

Prison Healthcare News

Newsletter of the project to promote better prison and public health in Eastern Europe and Central Asia

Editorial

IN THIS FOURTH ISSUE of the newsletter we have a number of hopeful developments to report. In Kazakhstan big changes are underway to improve prison health care and bring the treatment of prisoners with HIV/AIDS into line with the guidance issued by international organisations. In Ukraine part of a \$60 million loan from the World Bank for TB and HIV/AIDS control is to be assigned to a project in the prisons (see page 5). In Moscow in December 2002 a professional body for prison medical personnel from Eastern Europe and Central Asia was set up. The Russian Ministry of Justice has announced that all shutters must be removed from the windows of the pre-trial prisons by July 2003. In February 2003 the Ministries of Health and Justice in Kyrgyzstan held their first ever international joint conference on prison healthcare matters for prison medical personnel.

These developments are very welcome. However, they need to go hand in hand with a continued emphasis on measures to cut the number of prisoners so that overcrowding can be reduced and the risk of the spread of infectious diseases can be contained.

Vivien Stern, *Editor*
Anton Shelupanov,
Assistant Editor

POLICY CHANGES IN KAZAKHSTAN

In Kazakhstan 500 prisoners are known to be HIV infected. This represents a rapid increase in a very short time. The number of HIV positive cases has been increasing since 1997. The policy had been that all prisoners were required to submit themselves for testing and those found to be infected were kept in isolation. However, a new policy was announced in November 2002. The Ministries of Justice, Health and Interior have issued a joint instruction to their staff. The order was signed by the Minister of Health (order no. 893) on 25 September 2002 and by the Ministers of Justice (order no. 169) and Interior (order no. 728) on 20 November 2002 (the prisons holding pre-trial prisoners, SIZOs, are under the authority of the Ministry of the Interior).

Article 1 of the order provides for voluntary confidential testing of those held in places of detention. Article 3 states that HIV positive prisoners should not be segregated from the general prison population. These changes will bring practice in Kazakhstan into line with international guidance.

The instruction names Vice-Minister of Justice Mr Rahmibekov, Vice-Minister of Interior General Vlasov and Vice-Minister of Health Mr Aidarhanov as being responsible for implementing the new policy.

The healthcare service of the penitentiary system has established a computerised case-based surveillance system for TB. The new system will improve reliability of the TB data and allow analysis of the epidemiological position. It will also allow integration with the TB data from the civilian health service.



Dr Marat Akhmetov,
Head of Prison Healthcare,
Kazakhstan

Prison Medical Association established at Russian annual conference

At the conference in Moscow in December 2002 for the medical staff of the Russian penitentiary system (GUIN) the decision was taken to set up a professional body for prison medical personnel from Eastern Europe and Central Asia. The meeting was attended by high-ranking representatives of prison systems and health ministries from across the region.

The heads of prison healthcare services from CIS countries agreed to use the new professional association to co-ordinate prison and public health policy across the region and to reinforce the position of prison health professionals when dealing with other government departments.

page 2

The PHN Interview

Kasia Malinowska-Sempruch, Director of the International Harm Reduction Development Programme at the Open Society Institute in New York

page 4

News from the USA

page 5

New developments: Combating communicable diseases in

penitentiary systems in Ukraine, Russia and Kyrgyzstan

page 7

Recent CPT Report highlights: Netherlands, Slovenia, Lichtenstein, Denmark

page 8

News in Brief

Recent publication

Our readers write...

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The PHN Interview

PHN Assistant Editor Anton Shelupanov interviews **Kasia Malinowska-Sempruch, Director of the International Harm Reduction Development Programme at the Open Society Institute in New York.**

Please tell us a bit about yourself—where you were born, grew up, studied. I was born and grew up in Poland. I studied in the United States, first at Rutgers University and then at the University of Pennsylvania. Now, I am in a doctoral programme in public health at Columbia. I go back to Poland often, and even though the United States is now my home, Eastern Europe is where I come from and what I am about.

How did you get into the harm reduction field? I took a senior seminar on AIDS at Rutgers and knew that this would become my line of work. The class was amazing, exploring economics, gender inequalities, racism, and homophobia. An ACT UP activist explained the idea of civil disobedience and taught us how to safely take part in protests. Later, three Americans speaking at conferences in Eastern Europe offered me a harm reduction framework for running AIDS programmes in Poland. Robert Newman “converted” me to methadone, Ethan Nadelmann got me to think about drug policy, and Glenn Backes explained the amazingly simple and pragmatic way to prevent HIV infection among drug users.

What does “harm reduction” mean to you? Harm reduction is the most pragmatic, humane public health approach to drug use. It is premised on the conviction that it is more productive to integrate drug users into society than to separate them. It assumes that drug users, offered the opportunity, will make lifestyle changes that improve their overall health. The realistic goal of reducing the harms caused by drug use and draconian drug policies replaces the unrealistic goal of eliminating drug use altogether.

What shape can harm reduction programmes take? Harm reduction programmes meet drug users where they are, not where the rest of society would like them to be. Possible programme elements include a substitution therapy, a nurse who helps with an abscess, a friendly talk about sexual health, a syringe exchange, a referral to an HIV or sexually transmitted diseases (STD) physician, a shower and a sandwich, a warm cup of tea, and information about proper vein care if one is injecting. A colleague recently told me

about the need for harm reduction in Afghanistan, a country with a large number of heroin-addicted individuals who mostly smoke. Clearly, large-scale needle exchange programmes are not appropriate there, but drop-in centres are badly needed.

In what way is the implementation of harm reduction programmes different in prison than in other settings?

Implementing harm reduction in prisons should not be any different than in other settings. But unfortunately it is different because the unwillingness to officially accept that some people are using drugs may be even greater in prison than in the “outside” world.

What is your current assessment of the situation with infectious diseases and addiction in the region?

We are still only learning about drug use and HIV in our region. We have never before experienced drug use or trafficking through our region on such a scale. The drug landscape in Central Asia today is totally different than it was only five years ago.

Is there a gender issue? Is the situation worse for women? We know little about women and drug use. The number of women clients at needle exchange sites is usually from 5 to 20 percent. The easy answer is that the small percentage reflects the low number of women using drugs.

I do not think this is the case, however. The stigma associated with being a drug-using woman or worse, a drug-using mother, is so great that it prevents women from using services. Very few mothers will come to a needle exchange site, a place that, by association, identifies you as a user. For the same reason, women do not disclose their drug use to physicians and often choose not to seek medical services at all. In sexual relationships among drug users, women often inject second and sell sex to provide drugs for themselves and their partners, increasing their vulnerability to HIV.

What examples of successful harm reduction programmes are there from the region? There are a number of excellent harm reduction programmes.

When we started our initiative a few years ago, we never expected that harm reduction would take hold this strongly. All except two countries of Eastern Europe and the former Soviet Union have functioning harm reduction programmes. We cannot say the same for harm reduction in prisons, but here too there are excellent pilot projects that can be extended in Moldova, Kyrgyzstan, and Russia.

Are governments accepting of harm reduction programmes? This is a difficult question because government acceptance can be defined in various ways. A minimal measure of acceptance, present in all of the region's countries, is to permit harm reduction programmes to exist. Some governments contribute substantive financial resources to scale up programmes established by outside funding. Others go even further, funding harm reduction programmes without external support. Many governments have included requests for harm reduction funding in their proposals to the Global Fund. This important development indicates even greater acceptance. When resources are made available, governments welcome expansion of harm reduction programs.

How can one persuade governments of the value of harm reduction? The experience of the Open Society Institute has shown that "seeing is believing" was the right policy for our region. We started pilot programmes first and only then started to persuade government officials and others of their value. When morality, prejudice, and personal beliefs are involved, it is best to provide proof—to show that active drug users will use services offered in a respectful manner and that they will, in fact, manage to stabilize their lives.

Do such programmes encounter public opposition, and if so, what can be done to persuade public opinion to support them? A concerned neighbour of a needle exchange site will not be persuaded until he or she knows from experience that their children are not endangered. There is nothing we can say to convince them. We can simply show. The programs OSI supports devise different strategies to ameliorate negative public opinion. In St. Petersburg, for example, the mobile needle exchange decided to offer to check the blood pressure of the elderly, because the elderly were upset that drug users were getting care and they weren't. What a brilliant way to intervene and find allies in a potentially difficult moment! Each project has its own story – a story that is inspiring, brave, and full of wisdom.

Are donor bodies keen on harm reduction programmes?

As it becomes internationally known that drug use and consequently HIV are a major problem in our region,

donors are coming in with offers of support. The general situation looks much better this year than we had expected, but there is still a lot that is needed. We still have a long way to go in order to scale up the range of services necessary to have a real impact on the spread of HIV.

Prison staff sometimes feel threatened by harm reduction initiatives. What message, if any, have you got for them? Like anything new, harm reduction efforts in prisons are met with apprehension because they expose the existence of drugs behind bars. Many officials feel this is a poor commentary on them as professionals, for "letting the drugs in." The truth is that prison officials know that the problem exists and that something needs to be done. Making the arguments for harm reduction in quiet, informal discussions, as well as backing them up with examples from neighbouring counties, has shown some success. It is important, however, to put this in perspective: many are not interested and may never be persuaded. The ones willing to engage in a dialogue about harm reduction are certainly in a minority.

How do you see the position of the prison medical staff? Is it important that they embrace harm reduction work?

Successful harm reduction programmes rely on the medical staff of prisons to act as intermediaries. They attempt to offer some confidentiality to their patients. They are the ones whose job is to be helpful to prisoners; they are the closest to public health philosophy. Without them, the successful programmes we fund would not be successful.

How important are links between public and prison health services? How close do you feel these links should be? In many ways, the prison health system must deal with failures in public health approaches. It is therefore important that prison medical personnel participate in deciding whether prison is the right place for drug users. It would be powerful to have doctors and nurses working with prisoner advocates against minimum prison sentences and prison sentences for possession of drugs, and to have them argue that drug addiction is a recognized medical condition that should be treated appropriately. Locking up heavily addicted drug users without offering them maintenance therapy has grave medical consequences.

Do you think that the pace of prison reform in the region is quick enough? It is neither fast enough nor comprehensive enough. My view is that drug users should not be imprisoned for their drug use or drug possession. And until this discussion takes place, no reform will be quick enough.

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PHN Interview cont'd.

How do you see the health situation in the region in 10 years? We often hear that our region has a window of opportunity to prevent a large-scale HIV epidemic. If the estimates in Russia and Ukraine are correct, however, and we in fact already have 1 million Russians and 250,000 Ukrainians infected with HIV, this may no longer be true. It is true in other, smaller countries. How will the story evolve regionally? I am not sure. I do not feel very optimistic.

How can one ensure the political cohesion of harm reduction policy across the region? Harm reduction needs to be integrated into all relevant policies now being amended or created, including national AIDS programmes, drug control programmes, the work of the ministries of social welfare, education, interior and justice. For now, only health and public health people are taking on the issue. But they cannot do it alone. If drug users fear police harassment, for example, even the best of public health interventions will not work.

Could international bodies, especially the World Health Organization, be doing more to promote harm reduction? Yes. It is crucial that the voices of “standard setters” are raised in support of harm reduction among marginalized and vulnerable populations. And it is important that the message is not threatening to the general population, nothing alarmist like, “If you do not deal with drug users, the epidemic will spread.” But rather, that the message emphasize our humanity and our similarities, recognizing drug users as members of our community and our families, as our friends.

Imagine that you are minister of health of a large East European or Central Asian country for a day. What would you do? I would try to get other ministers, including the minister of finance, together to develop a strategy that works across all their portfolios. I would ask them to add AIDS and drug use to their itineraries as they visit other countries and to learn about what was done in Germany, the UK, the Netherlands, Switzerland, Australia, and elsewhere. I would discuss with the Ministers of Justice and Interior the possibility of changing policing practices to remove the arrest quotas. I would publicly support those who struggle with drug use and AIDS and encourage their families.

I would ask schools not to expel kids who do drugs but to offer them even more care and support. I would put together a group to create a proposal to the Global Fund that would include a full range of HIV treatment programmes for everyone who needs it, along with methadone to stabilize drug-using patients. And that would just be the first week.

News from the US

Outbreak in Los Angeles County Jails

More than 1000 prisoners in Los Angeles County Jails were infected with drug-resistant Staphylococcus infections in 2002. This is the largest outbreak of this infection ever to be reported in US prisons. The infection can cause deep abscesses and can be fatal if it spreads to the blood and the patient fails to respond to the antibiotics. The infection is believed to be spread by skin to skin contact or sharing personal items.

Associated Press 31 January 2003

New guidelines for Hepatitis B

Hepatitis B is 100 times more infectious than the AIDS virus and 10 times more infectious than hepatitis C. Prisoners in the United States are four times more likely to be infected than the general population. The Centers for Disease Control and Prevention (CDC) have issued new guidelines which strongly recommend that all prisoners should be given hepatitis B injections. Also, hepatitis A vaccinations should be given to all prisoners at risk, including drug-users and men who are involved in sexual activity in prison.

These guidelines replace earlier guidelines which only recommended vaccinations for long-term prisoners.

Corrections Journal, Vol 6 No 16

Reforms of the treatment of mentally ill prisoners

Los Angeles county jails hold about 20,000 prisoners. Of these about 2500 are mentally ill. In 1996 Justice Department officials ruled that the mentally ill prisoners were not being adequately cared for according to the law.

After years of discussions a new framework for dealing with mentally ill prisoners had been agreed. All incoming prisoners will be given a mental health screening. Personnel will be trained to administer immediate measures when a prisoner tries to commit suicide and will also be trained to deal with prisoners who have tried to hang themselves. All mentally ill prisoners will be kept in a humane environment.

Corrections Journal Vol 6 No 16

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Combating **communicable diseases** in penitentiary systems

World Bank loan for Ukraine

In December 2002 the World Bank approved a \$60 million loan to Ukraine for a tuberculosis and HIV/AIDS control programme with a large emphasis on the penitentiary system. The loan is the first to be approved by the World Bank to a European country for this purpose. The aim is to stabilise the two epidemics and strengthen Ukraine's capacity to deal with them effectively.

The Ukraine government has established a national programme to fight TB for the years 2002 to 2005. The World Bank loan will support this programme by improving diagnosis of TB, introducing DOTS treatment and setting up a better reporting system. HIV started to spread rapidly from 1995 especially amongst injecting drug-users. Official government figures shows that in January 2002 there were nearly 45,000 HIV positive people. UNAIDS estimates that many cases will not be registered so there are actually nearly a quarter of a million HIV positive people in Ukraine, equal to one per cent of the whole population.

Finance for the penitentiaries

The World Bank programme will last four years and has three parts. Part three will finance TB and AIDS control activities in the penitentiary system. It was essential to include the penitentiary system because prisons fuel the infection of both TB and HIV. According to the World Bank, about 30 per cent of all TB patients in Ukraine are in the penitentiary system. The problems in the prisons of overcrowding, malnutrition, late diagnosis and shortage of medicines aggravate the situation. Out of the 200,000 prisoners about 14,000 have active TB. Of all the deaths of prisoners about 40 per cent are due to TB.

The HIV epidemic is highly concentrated amongst



Prisoners in a penal colony in Central Asia

people who inject drugs or work as prostitutes and they too are likely to be found in prison.

The loan to help the prison system deal with TB will be \$9.2 million. It will help the prison system to improve its diagnosis, treatment and monitoring of TB. The treatment given will follow WHO guidelines for DOTS plus. DOTS plus is the appropriate treatment strategy because of the high levels of multi-drug resistant TB to be found in the prisons. Prison doctors and other health workers will be trained in close collaboration with the Ministry of Health. The Ukraine Government will provide drugs to the value of \$2.6 million. Second-line drugs for patients suffering from multi-drug resistant TB may become available in the third year of the project once the other basic elements are in place and there is capacity to test infected prisoners for drug resistance.

Condoms and disinfectant

The AIDS programme in the prisons will cost \$3.5 million. It will improve HIV prevention amongst prisoners. The main methods will be through

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information, education and communication. Condoms and bleach disinfectant will also be provided. Work will also be done to prevent transmission from mother to child and to treat all children under 3 years old.

The whole project will be managed by a Supervisory Council chaired by the Vice Prime Minister which will bring together the Ministry of Health and the State Department of Prisons. The work will aim to improve the referral of released prisoners to the Ministry of Health. The prison system project will use the same TB registers as the Ministry of Health.

For more information on the project see www.worldbank.org

Reform programme underway in Kyrgyzstan

Changes in the penitentiary health care system are an important part of the reform of the penitentiary system in Kyrgyzstan.

The view that changes were needed was expressed by Ministry of Justice and Ministry of Health representatives at a seminar held in Bishkek in February 2003. This was the first public event in Kyrgyzstan where penitentiary and civilian health services were discussed together and information on the health situation in penitentiary institutions made publicly available. The seminar was attended by representatives from the Republican AIDS Centre, NGOs, and the public health service.

Important policy issues such as the treatment of HIV infected prisoners were discussed and participants had the opportunity to hear of the experience of Kazakhstan in moving to no segregation, no compulsory testing and medical confidentiality. New developments in the legal base for the coordination of prison and public health services in Kazakhstan were also explained. Through the participation of UNAIDS participants were given the latest information on how transmission occurs and how to prevent it. The seminar heard about the pilot needle exchange project run in one prison in Kyrgyzstan by the Soros Foundation. The Moldovan experience in organising harm reduction activities in prisons was also put forward

The seminar also gave prison doctors their first opportunity to participate in a public discussion about their important role and their need for clinical independence. It gathered support for new policies that prevent the spread of infection and protect

prisoners rights. Finally it strengthened the regional network between penitentiary medical staff in Kazakhstan and Kyrgyzstan and laid the basis for an exchange of expertise.

The seminar was organised by Penal Reform International's Almaty office, and the Ministries of Justice and Health in Kyrgyzstan.

Penitentiary medical department set up in Tajikistan

Healthcare reform is a major part of the reform of the penitentiary system in Tajikistan. In July 2002 the responsibility for the prison system was transferred from the Ministry of Interior to the Ministry of Justice. In February 2003 a penitentiary medical department was set up. A new draft law on the penitentiary system is being produced that will include a chapter setting out the requirements for prison health care.

Disease control in North West Russia

A new project funded by the European Union will start in April 2003 in the penitentiary system in two pilot regions in North West Russia. The regions are Leningrad Oblast and St Petersburg and Pskov Oblast. The aim of the project is to improve the prevention and control of communicable diseases. It will address the health of the prison population as well as the interaction between the penitentiary institutions and the civilian public health services. The project will focus on primary and secondary prevention of TB, HIV/AIDS, sexually-transmitted diseases and viral hepatitis.

The project has a number of specific aims in the pilot regions. The project identifies a number of specific problems in the penitentiary system. According to the European Commission, around 20 to 25 per cent of prisoners are resistant to the main anti-TB drugs. About 42 per cent of all Russian TB patients and at least 60 per cent of all those with multi-drug resistant TB, are in prison. Each year about 300,000 prisoners are released from penitentiary institutions. Between 10,000 and 30,000 of these have active TB. The death rate from TB in the penitentiary system is about 180 per 100,000. It is estimated that about 30 per cent of prisoners released during their treatment do not attend the civilian health services on release.

Highlights from reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

The only region of the world with a supra-national inspection mechanism for its places of detention is Europe. The European Committee for the Prevention of Torture and Other Inhuman and Degrading Treatment or Punishment is the only inspection mechanism of places of detention that allows citizens of a state to inspect the institutions of another state and report their findings. In Prison Healthcare News from time to time we shall be bringing to the attention of our readers comments made by the CPT on prison health in the countries they inspect. We shall be doing this not to highlight the shortcomings of the countries visited but to give an insight into what standards the CPT expects and what role it expects prison healthcare staff to fulfil.

Visit to the Netherlands

The Committee visited the “Extra Security Institution” at the Nieuw Vosseveld Prison Complex. This is a special unit holding 14 prisoners in conditions of very high security. The Committee criticised the conditions under which the prisoners were held as being a potential threat to their mental health. They also criticised the system where physical examinations by the prison doctor took place in the presence of prison personnel. The Committee recommended that ‘all medical examinations should be conducted out of the hearing and – unless the doctor concerned requests otherwise in a given case – out of the sight of prison officers.’

Report to the Authorities of the Kingdom of the Netherlands on the visits carried out to the Kingdom in Europe and to the Netherlands Antilles by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) in February 2002, Strasbourg, 11 November 2002.

Visit to Slovenia

The Committee visited Dob, Ljubljana and Maribor Prisons in 2001. In Ljubljana Prison they saw a seriously mentally ill prisoner who had been kept in solitary confinement for several months, without being given proper medical help. The establishment’s Director reported that ‘it was difficult to arrange his transfer “because doctors were of a different opinion than the management”. The Committee recommended that mentally ill prisoners should be cared for in appropriate facilities with proper psychiatric care.

The Committee also noted that a substantial proportion of the prisoners were taking psychiatric medication, including tranquillisers, hypnotics, antidepressants and neuroleptics. Prisoners interviewed at each of the three prisons visited by the Committee claimed that tranquillisers were being prescribed generously in order to “keep prisoners quiet”.

Report to the Slovenian Government on the visit to Slovenia carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 16 to 27 September 2001, Strasbourg, 18 December 2002

Visit to Lichtenstein

The Committee visited Lichtenstein in June 1999. There is one prison in Lichtenstein, Vaduz Prison. The Committee was concerned about pre-trial prisoners held there in conditions that amounted to solitary

confinement. The CPT stressed that whenever a prisoner held in such conditions asks to see a doctor or a member of staff asks for such a prisoner to be seen by a doctor, there should be no delay in arranging a doctor’s visit. The doctor should conduct a medical examination, and make a written statement of the prisoner’s physical and mental condition. The consequences of continued isolation should also be assessed and the written statement should be sent to the competent authorities.

Report to the Government of the Principality of Liechtenstein on the visit to Liechtenstein carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Strasbourg, 27 November 2002

Visit to Denmark

The Committee visited Denmark in January – February 2002. At Vridsløselille Prison the Committee found that psychologist and psychiatrist reports about prisoners’ treatment were kept in prisoners’ general administrative files, and were therefore accessible to non-medical personnel. The Committee stressed the importance of medical confidentiality.

The Committee also reported that prisoners had to wait too long for medical attention and follow-up once medical problems had been discovered was inadequate. One prisoner with serious chest problems was only examined by a nurse 17 days – and by a doctor 20 days – after his arrival. The CPT found this unacceptable.

The CPT commended the measures being taken to deal with prisoners with drug problems. They noted that preventive measures had been introduced, such as making available condoms to prisoners and disinfectant for needles.

In the view of the Committee the presence in prisons of many prisoners with drug-related problems requires a range of services. They suggest that medical detoxification, psychological support, life skills, rehabilitation and substitution programmes for opiate-dependent patients who cannot discontinue taking drugs should be available.

Report to the Government of Denmark on the visit to Denmark carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 28 January to 4 February 2002, Strasbourg, 25 September 2002.

Recent publications

Drug-users in prison in the European Union

At least half of the 365,000 prisoners in the countries of the European Union have a history of using illegal drugs. This is the estimate made by the European Monitoring Centre for Drugs and Drug Addiction based in Lisbon in a briefing paper published in February 2003 entitled 'Treating Drug Users in Prison'. The Centre also says that rates of infection associated with drug use such as HIV, TB and hepatitis are high amongst prisoners. Many prisoners leave prison to return to drugs and crime. Therefore dealing with the addiction problems whilst the prisoners are in prison is important for public health and for crime prevention.

The paper notes that programmes for the exchange of syringes exist in Spain and some prisons in Germany. Disinfecting materials for cleaning syringes is provided more widely in prisons in EU countries. Most drug-addicted prisoners entering prison do not receive the well-developed services to help them that they need.

Drugs in Focus: Treating drug users in prison – a critical area for health promotion and crime reduction policy www.emcdda.eu.int

Our readers write ...

From Lucica Ditiu, TB Medical Officer for the Balkans, World Health Organisation

'I am receiving 'Prison Healthcare News' and I appreciate very much this initiative of the project. There are several things happening in the Balkan area in the area of TB and

HIV/AIDS control in prisons as well as the integration of these Control Programmes into the 'civilian – community' programmes. There are several people interested in receiving this newsletter both from Prison sector and public health sector.'

News in Brief

Drop in HIV cases in Latvia

There has been a drop in new HIV cases in Latvia in 2002. Between 2001 and 2002 a drop of one-third was recorded. The head of Latvia's AIDS Prevention Centre said that the drop was a result of prevention work with drug users and society as a whole. The population of Latvia is 2.35 million and it has 2307 recorded cases of HIV 81 per cent of the HIV infected population lives in the capital Riga.

Agence France Presse 15 January 03

Removal of shutters in Russia

The Ministry of Justice in Russia has announced that the heavy shutters are to be removed from the windows of all the pre-trial prisons by July 2003. The shutters prevent the entry of light and fresh air and thus contribute to the spread of infectious diseases.

Source: Address by Deputy Head of the Penitentiary System to the Council of Baltic States Conference on Pre-Trial Detention, St Petersburg, February 2003

Seminar on pre-trial detention

Removal of the shutters in pre-trial detention centres was urged as a priority by the seminar on pre-trial detention organised by the Council of Baltic Sea States in February 2003 and held in St Petersburg. The meeting also recommended that prison and public health should work together and share information.

South Africa

A South African ex-prisoner with HIV has reached an out-of-court settlement after suing the prison authorities. The prisoner claimed that he contracted HIV in prison, where he had unprotected sex with another prisoner. He was in prison in 1993-4, when condoms were banned, before the policy was changed in 1996. 41% of South African prisoners have HIV, according to research published last year by KC Goyer from the South African Institute for Security Studies.

Source: BBC News, 13 February 2003

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Design and Print: **Intertype**