COUNCIL OF EUROPE
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PARLIAMENTARY ASSEMBLY

SOCIAL AND HEALTH AFFAIRS COMMITTEE

DRAFT REPORT

on a coordinated European health policy
to prevent the spread of AIDS in prison

Rapporteur : Mr Martino

I. PRELIMINARY DRAFT RECOMMENDATION

The Assembly,

1. Recalling its Resolution 812 (1980) on the acquired immune deficiency syndrome (AIDS) ;

2. Deeply concerned by the rapid and continuing spread both in Europe and world-wide of the Human Immunodeficiency Virus (HIV) which may cause AIDS and a variety of other diseases ;

3. Realising that, whereas initially only particular risk groups were thought to be affected by HIV, it is now understood that the virus may strike anyone ;

4. Aware that despite considerable progress in medical research it has not yet been possible to develop an effective treatment of, or a vaccine against, HIV related illnesses ;

5. Noting that according to all currently available medical evidence HIV can only be transmitted through sexual intercourse, blood, during pregnancy and perinataly ;

* 6. Convinced that effective measures to contain the spread of HIV infection should be introduced immediately and that existing measures, such as the screening of blood and blood products, should continue to be applied with great care ;

7. Firmly believing that in order to be effective such measures should not be compulsory but should be based upon the voluntary cooperation of the population ;

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* The paragraphs marked * have been redrafted following the first examination of the text by the Committee in Zürich on 16 February 1988.

8. Paying tribute to and supporting the invaluable efforts carried out by the World Health Organisation (WHO) through its special programme on Aids ;

9. Welcoming Recommendation R (87) 25 concerning a common Health Policy to fight the acquired immunodeficiency syndrome (AIDS), adopted by the Committee of Ministers on 26 November 1987 and expressing its full support for the guidelines contained therein ;

* 10. Considering that particular attention should be drawn to the prison population which has a worryingly high incidence of HIV infection ;

* 11. Considering that the occurrence of homosexual activities and intravenous drug abuse in prisons, both of which entail a considerable risk of spreading HIV infection, amongst the prison population and eventually outside prison, at the moment must be accepted as realities ;

12. Convinced that under these circumstances avoiding the spread of HIV infection should be the overriding concern of prison authorities ;

13. Considering that as in the general population compulsory measures are likely to be ineffective, discriminatory and invidious ;

14. Recommends that the Committee of Ministers

A. invite the Governments of Member States

i) to provide regular information to all prison staff about HIV infection and its consequences ;

ii) to provide written information to prisoners, properly translated when necessary, about the modes and consequences of HIV infection and in particular about the risks of homosexual contacts and intravenous drug abuse in prison ;

* iii) to make HIV tests and counselling available to all prisoners, whilst ensuring that the results of these tests remain confidential;

* iv) to ensure that, unless future scientific findings should indicate otherwise, HIV infected prisoners not be isolated or segregated, provided they do not act irresponsibly ;

* v) to transfer all prisoners who have developed AIDS to specialised hospitals, and to permit final release of fatally ill prisoners on humanitarian grounds ;

* vi) to ensure that hygiene and food in prison be of such a standard as not to increase the risk of developing AIDS in prisoners who are already HIV-infected ;

* vii) to make condoms available to prisoners upon request and particularly prior to temporary and final release, whilst strongly promoting safer sexual behaviour ;

* viii) to take active steps to prevent the illicit introduction of drugs and injection equipment into prison, to offer help to drug addicts and to allow, in the last resort, clean, one-way syringes and clean needles being made available to intravenous drug abusers in prison ;

B. instruct the European Committee on crime problems (CDPC), to urgently elaborate standard minimum rules based on the above proposals for the treatment of HIV infected persons in prisons.

II. DRAFT ORDER

on a coordinated European policy on AIDS

The Assembly,

1. Recalling its Recommendation ... (1988) on a coordinated European health policy to prevent the spread of AIDS in prison ;

2. Aware of the enormous scope of the problems caused by AIDS, which impinge upon many aspects of society ;

3. Considering that the Assembly should play an active and leading role in finding solutions to these various problems, in conformity with the general aim of the Council of Europe ;

4. Accordingly, instructs its Social and Health Affairs Committee

a) to continue to actively monitor the various developments concerning AIDS ;

b) to report back to the Assembly at regular intervals.

II. EXPLANATORY MEMORANDUM
by Mr Martino

I. Introduction

1. Early in 1981, doctors in the United States reported an unusually high incidence of a rare form of cancer, Kaposi's sarcoma, in a number of young homosexual men. By July 1981, it had become clear that a new disease had arisen, which was called Acquired Immune Deficiency Syndrome (AIDS). This Committee already dealt with AIDS in 1983, when the Assembly adopted Resolution 812 (1983) presented on the basis of the report submitted by Mr Wilquin. At the time the information about AIDS was still very incomplete and the resolution therefore was of a general nature, and mainly concerned with avoiding discrimination against homosexuals and the promotion of research.

2. Meanwhile, AIDS has spread exponentially, both at global level and in Western Europe. Initially only particular risk groups were thought to be affected by the virus, but it is now understood that the virus may strike everyone. Accordingly, AIDS, and AIDS related diseases, have become the major challenge to public health authorities around the world (see Appendices I-IV)

3. This was recognised most recently at the World Summit of Ministers of Health on Programmes for AIDS Prevention held in London from 26-28 January 1988. This Summit, which was attended by about 100 members and 149 national delegations was concluded by the adoption of the London Declaration on AIDS prevention, describing AIDS as a serious threeat to humanity and supporting the co-ordinating role of the World Health Organisation (WHO) to fight the disease.

II. Nature of the epidemic

4. The AIDS epidemic is characterised by a series of highly particular factors which make its occurence so serious. The disease has a high mortality rate and morbidity rates have constantly been increasing. The disease is caused by the human immuno-deficiency virus (HIV) which can be transmitted in three ways : sexual contacts, in blood and from mother to unborn child. Initially, sexual contacts and transfusion of infected blood or blood products were the main modes of transmission. However, it now appears that an increasing number of intraveinous drug abusers is becoming infected with the virus through the sharing of infected needles and syringes (See Appendix VI)

5. Infection by HIV may lead to a variety of clinical states. Acute HIV infection (which should not be confused with AIDS) leads to acute feverish illness in between 20 and 50 per cent of all cases. These symptoms, which occur between 2 weeks and 3 months after the introduction of the virus into the body, usually last a few days. Recovery is generally spontaneous and towards the end of the period antibodies to HIV are found in the blood, and the person becomes seropositive.

6. About 50 percent of seropositive people remain totally free of signs of the illness during the five years following the acute infection. About 30 % of HIV infected persons develop a syndrome of chronic ill-health, but without the serious opportunistic infections or cancers that characterise AIDS. This situation is known as AIDS-related complex (ARC). Some remain in poor health for many years, some recover and others develop AIDS.

7. AIDS results from the destruction of the body's immune system by HIV. Its clinical symptoms are very variable but usually include opportunistic infections and cancers. The syndrome also attacks the nervous system, sometimes causing bizarre, antisocial behaviour. The disease has a very long incubation period and no certainty exists at present as to which percentage of HIV infected persons will eventually develop AIDS, though it is estimated that 20 to 30 percent of those infected will develop the disease within five years of infection. In addition, infected people are probably infectious themselves for life.

8. Despite considerable progress in medical research it has not yet been possible to develop an effective vaccine. Nor has an effective treatment of this illness been discovered so far. Additional complications are caused by the variability of the virus in relation to the development of a vaccine and by the appearance of new, related, virus with the same modes of transmission and the possibility of double infection.

9. In April 1987 overt 40.000 cases of AIDS had been reported to WHO from 21 countries. Moreover, in the United States alone between 1 and 2 million people are almost certainly infected and in Central Africa the incidence is probably even higher. For further details on the epidemiological situation in Europe, the Rapporteur refers to the Appendices which contain the most recent data made available by the WHO. The various attached statistics provide an inside into the spread and distribution of the disease in various countries.

III. Public policy

10. The traditional response by public health authorities to epidemics is to focus on ill people and/or on those at risk. Infectious individuals are reported to health officials and registered ; those capable of transmitting the disease are isolated. These compulsory measures are justified when they are clearly necessary to impede the spread of the epidemic and where the interference with the individual's rights is not disproportionate to the public health benefit sought to be achieved. This proportionality principle is, for instance, laid down in the European Convention on the Protection of Human Rights and Fundamental Freedoms.

11. However, this approach is not suited to the AIDS epidemic. The spread of HIV is not limited to any particular geographic area or population. Isolation of all carriers of the virus in Western Europe would already probably concern millions of people. In addition, since the virus is not incubated for a short period and cannot be treated, restrictive measures on carriers would potentially have to be applied for life. Moreover, isolation of carriers or exclusion from certain parts of society, e.g. schools, civil service, would unecessarily restrict the liberty of these people since HIV is not transmitted by normal social contacts.

12. Furthermore, compulsory measures to control the spread of HIV would have to identify all those capable of transmitting the disease, predict their future private and intimate behaviour and control that behaviour. Clearly these objectives are unrealistic, and efforts in this direction could well have the opposite effect of discouraging voluntary cooperation with public health authorities. Studies in the United States on compulsory measures aimed at containing venereal diseases have found these measures to be ineffective, discriminatory and invidious.

13. The decisions necessary to control the spread of AIDS are essentially political. However, politicians need authorised information and advice from medical and other experts. Therefore, several countries have set up expert committees including representatives of the relevant governmental sectors to advice the national health administration. Control policies are limited by budgetary constraints. The fight against AIDS requires substantial investment in, for instance, research, treatment facilities, the screening of blood and public education. Furthermore, other pressures on policy-makers exist : public alarm and irrational fears which may lead to unjustified compulsory measures and discrimination against minorities as well as to inhuman treatment of AIDS patients.

IV. International response

14. WHO has set up a Special Programme on AIDS, headed by Dr Jonathan Mann. At the end of 1987 over 100 countries were participating in this programme. The programme is based on the principle that AIDS can be prevented and controlled without violating human rights. Discrimination against certain persons, according to WHO, risks reversing the gain of educational programmes and drives those suffering from AIDS underground, thus threatening public health.

15. Recommendation R (87) 25 on a common European health policy to fight AIDS, adopted by the Committee of Ministers of the Council of Europe on 26 November 1987 explicitly states that there should be no compulsory screening, nor restriction of movement or isolation of seropositive persons. Reference is made in this respect to the European Convention on Human Rights. The Rapporteur considers that this approach is to be welcomed and supported.

16. The guidelines contained in Recommendation R (87) 25 generally establish the parameters of a common European public health policy on AIDS. Apart from urging the setting up of multidisciplinary coordinating committees at the national, regional and local leve, the recommendation covers the following fields : prevention, public health regulatory measures, strenghtening of health care services, training of staff, evaluation and research

17. In the light of this recommendation, it does not seem advisable at present to try and adopt as wide an approach since this would seriously entail risks of duplication and inconsistency. It would appear much more useful, also in view of the expressed wish of the Committee to act swiftly, to concentrate on a particular issue, already referred to in the Committee of Ministers' recommendation, which could be elaborated upon.

18. Consequently, the Rapporteur has decided to concentrate on the prison population, which appears to be at particular high risk with regard to AIDS and which could well contribute to spreading the disease among the general population. The reasons for this particular situation will be explained below.

V. The situation in prisons

19. It is clear that the prison population has a rate of seropositivity in excess of any other community. The Council of Europe's Secretariat General last year requested information from Member States on problems caused by AIDS in the prison system. Replies

were received from 12 countries and are found in Appendix VII. It is to be noted that the data were not really comparable since they have been collected in different ways. Certain countries do not have centralised data (Austria, Federal Republic of Germany, France, Norway and Switzerland) and medical secrecy in some countries is another reason for the lack of data.

20. Small-scale studies, carried out in Switzerland and France suggest that the rate of seropositivity amongst prisoners is between 50 and 200 percent higher than among the general population. Although only two countries have reported a significant number of prisoners actually suffering from AIDS, ie 10 in Italy and 22 in Spain, extrapolation from the "incomplete results" on seropositivity warrants the expectation that the number of AIDS cases among prisoners will dramatically increase in the coming years.

21. The main reason for this situation appears to be the fact that in most European prisons, 20 to 30 percent of inmates have a history of regular interveinous drug abuse. Various studies show that between 50 and 80 percent of persons with a history of regular interveinous drug abuse are seropositives. Some drug abuse continues in prison and since material for injection is difficult to obtain, dirty syringes and needles are often shared, thereby causing new infections.

22. Furthermore, prisoners generally come from underprivileged social groups and their health is often poor upon entering prison. Their health is likely to deteriorate even further due to a considerable number of pathogenic factors within the prison environment, such as stress, overcrowding and poor sanitation, unhealthy life styles, in particular cigarette smoking. Sometimes prisoners intentionally harm their health, using it as a bargaining chip vis-à-vis the prison administration.

23. As in many closed communities, such as ships, hospitals, homes for the elderly etc., the prison environment promotes the propagation of communicable diseases. Also linked to intravenous drug abuse, hepatitis has become a serious health hazard in prisons.

24. The above factors, whilst generally hazardous for the health of all prisoners, are particularly detrimental to seropositive prisoners, who need to pay special attention to their general health with varied diet, sport and regular sleep. It has been argued by experts that other viral infection, may directly influence the development of AIDS.

25. Another main problem in prisons is the occurrence of homosexual contacts. Although the frequency and type of homosexual contacts in prisons are not known exactly, evidence suggests that homosexual activities even between prisoners who have a heterosexual orientation outside prison are rather frequent. A recent study of a New-York prison indicated that as many as 30 percent of normally heterosexual men engaged in homosexual activity whilst in custody. This induced homosexual behaviour in prison therefore provides a "bridge" between two established high risk groups intervenous drug abusers, and homosexual men, persons who may upon release become a source of infection through heterosexual contacts. This bridging phenomenon may contribute significantly to the spread of AIDS among the general population.

26. The realisation that prisoners have a substantially higher risk of being seropositive than the general population has led to panic reactions and disorders in several European prisons. Questions posed by prison administrations included the transmission mode of the transmission of the disease, the necessity to screen all prisoners for HIV and the necessity to isolate seropositive prisoners.

VI. Measures taken by prison authorities

27. Information has been gathered in 17 European countries in a study carried out by Dr T.W. Harding on actual measures that have been taken in prison in response to the AIDS epidemic. An overview thereof is to be found in Appendix VIII. In 12 countries, prisoners belonging to risk groups are offered testing on a voluntary basis. In other countries, prisoners not belonging to particular risk group are also able to request testing.

28. In 6 countries (Austria, Denmark, France, Italy, Spain and Switzerland) seropositive prisoners are not subjected to any restriction. In Norway the normal prison regime is also applied except that violent seropositive prisoners may be separated from other prisoners. However, in the Federal Republic of Germany and Belgium, seropositive prisoners are placed in single cells. Whilst no other restriction applies in Belgium, the Federal Republic limits access to certain workshops with a high riks of injury and to kitchens. Segregation of seropositive prisoners is also found in the United Kingdom. Strict measures are taken in Portugal where seropositives prisoners are placed in strict isolation. In the Federal Republic of Germany and in England and Wales, segregation of seropositive prisoners is not based entirely on medical considerations. Reasons given are the need to avoid among fellow prisoners and avoiding provocation of panic reactions amongst other prisoners or staff.

29. Several countries stress the need to inform prisoners on precautions and written information to this effect is distributed upon entrance in Belgium, Cyprus, the Federal Republic of Germany and in Switzerland. Prison staff is also informed.

30. For the treatment of prisoners with AIDS, 6 countries indicate that hospitals outside the prison system are used. In France, specialised services are available in the centralised prison hospital services at Fresnes. Two countries (Federal Republic of Germany, Norway) mention the possibility of early release of prisoners with AIDS. In several countries the need to inform sero-positive patients of the test result and of the implications for their way of life is stressed. In Austria, all doctors have a duty to inform, as laid down day in the Austrian AIDS act.

31. In Spain, seropositive prisoners receive advice based on a WHO recommendation. The need to use condoms in all sexual relations is stressed but it is not clear whether condoms are also available in Spanish prisons. In Luxembourg, seropositive prisoners receive detailed information on their state and on modes of transmission. Emphasis is placed on the individual responsibility of the prisoner concerned. In Switzerland, information for seropositive prisoners is provided by prison medical services. Psychological counselling is available. In some prisons, for instance in the canton of Geneva, condoms are distributed on demand without charge by the medical service.

VII. AIDS control in prisons

32. In general, two different approaches with regard to AIDS control can be adopted. The first one is the moralistic approach, appealing for a return to the values of chastity and sexual fidelity in marriage. Although these values have been proclaimed in many societies, it is doubtful whether they have ever been respected to a high degree in any human society. Yet it is reassuring that it is possible for individuals to reduce and eliminate risks of contracting AIDS by their own decisions concerning sexual relationships or drug abuse. Another approach is the pragmatic one, which accepts that casual sexual relationships are bound to occur and that information should be disseminated about reducing the risk, for example, by using condoms. The Rapporteur believes that it should however to be avoided at all costs that the anti-AIDS campaign becomes an ideological battleground.

33. As in society, two alternative approaches can be envisaged with regard to AIDS in prison. The first approach, which may be called paternalistic is based on the principle that the prison administration has a direct responsibility to protect the prisoners and to prevent drug abuse and homosexual promiscuity. This approch would call for routine screening and isolation of seropositive prisoners. However, such measures would lead to discrimination within prisons and undoubtedly attach a further stigma to the prison population as such.

34. Moreover, Recommendation (87) 25 of the Committee of Ministers specifically states that there should be no compulsory screening of the general population, nor of particular population groups. In addition, it recommends that restriction of movement or isolation of carriers should, as a general rule, not be introduced on a compulsory basis.

35. WHO reaches similar conclusions. It convened a consultation on prevention and control of AIDS in prisons from 16 to 18 November 1987 in Geneva. The total of 37 specialists from 26 countries who participated included experts in public health, prison and medical administration, prisoner care, occupational health and safety, epidemiology and health policy. They recommended that prisoners should not be subjected to discriminatory practices regarding HIV infection or AIDS, such as involuntary testing, segregation or isolation, except for the prisoners own well-being.

36. The alternative approach is in line with these suggestions and stresses the individual responsibility of prisoners. This approach implies informing prisoners about AIDS risks and gives them the opportunity to take preventive measures. As all prisoners are concerned by the AIDS risks, counselling should be generally available and not be limited to the duration of the prison term, but should also be available upon release. This approach seems also to be in conformity with the position of the European Commission on Human Rights which has held that prison authorities are required, under the European Convention on Human Rights, to safeguard the health and well-being of all prisoners.

VIII. Conclusions

37. The AIDS epidemic is a serious threat to public health worldwide. It is likely that a considerable increase in both the numbers of HIV infected people and of actual AIDS sufferers would occur in the coming years. However, the modes of transmission have been identified and individual decisions may prevent infection.

38. The prison population in Western Europe has a rate of seropositivity far greater than that of any other community in this part of the world. Because of homosexual activities and drug abuse within prisons, these institutions risk to become nurseries of the HIV virus. Upon release, whether temporary or definitive, seropositive prisoners may become a source of infection through heterosexual contacts and thus constitute a dangerous bridge to the general population.

39. It is of utmost importance that in dealing with AIDS in general, and in prison in particular, basic human rights are respected. The Council of Europe bears a special responsibility in this field. With regard to prisoners, the additional imperative of avoiding attaching a further stigma presents itself. The recommendations of the Committee of Ministers, and the similar conclusions of the WHO, that no particular groups should be compulsory screened and that isolation of seropositive people should in general be avoided, need to be stressed and repeated.

40. In order to reinforce prevention of HIV-transmission in prisons two possibilities present itself. Whilst wishing to avoid an ideological stand with regard to the desirability of a "paternalistic" or "pragmatic" approach, the Rapporteur is of the opinion that certain realities must be accepted. Especially in view of the fact that prisons are considerably overcrowded in many countries, homosexual contacts between prisoners are likely to occur frequently. These activities entail a considerable risk of HIV infection, especially given the high degree of seropositivity already found in prisons. Moreover, such infections are likely to be spread among the general population, as many prisoners will resume heterosexual contacts upon release. Condoms have been proven to be particularly effective in reducing the risk of HIV infection during sexual contacts. The distribution of condoms to prisoners has been opposed with the argument that this would mean approval of illegal and/or morally unacceptable practices. It has also been argued that condoms could be used for the smuggling of drugs. However, these arguments have to be balanced against the need to effectively stop the spread of HIV.

41. A perhaps even greater dilemma exists with regard to the spread of HIV through drug abuse in prisons. Despite the best efforts, drugs are frequently smuggled in to prisons and syringes and needles have been found. Given the number of intravenous drug abusers in prisons, the latter are almost certain to be shared by a considerable number of men, who are prepared to inject any drugs available. If the illegal introduction of syringes and needles from outside cannot be prevented, the question arises whether clean injecting equipment should not be made available. The argument often put forward against this is that drug abuse would thus appear to be condoned. Needlestick injury from discarded equipment is also cited as an objection. Yet, HIV-infection is a greater threat to life than drug abuse and the greater of the two evils should merit priority, pending the development of other prophylactic measures.

42. On balance, the following concrete measures could be envisaged :

a. Information should be provided to all prison staff about AIDS and other communicable diseases. There should be regular updates of this information.

b. Prisoners should receive written information (translated for foreigners) about AIDS and in particular about the risks of homosexual contacts and intravenous drug abuse in prison.

c. HIV tests should be available on request to all prisoners. Subsequent counselling should be available. The results of the test should not be communicated to the prison authorities.

d. Seropositive prisoners should not be isolated or segregated.

e. Hygiene and food should be of a standard such as not to increase the risk of AIDS in seropositive prisoners.

f. Condoms should be made available to prisoners on request, and also prior to temporary and final release

g. Whilst taking active steps to prevent the illicit introduction of drug and injection equipment into prisons, clean, one-way syringes and clean needles should be made available to intravenous drug abusers in prison.

43. Finally, the Rapporteur would wish to stress the importance for the Assembly of continuing to monitor developments concerning AIDS. Given the enormous scope of the problem, an issue-oriented approach commends itself. In order to enable the committee to carry out this task, it is suggested that the Assembly be asked for a permanent mandate to report on developments related to AIDS. A sub-committee should be set up for this purpose.

APPENDIX I

TOTAL NUMBER OF AIDS CASES REPORTED IN 28 EUROPEAN COUNTRIES AND ESTIMATED PREVALENCE RATES PER MILLION POPULATION

30th June 1987

COUNTRY	JUNE 86	DEC.86	MAR.87	JUNE 87	RATE/M*
Austria	36	54	72	93	12,4
Belgium	171	207	230	255	25,8
Bulgaria	-	-	-	1	,1
Czechoslovakia	4	6	7	7	,5
Denmark	93	131	150	176	34,5
Finland	11	14	19	19	3,9
France	859	1221	1632	1980	36,0
German Dem.Rep.	0	1	3	4	,2
Germany, Fed.Rep.	538	826	999	1133	18,6
Greece	22	35	41	49	4,9
Hungary	0	1	3	5	,5
Iceland	2	4	4	4	20,0
Ireland	10	14	19	19	5,3
Israel	24	34	38	39	9,3
Italy	300	523	664	870	15,2
Luxemburg	3	6	7	7	17,5
Malta	5	5	5	6	15,0
Netherlands	146	218	260	308	21,2
Norway	24	35	45	49	11,7
Poland	0	1	2	2	,1
Portugal	28	46	54	67	6,5
Romania	1	2	2	2	,1
Spain	177	264	357	508	13,2
Sweden	57	90	105	129	15,5
Switzerland	138	192	227	266	40,9
United Kingdom	389	610	729	870	15,4
USSR	0	1	3	3	,0
Yugoslavia	3	8	10	11	,5
TOTAL	3041	4549	5687	6882	

*Source of population figures: INED, Paris, 1985
°Slovak R.S.: 2; Czech S.R.: 5

Sources : Appendices I - V
World Health Organisation

Appendices VI - VIII : Dr Harding

APPENDIX II

AIDS CASES BY AGE GROUP AND SEX FOR 28 EUROPEAN COUNTRIES*
30th June 1987

AGE GROUP	MALES	FEMALES	UNKNOWN	TOTAL	%
0-11 months	24	27	0	51	,7
1- 4 years	38	41	0	79	1,1
5- 9 years	18	6	0	24	,3
10-14 years	25	3	0	28	,4
15-19 years	53	11	0	64	,9
20-29 years	1515	367	0	1882	27,3
30-39 years	2379	164	0	2543	37,0
40-49 years	1409	49	0	1458	21,2
50-59 years	461	33	0	494	7,2
over 60 years	162	29	0	191	2,8
Unknown	64	1	3	68	1,0
TOTAL	6148	731	3	6882	100,0

*Austria, Belgium, Bulgaria, Czechoslovakia, Denmark, Finland, France, German D.R., Germany, F.R., Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxemburg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, Switzerland, United Kingdom, USSR, Yugoslavia.

A P P E N D I X III

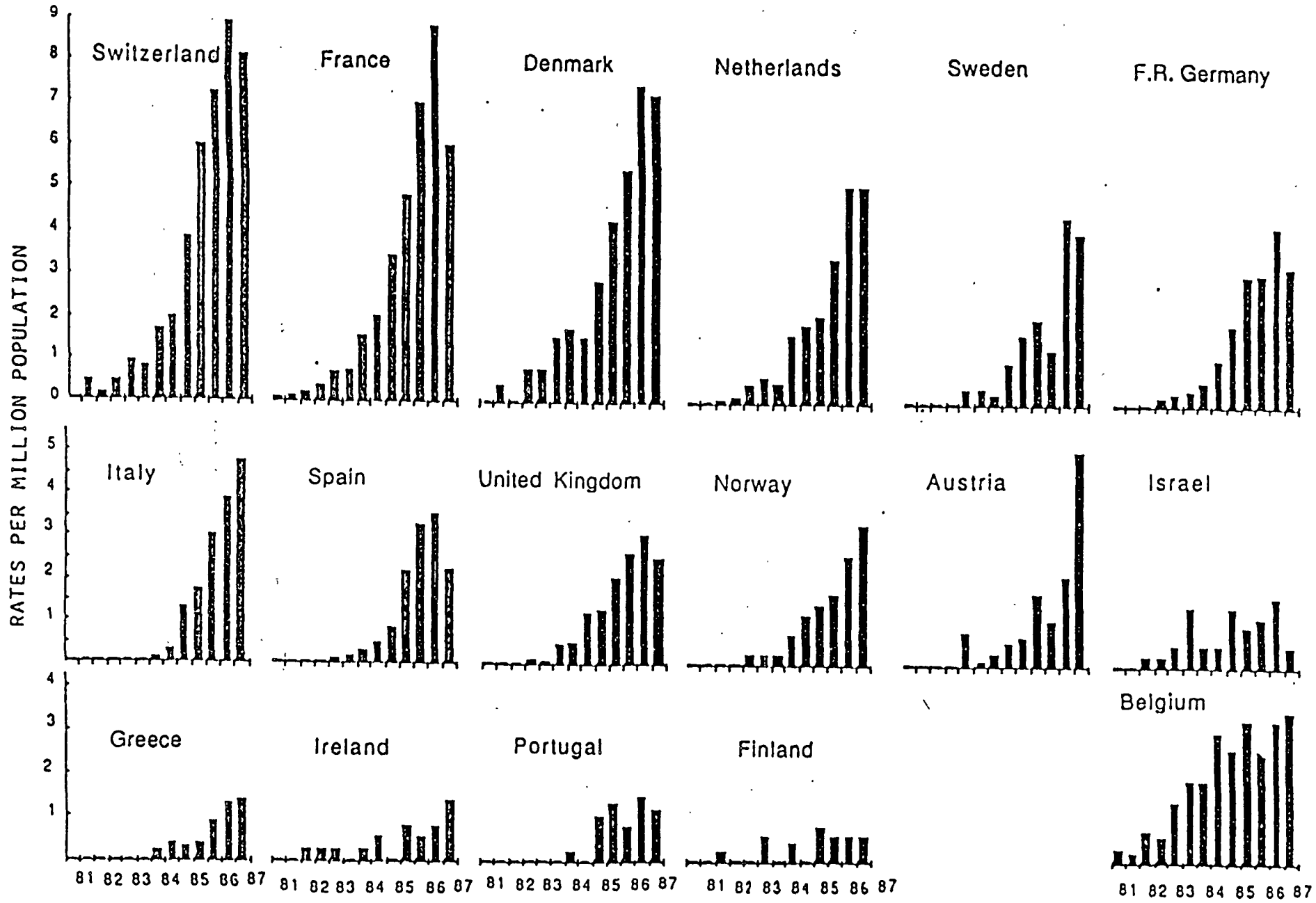
AIDS CASES BY TRANSMISSION GROUP AND GEOGRAPHIC ORIGIN FOR 28 EUROPEAN COUNTRIES*
ADULTS - 30th JUNE 1987

TRANSMISSION GROUP	GEOGRAPHIC ORIGIN				T O T A L	
	EUROPE	AFRICA	CARIBBEAN	OTHER	N°	%
Homo-/bisexual	3934	30	8	161	4133	62
IV Drug abuser	1124	9	1	2	1136	17
Homosexual & IVDA	168	3	0	8	179	3
Haemoph/coag.disorder	234	0	0	1	235	4
Transfusion	208	16	4	3	231	3
Heterosexual	300	217	61	8	586	9
Other/unknown	153	25	12	10	200	3
TOTAL	6121 (91 %)	300 (4 %)	86 (1 %)	193 (3 %)	6700	100

*Austria, Belgium, Bulgaria, Czechoslovakia, Denmark, Finland, France, German D.R., Germany,F.R., Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxemburg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, Switzerland, United Kingdom, USSR, Yugoslavia.

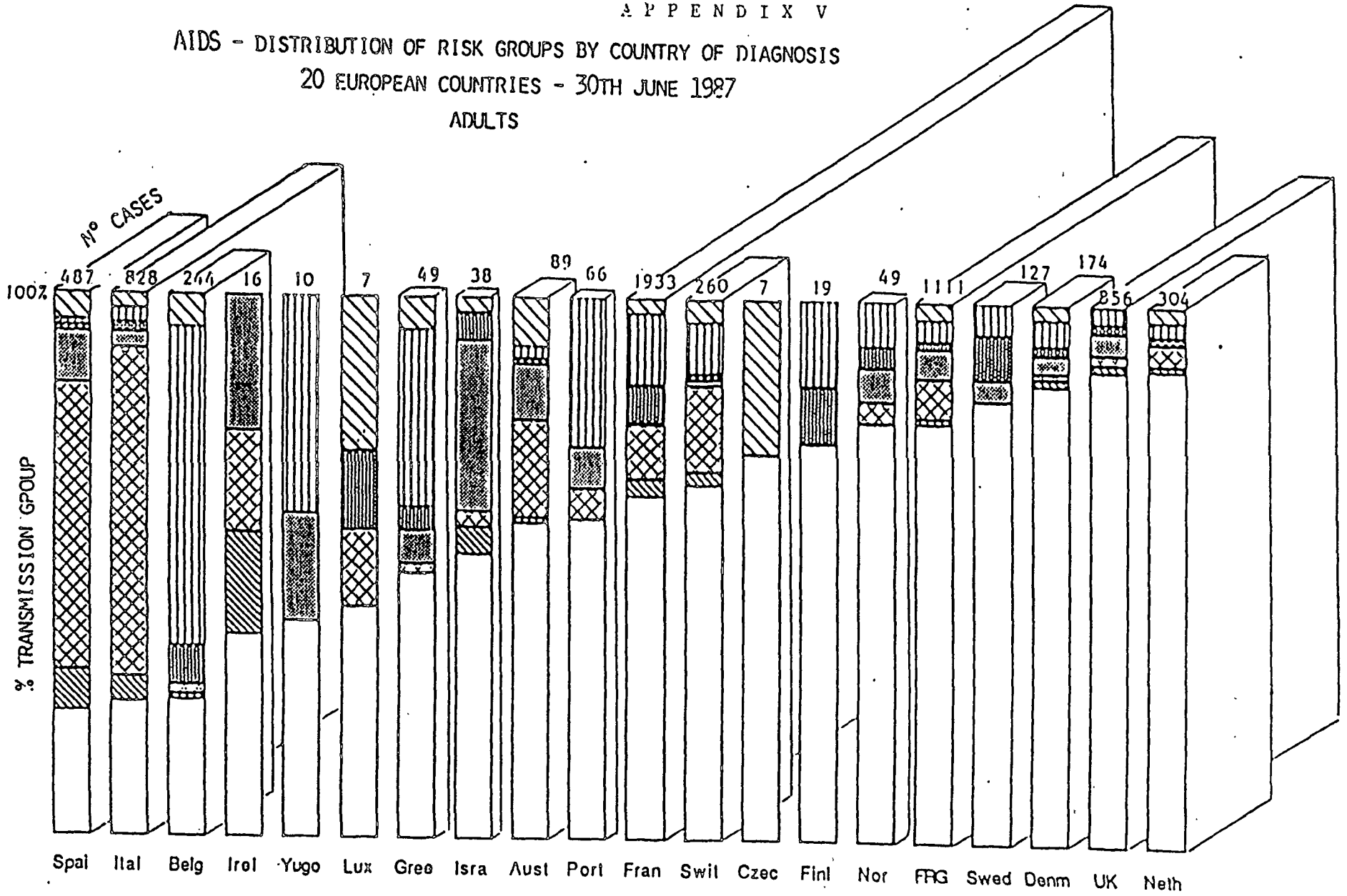
APPENDIX IV

AIDS - INCIDENCE RATES PER MILLION POPULATION BY HALF-YEAR OF DIAGNOSIS - 30.JUIN 1987



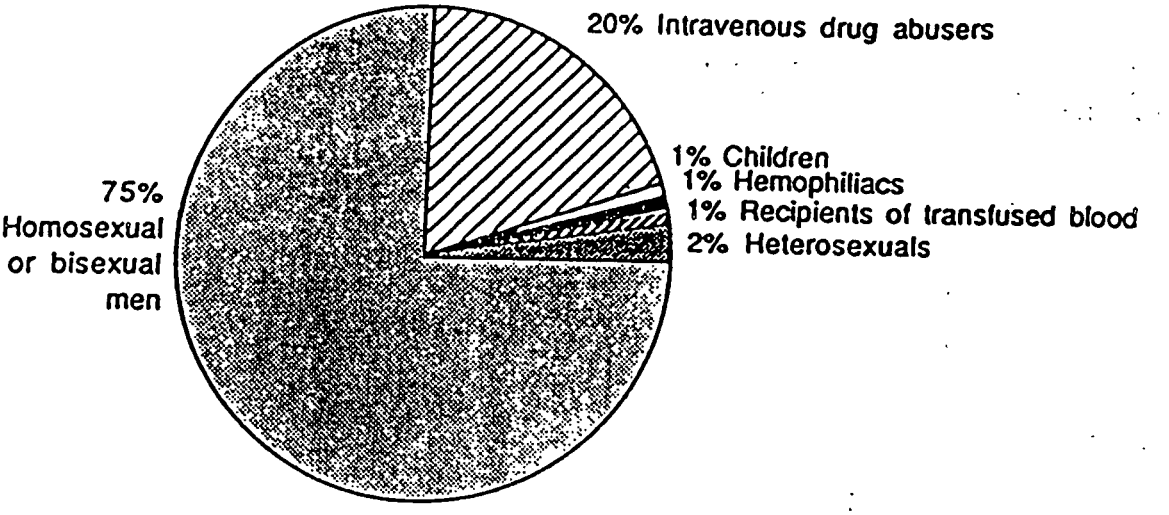
APPENDIX V

AIDS - DISTRIBUTION OF RISK GROUPS BY COUNTRY OF DIAGNOSIS
20 EUROPEAN COUNTRIES - 30TH JUNE 1987
ADULTS

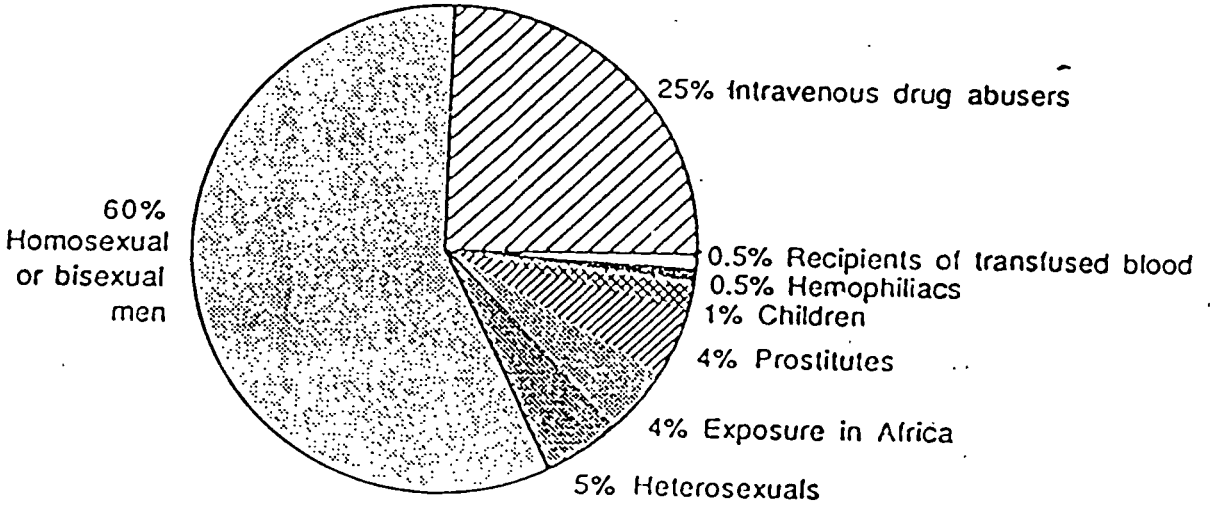


A P P E N D I X VI

Collated average percentage breakdown of groups of individuals who have developed AIDS in Europe and USA (end 1986)



Estimated average percentage breakdown of high risk groups who are HIV seropositive in Europe and USA (end 1986).



A P P E N D I X VII

Prison population and numbers of HIV seropositive prisoners and AIDS cases (end 1986)

	Men			Women			Total			
	Prisoners	HIV +	AIDS	Prisoners	HIV +	AIDS	Prisoners	HIV +	AIDS	Remarks
Austria	7.766	?	0	308	?	0	8.074	1%	0	*"Estimate" of HIV +*
Belgium	6.759	81 (1.2%)	0	343	10 (2.9%)	0	7.102	91 (1.3%)	0	*Routine testing*
Cyprus	215	0	0	7	0	0	222	0	0	*Screening high risk groups*
Denmark	3.373	?	0	154	?	0	3.527	?	0	*291 prisoners tested in two month period: 14(4.7%) HIV +*
Federal Republic of Germany	50.865	?	?	2.028	?	?	52.893	?	?	*Research underway*
France	48.380	?	?	2.053	?	?	50.433	13%	?	*Results on 500 consecutive entries*
Greece	3.662	4 (0.1%)	0	181	0	0	3.843	4 (<0.1%)	0	*Screening high risk groups*
Holland	4.700	?	0	120	?	0	4.820	?	0	*In Amsterdam, 11% HIV tve estimated*
Italy	. . .	. . .	9	. . .	. . .	1	41.547	16.8 %	10	*Results of screening in 30392 prisoners during 1986*
Ireland	1.851	35 (1.9%)	0	50	10 (20%)	0	1.901	45 (2%)	0	*Voluntary testing (incomplete)*
Luxemburg	299	6 (2%)	0	25	1 (4%)	0	324	7 (2.1%)	0	*Routine testing*
Norway	1.958	?	?	72	?	?	2.030	?	?	*Medical secrecy*
Portugal	7.906	3 (< 0.1%)	0	401	1 (0.2%)	0	8.307	4 (< 0.1%)	0	*Screening high risk groups*
Spain	24.897	6.424 (25.8%)	20	1.412	353 (25%)	2	26.309	6.777 (25.7%)	22	*Screening high risk groups*
Sweden	4.523	20 (0.4%)	0	227	6 (2.6%)	0	4.750	26 (0.6%)	0	*Voluntary testing*
Switzerland	. . .	. . .	. . .	. . .	. . .	. . .	3.500	11%	?	*Study in the Canton of Berne*
United Kingdom°	45.665	32 (< 0.1%)	0	1.569	4 (0.2%)	0	47.234	36 (< 0.1%)	0	. . .

° *Results relate to England and Wales only*

APPENDIX VIII

Screening policy, management of seropositive prisoners and AIDS cases in 17 European countries

	Screening for anti HIV	Management of seropositive prisoners	Management of prisoners with AIDS
Austria	On request	No special measures	Prison hospital with possible transfer to general hospital
Belgium	At risk groups (voluntary) and on request	Placed in single cells. Access to all activities	Transfer to University Hospital
Cyprus	At risk groups (no refusals) Re-testing every 6 months	No seropositive prisoners	No cases
Denmark	On request	No special measures, except solitary confinement 1) if behaviour creates danger of infection 2) on request	Transfer to hospital
Federal Republic of Germany	At risk groups (voluntary)	Placed in single cells (usually). Not allowed to work in kitchen nor workshops with injury risk	Possibly considered "unfit to serve sentence"
France	At risk groups (voluntary)	No special measures	Prison hospital; if necessary transfer to special centre (Fresnes)
Greece	At risk groups (test gradually extended to other prisoners)	Placed in special hospital section. Separate exercise yard. Dietary supplements	No cases
Holland	No screening measures	No special measures, except if prisoners threaten guards with contamination (disciplinary measure)	Transfer to hospital. Pardon and release possible if prognosis is bad
Italy	All new entries (voluntary)	No special measures	Possibility of hospital outside prison
Ireland	On request	Full separation of male prisoners. Separate cells for female prisoners. Restriction of work and recreation activities	Transfer to hopital outside prison
Luxemburg	All new entries** Re-testing of risk groups + drug addicts after leave of absence	Not allowed to work in kitchen, and certain other workshops	No cases
Norway	On request	No special measures, except if violent	Early release possible. Repatriation of foreigners
Portugal	On request	Personal hygienic measures to be followed	Civil hospital
Spain	At risk groups (no refusals) + on request	No special measures	Not specified
Sweden	All prisoners encouraged to be tested (voluntary)	No special measures. Psychological support	No cases
Switzerland	At risk groups (voluntary)	No special measures. Psychological support	Transfer to University Hospital. Sentence suspended in terminal cases
United Kingdom*	On request	Separation possible * for managerial reasons*	Treated in hospital ouside prison

** Information from England and Wales only. / ** Prisoners who refuse screening placed in isolation.*