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INFECTIOUS DISEASES

HIV prevention in prisons

Do international guidelines matter?

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Background: In spite of the availability of international guidelines, HIV prevention and management of care in prison is still unsatisfactory in many countries. Factors affecting the quality of HIV prevention policies in prison have not yet been elucidated. The present study had two aims: i) to assess national HIV prevention policies in prison in a selected group of countries; and ii) to determine which factors influenced such policies at the country level. Methods: HIV prevention policies in prison were reviewed comparatively in Moldova, Hungary, Nizhnii Novgorod region of the Russian Federation, Switzerland and Italy. The review of HIV prevention policies in prison was conducted through interviews with government officials, non-governmental organizations, professionals involved in this field, and visits to selected prisons. Information on the health of prisoners, including tuberculosis, sexually transmitted diseases, and other infectious diseases has also been collected. Results: The results indicated that all countries had adopted a policy, irrespective of the burden of HIV infection in the prison system. The content of the policy mirrored the philosophy and strategies of HIV prevention and care in the community. The 1993 WHO Guidelines were fully implemented only in one country out of four (Switzerland), and partially in two (Italy and Hungary). Conclusions: A greater effort aimed at dissemination of information, provision of technical know-how and material resources could be the answer to at least part of the problems identified. In addition, greater national and international efforts are needed to stimulate the debate and build consensus on harm reduction activities in prison.

Keywords: health policy, HIV prevention, prisons

Prisons are increasingly emerging as a critical area for HIV prevention, due to the high concentration of persons with behaviours at risk for HIV transmission and the scarcity of prevention means.[1] Studies conducted in several countries have shown that imprisonment remained significantly associated with HIV infection among injecting drug users (IDUs) after adjustment for other risk factors.[2–4] Furthermore, HIV transmission in prison has been documented in a number of countries.[5]

The World Health Organization (WHO) has issued technical recommendations for the management and prevention of HIV infection in prisons on two separate occasions, 1987 and 1993.[6,7] The 1993 WHO Guidelines emphasize voluntary testing, confidentiality, non-discrimination of HIV-positive inmates, availability of prevention means, and access to treatment equivalent to that in the community. However, several surveys have pointed out that HIV prevention and management of care in many penitentiary systems are still far from satisfactory.[1,3,8–10] Factors that hamper the implementation of the 1993 WHO Guidelines in penitentiary institutions have been the object of little systematic evaluation so far.

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In particular, it is not clear whether the content of the 1993 WHO Guidelines is inappropriate or too ambitious for prison settings, or whether insufficient efforts were made to disseminate and implement them. To answer these questions, a comparative study of HIV prevention policies in the penitentiary system of five Eastern and Western European countries has been conducted, with two main objectives:

- to assess the current situation of HIV prevention in prison in a selected group of countries; and
- to determine which factors influenced the national policies of HIV prevention and care in the prison system.

The results of this study will hopefully assist governments, National AIDS Programmes, and prison administrations in the evaluation of present policy choices and in the development of appropriate responses.

METHODS

Four countries have been selected for this study, two in Eastern and two in Western Europe: Moldova, Hungary, Italy, and Switzerland. In addition, the region of Nizhnii Novgorod, a large administrative region of the Russian Federation has also been included. It will be considered as the fifth country throughout the report, its HIV prevention policy in prison being that of the Russian Federation. The five countries differ considerably in terms of traditions, organization and resources of the penitentiary system, prevalence of HIV infection in

prisons, and implementation of prevention activities. These differences, however, are key to highlight the complexities of HIV prevention in Eastern and Western European prisons.

Traditional methods of policy analysis, which include both qualitative and quantitative approaches, have been employed. The review of HIV prevention policies in the penitentiary system has been conducted during visits to each country, from May 1997 to February 1999. Information has been sought from government officials, non-governmental organizations concerned with HIV/AIDS and prisoners' human rights, and professionals involved in this field, as well as through interviews with UNAIDS officials and members of the Committee for the Prevention of Torture of the Council of Europe. A list of institutions contacted in each country is given in *Appendix 1*. Interviews were conducted in English, Italian, and French. In Moldova, Nizhnii Novgorod and Hungary the presence of an interpreter has been necessary during most interviews. For each country quantitative data on the year of onset of the HIV/AIDS epidemic, the cumulative number of AIDS cases (or number of reported HIV infections), and the percentage of HIV/AIDS cases accounted for by drug use were extracted from national statistics. In addition, the rate of prisoners per 100,000 population and the estimated percentage of HIV-infected prisoners was reported.

The analysis of the country policy's objectives and implementation, and the identification of the most important policy players have been conducted following the general framework provided by Reich.[11] Policy analysis has been complemented by collection of available information on the health of prisoners, in particular HIV/AIDS, tuberculosis, sexually transmitted diseases (STDs), and other infectious diseases routinely collected through the prison health information system. Early in the study it became clear that it was impossible to understand HIV prevention policies in prison outside the context of the national HIV prevention policy for society at large. Accordingly, the latter has also been reviewed in each country, with special attention to HIV prevention among injection drug users (IDUs).

Finally, it was possible to visit prisons in Moldova, Nizhnii Novgorod, Hungary, and Switzerland, while permission was not granted in Italy. A detailed review of each country results is available upon request.

RESULTS

Summary information on the HIV/AIDS epidemic in each country is shown in *table 1*. The five countries studied differed in terms of HIV/AIDS prevalence in the community, onset of the epidemic and main mode of transmission. Switzerland and Italy had the highest cumulative incidence of AIDS cases in Europe, long established drug markets, and a substantial percentage of AIDS cases accounted for by drug use. In contrast, Moldova and Nizhnii Novgorod experienced a recent HIV/AIDS epidemic, intravenous drug use being the main mode of transmission. Finally, Hungary had a very low cumulative incidence of AIDS cases, and only one case accounted for by drug use, the main mode of transmission being represented by men having sex with men.

At the time of the visits the Ministry of Justice was responsible for the prison system in four of the countries considered, while in Switzerland the various cantons were in charge of prisons *(table 2)*. The five countries differed in the rate of incarcerated population, and prison overcrowding was serious in Italy, and very dramatic in Moldova and Nizhnii Novgorod Region, especially in the pre-trial detention centres. The most relevant health problems identified by prison health authorities were strictly dependent on the living standards in prisons, and on the composition of the prison population. Malnutrition, tuberculosis, and STDs were very serious in Moldova and Nizhnii Novgorod region.[19,20] Infectious diseases control was not a problem in Swiss prisons, where a high prevalence of mental health problems and heavy smoking had been revealed by a national survey of institutionalized populations.[21] In Hungary mental health problems were considered important by prison doctors, while the control of infectious diseases did not pose any problem. Little epidemiological information on the prevalence of infectious diseases and other conditions was available in Italy. However, several independent observers indicated the health consequences of overcrowding as the major health problem in Italian prisons, followed by the high prevalence of HIV infection among prisoners.

Table 1 Summary data on the HIV/AIDS epidemic

	Total population	Year of onset of the HIV/AIDS epidemic	Cumulative number of AIDS cases (or number of reported HIV infections)	Percentage of HIV/AIDS cases accounted for by drug use
Moldova	4,490,000	1987	97[a]	81
Hungary	10,246,000	1985	265[b]	0.4
Nizhnii Novgorod Region	3,500,000	1996	652[c]	~ 80
Switzerland	6,995,000	1982	4,995[d]	35
Italy	57,193,000	1982	~ 37,000[e]	58

a: Number of HIV infected, as of 25 March 1997.[12]
b: Cumulative number of AIDS cases as of 30 September 1997.[13]
c: Number of HIV infections reported, as of 17 February 1999.[14]
d: Cumulative number of AIDS cases as of 31 December 1995.[15]
e: Cumulative number of AIDS cases as of 31 December 1996.[16]

Health care in prison was differently organized in the five countries, but nowhere was it part of the national health care delivery scheme. In Moldova, Hungary and Nizhnii Novgorod Region medical services were a specific unit within the prison administration department and prison physicians were employed by the prison administration. In Italy approximately 4,000 contract physicians, both specialists and general practitioners, provided health care to prisoners. Contract physicians were not part of the administrative structure of the MOJ, and they did not hold positions of responsibility within the prison administration. Finally, in Switzerland the different cantons had their own arrangements, often under the responsibility of the Director of Justice and Police.

The impact of HIV in the prison systems was largely influenced not only by the prevalence of IDUs in society and by the degree of HIV infection among IDUs, but also by the sentencing policies adopted by each country for drug-related crimes. Sentencing policy was strict in Italy and Nizhnii Novgorod Region, leading to a high number of incarcerated drug addicts. The number of drug addicts in prison was still limited in Moldova and Hungary, due to the recent onset of drug addiction in the former and to the adoption of a policy of alternative punishment (detoxification in the community) in the latter country. Switzerland fell between the two extremes, with about one-third of prisoners convicted for drug-related crimes.[22]

The prevalence of HIV-infected prisoners is shown in *table 2*. With the exception of Switzerland, information on prevalence of risk factors in prison was anecdotal, for two main reasons. First, the penitentiary administrations lacked the necessary epidemiological skills and/or the resources to implement specific studies, and second some issues such as sexual violence and availability of illicit drugs within prisons were considered quite sensitive, and it was preferred to ignore them.

Overall, in the five countries considered the prison health administration dealt with any health problem using its own skills and resources, sometimes admittedly inadequate, without collaborating with other sectors of the public administration or receiving attention from non-governmental sectors. HIV/AIDS, however, represented the exception. The recognition of the problems linked to HIV prevention and management in prisons followed different paths in the countries studied. However, the local associations against HIV/AIDS played a key role in identifying the problem, soliciting solutions, and providing external support and advocacy throughout. Both the voluntary sector (better developed for historical reasons in Switzerland and Italy, and less in Hungary, Nizhnii Novgorod Region and Moldova) and the National AIDS Programmes considered HIV/AIDS as a global problem, investing all sectors of society. Prisoners became a legitimate target of advocacy and support. The activity of the associations had different emphasis in the five countries. In Italy the Italian League against AIDS (LILA) focused its attention on legislative changes aimed at early discharge of prisoners with AIDS, according to the principle of incompatibility between AIDS and prison. In Switzerland the National AIDS Commission suggested investigating the situation in Swiss prisons already in 1986, and continued monitoring the situation thereafter. In Hungary the National AIDS Programme started an early collaboration with the Prison Service, providing information material and medical supervision to HIV positive prisoners. In Moldova the United Nations Theme Group, the local association of international organizations against AIDS, funded the first seminar on HIV prevention in prisons. Finally, in Nizhnii Novgorod the local Association for Human Rights received letters from inmates with HIV/AIDS complaining about their situation, and decided to contact an international NGO for technical support.

HIV prevention in prison, and in particular harm reduction strategies, mirrored harm reduction strategies in society, which were in turn affected by the prevalent attitude towards drug addiction and its cure. Only Switzerland had implemented a wide spectrum of harm reduction activities in the community, ranging from exchange of syringes to prescription of heroin under medical supervision. These activities were a well-established pillar of the federal policy to fight drug addiction, and enjoyed large public opinion support as a necessary medical treatment to persons affected by a severe disease. In contrast, in Italy harm reduction activities were still debated and not widely implemented, in spite of the large proportion of HIV infection accounted for by intravenous drug use. In Hungary, the authorities in charge of drug addiction

Table 2 Institutional responsibility for penitentiary institutions, rate of inmates per 100,000 population, and number of HIV-positive prisoners

	Institutional responsibility	Rate of prisoners per 100,000 population	Percentage of HIV-infected prisoners
Moldova	Department of Penitentiary Systems, Ministry of Justice	219 per 100,000	~ 0.1[a]
Hungary	Hungarian Prison Service, Ministry of Justice	124 per 100,000	0.03[b]
Nizhnii Novgorod Region	Regional Administration of Penal Institutions, Ministry of Justice	800 per 100,000	0.8[c]
Switzerland	Department of Justice and Police, Cantonal authorities	81 per 100,000	4–12[d]
Italy	Department of Penitentiary Institutions, Ministry of Justice	83 per 100,000	~ 7[e]

a: Testing was limited to a few prisons.
b: Based on testing of all new admissions.
c: Based on testing of all new admissions.
d: Based on voluntary testing in selected prisons.[17]
e: Based on voluntary testing of about one third of new admissions.[18]

were still developing a national policy, but they were not in favour of harm reduction programmes. Only one needle exchange programme, implemented by a local NGO with international funding, was functioning in Budapest by the end of 1997. In Nizhnii Novgorod Region the federal legislation strongly discouraged any harm reduction programme. Finally, Moldova did not have any treatment or harm reduction programme at the time of the study, but a syringe exchange pilot project was considered.[23]

In our sample, Switzerland was the only country that adopted an active policy of HIV prevention and care in prison, including harm reduction activities, based on the principle of equivalence of prevention and care between prison and the community *(table 3)*. In Italy HIV policy in prisons focused on information, provision of care to HIV/AIDS cases, and early discharge of the terminally ill, while harm reduction activities, and in particular bleach, syringe exchange and condoms, were not implemented nor under consideration. In Moldova the prison administration intended to start a rather active programme of information and possibly some harm reduction activities in the prison system, fearing the extension of the HIV/AIDS problem to an unmanageable level, as in neighbouring Romania and Ukraine, countries with which Moldova had frequent exchanges. In Hungary, information was provided to all prisoners, but no harm reduction programme was implemented. HIV screening and isolation of positive cases was implemented to protect HIV-negative prisoners from the risk of becoming infected through sexual intercourse. In Nizhnii Novgorod Region the official policy in prison focused on mandatory screening and isolation of HIV-positive prisoners to protect other prisoners and staff.

Table 3 HIV/AIDS prevention in prisons: main policy objectives

Moldova	
	To provide information to all prisoners
	To implement limited harm reduction activities
Hungary	
	To provide information to all prisoners
	To protect HIV-negative prisoners from HIV transmission
Nizhnii Novgorod Region	
	To protect HIV-negative prisoners and prison staff from HIV transmission
Switzerland	
	To provide information to all prisoners
	To ensure equivalence of prevention and care between prison and the community, including provision of harm reduction activities
Italy	
	To provide information to all prisoners
	To provide treatment to HIV-positive/AIDS prisoners equivalent to that in the community

The main aspects of policy implementation in the countries considered are summarized in *table 4*, according to the main items of the 1993 WHO Guidelines. Voluntary testing was applied in Switzerland and Italy, but in the latter confidentiality of test results was not assured. Testing was mandatory and results not confidential in Hungary and in Nizhnii Novgorod Region, while mandatory screening was started in Moldova and then stopped for lack of funds. Treatment of HIV/AIDS cases was equivalent to that available in the community in four out of five countries, ranging from no treatment in Moldova, to treatment with AZT in Nizhnii Novgorod Region, to treatment with triple therapy in both Hungary and Switzerland. In Italy treatment with triple therapy was considered experimental in the community, and it was not yet available in prison. Concerning HIV prevention, information was provided in three out of five countries, while harm reduction activities (provision of condoms, disinfectant or syringes) were seldom implemented. In Moldova, Nizhnii Novgorod and Italy condoms were not made available. Harm reduction activities for IDUs, including syringe exchange and methadone maintenance, were implemented only in Switzerland out of the five countries considered.

DISCUSSION

The first goal of the study was to assess the current policies of HIV prevention and care in the prison systems of a selected group of countries. The countries studied are not homogeneous, and any further comparison has to take into account the differences in the prison traditions of

Table 4 HIV prevention and management in prison

	Moldova	Hungary	Nizhnii Novgorod Region	Switzerland	Italy
Management of care					
Voluntary testing	no	no[a]	no	yes	yes
Confidentiality of test results	no	no	no	yes	no
Segregation of HIV-positive prisoners	yes	yes	yes	no	no
Provision of equivalent treatment	yes	yes	yes	yes	no
Prevention/harm reduction					
Provision of information	no	yes	no	yes	yes
Condom availability	no	yes[b]	no	yes[c]	no
Bleach, syringes, methadone maintenance, opiates substitution	no	no	no	yes[c]	no

a: Test is mandatory, but consent is asked.
b: Before home leave.
c: Limited to some prisons.

Eastern and Western Europe. The prison systems in Hungary, and especially in Moldova and Nizhnii Novgorod, are in transition from a totalitarian and oppressive labour camp style of incarceration to one based on the values of the Council of Europe. The adoption of internationally accepted policies on the treatment of prisoners with HIV/AIDS is part of that process, which encompasses the assumption of new responsibilities for the health of prisoners in front of society.

The results indicated that all countries had adopted a policy (or were in the process of defining it), irrespective of the burden of HIV infection present in the prison system. Additional resources were allocated to prevent and control HIV infection even in Moldova, where very few HIV cases were registered, other diseases were prevalent, and resources were extremely limited. One aspect common to all countries was the co-operation between the prison health services and outside health agencies, which is a unique case in the panorama of health in prison, an area traditionally separated from community public health.[8] Two reasons may possibly explain such collaboration. First, the national and international mobilization created around AIDS, including the social and scientific discourse centred around human rights issues, had given legitimacy and visibility to the problem of HIV/AIDS in prisons. The associations and the National AIDS Programmes considered prisoners as vulnerable groups in need of specific attention, and solicited action from the prison administrations. Second, the latter were quite unprepared to deal with the challenges posed by prevention and care of HIV/AIDS in prisons, especially where co-morbidity with tuberculosis posed a serious hazard, and solicited co-operation and exchange. Such co-operation was not always smooth in all countries, but it was certainly innovative. It is worth noting that the 'external' attention to HIV in prisons has also created at the international level an unprecedented awareness of other health and safety problems of prisoners, including tuberculosis, mental health and violence. International initiatives and studies currently ongoing are focusing on mental health and hepatitis besides HIV/AIDS (WHO Health in Prison Network, the European Network on HIV/AIDS Prevention in Prisons and the European Network of Drugs and HIV/AIDS Services in Prisons).

The content of the policy mirrored in the five countries the philosophy and strategies of HIV prevention and care in the community, with delays due to the separation which existed between prison and society, and to the prevailingly custodial role of the prison system.[24] For example, voluntary testing and lack of segregation in Italian and Swiss prisons followed the directions and policies of the National AIDS programmes. In contrast, in Eastern European countries the epidemic was much more recent, and the national response to HIV/AIDS still followed the traditional approach to the control of infectious diseases requiring case identification, isolation and tracing of contacts. In all countries provision of information was part of the policy (or intended to be such in the case of Moldova and Nizhnii Novgorod Region, where the authorities had scarce resources available). Actually, the period spent in detention was seen by prison authorities as a good opportunity to convey a neutral message on what should and should not be done once freedom was regained. Provision of care was also equivalent to that available in the community, with obvious differences among countries, and with the only exception of Italy, where delays in the availability of the most updated therapies were registered. Finally, harm reduction strategies in prison followed the mainstream societal values on treatment of drug addiction, either preservation of life (through avoidance of infection), long-term abstinence (through a personal effort to get rid of any form of addiction), or simply repression of drug use. Switzerland in the sample was the only country with well-developed harm reduction strategies for drug addicts in the community, which was extended to prisons as well. Overall, the 1993 WHO Guidelines were fully implemented only in one country out of five, and partially in two (Italy and Hungary). A legitimate question was whether the 1993 WHO Guidelines were not followed because they were inadequate to prison settings, or whether other factors hampered their implementation at the country level.

The 1993 WHO Guidelines were written to provide indication to prison administrators on the most appropriate way to manage the care of HIV-infected in prison, and prevent new infections. Their main thrust was that public health concerns – preservation of individual life, limitation of epidemic spread – should override competing social considerations and institutional priorities even in prison settings. Furthermore, equivalence of care between prisons and the society needed to be assured. The 1993 WHO Guidelines were based on factual evidence (HIV is not transmitted through casual contact, bleach kills the virus), and on widely accepted procedures (voluntary testing, pre-post test counselling, etc.). One may disagree with such premises, but it is difficult to imagine different guidelines in the context of the current international discourse on the HIV epidemic. Furthermore, the 1993 WHO Guidelines were fully implemented in Switzerland, and partially in other countries, without major unintended consequences, pointing out that their implementation was feasible in different realities. But what factors hampered the implementation at the country level?

The main justification brought forward for partial implementation was the presence of legislation and prison rules that prohibited specific actions. However, the prison health staff were also ready to point out 'pragmatic' ways to overcome the current obstacles, or to suggest amendments to the current legislation. But other factors were at work in the countries considered. First, in Moldova and Nizhnii Novgorod Region the prison authorities were not aware that such guidelines existed, and did not have them available in the national language. Second, certain aspects were not relevant in some countries, as in Hungary where the number of IDUs imprisoned was negligible due to an alternative sentencing policy, and the provision of bleach

or syringes was therefore not envisaged by the prison authorities. Third, in some cases prison authorities did not have adequate knowledge of monitoring techniques such as anonymous unlinked surveys of prevalence and risk factors for HIV infection, and therefore mass screening remained the only solution available. Fourth, as in the case of Moldova and Nizhnii Novgorod, the prison administration had the will but not the resources to implement information or condom distribution programmes. And fifth, even when resources were available some issues remained controversial and politically sensitive, in particular syringe exchange, methadone, and condom distribution.

Usually, prisoners are not a group attracting sympathy from the public. In many societies it is felt that prisoners deserve punishment, and that they should have access to a minimal set of services. The provision of condoms or bleach may be seen as condoning sex and drug use in prisons, thus breaking the delicate balance between punishment and care. As a class, prisoners do not have influential friends, and the only way they can get attention is by violent or demonstrative actions.[24] In Moldova many public officials pointed out that it was difficult to propose activities benefiting prisoners. In Italy, NGOs active in the domain of prisoners' rights highlighted the scarce interest of the media and the Italian public in issues relating to prisons. Only in Switzerland was the attitude rather more positive, because of the declared rehabilitation goal of the penitentiary system. In none of the countries studied have prisoners or their families lobbied to have access to HIV prevention means. The League of Mothers of Prisoners of Nizhnii Novgorod, the only organized group of prisoners' relatives that the authors met, was actively lobbying to have better living conditions for HIV-positive prisoners. In Italy, HIV-positive prisoners performed demonstrative actions to attract attention to their condition in the early 1990s, and a hunger strike in October 1997 to protest against the difficult living conditions and inadequate care of drug addicts and HIV/AIDS cases.[25,26] It has to be noted that it was difficult for prisoners and their families to make direct requests for harm reduction, especially in prison systems which offered rewards pending good behaviour – sex and injecting drugs usually not considered as such in prison.

This study highlighted the complexities behind HIV prevention and management in prisons. Amending the 1993 WHO Guidelines would not ensure a step forward. Instead, a greater effort aimed at dissemination of information, provision of technical know-how and material resources could be the answer to at least part of the above problems, after a careful review of the needs of each country. The situation is particularly urgent in Eastern European countries, which are now facing the first wave of HIV infection in prisons, due to a delayed onset of intravenous drug use and HIV infection in the society compared to the rest of Europe.[27] But many countries in Western Europe and in the United States still do not implement harm reduction programmes, as indicated by the case of Italy in this study and by the results of recent surveys.[1,3,9] This finding highlights the fact that the solutions to the current problems are not only of technical nature. Implementing HIV prevention in prison touches sensitive aspects of each country's internal policy, and in some cases it accompanies a process of democratization and opening to outside scrutiny of the prison system. It is therefore necessary to implement joint efforts, both nationally and internationally, in order to stimulate the debate and to build consensus on the most controversial issues.

National AIDS Programmes should regularly review HIV prevention and management in prison, and advocate changes when needed on the basis of the principle of equivalence between prison and the community. International organizations active in this domain should increase their current efforts, fostering discussion and participation through country visits, policy reviews, regular monitoring of 1993 WHO Guidelines implementation, and international studies. Concerning the latter, it is important to stress that in the only country in this study where the 1993 WHO Guidelines were fully implemented – Switzerland – harm reduction activities were first introduced as pilot projects, duly evaluated, and then implemented on a larger scale.[28] There is no reason why such a strategy could not be replicated elsewhere, not only to influence national policies, but also to provide evidence at the international level on the best ways to implement prevention and harm reduction activities in prison.

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Appendix 1 List of institutions and organizations contacted in each country

Moldova
- Ministry of Health
- National AIDS Centre
- Medical Service, Department of Penitentiary Systems, Ministry of Justice
- Republican Hospital of Large Profile of the Department of Penitentiary Institutions
- 4th Colony, Cricova Village
- Association 'Drugs'
- Theme Group against HIV/AIDS

Hungary
- Department of Immunology and Tropical Medicine, St. Lázló Hospital, Budapest
- Department of Epidemiology, National Institute of Hygiene
- Planning Directorate, Hungarian Prison Service, Budapest
- Health Department, Hungarian Prison Service, Budapest
- Ministry of Welfare, Budapest
- Inter-ministerial Drug Committee, Budapest
- Hungarian Blood Transfusion Centre, Budapest

Nizhnii Novgorod Region
- Regional Administration of Penal Institutions
- Sanitary and Epidemiological Surveillance Centre of the Ministry of Interior
- Regional AIDS Centre
- Multi-regional AIDS Centre, Volga Region
- Nizhnii Novgorod Society for Human Rights
- League of Mothers of Prisoners
- NGO Support Centre
- Nonames Foundation, Moscow
- Future without AIDS
- Foundation anti-AIDS
- Regional Pre-trial Detention Centre
- Fifth Colony for male detainees
- Second Colony for women detainees

Switzerland
- Psychiatric Services of the University of Bern, Ostermundigen
- Institute of Forensic Medicine, Faculty of Medicine, Geneva
- Federal Office of Public Health, Bern
- Federal Office of Statistics, Bern
- UNAIDS, Geneva
- Comité Européen pour la Prévention de la Torture, Genève
- Hindelbank prison, Hindelbank

Italy
- Commissione Nazionale AIDS, Roma
- Dipartimento Amministrazione Penitenziaria, Roma
- LILA, Lazio
- ARCI, Roma
- CEIS, Roma
- Servizio Tossicodipendenti, Carcere Rebibbia, Roma
- Associazione Antigone, Roma
- Facolta' di Legge, Universita' di Bologna
- Centro Operativo AIDS, Istituto Superiore Sanita', Roma
- Ministero degli Affari Sociali, Roma