatments arrestees perceive should be continued during the period of arrest. § 29 of that order is foreseeing counselling on HIV/AIDS, § 3 is foreseeing visits of families and/or friends, § 14 is allowing conjugal visits (once a month for 3 hours).

During our meeting with representatives of the police board it became clear that it is necessary to facilitate communication of different institutions in order to identify an improvement of seamless provision of health care services (provision and throughcare of health care services, interagency cooperation). In Tallinn good contacts are maintained with the Merimaedser clinic.

With regard to capacity building training for medical doctors and nurses of arrest houses on HIV/AIDS, other infectious diseases, and modalities of long-term pharmaco-therapy for opioid dependent arrestees should be organised. Information should be given back to the MMTs in the communities in order to inform staff and clients of institutions of the possibility of continuation of treatment.

9 Other documents which regulate the provision of medical services in arrest houses are: Vangistusseadus, Tervishoiuteenuste korraldamise seadus; "«Vangistusseaduse» alusel osutatavate tervishoiuteenuste ning nende osutamiseks vajalike ravimite ja meditsiiniliste abivahendite soetamise riigieelarvest rahastamise maht, tingimused ja kord" and Arestialustele, vahistatutele ja kinnipeetavatele ning nendega vahetult kokkupuutuvatele vanglaametnikele ja valve- ning tervishoiutöötajatele kohustusliku kopsude radiograafilise uuringu tegemise kord

10 "Arestimaja sisekorraeeskiri"

3 Probation Service

The probation service was introduced in Estonia in May 1998 and currently has 195 staff in four regions supervising 8,099 probationers. These include those undergoing court ordered drug and/or alcohol treatment (as a condition of their sentence), juveniles and those on early release from prison. Probation staff also provides pre-sentence reports for courts. Probation officers have to meet with their clients within eight days of the sentenced being passed by the courts and use the first meeting to inform clients of the expectations and regulations of the probation service. Within the next six weeks, after a risk assessment and development of the probation plan, officers meet with clients four times, to monitor their progress and address any issues that arise. An interim report is completed every six months and presented to the court and a final report submitted at the end of the probation sentence. Officers have to report breaches of probation sentences to the courts, who will then inform the police if the client is to be arrested and sent to prison.

The role of the probation service has developed and now has closer links with the prison service and community based organisations. Previously, it was primarily linked with the police and its role was limited to the supervision of offenders and ex-offenders. The development of this role is seen as particularly important when working with juvenile prisoners and emphasises both the need to work in partnership with other organisations and to maintain the welfare of juveniles:

There needs to be a balance between control and counseling in the work with juveniles and also we need to work in partnership with people in the community, to be able to meet the needs of the programmes set up for juveniles on probation. (Probation Office, Tallinn)

Therapeutic communities for problematic drug users usually have programmes lasting between 1–6 months, which staff in the probation service feel is not long enough. The lack of services in the community is a matter of concern and probation staff emphasised the need to develop these programmes and make them available for longer periods of time. They reported that:

Problematic drug users are unstable and a hard group to deal with and it takes time to set up the programmes – there have been cases where potential clients have disappeared, before the programme was even set up. (Probation Officer, Tallinn)

For this reason, community sentences cannot be viewed as a realistic alternative to prison as they do not provide the support and supervision that such offenders need.

The probation service also has a 'Family Programme', in which officers work with prisoners' families to prepare them for release and to ensure that suitable accommodation is available. This is particularly important for juveniles, who need a stable home life to prevent them from re-offending. In addition to probation orders and working with juvenile prisoners on release, courts can also sentence offenders to community service (which includes a set amount of hours work), cautioning, attendance at special schools and mediation under victim support schemes.

The representatives of the probation service in Harju Country Court were generally responsible for 3,000 clients in the region of Tallin. Tackling drug use and drug addiction plays an important role in their daily work. Some prisoners get court orders to go to rehabilitation centres within 2 weeks after release. The medical doctors there either decide that they undergo treatment or getting the signature that in-patient treatment is not necessary or possible. This is supported by the probation staff.

Although most of the respondents have undergone training on HIV/AIDS issues 6 months ago, it was claimed that such trainings and education sessions is not provided in the Social

Work Faculty of the Universities. It was perceived as necessary to integrate HIV/AIDS issues in social work curriculums at the University.

The probation staff members deal differently with concrete actions on HIV/AIDS, some are having leaflets laying out or handed out to clients, some have information material on the wall and some lay out condoms for take away in their office.

4 Risk behaviour in prisons

The increasing use of drugs¹¹ in prison influences life in prison: the penal system as a whole changes, the behaviour of drug users in detention changes and drug service providers are faced with new demands. Prisons reflect social and individual problems. Thus, the rising spread of illegal drug consumption outside prisons and the implications arising from it may also be observed in prisons: drug-related deaths, drug-induced cases of emergency, increase in the number of drug users, dealer hierarchies, debts, mixed drugs, drugs of poor quality, incalculable purity of drugs, and risks of infection (HIV and hepatitis) resulting from the fact that no sterile syringes are available in detention and therefore contaminated injection equipment is shared¹².

This increase in drug consumption also has major implications for the penal system: drugs become the central medium and currency in prison subcultures. Many routine activities for inmates focus on the acquisition, smuggling, consumption, sale and financing of drugs. If the acquisition and use of drugs dominate the life of prison inmates, prison directors and staff have to make increased efforts to safeguard a regular course of prison sentences accomplishment. This is the primary goal to be achieved. Solving the problem of drug addiction in detention is secondary. The trans-national character of the problem has to be emphasised – many EU-MS are facing similar problems of drug use, infectious diseases in prisons, lack of throughcare and continuity of treatment.

Prison management is faced with increased public pressure to keep prisons drug-free. This affects all forms of detention for men and women: punitive detention, pre-trial detention, detention of juveniles. Only a small number of prison managers talk frankly about the issue in public, establish adequate drug services and develop new drug strategies. Frequently, however, confessing that drug use also appears in prison is to be mistaken for failing to maintain security in prisons: the prison system which is supposed to be impenetrable for drug trafficking, has turned out to be penetrable. There are still some prison managers who deny or ignore drug use in prison for political reasons. Admitting drug problems in the institution looks as if the security task has not been fulfilled. Thus many managers think they didn't do their security job properly¹³. Additionally, many prison doctors believe that they cure the inmates drug problem, when an inmate is temporarily obliged to stop using drugs. Against this background, it becomes obvious why dealing with addicts in detention is difficult: on the one hand the goal to achieve the convicts? Rehabilitation must be pursued; on the other hand prison management in many countries faces rising drug consumption among inmates and with political and economic restrictions that make it even more difficult to solve the drug problem.

11 Shewan, D.; Stöver, H.; Dolan, K.: Injecting in Prisons. In: Pates, R.; McBride, A.; Arnold, K. (ed.): Injecting Illicit Drugs. Blackwell: Oxford, 2005, pp. 69-81; www.hipp-europe.org

12 WHO, UNAIDS, United Nations Office on Drugs and Crime (UNODC) (2004): Policy brief: reduction of HIV transmission in prisons. Geneva, (WHO/HIV/2004.05; <http://www.who.int/hiv/pub/idu/idupolicybriefs>, accessed 19 October 2005)

13 WHO Regional Office for Europe (2005): Status paper on prisons, drugs and harm reduction. Copenhagen, <http://www.euro.who.int/eprise/main/WHO Progs/SHA/prevention/20050622>

The harms normally associated with drug addiction, and injection drug use are exacerbated in prisons.

The current situation in which judicial authorities find themselves is paradoxical: they have to find a solution to a problem that is not supposed to exist as drugs should be kept out of prison. The situation in prisons can be compared to the one outside prisons ten to fifteen years ago. In the meantime, the attitude of society towards illegal drugs has changed, and terms like acceptance, tolerance, or indifference may be used for describing this attitude. After 10 years, directors of penal institutions have realized that they cannot avoid adapting to the new situation: in some prisons (e.g. in North Germany) urine tests no longer include testing for cannabis consumption. With regards to the attitude to be taken towards users of opiates, a widely held view is that they do not actually belong in prison. Drug addiction is unanimously perceived as an severe illness¹⁴, which cannot be treated adequately within the prison setting. Just like their counterparts outside prison, drug users should be given the opportunity to undergo adequate treatment. Many countries are reporting an increasing in the use of illicit drugs in prisons¹⁵. The percentage of drug offences among sentenced prisoners (figure 4) is one indicator for the dimension of the drug problem in prisons, although this indicator has to be interpreted carefully, because many drug users are not convicted for directly drug related offences, but for other drug related crimes like property offences.

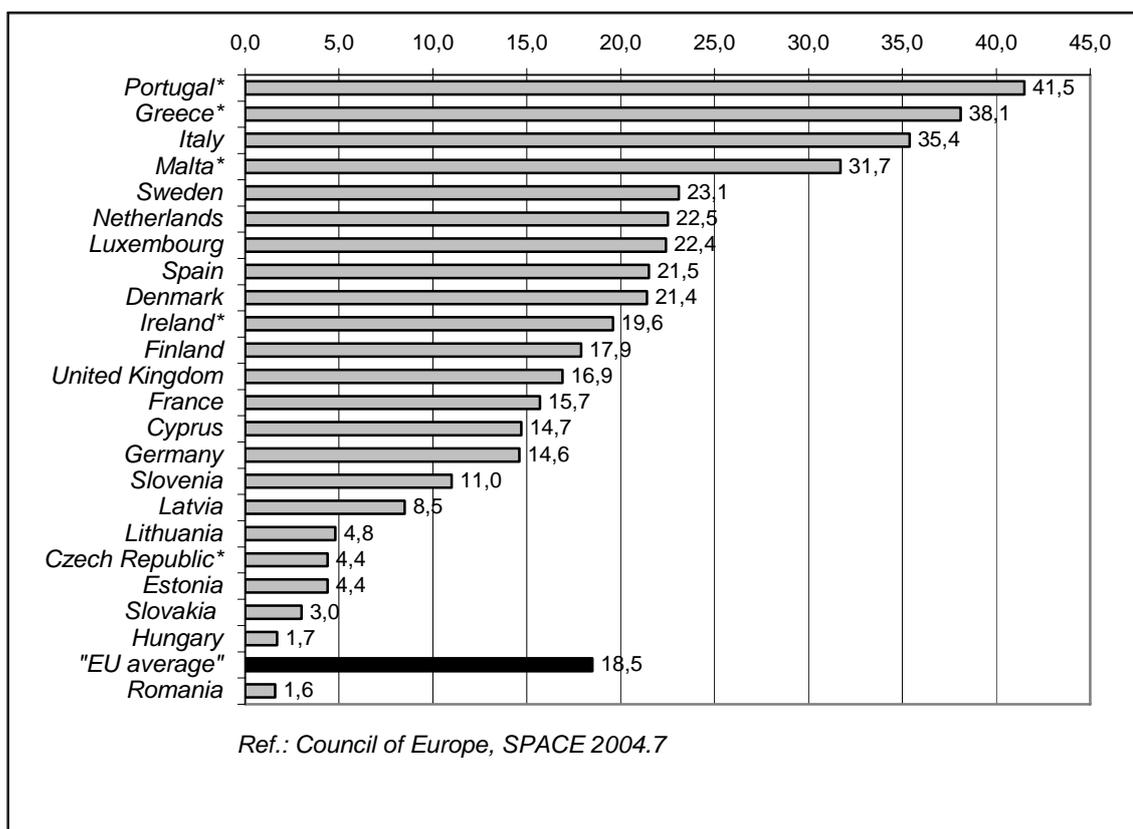


Table 5: Sentenced prisoners by main offence: drug offences in percent¹⁶

14 WHO, United Nations Office on Drugs and Crime (UNODC), UNAIDS (2004): Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: position paper. Geneva (http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf, accessed 11 September 2007)

15 Stöver, H.; MacDonald, M.; Atherton, S.: Harm Reduction for Drug Users in European Prisons. Oldenburg/Germany, London/UK 2007

16 Data on the percentage of drug offences among main offences are not available for Austria, Belgium, Poland and Bulgaria

Table 5 shows great differences in the composition of the prison population with regard to drug offences: In Portugal (41.5%) and Greece (38%), but also in Italy and Malta, drug offenders are an important group, while in Hungary (1.7%) and Romania (1.6%), but also in the Slovak Republic, the Czech Republic, Estonia and Lithuania, these crimes are of little importance. While the “EU average” is 18.5%, 11 from 22 member states range between about 15 and 23%. At the same time, all New EU Member States including Romania show figures clearly below 10% (plus Slovenia with 11%). The statistics do not reveal the indirect offences being committed in order to purchase drugs.

The EMCDDA estimates that at least half of the EU’s prison population has a history of drug use, many with problematic and/or injecting drug use¹⁷ (see table 6).

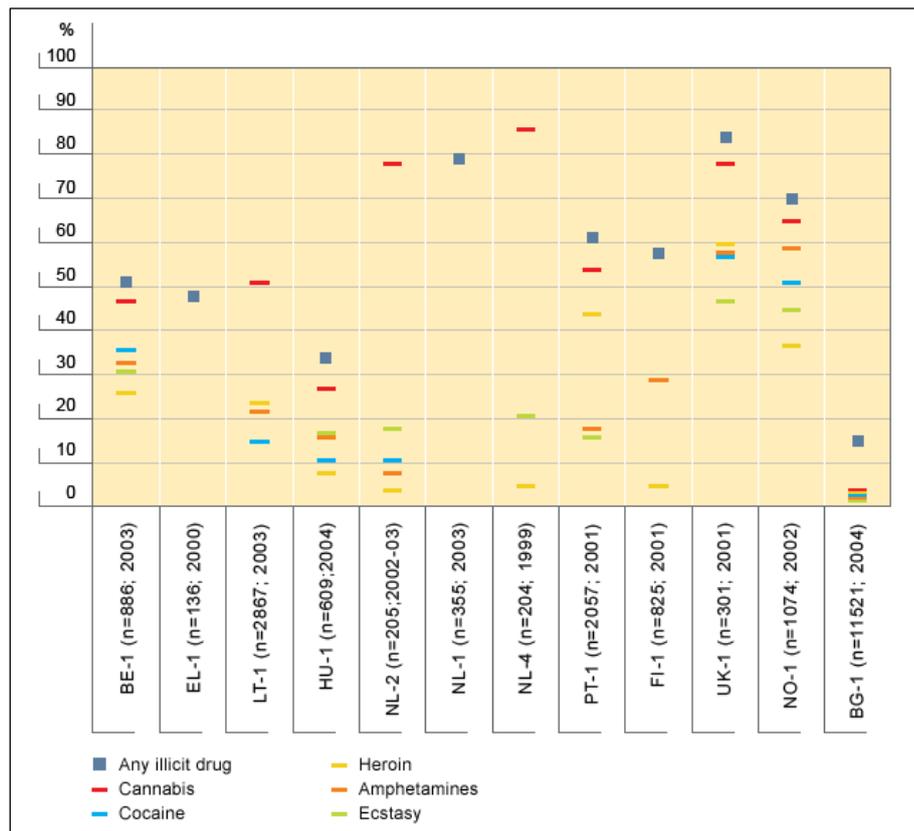


Table 6: Studies of lifetime prevalence of use of various drugs among prisoners, 1999 to 2004 in some EU countries, Source: EMCDDA Statistical Bulletin 2006

In the EMCDDA Annual report 2006 on the state of the drugs problem in Europe¹⁸ it was stated that “Data available on drug use among the prison population in the last 5 years (1999–2004) show that, compared to the general population, drug users are overrepresented in prison. Cannabis remains the most frequently reported illicit drug, with lifetime prevalence rates ranging between 4% and 86%, while lifetime use of cocaine was reported for 3–57 % of the detainees, amphetamines for 2–59% and heroin for 4–60% (1999 to 2004). Regular drug use or dependence prior to imprisonment is reported for 8% to 73% of inmates, while 7–38% of the prison population have ever injected drugs (1999 to 2004). Studies available show that 8–51% of inmates report having used drugs within prison, 10–42% report regular drug use and that 1–15% have injected drugs while in prison (1999 to 2004). Repeated surveys car-

17 EMCDDA (2003): 'Treating drug users in prison – a critical area for health-promotion and crime-reduction policy'

18 <http://ar2006.emcdda.europa.eu/en/home-en.html>

ried out in the Czech Republic, Denmark, Lithuania, Hungary, Slovenia and Sweden show an increase in the various prevalence rates of drug use among detainees, whereas France reports a significant decrease in the proportion of injectors among the prison population.”

A substantial number of drug users report having first started to inject while in prison. Studies on drug use in prison suggest that between 3–26% first used drugs while they were incarcerated and up to 21% of injectors initiated injecting whilst in prison.¹⁹ Drug related deaths in prisons and shortly after release as well as suicide attempts, self harm and several other drug use related diseases (mental illnesses, STIs, TB, etc) are higher than outside prisons walls.²⁰

Prisons and prison staff tend to understand illicit and non-prescribed drug use solely as a delinquent act to be punished, not as a disease. Any attempts to reduce the risks of continued use are viewed as supporting a prohibited behaviour and therefore unwelcome. Strict prohibition and rigid controls are regarded as the only acceptable prevention, and abstinence as an enforceable behaviour.²¹

Prison staff is at risk to get infected with blood borne diseases while searching cells or by accidental needle stick injuries²².

The opportunities for treating drug abuse and dependence and the related diseases (such as anti-retroviral and antiviral treatment) in prisons are limited in comparison to services in the community. Often only organisational measures are taken (drug free wings/zones) in order to allow prisoners to be separated from inmates using drugs.

Drug-related diseases, injuries and violence apart from costs dedicated to supply reduction measures are causing costs to society in the health, welfare, employment and criminal justice sectors in EU 27. However, these costs cannot be calculated due to a lack of reliable and current data.

4.1 Drug use in Estonian prisons

A study called “HIV prevalence and risk behaviour among IDUs in two cities in Estonia” (Tallinn and Kohtla-Järve; n=350 IDUs from Tallinn and 100 IDUs from Kohtla-Järve in May and June 2005) has been carried out in 2005 (funded by the GF programme in Estonia and implemented by the NIHD). Some of the relevant data will be presented here:

- 63% started injecting between 15–19.
- Fentanyl and amphetamine were the most frequently used drugs – more than 60% of the respondents had injected these substances in the last four weeks.
- The police had stopped 71% of the respondents in the last 12 months and 58% had been detained and arrested.
- 64% of the respondents had been in prison in their lifetime (Uusküla et al., 2005).
- The reasons given by the respondents for being arrested or stopped by the police at least once during the last year were: 8.6% (N=39) for having sterile needles, 16% (N=71) for

19 EMCDDA (2003): Treating drug users in prison – a critical area for health promotion and crime reduction policy. *Drugs in Focus* Jan–Feb. 2003, No. 7

20 Drug-related deaths by region, sex, and age group per 100 injecting drug users in Scotland, 2000–01. *The Lancet*, 362, 9388, 941–944 S. Bird, S. Hutchinson, D. Goldberg; Male drugs-related deaths in the fortnight after release from prison: Scotland, 1996–99. *Addiction*. 98(2): 185–190, February 2003. Bird, S.; Hutchinson, S.; Mortality among Danish drug users released from prison *International Journal of Prisoner health*, 2006 (2), 13–19, Christensen, P.B.; Hammerby, E.; Smith, E.; Bird, S.M.

21 Uchtenhagen 2006: *The Lisbon Agenda for Prisons*

22 Bögemann, H. (2007): Promoting health and managing stress among prison employees. In: Møller, L.; Stöver, H.; Jürgens., R.; Gatherer, A. (Ed.): *Promoting health in prisons. The essentials*. Copenhagen/Denmark (in press)

having used syringes, 27% (N=118) for theft, 4.0% (N=18) for drug sale, 4.0% (N=18) for alcohol use.

- Almost one third (29%, 84/286) reported injecting drugs during imprisonment. Two thirds (69%, 58/84) of those reporting injection drug use during imprisonment also reported sharing needles²³.

These data indicate that injecting drug use is started already in very early lifetime (mostly Fentanyl and amphetamines). Most of the IDUs have been already in contact with either police and/or prisons. Thus drug use and risk behavior (sharing needles) also plays an important role in Estonian arrest houses and prisons. This fact is perceived as a major concern (Oole et al., 2006). The above presented data also indicate the crucial role of police and arrest houses in dealing with drug issues, continuity of treatment and possibly provision of harm reduction measures. Many respondents (approx. a quarter) were stopped/arrested for having either clean or uses syringes with them. That means that carrying/possessing drug injection equipment is seen as a crucial indicator for drug criminality by the police and would possibly lead to the fact that drug users would try to avoid carrying their works. This of course increases risks of sharing needles, once drugs are available and no sterile injection equipment.

The Ministry of Justice carried out the survey “Drugs in Prison” (Kikas et al., 2006) covering mainly the year 2005. The purpose of the survey was to identify the attitude and knowledge of prisoners and prison officers about narcotic substances; map drug use problems to plan long-term activities in the field of prevention of drug use in prisons, make suggestions for the development of appropriate rehabilitation programmes. This study revealed that almost all respondents agreed that less than 10% of the inmates using drugs had started to use drugs in prison.

The findings of the survey indicate that both prisoners and staff members were uncertain about the proportion of prisoners not using substances. According to the respondents the share of prisoners not using drugs was 1 to 80%, according to the majority of respondents it was 15–50%.

According to the findings of Kikas et al. (2006) the most widely used drugs in prison were products made from cannabis and amphetamines, followed by heroin and Fentanyl. A few respondents mentioned cocaine but added that it had been used rarely. Cannabis products were most readily available in prison during the last 12 months, followed by amphetamines and China White (Fentanyl). Other substances were available only occasionally.

In the already mentioned study on “HIV/AIDS and drug related knowledge, attitude and behaviour among prisoners” (Lommus/Trummal, 2006) 34% (n=205) of the respondents admitted having used drugs in prisons (while 25% did not report any data on their drug use). These data become more interesting, when looking at the routes of administration of drugs. Nearly two third of the respondents reported injecting of drugs as way of using the drugs.

23 See also confirming data by Trummal, A.; Lõhmus, L. (2006, 43f)

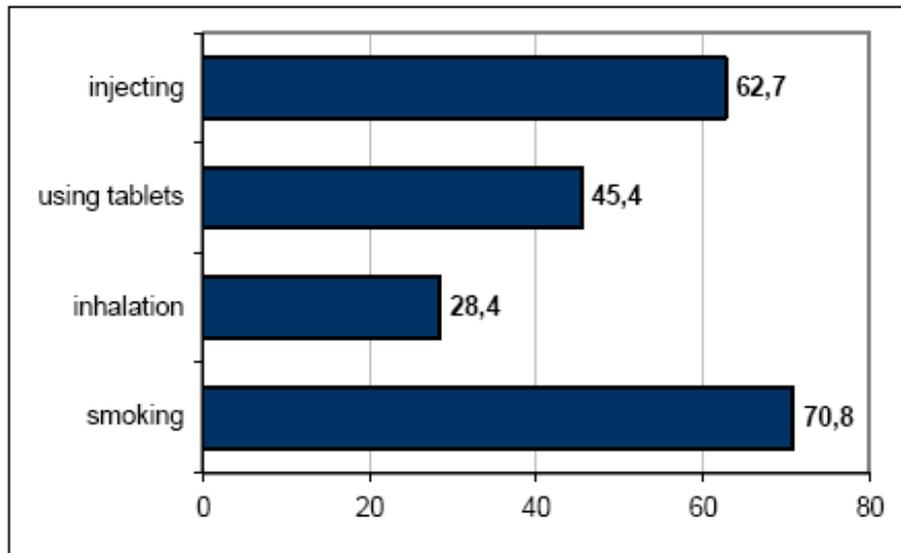


Table 7: Way of using drugs in prison settings (Source: Lommus/Trummal, 2006)

The authors assessed the mean number of drug use within the last four weeks. Due to a lack of data statistics on the prison population and the ethnics could not be updated²⁴.

In assessing the overall situation of HIV/AIDS in Estonia Anya Sarang was conducting focus groups with IDU clients of drug services in Tallinn and Kohtla Järve²⁵. Participants of the Tallinn focus group said that drug use is prevalent in correctional facilities. “Drugs are available at the ‘zona’ (colony) and prisons. Sometimes there are even more drugs over there than in the city...” “In late 90s there was a period when drugs were nowhere to be found so we would go to the colony to get them... and still, sometimes drugs are of better quality inside prisons than outside”.

Participants from Kohtla-Järve confirmed some of these observations: “[Are drugs available in prisons?] In prisons you can get anything if you have the money”.

However, participants of both focus groups thought that syringes are harder to acquire than drugs. “With syringes its more difficult, there are no as plenty [as drugs]... so many people boil it, or just shoot with one syringe” – said a person from Kohtla-Järve. “In rooms where they live by five people, all five will be using the same syringe”. Another participant from Tallinn shared: “One syringe may cost 5 packs of cigarettes, or about 100 kronas. So syringes may be shared between hundreds of people... they just sharpen the needle”.

As in other countries, the perceived feeling of security provided by the fact that inmates are tested for HIV inside prisons and know their status may contribute to risky practices. One participant said that 2 different syringes would circulate between HIV positive and HIV negative inmates: “There are designated syringes for HIVs and non-HIVs. In prisons they test you right away so you know your status”. However on other occasions, focus groups participants shared that some prisoners try to conceal their HIV status, so in the situation of group use they would not want to be seen as HIV positive. Besides, such practice may be particularly risky as it creates a false sense of protection and disregard of safety measures in the situa-

24 However, data from the Estonian Ministry of Justice revealed that in the year 1998, 18% of convicted drug users were ethnic Estonians and 82% were Russian-speaking

25 The Tallinn focus group included 6 men aged approximately 25–35 y/o. and the Kohtla Järve focus group included 4 men aged approximately between 23–45 y/o. The focus groups were not tape recorded but recorded by hand. Both focus groups lasted between 1.5 and 2 hours

tion when no one can guarantee that the sharing partner is not HIV positive either due to unwillingness to reveal the status, or due to seronegative window period.

Drug users were also sceptical about general quality of medical treatment in prisons: “Medical assistance – you know how it happens... they take one tablet, break it in halves and say: this half is for your headache and that is for your stomachache and don’t muddle them up!!”

4.1.1 Sharing of needles and paraphernalia

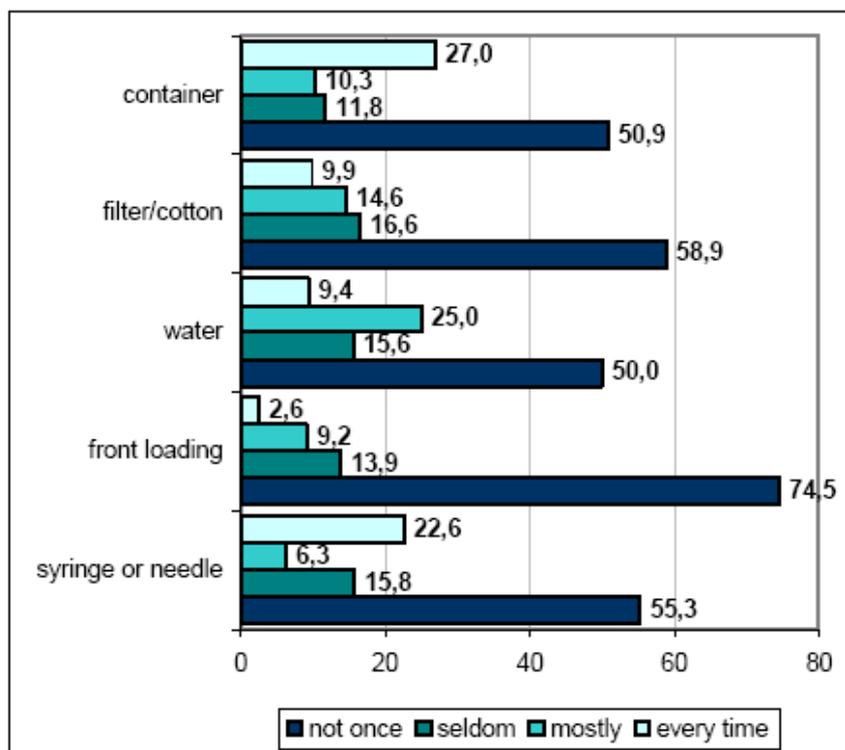


Table 8: Frequency of sharing injection equipment with others during last 4 weeks (% of those who had injected during the last 4 weeks; source: Lommus/Trummal, 2006)

The data in table 8 show convincingly that sharing of any injection equipment is quite widespread in Estonian prisons.

4.2 Sexual contacts

With regard to sexual relationships 25% in the study of Lommus/Trummal (2006) affirmed to have sexual intercourse while in prisons. The authors report that 71% of those who had sexual intercourse during the last 12 months had it with a regular partner, 54% with casual partner and 42% with same sex partners. The mean number of sex partners in the last 12 months was 2.1. 56% of those with heterosexual, and 17.4% of MSM used condoms during the last sexual intercourse. 2.5% said they had sex against their will. No data were available regarding the nature of sexual relationships among prisoner (consensual, rape, violence and sex, or sex as currency)²⁶.

26 See “Sex and prisons”: http://www.hawaii.edu/hivandaids/links_prisonsex.htm

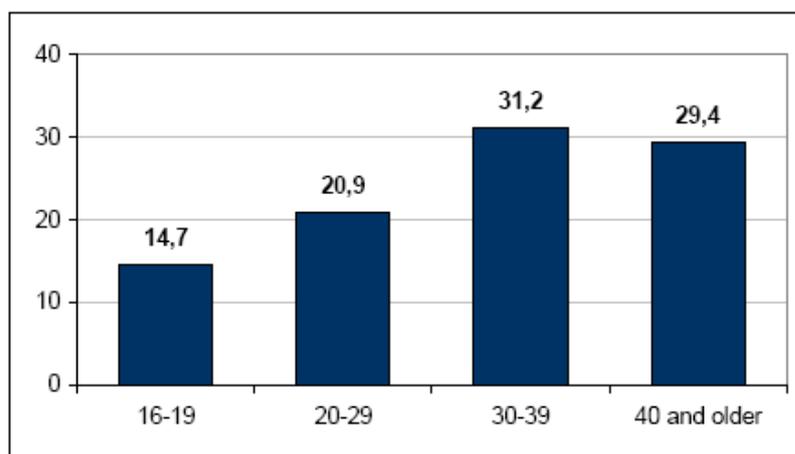


Table 9: Percentage of age groups of respondents who have had sexual intercourse while in prison settings (%) source: Lommus/Trummal, 2006)

4.3 Tattooing/Piercing

No data were available on culture and current practice of tattooing and piercing in Estonian prisons.

5 Infectious diseases in the community and in prisons

Blood borne infections (e.g. HIV, Hepatitis B and C) and other communicable diseases (e.g. TB) that are transmitted between drug users by unsafe injections, sexual practices, tattooing and piercing are massively overrepresented in prisons compared to the community²⁷.

Needle-sharing is prevalent in many prisons, but prisoners who use drugs on the outside usually will reduce their levels of drug use in prison. Many studies from countries around the world report high levels of injecting drug use, including among female prisoners. “Long experience has shown that drugs, needles and syringes will find their way through the thickest and most secure of prison walls,” (UNAIDS, 1997, p. 6). Studies show that:

- The extent and pattern of injecting and needle sharing vary significantly among prisons²⁸;
- many people who injected before imprisonment reduce or stop injecting when they enter prison, but many continue to inject upon release either on a regular or occasional basis;
- those who inject in prison usually inject less frequently than outside but are much more likely to share injecting equipment than are drug injectors in the community and; they are sharing injection equipment with a population – fellow prisoners – that often has a high rate of HIV and hepatitis C virus infections²⁹.

27 CEEHRN (2007): Hepatitis C prevention, treatment and care among injecting drug users in the new EU Member States and neighboring countries: situation, guidelines and recommendations; Lines, R. (2007): HIV infection in prisons; Laticevschi, D. (2007) Communicable diseases, both in: Møller, L.; Stöver, H.; Jürgens, R.; Gatherer, A. (ed.): 2007): Promoting health in prisons. The essentials. Copenhagen/Denmark

28 Shewan, D.; H.S., Dolan, K.: Injecting in Prisons. In: Pates, R.; McBride, A.; Arnold, K. (ed.): Injecting Illicit Drugs. Blackwell: Oxford, 2005, pp. 69-81

29 Stöver, H.: Assistance to drug users in European Union prisons. An overview study. Portugal: European Monitoring Centre for Drugs and Drug Addiction, 2001. See also Lines, R.; Jürgens, R.; Betteridge, G.; Stöver, H.; Laticevschi, D.; Nelles, J. (2006): *Prison Needle Exchange. Lessons from a Comprehensive Review of International Evidence and Experience* (Second edition 2006), Montreal: Canadian HIV/AIDS Legal Network, 2004; second edition: 2006. Available online at www.aidslaw.ca

- quite a substantial percentage of prisoners start injecting in prison for the first time in their life; and Injecting drug use in prisons was also associated with HIV outbreaks in several prison systems (e.g. Alytus prison in Lithuania³⁰).

In a prison, a syringe may circulate among (often large) numbers of people who inject drugs, or be hidden in a commonly accessible location where prisoners can use it as necessary. A needle may be owned by one prisoner and rented to others for a fee, or it may be used exclusively by one prisoner, reused again and again over a period of months until it either disintegrates, is rendered totally unusable or is confiscated by prison staff³¹. Sometimes the equipment used to inject drugs is homemade, with syringe substitutes fashioned out of available everyday materials, often resulting in additional vein damage, scarring, and injecting-site and other infections.

Besides risky use of injectable drugs, unprotected sexual contacts and in particular rape and other forms of sexual violence, tattooing and piercing play a significant role in the transmission of blood-borne-viruses³².

Major differences in the epidemiology of infectious diseases like HIV, hepatitis and other sexually transmitted diseases in the general population have an impact on the epidemiological situation of these diseases in the respective prison settings. Due to several methodological problems, it is difficult or impossible to directly compare the prevalence or incidence data in the prison population and the general population. From the prison setting, only very little epidemiological data is available and due to the different turn-over rates, incidence data from prison (if available) is not comparable with incidence data in the general population. Furthermore, the age- and gender-distribution of the prison population (mainly men in younger age groups) differs a lot from those in the general population so that direct comparisons of rates are even more problematic to interpret. However, it has been shown that infectious diseases are overrepresented in the prison setting due to a high density of problematic drug users³³.

Table 10 shows in a decreasing order the newly diagnosed HIV infection rates per million population in the EU member states in 2005. Actually, in all New EU Member States low rates are to be found with the exception of two Baltic States with a very high rate (129.6) for Latvia and an extremely high rate (467) for Estonia³⁴. Estonia's rate is 6.5 times higher than the average rate of newly diagnosed HIV infection rate per million population (based on figures from 2005). The incidence rate of HIV infection in Estonia is by far the highest in the European Region.

30 Caplinskas, S.; Likatavicius, G. (2002): Recent sharp rise in registered HIV infections in Lithuania. *Eurosurveillance Weekly* [1812–075X], 2002 June 27; 6(26) 020627. Online: <http://www.eurosurveillance.org/ew/2002/020627.asp#3> [accessed Jan 23, 2007]. See also: UNAIDS: Outbreak of HIV Infection in the Lithuanian Prison System. Assessment of the Situation and the Developing Response. Jean-Paul C. Grund, Regional Technical Advisor HIV and IDU, Vienna, September 12, 2002

31 Lines, R. (2002): Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card. Montreal: Canadian HIV/AIDS Legal Network

32 Samuel, M.C.; Doherty, P.M.; Bulterys, M.; Jenison, S.A. (2001): Association between heroin use, needle sharing and tattoos received in prison with hepatitis B and C positivity among street-recruited injecting drug users in New Mexico, USA. *Epidemiology and Infection*, 127(3): 475–84.

33 World Health Organization, UNAIDS, UNODC (2007): Effectiveness of Interventions to Manage HIV in Prisons – Needle and syringe programmes and bleach and decontamination strategies. See also Stöver, H.; Lehmann, M.; Olsena, S.; Upmace, I.; Skripste, I.; Trautmann, F.; Weilandt, C. (2007): Capacity building for institutions involved in surveillance and prevention of communicable diseases in Latvian's penitentiary system. www.archido.de; accessed 5. Nov. 2007

34 In 2006 this rate was 504.2 (see EuroHIV 2007, 19). EuroHiv (2007) reports the probable route of HIV transmission has not been reported from Estonia (and Austria). That means that detailed analysis can not be undertaken regarding transmission routes

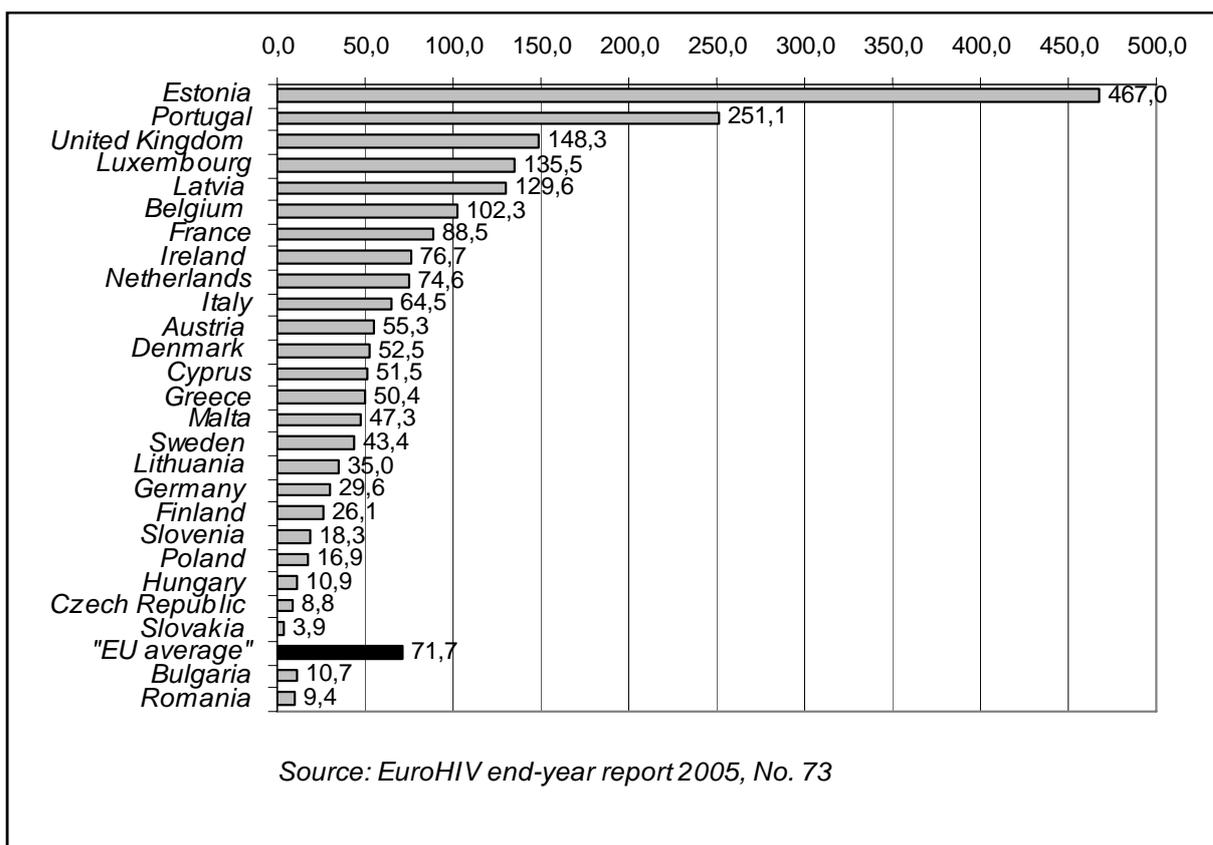


Table 10: Newly diagnosed HIV infection rate per million population in 2005

Data provided to the EMCDDA and the European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) suggest that, by the end of 2005, the transmission of HIV among injecting drug users (IDUs) was low in most countries of the European Union. This may at least partly follow from the wide introduction of harm-reduction measures such as substitution treatment and needle and syringe programmes, although other factors, such as the declines in injecting drug use observed in several countries, may also have played an important role. In several EU countries and regions, however, it is likely that IDU-related HIV transmission still continued at relatively high rates in 2005, underlining the need to ensure the coverage and effectiveness of local prevention practice (see table 10).

In addition to the extensive evidence of high risk behaviours among prisoners in many countries, there is also documented evidence of the transmission of HIV, as well as blood-borne infections such as HCV, within prisons³⁵.

The groups most vulnerable to HIV/AIDS are also often those at increased risk for incarceration as a result of socioeconomic conditions. For example, prohibitions of drug use and increased law enforcement have resulted in the systematic incarceration of people who inject drugs, thereby increasing the number of incarcerated injectors, and the likelihood of unsafe injecting practices in prisons.

35 See overview: Lines et al. 2006

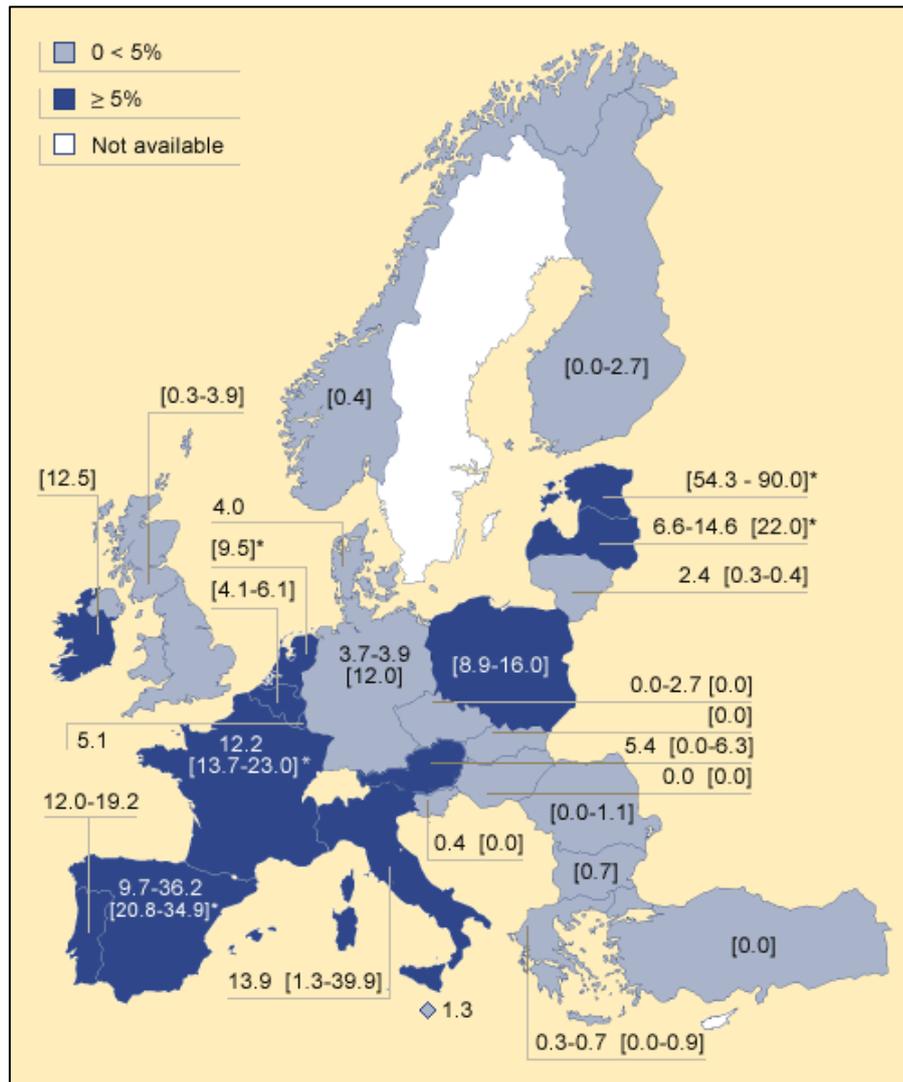


Chart 3: HIV prevalence (percentage infected) among injecting drug users; studies with national and sub-national coverage, 2003–2004**

Notes:

Figures represent the (range in) percentage infected among national and [subnational] samples of IDUs. Colour indicates the midpoint of national data, or if unavailable, of subnational data. Data for Italy and Portugal include non-IDUs and are likely to underestimate prevalence in IDUs.

* Data in part or totally before 2003 (Spain 2002–03; France 2002-03; Latvia 2002–03; Netherlands 2002) and from 2005 in case of Estonia.

** Wiessing, L.; Nardone, A.: Ongoing HIV and viral hepatitis infections in IDUs across the EU, 2001–2005. *Eurosurveillance* 2006; 11 (11): 061123

Detailed data on HIV infection rates and transmission in prisons are available in only few countries. In Spain, it is estimated that overall HIV prevalence among prisoners is 10%, with a figure as high as 31% in some regions³⁶. HIV prevalences in Spanish prisons have been reduced mainly by massively implementing harm reduction and treatment programmes (Chart 3).

36 Infección por VIH y SIDA en España. Plan Multisectorial 2001–2005: Indicadores. Secretaría del Plan Nacional sobre el SIDA. Ministerio de Sanidad y Consumo. Madrid, 2003. pp. 17. This document is available via www.msc.es/Diseno/enfermedades/lesiones/enfermedades_transmisibles.htm; see also Spanish Focal Point. National Report 2001 for the European Monitoring Centre for Drugs and Drug Addiction. Madrid: Government Delegation for the National Plan on Drugs, October 2001, at 84, with reference

In Italy, a rate of 12% (entering prison in 2005) has been reported³⁷. High HIV infection rates among prisoners have also been reported in France (13% based on testing of 500 consecutive incarcerations), Switzerland (11% in a cross-sectional study in five prisons in the canton of Berne), and the Netherlands (11% in a sample of prisoners in Amsterdam)³⁸. However, other countries – including Belgium, Finland, Iceland, Ireland and the United Kingdom – and some German states report lower levels of HIV prevalence³⁹.

In Central and Eastern Europe, high rates of HIV infection among people who inject drugs and prisoners have also been found. Various sources have reported high rates of HIV infection among prisoners in Belarus, Estonia, Kazakhstan, Latvia, Lithuania, the Republic of Moldova, the Russian Federation and Ukraine⁴⁰. Official figures from 1996 to 2003 show that HIV prevalence in Russian prisons increased more than 30-fold, from less than 1 inmate per 1,000 to 42.1 per 1,000⁴¹.

While HIV infection in IDUs in the EU is mainly concentrated in a few high-prevalence countries, viral hepatitis, and in particular infection caused by the hepatitis C virus (HCV), is much more evenly distributed and more highly prevalent.⁴² As HCV is not transmitted as easily through sexual contacts as HIV, and other transmission routes such as blood and blood products have been successfully prevented, HCV infection prevalence may currently provide an important proxy indicator of HIV injecting risk behaviour such as the sharing of injecting materials. Any other burden (e.g. HAV or HBV infection) for the immune system of individuals is a severe health damage and needs to be avoided⁴³. However, a high percentage of HIV-positive prisoners are co-infected with HCV. Co-infection with HIV and HCV or hepatitis B virus (HBV) is associated with a significantly poorer prognosis regarding the hepatitis infection, and liver disease is currently a leading cause of death among IDUs in Europe.

HCV infection is still extremely prevalent in IDUs across the EU. Antibody levels of over 60% among IDU samples tested in 2003–2004 are reported from Belgium, Denmark, Germany, Greece, Spain, Ireland, Italy, Poland, Portugal, the United Kingdom, Romania and Norway. The highest prevalence (over 40%) among IDUs under age 25 was found during 2003–2004 in samples from Belgium, Greece, Austria, Poland, Portugal, Slovakia and the United Kingdom. The highest prevalence among new IDUs (over 40%) was found in samples from Greece, Poland, the United Kingdom and Turkey.

Data about rates of HCV prevalence among prisoners in surveyed countries are limited, in part because of the limited availability of HCV testing. But the data that are available show a

37 Annual Report of the National focal point Italy

38 Heilpern, H.; Egger, S. (1989): AIDS in Australian prisons: issues and policy options. Canberra, Department of Community Services and Health

39 Harding, T.; Schaller, G. (1992): HIV/AIDS and prisons: updating and policy review: a survey covering 55 prison systems in 31 countries. Geneva, WHO, 20.7

40 Schönteich, M. Latvia: exploring alternatives to pre-trial detention. Justice Initiatives, 2003, August (http://www.justiceinitiative.org/db/resource2/fs/?fi_le_id=14246, accessed 19 October 2005).; see also: AIDS epidemic update: December 2002. Geneva, UNAIDS/WHO, 2002:15 (<http://www.who.int/hiv/pub/epidemiology/epi2002/en/index.html>, accessed 19 October 2005); see also: Bollini, P.; Gunchenko, A. (2001): Epidemiology of HIV/AIDS in prisons. In: Bollini, P. (ed.): HIV in prisons. A reader with particular relevance to the newly independent states. WHO Regional Office for Europe, Copenhagen 2001, pp. 2–5

41 Roshchupkin G. HIV/AIDS prevention in prisons in Russia. In: Lokshina, T. (ed.): Situation of prisoners in contemporary Russia. Moscow, Moscow Helsinki Group, 2003:213

42 EuroHIV. HIV/AIDS Surveillance in Europe. End-year report 2005. No. 73. Saint-Maurice: Institut de veille sanitaire; 2006. <http://www.eurohiv.org>

43 Stöver, H. (2007): "Prevention of the spread of HIV/AIDS, Hepatitis C, other blood-borne infections and diseases – A Public Health Perspective". Presentation: Council of the European Union, Horizontal Drugs Group, Brussels, 11th January 2007; CEEHRN (2007) Hepatitis C prevention, treatment and care among injecting drug users in the new EU Member States and neighboring countries: situation, guidelines and recommendations

wide range – although overall high rates – of HCV prevalence among prisoners. Data from Estonia suggest that there is a high prevalence of HCV among inmates – from 82% to up to 97.4% (though sample sizes were small. In several other studies from the Czech Republic, HCV prevalence was also high (18–78%)⁴⁴.

The prevalence of HBV infection markers varies even more than for HCV, which may be due to differences in vaccination levels. The most complete data are for the antibody to the hepatitis core antigen (anti-HBc), which indicates a history of infection. In 2003–2004, prevalence rates of over 60% among IDU samples were reported only from Italy and Poland, suggesting low levels of vaccination coverage in earlier years⁴⁵.

Year	Number of tested	Number of positives	%
2003	343	30	8,75
2004	248	30	12,1
2005	187	35	18,7
2006	238	41	17,2

Table 11: HIV-infection among IDUs, 2003-2006 (Source: Health Inspection Protectorate)

Data in table 11 show that the HIV prevalence rates among IDUs is alarmingly high and exceeds the rates of HIV-positively tested prisoners manifold (approx. 7-fold in 2006), expressing that unsafe injecting drug use is the main driver of the HIV epidemic (see table 12).

5.1 HIV/AIDS in Estonian prisons

Alijev (2007, 17) pointed out that a basic problem in tackling HIV/AIDS and other infectious diseases in Estonian prisons was the absence of medical and social support in post-Soviet prisons and that the provided basic knowledge of health and hygiene was very poor. Another major concern was the negative attitudes of other prisoners. Prison officials discovered many cases of unwillingness to share a cell with an HIV-positive prisoner. Once HIV diagnosis was disclosed, certain prisoners became outcasts, and beds in isolated parts of prisons were discovered.

In the words of one prisoner: *“I learned that I was HIV positive when I took the test in prison. I was ready for the result and was not shocked. But I was shocked by the attitudes of other prisoners toward HIV- positive individuals. I thought it was time to hang a bell round my neck, just as lepers had to do in the past”*.

According to our interview partners hostile attitudes and discrimination of HIV-positive prisoners has been reduced significantly by delivering continuing education about HIV. This is due to the integration and work of NGOs in the prisons and due to the efforts undertaken by the medical units to implement HIV/AIDS prevention, treatment and care services. HIV positive inmates now are no longer segregated and live together with other inmates. Increasing knowledge about HIV has definitely supported HIV positive inmates to lead a normal life both in prison and in the community.

44 CEEHRN (2007) Hepatitis C prevention, treatment and care among injecting drug users in the new EU Member States and neighboring countries: situation, guidelines and recommendations. <http://www.ceehrn.org/EasyCEE/sys/files/Hepatitis%20C%2011%20psl.pdf> (accessed 23rd August 2007)

45 Wiessing L, Nardone A. Ongoing HIV and viral hepatitis infections in IDUs across the EU, 2001–2005. *Euro-surveillance* 2006; 11 (11): 061123

MoJ (2008) is stating that "between 2004–2005 the majority of the prison personnel and prisoners participated in training on prevention of HIV/AIDS and other venereal diseases 50% of prison staff was trained on HIV. Since 2004 prisons have started programs for prison guards. They all pass educational sessions about HIV and other contagious diseases, and also how to give first aid and trained to use protective measure if needed. Since 2008 we also provide professional education for Viru Prison personnel. All protective measures are available for prison staff. Medical staff education has been essential". This is indicating that training has become a major issue in the training and education of staff.

According to Rüttel/Lohmus (2007) the first HIV-case in a penal institution was registered in May 2000. In that year 80 prisoners with HIV were detected (20% of all new HIV-cases registered that year). In the following years the proportion of prisoners increased; in 2003, 266 people were detained in a penal institution upon the moment of HIV detection, accounting thus for 32% of all new cases. Since 2004, the proportion of prisoners among new HIV-cases has decreased being 19% in 2005. In 2006 there were more than 600 HIV-positive prisoners in Estonian prisons.

At the time of the visit (early January 2008) there were 486 HIV-positive prisoners in Estonian prisons⁴⁶, which means that 14% of the total prison population were HIV-infected. No incidence data for HIV/AIDS were available. The number of HIV-positive prisoners comprises 8.5% of the total number of HIV-infected people living in Estonia (total 5,731 in 2006; Rüttel/Lohmus, 2007). This number has considerably decreased: In 2003 the proportion of prisoners among new HIV cases was 32% of all cases, in 2005 19% (WHO, 2007).

Most prisoners have been infected before imprisonment. There have been seven cases (according to the data from Ministry of Justice) of HIV-transmission in the prison: 1 through sexual contacts, 2 through tattooing, 4 through sharing contaminated syringes and/or injecting equipment).

Uusküla et al. (2005, 22) pointed out that IDUs who had ever been in prison had nearly twice the odds of being HIV positive compared to their counterparts: One third of the respondents reported continuing injecting while incarcerated – needle sharing was reported by 69% of the injectors in prisons. This indicates that prisons are a high risk environment and risk behaviour is widespread.

A substantial proportion of the IDUs surveyed reported being in prison, and one third of them also reported continuing injecting while incarcerated. Noteworthy here is that while one third of the sample reported sharing needles/syringes within last 4 week (out-side of the prison setting), sharing was reported by 69% of the injectors in prison. We argue that incarceration associated to increased risk of HIV infection can be attributed to sharing needles, most frequently with multiple partners.

Year	Number of tested	Number of positives	%
2003	5009	266	5,3
2004	4717	163	3,5
2005	4819	121	2,5
2006	4530	107	2,4

Table 12: HIV-infection among prisoners, 2003–2006 (Source: Health Inspection Protectorate)

46 (Personal communication, MoJ)

Table 12 shows that according to the data of the Health Inspectorate only a small number of prisoners is HIV-positive. However, data provided by the Ministry of Justice gives an impression of higher prevalence numbers (e.g. for 2006, see below).

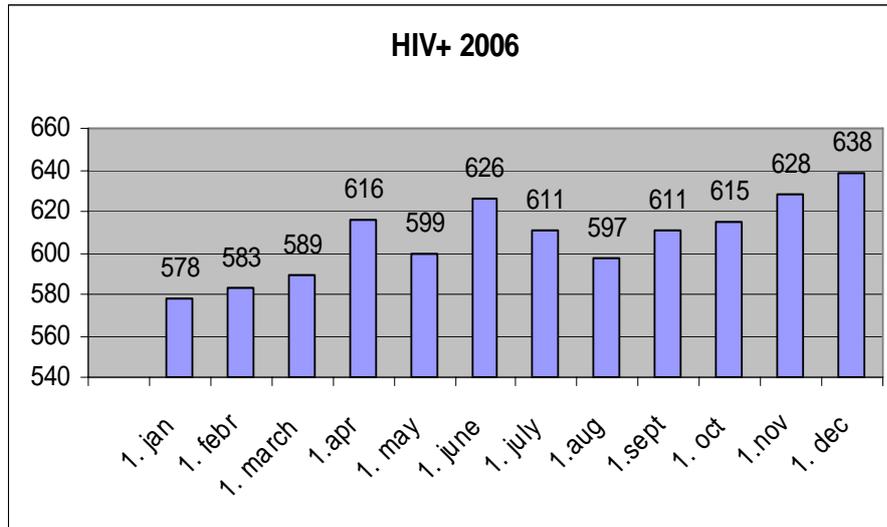


Table 13: Number of HIV+ in the prison system 2006 (Source: Katkosilt, 2007)

On the first of December 2006 there were 638 HIV positive prisoners in all Estonian prisons, from those 225 in Murru Prison, 34 in Harku Prison and 3 in Viljandi Prison. Out of these 638 HIV+prisoners 105 received HAART therapy (Ministry of Justice).

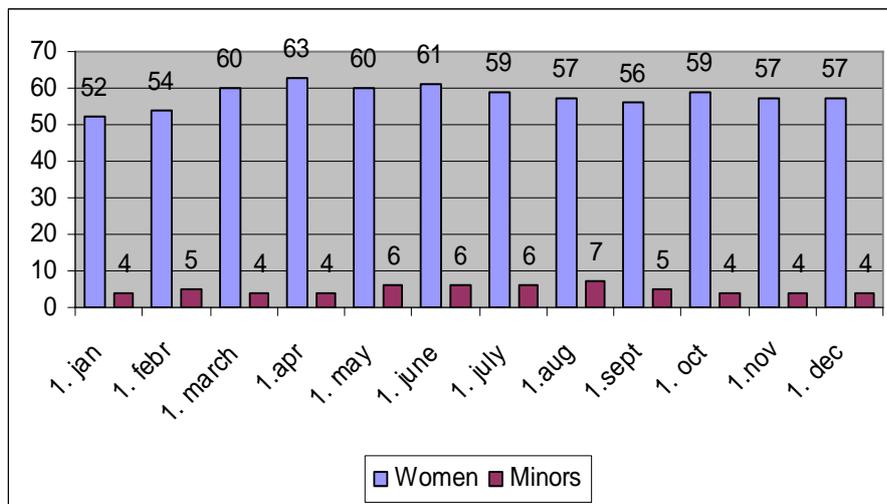


Table 14: HIV + female prisoners and minors 2006

Year	Male		Female		Total	
	Number	% of cases registered in penal institutions	Number	% of cases registered in penal institutions	Number	% of all cases in country
2000	73	91	7	9	80	20
2001	371	88	49	12	420	28
2002	216	89	27	11	243	27
2003	241	91	25	9	266	32
2004	151	93	12	7	163	21
2005	114	94	7	6	121	19
2006	94	88	13	12	107	16

Table 15: The number of prisoners at the moment of HIV detection by sex (2000–06; source: Rütel/Lohmus, 2007)

There are about 10 AIDS cases at the moment (7.5% of all Estonian people (134) diagnosed with AIDS); 120 prisoners are under ARV-treatment at the moment. During our visit of Murru prison prisoners got their ARV-medication pills in a plastic bag for a week, which gives no security if the pills are really taken daily and adherence might be undermined. According to the Ministry of Justice serious efforts are being made to change this procedure by changing the structure of medical services together with closer monitoring of its practice. In all other prisons ARV-medication is provided by nurses and inmates get their daily doses.

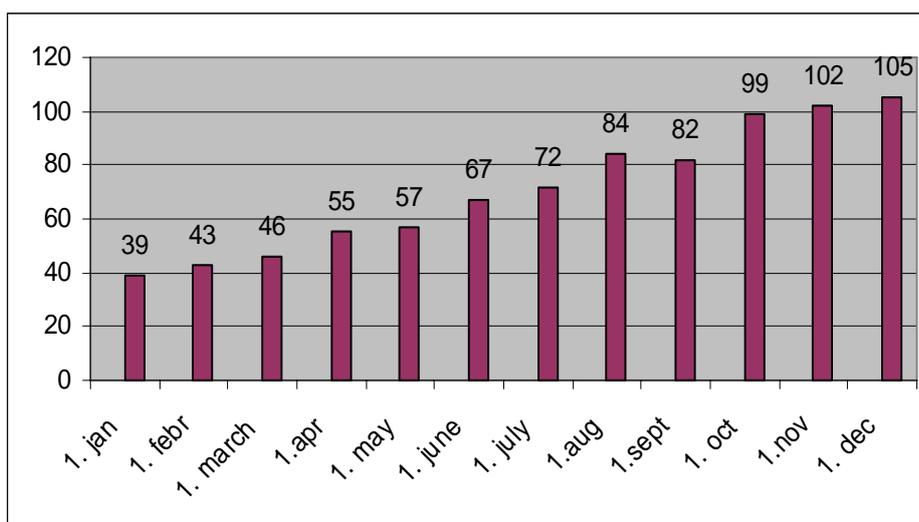


Table 16: ARV patients in Estonian prisons in 2006 (Source: Katkosilt, 2007)

5.1.1 HIV-testing

HIV testing in the Estonian prison system is completely voluntary and may be performed only upon the person's informed consent. That means that the first time a person goes to prison he/she is offered the possibility to make a HIV test. If someone is not interested then it is not a forced test. At least once a year prisoners get an offer to undergo a HIV test and also when they leave the prison. VCT is provided to all prisoners⁴⁷. Prison medical staff are informing prisoners about the risks and how to avoid HIV infection through a training program.

About 20–30% of Estonia's new HIV cases are detected within the prison system, mostly (89%) among men 15–24 years old (Uusküla et al., 2005). The percentage of new cases detected among prisoners was 28.5% in 2001, 27% in 2002, 31.7% in 2003, and 21.9% in 2004

⁴⁷ According to the personal experience of some of our respondents in some prisons there still problems with the test results exist in single cases (e.g. prisoners get their results 9 months later)

(Uusküla et al. 2005b). In this study HIV-testing in prisons comprises the second biggest number of detected new HIV-cases (21.9%) in Estonia (after anonymous testing in the community, 32%).

Depending on his/her health status further examinations and treatment will be assigned to him/her. Condoms are available in the medical departments of prisons and disinfectants in the toilet rooms.

As part of the National HIV and AIDS Strategy confirmatory tests for those found to be HIV positive are paid by the state (NIHD).

Lommus/Trummal 2006 reported that 76% of the respondents have had an HIV test in the prison setting (20% during the last month prior to the study). Obviously there is about one quarter of prisoners who do not undergo HIV-testing.

Indicator	baseline 2004	2006
Percentage of convicts who have been tested for HIV during imprisonment	61%	74%

Table 17: Indicator on HIV-testing among convicts 2006 (source: ESTONIAN PROGRAM OF GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA 10.2003–09.2007)

According to this indicator the goal has been reached in 2006.

5.1.2 Psychosocial support for PLWHA in prisons

In order to improve the quality of life, PLWHA need integrated health, psychological and social counselling, welfare services and legal advices based on their needs. Also the relatives and close ones of HIV-positive people need support. (National HIV/AIDS Strategy for 2006–2015). According to the data available approx. 10% (165 people, detainees excluded) of HIV-positive people in the community attended support groups in 2005. All five organizations that offered this service were non-governmental (WHO, 2007). The coverage rate is much higher in prisons.

In this case the prison provisions are covering much more HIV-positive persons than in the community. The Evaluation of the Estonian GFATM Programme (Drew & Leukamm-Josten 2006, 14) confirmed this fact by stating that services expanded in prisons: “Previously, work was conducted in 1 prison only. Now, the NGO Convictus operates 12 groups in 7 prisons offering a range of services”.

In 2006 even 16 support groups for PLWHA in the prisons have been organised under the activities of the GFATM programme by the NGO “Convictus” (Trummal & Lõhmus, 2006). There were 9 support groups in the first quarter of 2004. In the course of the two years 473 prisoners have been involved in the support groups (222 of them have been released in the meantime).

“Convictus Estonia” offers individual or small group consultations in all prisons to people under preliminary investigation and to convicted persons. They also organise information hours with discussions on HIV/AIDS and associated topics. There were a total of 600 individual consultation in 2004 and 968 in 2005. The number of people participating in the information hours in the two years was 2313 and 3514 respectively.

5.1.3 Attitudes towards PLWHA

Regarding the attitudes towards PLWHA, nearly three quarters of prisoners agreed to continue communicating with an acquaintance who is infected with HIV, and approx. half of the respondents agreed to not segregate PLWHA and agreed to live in the same chamber with PLWHA.

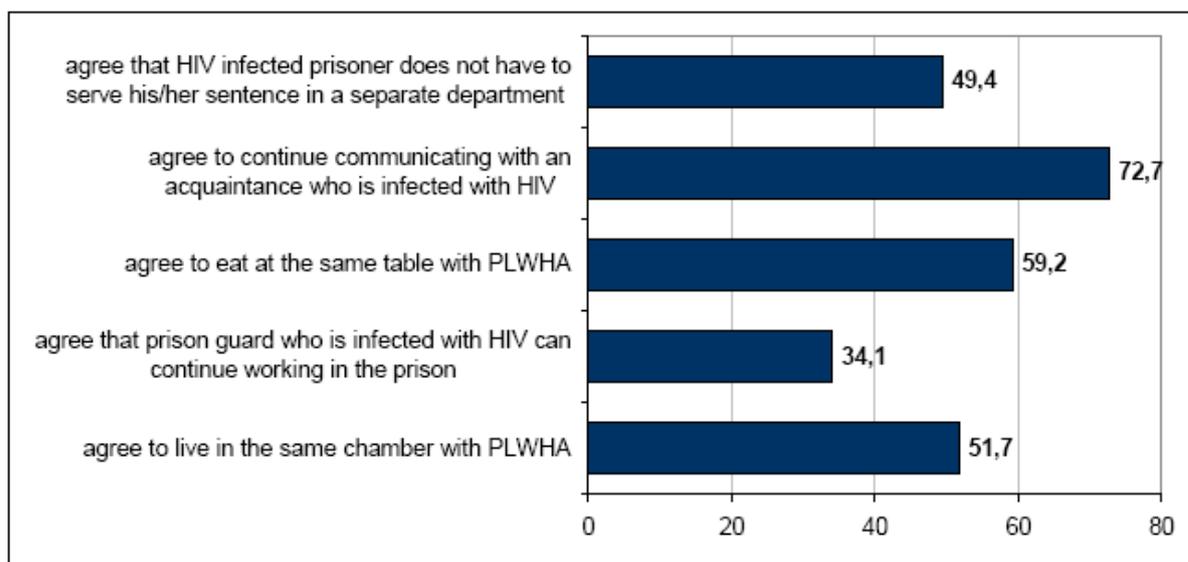


Table 18: Respondents who agree to have contacts with PLWHA (Source: Lommus/Trummal, 2006)

During our field visits within the assessment mission views have been expressed by staff of medical units and NGOs that the atmosphere towards PLWHA has changed over the past 5–8 years: From more hostile attitudes in the beginning of the epidemic to more understanding attitudes currently. Trummal & Lõhmus (2006, 42) found in their study on knowledge and attitudes:

- 60% of the respondents find that HIV infected prisoner should not serve the punishment in a separate department.
- Prisoners with accurate knowledge of the ways of HIV transmission are significantly more tolerant to PLWHA
- Approximately 1/2 of the prisoners believe that PLWHA themselves are at fault for contracting the infection and more than half think that a carrier of the infection should notify his or her acquaintances and friends about it.
- Less than 1/5 of the respondents found that the life of a HIV infected person loses meaning. The difference between data from new and regular members of support group is not statistically significant.

During our meeting with staff of Convictus the situation of HIV-positive prisoners was explained. Even five years ago HIV+ prisoners were beaten by others, segregated then, had no allowance to take part in any common activities (like sports) – the general attitude of prisoners against PLWHA was hostile and discriminatory. This was true for small institutions like Viljandi where there were 110 prisoners and 10 were HIV+.

5.1.4 HIV/AIDS-preventive services in prisons

Lommus/Trummal 2006 found that approx. one third of the respondents knew about free access to disinfectants and more than two third knew about free access to condoms in the prison (lubricants 12.3%). 75% reported that they did not need condoms during the last 12 months and 53% did not need disinfectants.

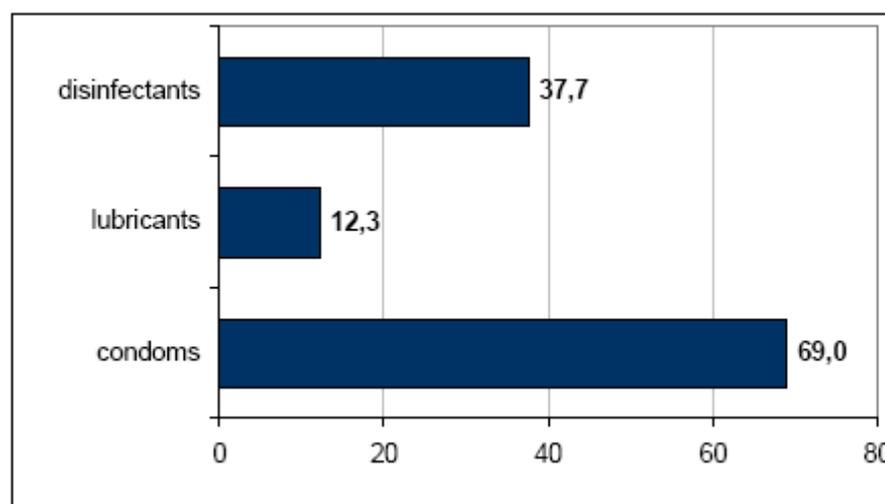


Table 19: Respondents who knew about the equipment available free of charge in prisons (Source: Lommus/Trummal, 2006)

Additionally, regular training courses are organised for the prison staff. In 2004 and 2005 the training courses covered the following topics: HIV testing and counselling; HIV/AIDS, accompanying diseases and treatment; promotion of healthy sexual behaviour and prevention of HIV/AIDS and STIs.

5.2 Other infectious diseases

5.2.1 TB

The Ministry of justice⁴⁸ issued that there are 22 TB cases in Estonian prisons resp. prison hospital. At the moment there are 7 MDR-TB cases known in Estonian prisons. Prisoners who are diagnosed HIV-positive are recommended to undergo TB-screening. However, in prisons all detainees are requested to undergo TB-screening. According to a TB specialist in Murru prison approx. 90% of all prisoners undergo these tests. "In 2005 there were 24 TB cases in Estonian prisons. Generally, the number of TB cases has been quite stable during the period 1996–2005" (WHO 2007, 9).

5.2.2 Hepatitis

A recent study found that a large number of prisoners in Estonia are at risk of contracting hepatitis B and C infection as a result of sharing syringes while injecting drugs and of unhygienic tattooing practices. It has been estimated that about 30% of Estonian prisoners are injecting drugs (Eurosurveillance, 2006). The study found that at Tallinn prison, from a sample of 122 HIV-positive prisoners, 89% had HBV antibodies, 98% HCV antibodies and that 89% had both HBV and HCV antibodies. These findings are significantly higher than those found in IDUs in the community who have visited anonymous HIV testing facilities (MacDonald et al., 2007).

48 (personal communication)

However, in a recent study from Tefanova & Priimägi (2007) found lower rates of HBV and HCV markers among prisoners as Table 20 indicates

VH markers	Murru Prison, n=395	Harku Prison, n=97	Viljandi Prison, n=100
HBsAg	13/3.29	4/4.12	1/1.0
anti-HBc total	170/43.04	54/55.67	8/8.0
anti-HBcIgM	4/30.77	0/0	8/8.0
Anti-HCV	193/48.86	52/53.61	23/23.0

Table 20: Seroprevalence (abs/%) of HBV and HCV markers among studied prisoners (source: Tefanova & Priimägi, 2007)

However, these figures also indicate that co-infections (HIV/HCV/HBV) are extremely widespread in prisons, which adds to the vulnerable situation prisoners are in. These burden for the immune system have also to be discussed within a comparably high risk of TB-infections in prisons.

Since 1997, the HBV vaccination is provided free of charge for health care workers, those aged 13 (since 1999) and since 2003 to newborn babies. However, due to a lack of sustainable programmes and the cost of the vaccine, efforts to vaccinate adults both in the community and those in prison (particularly people with problematic drug use) has been limited (Eurosurveillance, 2006). Nonetheless, at Tallinn prison an accelerated schedule for hepatitis B vaccination amongst injecting drug users was carried out where the full vaccination course (three vaccinations) was administered to 457 IDUs (81% of 566 inmates included in the study). The results revealed that a short hepatitis B vaccination schedule among imprisoned IDUs has a significantly higher compliance and zero-protection rate than the standard six-month schedule, and should therefore be recommended for use in this population. Low zero-protection rate was correlated to concurrent hepatitis C infection (EuroHIV, 2005).

A specific study on IDUs shows a very high prevalence of HBV and HCV among IDUs. The findings of a survey on 222 IDUs including 100 visitors of Anonymous AIDS centres and 122 detainees of the Central Prison show that 65% of the visitors of Anonymous AIDS centres and 89% of the detainees were HBV seropositive and 90% and 97.5% were HCV seropositive, respectively (Priimägi et al., 2003). The share of injecting drug users in the sample was very high and 85% (N=189) of the surveyed IDUs had shared syringes. Besides sharing syringes unhygienic tattooing seems to be a risk factor (Tefanova et al., 2003).

The epidemiological situation with regards to viral hepatitis indicates the need for preventative measures and behavioural interventions to reduce the harms associated with HBV/HCV infections. It is also important to provide HBV vaccination and proper medical care of those infected, both among IDUs and the community as a whole, in order to prevent a serious public health problem (Eurosurveillance, 2006).

6 Specific issues of most-at-risk-groups within prisons: women, migrants and juveniles

The prevalence of drug use and sharing injection equipment among incarcerated women is in most countries higher than that among incarcerated men⁴⁹. Analysing data for Estonia this seems to be also true for female prisoners: approx. 166 female prisoners and 57 HIV+ female prisoners (see Table 13), which results in a HIV-prevalence rate of approx. one third of all female prisoners (data: 25 July 2007⁵⁰).

One possible explanation is that the percentage of drug using women in prison is very high in most of the EU countries and also in Estonia. In some countries, data suggest that two-thirds of women entering prison report a history of severe drug and/or alcohol use prior to imprisonment and drug use is a widespread pattern.

A study on the prevalence of female drug users in prisons⁵¹ carried out in Europe revealed that only few data are available: Half of the 17 countries/regions which could provide any data for the year 2002 reported a proportion of 10–30 % female drug users among the female prison population. For the other half of the countries/regions, the proportion of female drug users in prison was 40–60%. The highest proportion of female drug using prisoners was reported by Finland, where 70 % of the female prisoners were regarded as drug users. In five countries (Latvia, Lithuania, Slovenia, Luxembourg and Germany) nearly all of the female drug users in prison are supposed to have a history of use of illicit drugs. Scotland and England/Wales reported that 75% and 54% respectively of the female prisoners had a history of illicit drug use. In Catalonia this was the case for 48% of the female prisoners.

Only six out of 27 regions/regions had data on the number of female prisoners who continued the use of illicit drugs while incarcerated. According to the data, rates of illicit drug use during imprisonment were between 1–20 %. In Scotland, 56% of the female prisoners were perceived to use illicit drugs in prison.

Women prisoners who use drugs are exposed to physical and emotional strain, and their drug use is often a strategy to cope with experiences of prostitution, emotional, physical and sexual abuse, and violence.⁵² This mode of behaviour (i.e. trying to solve a problem inwardly or even to blame oneself for it) is not unusual for women. According to the Scottish Prison Service in 2000, "Victimisation has many implications for women in general, but perhaps particularly for those in custody. Increased substance abuse is one possibility. Vulnerability during withdrawal from drugs or alcohol is another problem and women are particularly vulnerable during the first few days and weeks in custody. Feelings of shame, isolation or self-blame, which in turn reduce their self-esteem, are not uncommon. This is particularly true of women who have been victims of abuse, when even standard prison procedures such as body or cell searches, and the loss of autonomy which is a basic part of prison life can trigger feelings of helplessness and frustration reminiscent of the experience of abuse itself."

49 Stöver, H.; Lines, R. (2006): *Silence Still = Death. 25 years of HIV/AIDS in Prisons*. World Health Organisation/WHO – Regional Office for Europe (ed.): *25-Years of HIV/AIDS in Europe*, (pp. 67–85); see also European Monitoring Centre for Drugs and Drug Addiction. *Annual report on the state of the drugs problem in the European Union and Norway*. Luxembourg: Office for Official Publications of the European Communities, 2002

50 Data see: www.prisonstudies.org; The result of the comparison is a rough one, because the basic data of HIV+ women in prisons and number of female prisoners are not identical, they are coming from 2006 esp. 2007) and thus do not claim to be scientifically precise

51 Zurhold/Stöver/Haasen (2004): *Female Drug Users in European Prisons – Best practice for Relapse Prevention and Reintegration*. Hamburg/Germany

52 See Antonietti/Alberto (1997)

Problems of sexual abuse, rape and violence often cannot be targeted within the prison setting, because adequate help is not provided.

Specific strategies to support women drug users in prison should include parenting and childcare issues (care for pregnant drug users and impact on unborn child) and general women's health and reproductive health (special medical support for gynaecological examinations etc.). The separation of women from their families, relatives and their children constitutes a specific form of social exclusion, which needs to be addressed.

Community-based and civil society organisation should therefore be encouraged to offer appropriate help in the community after release.

7 Migrants/Ethnic Minorities: Russian Speaking Prisoners

There is generally little data available of the proportion of migrants, ethnic minorities, and displaced persons using drugs in prisons. Generally many respondents said that non-ethnic Estonians (mostly Russian speaking prisoners) are more involved in IDU and are also disproportional spread in prisons.

Migration and displacement especially are often associated with difficult living conditions, poverty, and social exclusion, which can facilitate risk behaviour in terms of sexuality and drug use. It can also have significant negative effects on the overall health of the individuals.

In some regions of the world, migrants are active in the sex business. For instance people (in the majority women) from Ukraine, Moldova, and Russia are working as sex workers in Western, Central and South Eastern European countries. If they come from countries with high prevalence of HIV and sexually transmitted infections, they – along with their clients – are a “bridging population” that can spread those diseases. These individuals are themselves vulnerable to infection.

In many prisons migrants, ethnic minorities and displaced persons have limited access to health information (e.g. HIV/AIDS education) simply because information is not provided in the appropriate languages and/or cultural forms. Moreover, access to prevention, treatment, and care services is hampered by the anticipated discontinuity after release from prison, when they are deported to their home countries where essential medical services might not be delivered (i.e., antiretroviral/interferon or substitution therapy).

Juvenile Prisoners

Although there are no epidemiological data on the prevalence of HIV/AIDS among prisoners in young custody facility in Estonia, juvenile offenders seem to be even more at risk than their adult counterparts. This is because young people are far more often involved in risky drug using behaviour.

Within the prison setting Keppler⁵³ found high-risk patterns of intravenous drug use and sero-conversions (hepatitis B and C) among young offenders. Many prison experts confirm this pattern, and report an often less cautious approach to drug use, incorporating higher risks behaviours such as injecting drug use. This may be due to feeling of inviolability. This behaviour becomes extremely important in the prophylaxis of blood-borne viruses⁵⁴.

53 Keppler, K. (2001): AIDS- und Hepatitis-Viren: Infektionserfassung und Prävalenz bei Frauen im Strafvollzug Bibliotheks- und Informationssystem der Universität Oldenburg

54 See also: Keppler, F.; Nolte, H.; Stöver, H. (1996): Transmission of infectious diseases in prisons – results of a study for women in Vechta, Lower Saxony, Germany. *Sucht*; 42: 98–107 at 104

Gaps in data on HIV infection among juvenile prisoners may also be exacerbated by a low uptake of voluntary HIV testing among young people generally, whether inside or outside prison.

Juveniles, as well as migrants are at particular risk to acquire infectious diseases, as they often have a poor understanding of the nature and character and the dynamics of infectious diseases in closed settings⁵⁵.

55 MacDonal, M.; Atherton, S.; Stöver, H. (2007: Juveniles in Secure Settings: Services for problematic drug and alcohol users. EUROPEAN NETWORK ON DRUGS AND INFECTIONS PREVENTION IN PRISON (ENDIPP) and CRANSTOUN DRUG SERVICES. London/Brussels 2007

III. Evaluation of national responses to HIV and AIDS in prison settings

In the Estonian national HIV and AIDS Strategy (2006–2015) the goals regarding prisons are clearly stated:

- To enable injecting drug using detainees the availability of harm reduction service and in prisons to reduce the demand for drugs. To increase the availability of high-quality counselling and HIV and STI testing services in the detention institutions.
- To enable the detainees the availability of condoms, lubricants, disinfectants and other disposable means in the places of detention. To enable all the persons working and operating in the detention institutions a safe working environment and the detained persons a safe working and living environment.
- To provide the detained persons training regarding HIV transmission, information and conversations in the form of individual or group work and the prison staff trainings regarding the possibilities for avoiding HIV transmission, how to avoid the use of violence in the prisons and respect the rights, self-esteem and welfare of the detained persons.
- To enable the detained PLWHA the availability of health, psychological and social counselling and legal and welfare services.

The strengths of the Estonian response to HIV/AIDS in prisons are

- Voluntary counselling and testing is accessible for every inmate (VCT – 2671 inmates in 2006 during first 6 month).
- Informative booklets (over 32,000), condoms are available for all prisoners for free (Condoms/lubricants – 11,134/3800 (2006 first 6 month)¹.
- Vaccination against B-hepatitis for all prisoners who are convicted for more than 7 months is available (320 inmates – 2006 first 6 month).
- Trainings for prisoners and staff about HIV/AIDS and other communicable diseases, sexual behaviour, social programs for IDUs.
- Support groups for HIV + drug users by NGO Convictus (21 groups with 300 members).
- ARV treatment is offered (110 patients).
- Other health care services are offered (e.g. TB screening; see als Katkosilt, 2007).

The National HIV and AIDS strategy (2006–2015) on HIV prevention states that “*all HIV prevention interventions that have been implemented outside prisons should be equally available also in prisons*” and specifies needle exchange and substitution therapy and substitution as examples.

However, the main HIV/AIDS prevention activities in Estonian prisons remains Voluntary counselling and testing (VCT), trainings for prisoners and prison staff on HIV/AIDS-related topics, counselling and psychological support for people with HIV and AIDS; distribution of disinfectants and condoms. The latter seem to be in discussion again as there is suspicion they might be used for other purposes.

VCT/HIV-testing is recommended to all first time offenders and is available at different stages of imprisonment. This test is paid from the state budget through MoJ, the verification of the positive test is funded by NIHD (National HIV/AIDS Prevention Program). In case a person is diagnosed with HIV, the MoJ will finance all needed diagnostics and treatment. All in all, the

1 However, these numbers are much lower in 2007

Ministry of Justice is responsible for administrating all the health care and social support services in prisons (WHO, 2007).

Drew & Leukamm-Josten (2006, 23) pointed out² that there is a continued absence of key, proven, prevention services, such as needle exchange and opioid substitution programmes, which remains a major gap in running an effective response to HIV/AIDS in Estonia.

Grund (2005) is supporting this view: "Many IDUs in Estonia spend time in prisons and injecting drug use is the main way that HIV is spread within prisons. ... For these reasons, introduction of effective HIV prevention activities in prisons should be a top priority for Estonia's response to HIV/AIDS. *'Programs to reduce HIV transmission in jails and prisons, including drug abuse treatment of inmates, syringes exchange, and programmes to reduce the likelihood of incarceration of IDUs, are urgently needed* (Grund, 2005)."

These two missing key strategies in combating the spread of HIV/AIDS via intravenous drug use and sharing of injection equipment can not be replaced by the provision of disinfectants or counselling and drug reduction programmes.

Other problems that were reported relating to delivery of services in prisons include (see also Drew & Leukamm-Josten (2006):

- Although much progress has been achieved, still negative staff and partly prisoners' attitudes against PLWHA.
- Condoms seem to be available in the medical units, via NGOs and in the prison shop, the question remains whether condoms (and lubricants) are really accessible in a discreet way.
- In at least one prison visited prison health care service is not able to provide daily medications, e.g. ARVs (prisoners get their pills in a plastic bag for a whole week on their cell).
- Prison health staff have limited HIV/AIDS knowledge.
- Prison health care is partly lacking an understanding of medical ethics³ as prerequisite for trustful doctor/nurse-patient-relationship.
- Lack of throughcare and seamless provision of services for prisoners on leave and after they are released (only 50% of ARV-patients continue their treatment once released).
- Gap between high numbers of HIV-positive prisoners and those receiving ARV treatment.
- Disinfectants seem to be available ("in the toilet"). confirmed that bleach (Natrium-Hypochloride) is absolutely not to be recommended as a safe disinfectant for needles and syringes in prisons (also not as second line strategy) without proper and detailed transfer of knowledge of how to use it safely and which solutions can be used in which strength etc.

1 Transmission route: injecting drug use

The World Health Organization's Status Paper on Prisons, Drugs and Harm Reduction (May 2005) says that the evidence that HIV transmission can be reduced in prisons through prevention programmes is now overwhelming. Such programmes usually include:

- Information, education and communication on HIV/AIDS.
- Voluntary testing and counselling.
- Distribution of condoms.

2 In an evaluation of the Estonian GFATM Programme

3 According to MoJ (2008) medical care is administered by empathetic and well educated providers. There is confidential relationship between inmates and medical staff. Staff who knew a prisoner's HIV status are limited and all medical information is treated in confidence. However some difficulties have been met in recruiting of competent staff. This appears to be much serious problem in case of the largest camp-type prison in Murru. The salaries and recreation of medical staff have been a priority for the MoJ, which allows to hope that measures taken by prison administrations will result in more competent staff during 2008"

- Distribution of bleach or other disinfectants including target group specific information on how to use bleach to disinfect needles and syringes.
- Exchange of needles and syringes.
- Substitution therapy including counselling and psychosocial support.

Additional components of harm reduction programmes with a significant potential to reduce individual risk behaviour include treatment and care related to HIV/AIDS, Hepatitis and Tuberculosis, including access to highly active antiretroviral therapy.

Also drug free orientation may of course be considered as a drug strategy and subsequently as a module of HIV strategy (see following chapter).

1.1 Drug Treatment

General

The WHO/UNAIDS/UNODC (2007, p. 11) "Evidence for Action Technical Paper" reviewed a wide range of studies on their effectiveness to manage HIV in prisons. Regarding 'drug-free' units it is said that "there is some evidence from a small number of studies that so-called "drug-free" units may assist prisoners to reduce their drug use while in prison. However, the studies do not say anything about whether these units appeal to, and are successful in retaining, the most problematic users, in particular injecting drug users. Therefore, it is recommended that: ... prison systems should provide prisoners with the option of living in a "drug-free" environment. However, there is currently no data on the effectiveness of "drug-free" units as an HIV prevention strategy. Therefore, evaluations of their effectiveness in attracting and retaining injecting drug users and in reducing drug injecting and needle sharing should be undertaken".

Estonia

According to the Ministry of Justice (2008), it is intended to "develop a special drug treatment program and to open special rehabilitation units for drug addicted prisoners. In the Tartu prison the drug free unit was opened in April of 2006 for adult male prisoners (12 places). This led to wider specialization and by the end of this year the all unit will be specialized to drug treatment (174 places). The Harku prison (women's prison) opened the drug free unit in May 2007 (8 places). In the new Viru prison two drug free units will be opened (44 places for male plus separate unit for juveniles).

These intentions are very valuable, however, the practice should be monitored in order to assess the efficiency of these approaches.

1.2 Substitution treatment

General

UNODC (2007, p. 7) stated that there is growing number of studies and recommendations that methadone and buprenorphine maintenance therapy should be a part of HIV prevention strategies in prisons as important and highly effective public health intervention (WHO, 2005c).

The term "substitution treatment" refers to the medically supervised treatment of individuals with opioid dependency, based on the prescription of opioid agonists such as methadone or buprenorphine (Thomas, 2001). The treatment options include the management of withdrawal on admission as a gradual detoxification (proceeding to abstinence-oriented treatment) or to long-term substitution maintenance. Substitution therapy has been widely recognized as an effective treatment for opioid dependence in the general community (Farrell et

al., 2001; United Nations Office on Drugs and Crime (UNODC, UNAIDS, 2004) and as having crime reducing effects (Lind et al., 2004; Stallwitz/Stöver, 2007). Despite this and the fact that methadone and buprenorphine have just been added to WHO's Model List of Essential Medicines (2005), it is introduced in almost all EU-Member States, but remains highly controversial in prison settings (Trimbos Instituut, 2006, p. 51f and 64; see also Stöver et al., 2006). In addition, experience has clearly shown the benefits of this treatment in prisons (World Health Organization, UNODC, 2007; Heimer et al., 2005; Dolan et al., 1998). The World Health Organisation states:

The advantages of using substitution therapy are very great. These include reducing suicide and self-harm during withdrawal, improving regimen management problems during withdrawal and reducing the risk of fatal overdose following release from prison. The high-level endorsement by international organizations and the growing appreciation that this does work, and cost-effectively, indicates that the priority in the immediate future is to develop the clinical and other standards urgently required. (WHO, 2005:15)

In countries that provide methadone in prisons, it is most commonly used for short-term detoxification, and less frequently as a maintenance treatment. In some countries, such as Austria and Spain, substitution treatment is provided as standard therapy to all prisoners who began treatment in the community and are deemed likely to continue it after release (Stöver et al., 2004). In others, including Greece and Sweden, it is not available in prisons at all.

Acknowledgement that the benefits of substitution treatment in the community might also apply to the prison setting has taken years. The source of the controversy – and the slow and patchy manner of the intervention's implementation thus far – can be traced to the prison ethos of coercion, which usually manifests itself in a strict abstinence-based approach to drug use. Therefore, while opioid-dependent individuals in the community may be treated as patients and receive substitution treatment, in prison they continue to be treated as prisoners who are supposed to remain drug free. This double standard leads to frequent interruptions in treatment and inconsistency in dosages, especially as many opioid users spend periods of time incarcerated.

More than half million opioid dependent persons receive substitution therapy in the European Community (EMCDDA, 2002)⁴. In other parts of the world (e.g. eastern European) however, use of substitution therapy remains highly limited. The Position Paper from WHO, UNODC and UNAIDS (2004) on substitution maintenance therapy concludes that the provision of substitution maintenance therapy of opioid dependence is an effective HIV/AIDS prevention strategy that should be considered for implementation as soon as possible in communities at risk of HIV/AIDS. However, since the 1990s, methadone provision within prisons has expanded in many countries, for example, Canada, Australia, Poland, Iran, Indonesia, and most of Western Europe. Several studies have demonstrated that substitution treatment has become more widespread in many countries, prison administrations are considering developing standards and protocols to introduce substitution treatment, there is wider access generally, and a greater range of drugs to use in substitution programmes (Stöver et al., 2004).

Evidence shows that methadone maintenance treatment (MMT) can reduce injecting risk behaviour in penal institutions such as reduced frequency of illicit drug use in prison and reduced involvement in the prison drug trade (Dolan et al., 1998). Studies have also demonstrated that methadone maintenance treatment provision in a prison healthcare setting was effective in reducing heroin use, drug injection and syringe sharing among incarcerated heroin users (Dolan et al., 2002). A sufficiently high dosage also seems to be important for an increase in the retention rate, which then can be used for additional health care services.

4 This number has even increased to approximately 600,000 in 2006

There is also evidence that continued MMT in prison has a beneficial impact on transferring prisoners into drug treatment after release. The initiation of MMT in prisons also contributes to a significant reduction in serious drug charges and in behaviour related to activities in the drug subculture. Offenders participating in MMT also had lower readmission rates and were readmitted at a slower rate than non-MMT patients. For example, a 2001 evaluative study of the methadone programme of the Correctional Service of Canada (CSC) concluded that participation in methadone programmes had positive post-release outcomes. The study found that opiate users accessing methadone maintenance therapy (MMT) during their incarceration were less likely to be readmitted to prison following their release – and were less likely to have committed new offences – than were those not accessing methadone. The study further concluded that:

An important implication of these findings is that CSC may spend less money on these offenders in the long term. The cost of the institutional MMT program may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving MMT. In addition, health related costs such as treatment for HIV or Hepatitis C infection would be affected by MMT availability in prisons. (Correctional Service of Canada, 2001)

Research into the subjective experiences of prisoners participating in substitution programmes reveals the heterogeneity of prescription practices in prisons. In particular, short courses of methadone detoxifications were frequently experienced as insufficient and inadequate. Most striking was the inconsistency in substitution treatment inside prison compared to the community. Forty years after the introduction of substitution treatment for opioid dependent persons its implementation is often far from adequate in prison settings. Here the availability, the implementation, clinical management, and the evaluation of substitution treatment is often deficient (Stöver et al., 2004). The practice and policy of substitution treatment differs not only from country to country, but also from state to state, and from prison to prison (Michel/Maguet, 2003). Notably, the disruption of treatment when entering the institution often leads to physical and psychological problems and increases the risk of intravenous drug use and sharing of injection equipment (Stöver et al., 2004). In 1995, prisoners in Oberschöngrün prison, in Switzerland, were enrolled in a heroin maintenance trial that coincided with a community trial and which found it was feasible to implement a heroin prescription programme in prisons (Kaufmann et al., 1997, 1998).

Substitution treatment also offers daily contact between health care services and prisoners, forming a relationship that can serve as baseline for raising further health issues and a linkage with other HIV/AIDS preventive strategy matters. It is also a central topic in preventing relapse the high mortality of drug users after release, as studies have shown that there is an increase in drug related deaths of 20–50% during the first week after release, which then slows down up to the fourth week after release (Farrell, 2005). A first manual on Opioid Substitution Treatment in custodial setting has been published recently with support of WHO (Kastelic et al., 2008).

Estonia

Also the evaluation of methadone maintenance therapy programme in Estonia revealed that nearly all MMT service providers reported improvement of social status of clients (e.g. finding and maintaining jobs). HIV testing and ARV therapy free of charge was generally available at MMT sites. Scaling-up of MMT has been included in the National HIV strategy in Estonia.

According to the Ministry of Justice (2008) “methadone treatment is available for those who have received it before prison and have a correct documentation. Methadone is used only for detoxification purposes”. During our field visits we didn’t hear of this practice. The MoJ further states: “The development plan of the Ministry of Justice until the year of 2011 includes

special attention to HIV/Aids prevention in prisons. It indicates the activities in this area and one of these activities is to assure detoxification and OST in prisons. OST is planned to pilot in 2008 (Ministry of Justice) parallel with continuing detoxification”.

1.3 Needle exchange programmes in prisons

Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System identifies syringe exchange as one component of “a comprehensive package for HIV prevention among drug abusers”, stating that:

Several reviews of the effectiveness of needle and syringe exchange programmes have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase into injection drug use or other public health dangers in the communities served. Furthermore, such programmes have shown to serve as points of contact between drug abusers and service providers, including drug abuse treatment programmes.⁵ (UN, 2001)

In prisons, syringe exchange/distribution programmes have been operating successfully for more than 15 years. The first prison syringe exchange programme was established in 1991/92 in Switzerland. At present, there are programmes operating in more than 60 prisons⁶. In some of these countries, syringe exchange is available in only a few prisons⁷, while in Spain and Kyrgyzstan syringe exchange is authorised in all prisons. In several other countries (Kazakhstan, Tajikistan, and Poland) the implementation of pilot projects is considered.

In each of these countries, syringe exchange programmes were introduced in response to significant evidence of the risk of HIV transmission within the institutions through the sharing of syringes.

Syringe exchange programmes have proven to be an effective HIV prevention measure that reduces needle sharing, and therefore the risk of HIV and HCV transmission, among people who inject drugs and their sexual partners. As a result, many countries have implemented these programs within community settings to enable people who inject drugs to minimise their risk of contracting or transmitting HIV and HCV through needle sharing. Despite the success of these programs in the community, only a small number of countries have extended syringe exchange programmes into prisons. Those countries that have initiated syringe exchange in prisons have been met with remarkable success. Prison syringe exchange programmes have been implemented in both men’s and women’s prisons, in institutions of varying sizes, in both civilian and military systems, in institutions that house prisoners in individual cells and those that house prisoners in barracks, in institutions with different security ratings, and in different forms of custody (remand and sentenced, open and closed).

Syringe exchanges were typically implemented on a pilot basis, and later expanded based on the information learned during the pilot phase. Several different methods of syringe distribution are employed, based on the specific needs and the environment of the given institution. These methods include automatic dispensing machines; hand-to-hand distribution by prison physicians/health-care staff or by external community health workers; and programs using prisoners trained as peer outreach workers.

5 Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System (Approved on behalf of ACC by the High-Level Committee on programme at its first regular session of 2001, Vienna, 26–27 February, 2001). Paragraph 37

6 Lines, R.; Jürgens, R.; Betteridge, G.; Laticevski, D.; Nelles, J.; H.S: Prison Needle Exchange: Lessons from a Comprehensive Review of international Evidence and Experience. Canadian HIV/AIDS Legal Network; 2nd edition 2006; also available in French and Russian (www.aidslaw.ca)

7 e.g. Germany only one prison, Switzerland in five prisons etc.

The experiences and evidence from the six countries where prison needle exchange programs exist demonstrate that such programs:

- do not endanger staff or prisoner safety, and in fact, make prisons safer places to live and work;
- do not increase drug consumption or injecting;
- reduce risk behaviour and disease (including HIV and HCV) transmission;
- have other positive outcomes for the health of prisoners, including a drastic reduction in overdoses reported in some prisons and increased referral to drug treatment programmes;
- have been effective in a wide range of prisons; and
- have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons;
- Have successfully cohabited in prisons with other drug addiction prevention and treatment programmes (Meyenberg et al., 1999).

1.3.1 Political and moral resistance to needle exchange programmes in prisons

In view of the increased spread of needle/syringe sharing and drug use in European prisons, it is necessary to raise the issue of infection risks and protection possibilities in every penal institution out of damage limitation considerations. This does not necessarily mean that syringes have to be provided or that syringe vending machines must be installed in every prison. The type of individual measures necessary for infection prevention or the choice of how syringe provision takes place (hand-to-hand or vending machine) can be made according to the needs, the structure of the prison, the prison's spatial conditions and staff capacity as well as the prisoners' culture of drug use. For instance, intravenous opiate use in parts of England, but particularly in The Netherlands, is traditionally far less widespread than, say, inhaling or smoking. Despite evidence from 15 years of syringe provision in penal institutions, the question remains unanswered as to why syringe provision in prison settings is still so controversial. Syringe provision has only been introduced in 4 European countries to date (with compared to Estonia low HIV prevalence among inmates), and even there only in specific penal institutions in aid of infection prophylaxis and harm limitation in relation to the use of illegal drugs. There is sufficient fundamental experience in, and knowledge about, syringe provision in penal institutions to justify an extensive introduction of these measures (see Lines et al., 2006). Measures for syringe provision cannot be imposed, as the experience in Switzerland has shown, where despite an official order a number of prisons rejected them. Firstly, one must work on translating these measures into reality: all-encompassing political decisions and support to the penal institutions in practical, individual questions (legal, communicative and technical aspects) are required, to help obtain the necessary breakthrough as regards effective harm reduction in prisons (Lines et al., 2006).

1.4 Bleach/disinfectants

General

Many prison systems have adopted programmes that provide disinfectants such as bleach to prisoners who inject drugs as a means to disinfect injecting equipment before re-using it. According to UNAIDS in 1997, the provision of full-strength bleach to prisoners as a measure had been successfully adopted in prisons in Europe, Australia, Africa, and Central America. The WHO further reported that concerns that bleach might be used as a weapon proved unfounded, and that this 'has not happened in any prison where bleach distribution has been tried.'⁸

8 Joint United Nations Programme on HIV/AIDS (UNAIDS), Prisons and AIDS: UNAIDS technical update, p. 6

By August 2001, bleach was provided in 11 of 23 pre-expansion EU prison systems (Stöver et al., 2004). Disinfectants are also made available to prisoners in Canada, Moldova, Turkmenistan, Iran, Kyrgyzstan, and some parts of the Russian Federation. Disinfection as a means of HIV prevention is of varying efficiency, and is regarded only as a secondary strategy to syringe exchange programmes (WHO, 2005). The effectiveness of disinfection procedures is also largely dependent upon the method used. Before 1993, guidelines for syringe cleaning stipulated a method known as the '2x2x2' method. This method involved flushing injecting equipment twice with water, twice with bleach and twice with water. Research in 1993 raised doubts about the effectiveness of this method in the decontamination of used injecting equipment, and recommended new cleaning guidelines where injecting equipment should be soaked in fresh full strength bleach (5% sodium hypochlorite) for a minimum of 30 seconds (Shapshank et al., 1993).

All of these developments further complicate the effective use of bleach and disinfectants in prisons, where fear of detection by prison staff often means that drug use happens quickly, and that prisoners will often not take the time to practice optimal disinfection techniques properly (WHO, 2005). If done thoroughly, bleach might be effective in killing the HIV virus, but not 100% the hepatitis C virus, which can mislead prisoners into a false sense of security of having equipment cleaned efficiently.

Estonia

According to the MoJ (action plan – Activity 3.1.) house-hold bleach is provided in small quantities to each cell, provision of condoms has started, however, remains controversial in some prisons. The use of bleach is discussed controversially throughout the world. The WHO states "... field studies have cast considerable doubt on the likelihood that these measures could ever be effective in operational conditions" (WHO, 2004 at 28). They concluded that disinfection of needles with bleach appeared to offer no protection, or at best little protection, against HIV infection" WHO 2007, 26). Whereas the effectiveness remains very controversial in the community, prison settings are the most unsuitable setting to provide bleach/disinfectants. In prison settings bleach (Natrium-Hypochloride) is absolutely not to be recommended as disinfectant for needles and syringes in prisons for several reasons:

- (i) because the administration/handling of bleach is delicate and difficult: Is the correct concentration/solution of bleach? Are decontamination schemes known? Is there any communication and education going on in prisons about proper use of disinfectants? Is it used correctly by drug users (Natrium-Hypochlorid dissociates) and applied long enough (drug use is a clandestine behaviour, thus not much time can be spent on the exact procedure)? Moreover, bleach is very aggressive: The rubber parts of the syringe will be affected by the bleach and biofilms will occur, in which germs would probably grow.
- (ii) The existence of bleach and it's improper use would lead only to a kind of "pseudo-security".

Within an efficient strategy of prophylaxis of infectious diseases clean injection equipment should be made available to prisoners; disposable syringes and needles are the first choice to be used instead of (quite unsafe) disinfectants.

2 Transmission route: unprotected sexual contacts

General

Condom use is internationally accepted as the most effective method for reducing the risk of the sexual transmission of HIV (WHO, 2001). As a result, many prisons across the world provide condoms to prisoners as part of their institutional health policies. As early as 1991, a World Health Organization study found that 23 of 52 prison systems surveyed provided condoms to prisoners (Canadian HIV/AIDS Legal Network, 2002). By August 2001, 18 of the 23 prison systems in the pre-expansion EU were distributing condoms (Stöver et al., 2001). Condoms are also provided in prisons in countries including Canada, Australia, Ukraine, Moldova, Estonia, Turkmenistan, Iran, some parts of Russian Federation, and a small number of the jurisdictions in the United States. This is in keeping with the recommendation of the WHO *Guidelines on HIV Infection and AIDS in Prisons* recommends that:

Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention. They should also be made available prior to any form of leave or release.⁹

Despite the availability of condoms, barriers exist to their use in many prisons, and there is often poor knowledge among prisoners of sexual risk behaviour and individual risk prevention (MacDonald, 2005; Todts et al., 1997; WHO/UNAIDS/UNODC, 2007). These barriers include the fact that homosexuality or same-sex-activities are not accepted by most of the prison population and prisons do not offer enough privacy for the occurrence of this behaviour. Furthermore there is evidence that condoms, dental dams, and water-based lubricants are not easily and discreetly available, or are not available on a 24-hour basis. In many prisons, consensual sex is also prohibited, which can result in prisoners being reluctant to access safer sex measures for fear of identifying themselves as engaged in such activities.

The WHO/UNAIDS/UNODC stated in 2007 that there is evidence that provision of condoms is feasible in a wide range of prison settings. No prison system worldwide allowing condoms has reversed its policy, and none has reported security problems or any other major negative consequences. "In particular, it has been found that condom access is unobtrusive to the prison routine, represents no threat to security or operations, does not lead to an increase in sexual activity or drug use, and is accepted by most prisoners and prison staff once it is introduced. At the same time, there is evidence that making condoms available to prisoners is not enough – they need to be easily accessible in various locations in the prison, so that prisoners do not have to ask for them and can pick them up without being seen by staff or fellow prisoners. Studies have not determined whether infections have been prevented thanks to condom provision in prison, but there is evidence that prisoners use condoms to prevent infection during sexual activity when condoms are accessible in prison. It can therefore be considered likely that infections have been prevented". Therefore, WHO/UNAIDS/UNODC (2007,9) recommend that

... "Condoms should be made easily and discreetly accessible to prisoners so that they can pick them up at various locations in the prison, without having to ask for them and without being seen by others.

Together with condoms, water-based lubricant should also be provided since it reduces the probability of condom breakage and/or rectal tearing, both of which contribute to the risk of HIV transmission.

Educational and informational activities for prisoners and for staff should precede the introduction of condom distribution programmes, which should be carefully prepared.

Female prisoners should have access to condoms as well as dental dams".

9 WHO, Recommendation 20

Estonia

In 2004 5023 condoms were distributed by the penal institutions under the GFATM programme, with the number increasing to 29257 in 2005. Cooperation with the Central Pharmacy of Prisons for the distribution of condoms started in the last quarter of 2004. (Trummal & Lõhmus, 2006)

The provision of condoms for prisoners was organized by the medical department of the prisons and by Convictus. According to the data of the GFATM the provision of condoms to the prison population has improved between 2004–2005, the number of condoms has increased 5.8 times – from 5,023 condoms in 2004 to 29,257 in 2005 (Trummal et al., 2006). During the year condom provision was organized within the framework of different information campaigns and events such as the Remembrance Day of AIDS Victims, the World AIDS Day and other events.

Condoms are available free of charge in the healthcare departments, conjugal visit rooms of the prisons and distributed by Convictus. According to the MoJ they can also be purchased in the prison shop. The number of provided condoms decreased over time (condoms have been distributed to convicts through Tallinn Prison and Convictus Estonia):

- 3,316 during the first program year,
- 27,420 during the second,
- 13,390 during the third and
- 10,147 condoms in the last program year.
- 2,247 in 2007¹⁰

However, condoms may be available in Estonian prisons – the question remains if they are accessible discreetly. Generally this is viewed as an important element in the successful implementation and continued use of condoms, by maintaining the confidentiality of those who wished to access them.

3 Transmission route: tattooing and body piercing

General

Tattooing amongst prisoners is a common practice in many countries (Bammann/Stöver, 2006). Research has revealed high levels of tattooing among prisoners in many countries including Australia (Dolan, 1999), Canada (Correctional Services Canada, 1996), Ireland (Long et al., 1999), Spain and the United States (Dolan, 1999). Tattooing is an activity that takes place secretly, often in unhygienic environments, using homemade equipment and inks, and as quickly as possible so as to minimize the risk of detection by prison staff. All of these factors increase the risk of negative health consequences via tattooing in penal institutions.

Tattooing among prisoners is difficult to monitor, but there were instances reported and staff were also aware that prisoners would use a range of methods, including ‘branding’ and various types of injecting equipment. This highlighted a need for prisoners to have access to disinfectants or better to clean equipment, as healthcare staff reported minor injuries and infections associated with this.

Estonia

No data have been provided re tattooing and body piercing in Estonia

¹⁰ Personal communication MoJ (Jan. 2008)

4 The work of Civil Society/NGOs

4.1 Convictus

In December 2002 Convictus started to work in prisons, when they received a permission to work in one of the oldest and largest prisons in Estonia (Murru Vangla), where HIV-positive prisoners were housed in special isolated units. The problems arising were that prisoners did not understand Convictus' role in the beginning and denied their own situation. The negative and partly hostile attitudes against PLWHA five years ago was an obstacle for starting prisoner's support groups, because when prisoners showed interest to participate it became clear that they were HIV+. In Murru prison there were 160 HIV+ prisoners who were isolated in the so called "7th Division". Thus segregation policy fuelled negative attitudes, fears, stigmatisation, and discrimination.

However, Convictus continued to organise group meetings with drug-dependent prisoners and conducted lectures and presentations for prisoners on health issues in prisons, pre-test counselling, distribution and developing of materials, brochures and posters, and conducted campaigns that promoted voluntary HIV testing in co-operation with medical personnel in an informal atmosphere.

With the financial support of the Global Fund (funding from October 2003 to September 2007), Convictus began to expand its activities to seven prisons in Estonia, finally setting up 21 support groups divided by different needs: drug-dependent men; drug-dependent prisoners, who experienced discrimination; men, who have sexual relations with men; pregnant women, HIV-infected young women; minors, who were dependent on illegal drugs. Each group had its own goals, tasks and members, allowing to deal with the complexity of HIV/AIDS. The aim of these groups is to give psycho-social help as well to fight against drug addiction and diseases that spread in prison. Moreover Convictus is also targeting prison staff in organising thematic awareness for HIV/AIDS (round tables).

Convictus main goals are:

- Increase life quality of HIV-positive prisoners.
- Raise prisoners awareness of HIV/AIDS and other sexually transmitted diseases.
- HIV first and secondary prevention.
- Increase prisoner's tolerance towards HIV-positive persons.
- Decrease prisoners risk behaviour.
- Monitor ARV treatment for prisoners; improve knowledge about treatment through medical counselling.
- Cooperation between NGO Convictus and prison administration for common goals (HIV/AIDS prevention and education) and activities.
- Developed a network of support groups.

In autumn 2007 Convictus and the Ministry of Justice signed a contract to continue the work started with support from the Global Fund. The quantity of CONVICTUS' work in prisons is 130 hours per month in all Estonia prisons¹¹.

The Global Fund support was crucial in establishing such a multi-professional support net.

11 Personal communication, Ministry of Justice

5 Aftercare/Throughcare

General

Several studies (Zurhold et al., 2005) show that effective aftercare for drug using prisoners is essential to maintain gains made in prison-based treatment. Nevertheless, prisoners often have difficulty in accessing assessments and payment for treatment on release under community care arrangements. The following conclusions are drawn from a multi-country survey on aftercare programmes for drug-using prisoners in several European countries (Fox, 2000):

- Aftercare for drug-using prisoners significantly decreases recidivism and relapse rates and saves lives.
- Interagency cooperation is essential for effective aftercare. Prisons, probation services, drug treatment agencies and health, employment and social welfare services must join to put the varied needs of drug-using offenders first.
- Drug treatment workers must have access to prisoners during their sentence to encourage participation in treatment and to plan release.
- Short-sentence prisoners are most poorly placed to receive aftercare and most likely to re-offend. These prisoners need to be fast-tracked into release planning and encouraged into treatment.
- Ex-offenders need choice in aftercare. One size does not fit all in drug treatment.
- Aftercare that is built into the last portion of a sentence appears to increase motivation and uptake.
- In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-offenders are most likely to relapse and re-offend.

Estonia

According to the data of the Statistics Estonia in 2005 2,606 persons stayed in shelters and rehabilitation centres indicating no change when compared to the year 2004. The main reason for using the services was release from prison (22%) (Statistical Yearbook of Estonia, 2006).

The MoJ is making efforts to assure continuity of care and follow-up of HIV+ persons in the community after they are released from prisons. The transition for prisoners from custody to community is often problematic. In this phase health care is likely to take lower priority than the search for housing, jobs, rebuilding personal relationships, etc. Inmates should be provided with information about resources in the community and should be accompanied and assisted with enrolment for housing, health services, drug rehabilitation, financial benefits, HIV counselling and psycho-social support.

In interviews with experts from prisons it was stated that the continuity of treatment after release was lacking: only 50% of prisoners would seek ARV – treatment in the community once being released.

6 Funding of HIV/AIDS prevention in prisons

Estonia

The Ministry of Justice receives funds from the State Budget to provide health care in prisons. The costs of VCTs in penal institutions is paid by MoJ, verification tests are financed by NIHD.

Within the programme ‘National Partnership to Increase the Scale of Estonia’s Response to a Concentrated and Rapidly Developing HIV/AIDS Epidemic’. the GF allocated a total of EUR 1,640,001 in 2005. The funding has been divided between 7 main targets of the pro-

gramme such as young people, IDUs, commercial sex workers (CSW), prisoners, men who have sex with men (MSM), HIV-infected and people in need of ARV treatment, monitoring and evaluation, programme management and trainings. 50,732 € have been spent to prevent the spread of HIV in prisons (see Oole et al., 2006).

Lubricants	40 612	0,3%	MoJ, GF
STI analyses and treatment	986 000	6%	MoJ
Laboratory services	1 851 534	11%	MoJ
Disinfectants	369 000	2%	MoJ
VCT	942 275	6%	GF, MoJ
Support groups	704 013	4%	GF
Information materials	83 960	0,5%	GF, MoJ
M+E+S	50 664	0,3%	NIHD
TOTAL (EEK)	16 234 005	100%	
TOTAL (EUR)	1 037 542		

	Costs (EEK)	%	Purchasing Agent
Staff	5 330 755	33%	MoJ
Training	106 615	1%	MoJ
Running cost	627 940	4%	MoJ
Commodities and services			
Drugs	4 873 000	30%	MoJ
Useables	227 157	1%	MoJ
Condoms	40 480	0,2%	MoJ, GF

Table 21: Costs of TB and HIV interventions in Estonian prisons in 2005 (source: WHO, 2007)

Most parts of the money goes into staff involved in HIV/AIDS services and drugs for HIV-positive prisoners. WHO (2007, 42) estimated that dealing with patients with HIV or/and TB takes approximately 60% of medical staff's time (the staff costs presented by Tallinn Prison included costs for all medical staff).

IV. Conclusion

The support by the GF programme seemed to be a good opportunity to introduce systematic responses to the HIV/AIDS epidemic in the community and in prisons in Estonia. The activities funded (like psycho-social care and support done by Convictus and many other activities in Estonian prisons) have been prolonged with funds from the State budget from October 2007. The commitment by the state is indicating a strong will to reduce the transmission risks in all settings in Estonia and also in custodial settings. New prisons have been and will be built in order to improve living conditions of prisoners and working conditions of personnel. By building new prisons (e.g. Viru prison opening end of April 2008, closing of juvenile institution of Viljandi and female prison of Harku). Although substantial efforts have been made to reduce the number of prisoners (currently 3,400) Estonia still has one of the highest numbers of citizens per 100,000 population in prisons in Europe: 260. Medical units seem to be well equipped with all screening and diagnostic instruments. ARV treatment and VTC is available to any prisoner. Infrastructural measures have been taken to support first supply and second drug demand reduction strategies. Education, information and communication about BBV-transmission risks have been started successfully for both groups, staff and prisoners.

The main HIV/AIDS prevention activities in Estonian prisons are voluntary counselling and testing (VCT), information, trainings for prisoners and prison staff on HIV/AIDS-related topics, counselling and psychological support for people with HIV and AIDS; distribution of disinfectants and condoms. The latter seems to be in discussion again as there is suspicion they might be used for other purposes.

Despite alarmingly high prevalence and incidence rates of HIV/AIDS and other communicable diseases, and also high spread of injecting drug use among prisoners, the two key prevention strategies, that have been proven successful in the community and in prisons – opioid substitution and needle exchange programmes – have not been implemented yet. This is a major gap in running effective responses to HIV/AIDS in prisons.

This does not meet the ambitious goals of equivalence of healthcare inside and outside of prisons, formulated in the draft strategy on HIV prevention that “*all HIV prevention interventions that have been implemented outside prisons should be equally available also in prisons*” – needle exchange and opioid substitution treatment are mentioned as examples. The major approach in delivering treatment services is abstinence-based. Abstinence-based treatment programmes provide a good opportunity for those prisoners who wish and are able to change their drug use, there is a lack of provision of harm reduction measures for those who are not motivated or able to stop using drugs.

Not all the national prison administrations considered harm reduction to be a key priority. That risk behaviour is occurring in prisons has been acknowledged and demonstrates the need for a range of harm reduction measures.

Apart from HIV/AIDS, TB, hepatitis B and C are major challenges facing prisons in Estonia. This calls for a comprehensive and multi-disciplinary and comprehensive approach.

V. Recommendations for further improvement

On the basis of the UNODC/WHO/UNAIDS document “HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings” (2006), nine areas of successful actions leading to sustainable results that serve as a basis for future strategies to upscale interventions and measures of HIV/AIDS prevention, treatment, care and support are recommended. These include:

1. *Political leadership*
According to the Declaration of Commitment—United Nations General Assembly Special Session on HIV/AIDS [“UNGASS Declaration”], “Strong leadership at all levels of society is essential for an effective response to the [HIV/AIDS] epidemic.” This is particularly true in the area of prisons.
2. *Legislative and policy reform*
Recommendations to create frameworks of legislation, prison policy, and prison rules that promote effective and sustainable responses to HIV/AIDS in prisons.
3. *Prison conditions*
Recommendations to house prisoners in conditions that meet the recognized minimum international standards.
4. *Funding and resources*
Recommendations to develop and implement national and international funding plans to address HIV/AIDS in prisons on the national, regional, and local levels.
5. *Health standards and continuity of care and treatment*
Recommendations to meet international obligations to provide health care within prisons equivalent to that available to the outside population, and to ensure continuity of health care services between correctional institutions and jurisdictions, and between the prison and the community.
6. *Comprehensive and accessible HIV/AIDS services*
Recommendations to implement comprehensive HIV/AIDS prevention and education, voluntary counselling and HIV testing (VCT), HIV/AIDS care and treatment for prisoners, and drug dependence treatment programmes in prisons.
7. *Staff training and support*
Recommendations to provide all prison staff with the knowledge, training, and support on HIV/AIDS necessary to meet the requirements and responsibilities of their work.
8. *Evidence-based practice*
Recommendations to implement HIV/AIDS policies and programmes based upon established need, on empirical evidence of effectiveness, and evaluated models of best practice.
9. *International, national, and regional collaboration*
Recommendations to share knowledge and expertise on effective prison management and HIV/AIDS nationally and internationally, and to enhance the development of evidence-based practices by building upon the successes of other countries and jurisdictions

Generally, HIV/AIDS and related issues in all custodial settings (police detention, arrest houses, prisons and also within the probation service) should be more actively addressed in

Estonian drugs and HIV/AIDS strategies and more attention and resources should be paid to their implementation. This would include a more systematic monitoring and evaluation of HIV/AIDS and related issues in prisons in order to notify progression or persisting gaps. This includes also filling gaps in implementing strategies that have been agreed on in national action plans. Interventions should be evaluated in order to measure strengths and weaknesses and to develop a sustainable policy and practice.

1 Police Detention/Arrest Houses

A new order has been issued on 1st of January 2008 highlighting (amongst other issues) three new developments:

- A continuation of treatment started in the community in arrest houses.
- Medical staff will be employed in order to secure improved health care services.
- Questionnaires (one self administrating, one administered by health care staff) have been elaborated to assess the health status and needs of arrestees.

Facilitate communication of different institutions in order to identify an improvement of seamless provision of health care services (provision and throughcare of health care services, interagency cooperation, continuity of treatment: ARV and opioid substitution treatment).

Capacity building: Training for medical doctors and nurses of arrest houses on HIV/AIDS, other infectious diseases, and modalities of long-term pharmaco-therapy for opioid dependent arrestees. Information should be given back to the MMTs in the community in order to inform staff and clients of institutions of the possibility of continuation of treatment.

2 Prisons

In Estonian prisons drug problems form a major challenge for the health care service and the security of the whole. Efforts should be scaled up to address health and social risks for continuing drug use (especially transmission of BBVs and subsequently TB) by all means and continuously (methodologically with new efforts peer-support groups, training courses led by NGOs).

However, risk behaviour in general and drug use in particular will not be stopped by drug supply and demand reduction measures. Despite all efforts a substantial number of prisoners will continue to use drugs – also in a high risk ways like injecting. Establishing a pilot project on long-term pharmaco-therapy for opioid dependent prisoners seems to be a key approach to reduce transmission risks in the custodial settings. Tartu prison seems to be most eligible for this project, because qualification and willingness among professional staff seems to be present there. It may be helpful to include the NGOs with their experiences in this area into the discussions of designing such a project. It should be possible to start substitution treatment in prison without having previously been on a community based substitution programme.

A national strategy (with clear protocols and memorandum of understanding) should be prepared for the implementation of the substitution programme, in order to overcome problems with the transfer of prisoners between prisons, from prisons to the community, and from arrest houses to prisons and back.

Needle exchange pilot programmes should be considered for future implementation in adult institutions. A programme of staff training should be established to ensure the future cooperation of staff working in prisons and secure settings in such programmes.

Short hepatitis B vaccination schedules should be offered to all risk groups in prison (including staff). For imprisoned IDUs these short hepatitis B vaccination schedules have proven to be successful and would reduce their health burden.

A harm reduction strategy should be developed to ensure the provision of information and services to meet the health and social needs of prisoners;

- Harm reduction materials should be available for all prisoners both sentenced and pre-trial, and detainees in arrest houses. There should be clear procedures, measurable standards, monitoring and evaluation of the provision.
- Materials should be made available where appropriate to meet the needs of non-national prisoners (to overcome language and cultural barriers).
- Safer tattooing projects be provided or piloted within custodial institutions.
- Courses that address prevention and harm reduction in an interactive way (i.e. courses on the safer use of drugs and on safe sex) should be supported and provided on a regular basis for prisoners and staff.

Workshops in medical ethics in which problematic areas (human rights and ethical dilemmas between health and security) in prisons are dealt with¹.

Stronger implementation and possible adaptation of the trainings manual "Risk Reduction for Drug users in Prisons" (already available in Estonian).

The prevalence of drug use and sharing injection equipment among incarcerated women is in most countries higher than that among incarcerated men. Particular strategies have to be introduced for this target group.

Intensifying education and information in order to reach a higher proportion of HIV-positive prisoners to start ARV-treatment (e.g. in Murru prison only 27% receive ARV-treatment). Peer-support groups with assistance from NGOs can play a bigger role.

Close cooperation and links with community-based services need to be established.

Introduce case management for HIV/AIDS and TB patients to promote continuity of care across the system and facilitate patients' access to health services. Progress in this area will benefit of on-going assessment and evaluation of improvements in continuity of care.

Intensifying efforts to reach a higher compliance for patients receiving ARV-treatment after release (at the moment only approx. 50% continue their treatment).

The fact that only one third of the respondents knew about free access to disinfectants and more than two third knew about free access to condoms in the prison is indicating the fact that both prevention strategies are not fully understood and accepted by prisoners. The provision of condoms and lubricants needs a comprehensive and unified approach: Condoms should be made available anonymously, free of charge and without having to ask at the medical unit.

The NGO "Convictus" plays a crucial role in getting into contact with PLWHA, educate and teach them. Furthermore Convictus contributes considerably to a reduction of negative attitudes against HIV+ inmates.

Staff training is important in a number of areas and training was identified as a key issue by participants in the research. It is suggested that:

- The precise training needs of the staff working in prisons, custodial and secure settings should be evaluated in terms of the changing nature of the juvenile prison population.
- Courses that address prevention and harm reduction should continue to be supported and provided on a regular basis for staff.

1 See for instance: <http://www.lupin-nma.net>; accessed 28th of February 2008

- Courses that address drugs issues should be provided in order to decrease negative feelings towards drug users amongst some staff.
- Induction programmes and mentoring schemes should be provided for new staff, where appropriate.

It should be ensured that funding for HIV prevention, treatment, care and support in prisons is maintained for all activities supported by GFATM, including the involvement of NGOs.

3 Probation Service

Intensifying training for probation officers of the nature of HIV/AIDS and related diseases and health problems as well as capacity building in dealing with HIV/AIDS – related issues like counselling/treatment infrastructure in Estonia. The existent provision of condoms and information material in some offices is a good example of raising HIV/AIDS-related issues and health risks.

4 General

According to the Declaration of Commitment – United Nations General Assembly Special Session on HIV/AIDS [“UNGASS Declaration”], “Strong leadership at all levels of society is essential for an effective response to the [HIV/AIDS] epidemic.” This is particularly true in the area of prisons. Political leadership is needed to allocate funds and resources in order to achieve the same standard of health care for prisoners than for the other members of society. Permanent coordination and facilitation among the various stakeholders will be of crucial importance.

Training in social work faculty needs to be readjusted to the needs of the clients, especially in the field of HIV/AIDS prevention, treatment, care and support.

Financial and managerial separation of the (i) prison health system and (ii) of the health care in police detention and arrest houses from the rest of the health system might result in different levels and quality of care provided to detainees.

Health professionals working in prisons are employed by Ministry of Justice under different contractual conditions and might also have different opportunities for continuous training with respect to colleagues working within the health system. Health professionals working in police detention/arrest houses again have different contractual conditions and opportunities.

A limited monitoring and evaluation system impedes accurate assessment of public health programmes effectiveness, in particular in reaching target population. In the context of fragmentation, it is important that a comprehensive monitoring and evaluation (M&E) system is in place in all custodial settings. M&E could assist in identifying the overall effectiveness and efficiency of programmes, in particular when they assist the same target population in different settings and/or through different providers. What is required is good quality, bio-behavioural surveillance among populations in custodial settings every 2–5 years.

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Annex

List of experts interviewed

Institution	Experts
Convictus Estonia, interventions in prison settings	Latšin Alijev, Krista Joost, Alla Tannil, Jelena Tsõganova, H. Tarvis
Harju County Court	Anna Lebedeva, Ursula Murula, Merily Friedemann, Reet Ruubel
Low Threshold Centre "Allium"	Vjatšeslav Akimov
Ministry of Internal Affairs; Police Board	Veiko Kommusaar, Siiri Pars
Ministry of Justice, Tartu Prison	Aire Põder, Kristel Jürgens, Piret Paap, Hanna Sova
Ministry of Social Affairs	Ülla-Karin Nurm, Merlin Mäesalu, Maris Salekesin
Murru Prison	Krista Parts
Narva Police Department	N.N.
Narva Rehabilitation Centre for Alcoholics and Drug Users	Tatjana Magerova, Juri Magerov
National Institute for Health Development	Aire Trummal, Annika Veimer, Aljona Kurbatova, Kristi Rüütel, Ave Talu, Katri Abel-Ollo
Police Board	Tarmo Miilits, Melis Smit
Tallinn Prison	Ene Katkosilt
Tallinn Prison Hospital	Ülla Porgasaar
WHO	Jarno Habicht, Agris Koppel