



**Assessment of the Implementation
of 2009-2013 National AIDS Programme:
Prevention, Treatment and Care in the
Penitentiary System of Ukraine**

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
AFEW	AIDS Foundation East-West
ARV-therapy	Antiretroviral therapy
BSS	Bio-behavioral study
CPT	The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
EC	European Commission
EMCDDA	European Monitoring Center for Drugs and Drug Addiction
GF(ATM)	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immune deficiency virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
IDU	Injecting drug user
ITT	Transliteration for Ukrainian abbreviation for Temporary holding facility
MARP	Most-at-risk population
M&E	Monitoring and evaluation
MOH	Ministry of Health of Ukraine
MSM	Men having sex with men
NAC	National AIDS Center
NGO	Non-governmental organization
OST	Opioid substitution therapy
PEP	Post-exposure prophylaxis
PLWH	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PNSP	Penitentiary needle-syringe programme
PWID	People who inject drugs
RAC	Regional AIDS Centers
RHAC	Regional HIV/AIDS Councils
SIZO	Transliteration for Ukrainian abbreviation for Pre detention jail
SMT	Substitution maintenance therapy
SPSU	State Penitentiary Service of Ukraine
STI	Sexually transmitted infection
TB	tuberculosis
UN	The United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNDP	United Nations Development Program
UNODC	United Nations Office on Drugs and Crime
UNPLWH	All-Ukrainian Charitable Organization "All-Ukrainian Network of PLWH"
VCT	Voluntary counseling and testing
WHO	World Health Organization

1. SCOPE OF PROGRAMS AND ACTIVITIES

According to a bio-behavioural study (BBS) conducted in 2011 out of all prisoners in Ukrainian prisons 13,6% are HIV-infected. This situation is accompanied by other risks such as high prevalence rates of other blood-borne-virus infections (Hepatitis C Virus - HCV, Hepatitis B Virus - HBV), syphilis (other STIs) and tuberculosis (TB). Only approximately one third of prisoners infected with HIV are known to the State Penitentiary Service of Ukraine (SPSU).

In line with the National AIDS Program (National Program for the Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients for 2009–2013), a relevant sectoral program for prisons entitled “Program to Ensure Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients in Penitentiary facilities and Remand Prisons of the State Criminal Execution Service of Ukraine for 2009-2013” is currently operating. Furthermore GFATM funds are utilized for prevention, treatment, and care and support activities. Finally additional programs focusing on specific thematic areas (training, manuals etc.) have been carried out (UNDP, EC, funds, national support).

Progress in the responses to HIV/AIDS has been achieved especially in offering ARV treatment, prevention, care and support, and training over the last years. However, these efforts are still far below an adequate public health response to the HIV epidemic. Especially a lack of equality of health care comparing community and prison services can be noticed. Prisoners do not benefit from the introduction of evidence-based interventions in the community. There is an insufficient access to antiretroviral therapy (ARV), almost absence of evidence-based drug dependence treatment (opioid substitution treatment) despite the fact that 60% of all HIV-infected persons are or were former drug users (Kryvoruk 2012), and harm reduction (PNSP, condom/lubricant, and disinfectant provision).

Prison staff and administrative are isolated and lacking competences and networks that service providers in the general community have started successfully to develop. With regard to the internationally demanded equivalence of health care services in the community and in prisons, coverage and quality standards of services should be complementary and moving along the same line.

Access to and quality of VCT, ARV, should be enhanced. Other evidence-based interventions should be introduced (OST, condoms/lubricants, disinfectants and PNSP). Key indicators will be the number and quality of VCTs, ARVs, condoms/lubricants, disinfectants, OST and PNSPs (first legal introduction).

Trainings activities have also to be intensified due to the high turnover rate of prison staff. NGOs have played and have to play an important role in the general response to HIV/AIDS. Involvement of civil society is pivotal.

Legal structures which hamper adequate and evidence-based responses to the HIV epidemic, have to be analyzed in order to overcome these barriers.

Finally gender issues should be very carefully looked at. Most of the incarcerated women have children therefore parenthood, PMTCT are central issues in the care of female IDUs and female prisoners in general in prisons. This opportunity to bring up positive changes in the women’s life has to be utilized whenever possible.

1.1. Current state of the epidemic related to prisons

1.1.1. General information on prisons in Ukraine

The situation in prisons has to be considered in line with other key issues related to the HIV epidemic and injecting drug use (IDU) and is partly mirroring the development in the community. The most relevant information is summarized here.

Ukraine counts 153,318 prisoners in 183 penitentiary facilities under the SPSU mandate that includes 29 pre-trial detention centers and 146 male and female correctional facilities and 8 juvenile correction centers. Out of the total number of prisoners 25% are in pre trial and 5.2% are women. Although living conditions in custodial settings in general seem to have improved over the last years (Human Rights Council 2008), still the conditions in many institutions remain quite poor (CPT 2011a), especially in often overcrowded institutions of the SIZO (*sledstvennyi isolator*) facilities for remand detention. In total 53,000 staff members are being employed.

The prison population rate (per 100,000 of national population) is 338, which almost threefold higher than the European average. There are remand prisons and execution centers or penitentiary facilities (lockup houses, special correctional facilities or correctional colonies). More precisely, according to the statistics of the Council of Europe Annual Penal Statistics (SPACE (*Statistiques Pénales Annuelles du Conseil de l'Europe* <http://www3.unil.ch/wpmu/space/>), Ukraine counts (2012 data) 142,457 males, 9,480 females and 2,092 juveniles prisoners. The number of penal establishments and pre-trial institutions is 183 (128 for male, 14 for female – 14, 8 for juveniles - 1 for girls), and 33 pre-trial institutions). The median

duration of incarceration is 42 months.

Prisoners are predominantly young (42.2% between 20–29 years in the penal colonies; 33.2% between 30–39 years and 18% between 40–45 years). 18% are convicted for drug related crimes, and among them more than 55% for possession of drugs for personal use (21,300 out of 118,909 in July 2012) (Official statistics of the State Penitentiary Service of Ukraine. 5 July 2012, reported by (Country Report Task Force for the adoption of lists of issues on Ukraine 2012).

Drugs are seized in prisons (EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol And Drugs of the Ministry of Health of Ukraine 2011). Staff in some occasions is being reported to be involved with smuggling (Balakireva, Sudakova et al. 2012).

In 2010, 47,000 people entered the prisons and 37,500 were released. Rehabilitation of addicted offenders was largely ignored in the past. It relies on social services of the penitentiary institutions and NGOs (EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol And Drugs of the Ministry of Health of Ukraine 2011). In other words (1) the turnover of prisoners is high and the impact on healthcare (or absence of it) is significant; (2) preparing the release and continuity of treatments (in particular for HIV, TB, and drug dependence problems) is a paramount issue.

Health care of detainees in police arrest custody is in the responsibility of the Ministry of Health (MOH) through Public Health agencies, whereas it is under the State Penitentiary Service of Ukraine (SPSU) for detainees in pre-trial Centers and sentenced prisoners, through prison health care. This implies important efforts of coordination for continuity of treatment (field visit).

1.1.2. HIV epidemic situation in prisons

The epidemic in prisons is mostly driven by the transmission through injecting drug use. Approximately 40% of prisoners have used drugs intravenously, in some prisons up to 60%, and in some women's prisons even up to 70-75% (field visit). Regarding the HIV/AIDS epidemic (*in close settings – ed.*), the numbers differ according to the source reported in (Balakireva, Sudakova et al. 2012):

- Ukrainian Center for AIDS Prevention and Control: in 2011 2,463 new HIV infections were detected (out of 23,779 people tested): prevalence rate is 10.4%.

SPSU: in 2011 2,819 new HIV infections were detected (out of 28,181 prisoners tested). The number of AIDS related deaths was 388 (steady increase between 2007 and 2011), which represents one third of deaths in prison and means that AIDS-related diseases are the first cause of death among prisoners. 216 out of 388 deaths were caused by TB. Although the number of people diagnosed with TB and the deaths caused by TB are known (in the decrease since 2009), reported TB-related mortality does not include those who died from HIV-associated tuberculosis (p 28). BBS conducted in 2011 (Balakireva et al. 2012) according to the National M&E Plan (involving 1,300 participants at 24 penal and 2 correctional colonies: 1,000 males, 200 females and 100 juvenile offenders) showed that 13.6% of prisoners were HIV positive with a prevalence three times higher among women compared to men (33,0% among females and 10,1% among males). This is constant since 2009. HIV infection rates are higher in older age: 21% in 30–34 years group and 20.5% in 35–39. This value is also reported in the Ukraine Progress report (International HIV/AIDS Alliance in Ukraine 2012).

SPSU provides a lower figure according to the number of prisoners and registered PLWH of 4,8% (basis: about 144,000 prisoners and up to 7,000 registered HIV-positive cases).

According to another bio-behavioral survey (BBS) conducted among 402 participants in 12 prisons (4 of them are female) across Ukraine in 2012 (Altice, F., & Dvoryak, S. (2012): 48% are IDU (self reported). 19% were tested HIV positive (comparable to the prevalence rate within IDU in general).

During the field visits even higher percentages of HIV infections among prisoners in some facilities have been reported (>20%; see Annex 3). Depending on the penal institutions considered and the region (i.e. male/female prison, hospital ward, pre trial Centers/colonies, small or larger cities), variations in the proportion of IDU and HIV prevalence can be observed (70-90% of admissions are IDU and the prevalence of HIV is 22% in Kyiv, pre trial detention jail). In practice, according to field workers, HIV prevalence among prisoners is estimated to lie between 15%-30% (International HIV/AIDS Alliance in Ukraine 2012), 60% being (former) injecting drug users, up to 70-75% in female prisons (e.g. Chernighiv).

- The number of AIDS-related deaths in prisons is extremely high in Ukraine. In 2011, 388 deaths in custody have been reported. It was reported that it was difficult for prison doctors to distinguish the exact cause of death (TB/AIDS). However, HIV in prisons is the death cause number one (2010 and 2011). The massive threat to other infectious diseases with high risk to acquire other BBVs often results a sentence into a death sentence.

According to the National M&E Unit, the reporting data of BBS (Balakireva et al. 2012) that was approved by the SPSU, is the key data basis to operate with and is being centrally used in this report.

1.1.3. Risk behavior in prisons

As outside in the community sharing unsterile injecting equipment and paraphernalia among IDU is the key driver of HIV and hepatitis C epidemics in prisons. Participants of the BBS (Balakireva, Sudakova et al. 2012) conducted in 2011 reported:

- A lifetime prevalence of injecting drug use of 40% with 17% reporting use during the imprisonment also (20% of men and 3.5% of women). Drugs used were cannabis (15.5%), opiates (8%) methamphetamine (5%), stimulants and hallucinogens (3%). According to field visits, simultaneous multiple drug use is also prevalent.
- Sexual intercourse in the 6 months prior to the study: 14% of reported heterosexual contacts with visitors in the last six months (7% unprotected); 4% had contacts with other prison inmates (2% unprotected).
- Tattooing: 20% made tattoos during incarceration
- According to the data of the BBS, the group of “potentially” at risk of HIV infection comprises more than one third of all respondents (38.5%), including 42% among male and 19% among female convicts. In the age group of 20–24 years the share reached 44%. The group of “real” risks consists of 16% of respondents (17% among men and 9% among women). Almost every fifth respondent in the age of 25–29 years and 30–34 years of age (18% and 19% correspondingly) confirmed practices that lead to “real” risks of HIV infection.

There is a lack of equivalence of harm reduction and treatment measures between drug users in the community and in prisons (e.g. absence of needle exchange and opioid substitution therapy - OST in penitentiary institutions).

The free access of inmates to medical care is hampered by lack of health care staff especially in pre-trial detention centers.

In its visit in 2009, the European Committee for the Prevention of Torture (CPT) also stresses the importance of access to drug dependence treatment. “CPT considers that there should be a multifaceted strategy vis-à-vis inmates with drug-related problems, which combines prevention of the entry of drugs with the provision of treatment, assistance and information. The services made available to such prisoners should include, inter alia, medical detoxification, psychological support, life skills, rehabilitation and substitution. The Committee recommends that the Ukrainian authorities develop a comprehensive and coherent prison drug strategy, including the provision of assistance to inmates with drug-related problems.” (CPT 2011).

1.1.4. Level of knowledge regarding HIV among prisoners

The level of knowledge of prisoners regarding HIV transmission is quite high and did not change dramatically over last years. Data of 2007 showed that 82% of prisoners were aware that sharing a syringe or needle was exposing them to HIV transmission, and 80% that the use of condoms was protecting from transmission, respective data of 2011 showed 82% and 74%. However, if we compare the level of general knowledge regarding HIV, it decreased since 2009 - from 41 % to 30,5%. This tendency corresponds to the decrease of coverage with prevention programs for prisoners within the GF Rd6 Project. The data confirm the need to strengthen the work among prisoners to raise their awareness of HIV infection and related diseases. Among those who injected in the preceding 12 months, 46% used a shared syringe or needle; 88% reported having had sex with other men, and 87% having never received any condom (Data from UNGASS Report, p 72(UNAIDS 2009). Latest research showed that those prisoners who injected drugs over the last 30 days did it mostly unsafe. Such data have to be considered in the context of poor access to prevention and harm reduction means. They do not necessarily reflect a level of knowledge, since, even when knowing the proper means to protect, in the absence of proper prevention means, the behavior will remain at risk.

1.1.5. Epidemiological data on tuberculosis (TB) and hepatitis in prisons

With an incidence of 100/100,000 per year, Ukraine has the second highest burden of tuberculosis in the European Region, behind Russia. One in five new diagnosed TB is resistant to treatment. This situation is reported to be due to a complex interaction of factors: poor adherence to TB treatments, high rates of TB in prisons, poor infection control in prisons and health facilities, insufficient supply and prescription of TB drugs, lack of adequate government support for opioid substitution therapy (Mburu 2011).

Except the data mentioned above on the high burden of death caused by TB among HIV infected people, accurate data on TB in prisons are missing which impedes a precise overview of the situation: the rates of HIV positive people among

those diagnosed with TB are unknown; the rates of TB diagnosed among HIV positive persons are unknown. Comparative values outside prisons report that 70% of HIV positive patients have TB latent infection (field visit). There is no clear data on TB resistant to treatment. According to HIV/AIDS Alliance, one in five new diagnosed TB is resistant to treatment. Due to the spread of HIV/AIDS, high density in occupancy, prisons seem to represent a high risk place for developing TB (personal communication during visits; (Mburu 2011).

During its visit to Ukraine penitentiary institutions in 2009, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) addressed the issue of tuberculosis control. Screening (X-rays) is implemented and treatment initiated in the temporary holding facility (ITT). However interruptions of treatment do occur during transfers to pre trial centers. The CPT recommends: *"Despite the steps taken in recent years, the provision of adequate care to prisoners with TB continues to be a serious problem resulting in significant levels of morbidity and mortality. It is clear that further improvement is needed to ensure coherent assessment, treatment and preventive strategies. The CPT recommends that urgent steps be taken to ensure:*

- *the provision of sufficient quantities and types of anti-TB medication in all penitentiary establishments (including SIZOs);*
- *the possibility to transfer remand prisoners suffering from TB to specialist units within or outside the penitentiary system so as to offer adequate treatment;*
- *systematic treatment of prisoners in accordance with the DOTS method for tuberculosis control."* (CPT 2011)

Data on hepatitis is scarce; some were collected in the bio-behavioral survey (BBS) conducted in 2012 among 402 prisoners (Altice, F., & Dvoryak, S. (2012). Among the 19% of prisoners tested HIV positive 92% were co-infected with HCV; 60% are HCV positive; 5% are HBV positive. Furthermore there is no hepatitis testing, vaccination (HAV and HBV), or HBV and HCV treatment. In rare single cases the prisoner is taking charge of hepatitis-related support.

1.2. Current responses to HIV/AIDS challenges in prison settings

In line with the National AIDS Program (National Program for the Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients for 2009–2013), a relevant sectoral program for prisons entitled "Program to Ensure Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients in Penitentiary facilities and Remand Prisons of the State Criminal Execution Service of Ukraine for 2009-2013" is currently operating.

Furthermore GFATM funds are utilized by NGOs throughout the country for prevention activities, ARV treatment (almost 80%), and care and support activities (reaching the targets).

Finally additional support programs focusing on specific thematic areas (human rights) or methods (training, manuals etc.) have been carried out by various initiatives and under varying funding (UNDP, EC, funds, national support, e.g. The Netherlands).

1.2.1. Service provision

Formally prison health care is under the auspices of the SPSU are responsible for any treatment of the prisoners. However, a clear and comprehensive strategy to tackle the HIV/AIDS challenges, co-infections (TB, STIs, hepatitis) and drug dependence with guidelines, standards and protocols is missing, in particular the exact processes of providing and carrying out HIV tests (VCT), CD4 tests, follow-up and the initiation of ARV (information about impact, side effects etc.).

ARV is prescribed and administered under the supervision of physicians from the Regional Centers of Prevention and Control of AIDS (called Regional AIDS Centers, RAC) and the doctors of the State Penitentiary Service according to the National clinical protocols for treatment of HIV infection in adults and adolescents, approved by the Ministry of Health of Ukraine from 12.07.2010 № 551.

ARV treatment is provided along a cascade way with the NGO UNPLWH handing it over to the National AIDS Center, which then distributes it via regional AIDS Centers.

Prison doctors, even infectiologists are not allowed to diagnose, initiate, prescribe, and monitor ARV to prisoners at the facility. It has to be done at specialized HIV/AIDS prison clinics of SPSU or by certified infectiologists at the Regional/ National AIDS Centers. The doctors of the RAC are not obliged to provide services to prisoners and technically and logistically are currently not able to screen, treat and monitor all approx. 6,900 HIV-infected prisoners. During our visit, representatives of several organisations suggested a change that doctors from prisons/colonies – after undergoing certified training – should be allowed to prescribe ARV - under the supervision of RAC doctors.

The question to implement independent community health care services in prisons is under discussion. Currently, once

ARV is prescribed in the community, incarcerated patients are administratively under the charge of the National AIDS Center, according to an interdepartmental agreement including NAC – Ministry of Health and the Ministry of Justice. Consultants from NAC are regionally available. The quality of care and cooperation with the NAC is highly variable according to the different regions.

Parallel to the HIV-related work of prisons, and prison administration Regional HIV/AIDS Councils (RHAC) do exist. Their role is to coordinate and support regional response to HIV, of which prisons are a part of. The Regional HIV/AIDS Councils include people from the local penitentiary institutions, NGO's (regional representatives of UNPLWH, and other key actors (e.g. Médecins sans Frontières), regional health care staff, deputies, personal and professional counselors and Regional AIDS Center. The RHACs are supposed to be implemented in each region, working with varying intensity in involving prisons. Their task is mainly technically oriented, with aspects related to HIV/AIDS/TB treatments.

Although we did not get a complete overview of scope and quality of service provision, quality of the relationship between RAC, RHAC and penitentiary institutions during the limited period of time of prison field visits, interviewees indicated a very varying service provision and care for prisoners needs. In some cases and areas the service provision is very good, in others not. This is mostly due to geographical issues (remote situation of prisons). Thus it depends from oblast to oblast. The NGOs play a crucial role in facilitating, moderating, and organizing HIV/AIDS related services on the ground. Much of good linkages seem to depend on the abilities of NGOs in communicating and organizing.

A solution to the service provision gaps observed during field visits was that some NGOs within care and support projects (GFATM) provide transportation for doctors from the RAC venue to the prisons. In many instances doctors are paid by the NGOs, just to fill the gap of health care provision. Generally spoken NGO improved the access to services.

There are two "HIV/AIDS" clinics (with units for HIV positive people from penal institutions (40 beds with only limited beds for women (5) at colony #10 – Kherson region, 60 beds in Donetsk (colony #124). It is planned to provide more beds in Zhytomyr region in 2012 (colony #73) (UNAIDS 2012).

1.2.2. Access to HIV screening and VCT

Prisons are a central place to undergo screening, since one tenth to one sixth of new HIV infections are detected among incarcerated people. The testing was mandatory on entry before 1998, since then it is voluntary and confidential (Kryvoruk 2012). However, the CPT reports that in 2009 some prisoners requiring the testing were not provided due a limited number of tests that could be performed (CPT 2011).

As from 1987 to January 1, 2009 27,017 primary HIV infections have been detected in the institutions of State Penitentiary Service of Ukraine (State Penitentiary Service of Ukraine 2009). However, among the estimated 230,000 PLWHA (2012 data), the majority does not know that they are infected. The coverage of testing among MARPs is too low, in particular among IDU, TB patients and prisoners. At the same time, the number of infections reported might be inadequate due to lack of quality in the epidemiological surveillance and reporting system in prison. It is also difficult to define precisely if people have been infected before or during incarceration. Inadequacies in the reporting of HIV/AIDS cases involving prisons have also been identified (UNAIDS 2009). This is impeding the demands for funding support that should be based on epidemiological data and needs in terms of treatment, not the achievement of targets defined by the GFATM supported project. If VCT (based on rapid tests) are available (within the limits described), the problems arise mainly in the further steps of confirmation of diagnosis and starting the treatment (EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol And Drugs of the Ministry of Health of Ukraine 2011).

According to the BBS (Balakireva, Sudakova et al. 2012) in prisons 39% of prisoners were tested for HIV while in prisons. HIV testing is done at request of prisoners, except before surgeries (done upon health care services providers' initiation – information during field visits) and in TB hospitals (10 across Ukraine), where it is systematic and providers initiated. 96% of TB patients undergo HIV testing.

Prisons do not have their own laboratories. The Regional AIDS Centers do provide the prisons with a limited amount of HIV-test kits. In some prisons all incoming prisoners are offered VCT – blood samples are usually taken on a fixed date and transported to the Regional AIDS Center. Inconsistencies between the number of identified positive results and the estimated prevalence of HIV were reported; results are not systematically transmitted to prisoners; post-test counseling is not always available (especially if the results are negative) (Balakireva, Sudakova et al. 2012).

As the number of tests available is limited, it remains unclear what are the specific criteria used to offer prisoners HIV-testing (risk behavior, no test before, clinical signs of AIDS)?

1.2.3. Access to ARV-treatment and follow-up

The number of PLWH being under medical follow-up for HIV/AIDS has been increasing over the last three years (approx. 6,900 in 2012) (Balakireva, Sudakova et al. 2012). However, according to the studies available, if one assumes that 13,6% of all prisoners (155,000) are HIV positive, this would represent an estimation of approx. 20,000 HIV-infected prisoners. In other words at the moment approximately only one third of the estimated 20,000 HIV-infected prisoners is being officially registered (6,910) and might be covered with special offers. And this is a conservative calculation. Based on data of the most recent BBS from Altice & Less (2012) 19,4% of the tested prisoners were HIV-positive. This would mean that approx. 30,000 prisoners are supposed to be HIV-positive.

CD4 cells count diagnosis are extremely limited in prisons (Balakireva, Sudakova et al. 2012) and are not covering the needs to properly monitor the progress of HIV. Test kits are mostly procured within GFATM supported project (see Annex 5).

Regional AIDS Centers also provide testing for CD4 cell counts. However, only a certain amount of tests is dedicated to prisons, the prison department is not planning CD4-cell testing on a large scale. Monitoring and planning is almost completely left to the MoH and NGOs (e.g. UNPLWH).

The laboratory necessary for follow-up of ARV is provided by the Regional AIDS Center, but procured by UNPLWH.

There is a steady increase in the number of patients receiving ARV. As of 1 January 2009, 205 patients received antiretroviral treatment within the institutions of the State Penitentiary Service of Ukraine (one quarter started it before the imprisonment). The expansion of the coverage was planned with the supply of ARV with the support of "All-Ukrainian Network of People Living with HIV" (GAFTM funding) (State Penitentiary Service of Ukraine 2009). As of January 01, 2012, 986 AIDS patients across 22 remand prisons and 192 penitentiary facilities in all oblasts of Ukraine are provided with ARV (Balakireva, Sudakova et al. 2012), By the end of June 2012, the number of patients provided with ARV was 1236 (source: xls – GAFTM- 2009 – August 2012), out of the officially registered 6,910 PLWHA. 218 treatments are provided through the Regional AIDS Centers, and 1018 through the Network of People Living with HIV (GAFTM funding). Plan for coverage within GFATM Rd10 Project should mount up to 1,200 prisoners in ARV at the end of the year 2012 (see Annex 1) and to 3000 by the end of 2017 within GFATM Rd10 Project (field visit).

Continuity of ARV for prisoners who started it in the community was ensured (Kryvoruk 2012).

When one considers that approx. 57% of the officially registered 6,910 HIV positive prisoners might be eligible for ARV (Altice & Dvoryak 2012), less than one third of the needs are covered. If one calculates with the realistic number of 20,000 HIV-infected prisoners, approx. only every tenth prisoner is receiving ARV. This number still has to be compared with the figures in the community.

The insufficient coverage of ARV is due to insufficient planning, funding for the treatment and laboratory. Regarding treatment for opportunistic infections, SPSU, and patients themselves cover the costs, due to insufficient available funding (UNAIDS 2012).

1.3. Training aspects

Medical staff can benefit from training in pre-post counseling. Due to a high turn over of doctors and other medical staff (e.g. feldsher), which has been described from nearly all sites visited, it is necessary to offer recurrent training to maintain the presence of well-capacitated qualified staff.

One of the key recommendations of the external evaluation was to provide non medical staff (procurators, courts, police, prison staff, social worker) who provide services to MARPs with basic training in HIV/AIDS transmission, stigma and discrimination (UNAIDS 2009).

HIV/AIDS-related training was developed and incorporated into the state department's obligatory training program for all prison staff. A resource Center on the premises of the Correctional Department was established and equipped. An educational manual 'Health Promotion in the State Department of Corrections' was developed together with prison staff. It is accompanied with a series of posters, CDs with presentations for use during training sessions and an anthology of materials that can be used in the prevention education of prisoners. All correctional facilities in Ukraine have been equipped with these materials. A national team of 27 trainers is now qualified to conduct training of prison staff on issues such as health promotion in prisons and the prevention of HIV, STIs and tuberculosis. Some members of the team took part in a study tour to Amsterdam in 2008. Local teams of trainers are based in 4 regional Centers – Zaporozhye, Lugansk, Odessa and Ternopil. To date, 84 trainers have attended preparatory courses and 68 people have received training certificates.

Across all regions 140 specialists were trained to conduct educational sessions for other personnel. Altogether, 281 employees of the State Department of Corrections participated in this project.

NGOs play an important role in prison staff training. They publish manuals on the issue of prevention. For example "Step by step. NGOs' prevention activities in penitentiary institutions of Ukraine (available at <http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/library/our/stepbystep/index.htm>).

It remains unclear how such trainings are integrated in the curriculum of prison staff training centers.

The NGO AIDS Foundation East West (AFEW) (<http://www.afew.org/about-afew/our-mission/>) is active both in training inmates and staff in Ukraine. The hours dedicated to staff training in health issues (HIV/AIDS and TB) has increased over the years, but those activities are not regularly provided even though 220 people benefitted from it. A training handbook endorsed by SPSU has been issued. (field visit).

1.4. Funding

Funding of currently accessible services are shared among the government/SPSU, state budget (opportunistic treatments, STI), and GFATM via UNPLWH (ARV and follow-up testing), which implies uncertainty regarding the sustainability and even insufficiency regarding HIV-test kits, CD4-count testing, ARV, and opportunistic treatments. Local budgets at each oblast pay for the screening.

Furthermore, the government of Ukraine has been considered to invest very little means in the prevention among IDUs and prisoners (UNAIDS 2009). The needs for diagnostic tests and treatments have to be estimated each year and applied for. This work is done by the MOH, but not by the SPSU. The funds for implementing the NAP are not fully utilized in prisons, where medical staff relies on the RAC without involving themselves to a larger extent (except provision of medication and monitoring).

The tentative amount of funding for the NAP activities related to the penitentiary system for 2009-2013 is 154,6 million UAH. However, for the year of 2009 the planned amount of funding from the State budget was more than 23 million UAH, but according to the SPSU no funds were transferred.

Almost 85% of the funding for ARV treatment is provided by GFATM funds (through the Network of People Living with HIV). From 1,026 receiving ARV at 01.04.2012, 165 persons were receiving it through the AIDS Centers.

Furthermore, data provided by penitentiary institutions to the Ukrainian AIDS Center are reported not to be reliable, which furthermore impedes forecasting, planning and application for adequate funding. During prison field visits an absence of capacities among prison staff in those important administrative matters has been reported (e.g. not applying for possible funds for hepatitis-related grants as principal recipient in Round 9 GFATM). This problem in planning issues does also result from the isolation of the prisons, which work in a closed system and not along way with the health structures in general (International HIV/AIDS Alliance in Ukraine 2012).

2. STRENGTHS AND ACHIEVEMENTS

Some of the main achievements cited in the table are described in more details above (see chapter 1.2. current responses to the epidemic situation).

Table 1: Major expected results, targets and main achievements

Major expected results, targets and main achievements	
A. NAP 2009-2013	
(Targets are under B., see below)	
B. SPSU Action Plan	
1. Participation in activities of national and regional councils on prevention of TB and HIV/AIDS and development of materials for the meetings	SPSU representatives participated in meetings of relevant councils.
2. Development of the National report of Ukraine on fulfillment of the Declaration of Commitment on HIV/AIDS	SPSU provided organizational support to the bio-behavioral studies to collect data on 'prison indicators'; information which was included into Reports from Ukraine was approved by authorized SPSU managers.
3. Improvement of normative-legislative acts of the SPSU as to prevention of HIV/AIDS, especially as regards the prevention activities among inmates	No information
4. Control of adherence to legislation on HIV/AIDS in the contexts of personnel management aimed at elimination of discrimination of people with HIV	No objectives and indicators.
5. Participation in the development and implementation of mechanisms to engage NGOs in the provision of social and other services as required by the public needs	No information on the results of 1 activity (planned for 2009).
6. Development of regional programs on HIV prevention, care and treatment for people living with HIV/AIDS for the period of 2009-2013, in cooperation with local health care institutions	HIV prevention, care and treatment for people living with HIV/AIDS have been carried out, although with funds of GFATM (see C.). The targets have been reached with activities re care and support, but not so with regards to prevention.
Designing procedure of providing social follow-up, medical care, and social support to children born to HIV+ mothers that stay at child homes attached to penal colonies, as well as to HIV+ minors staying at penitentiary settings	It was reported by SPSU that a procedure was developed in 2009, whether it has been approved or not remains unclear.
7. Awareness raising activities and obligatory knowledge testing related to HIV/AIDS, prevention and free testing for HIV-infection, as part of professional training for the regular and managerial staff.	A resource Center on the premises of the Correctional Department was established and equipped. An educational manual 'Health Promotion in the State Department of Corrections' was developed together with prison staff. It is accompanied with a series of posters, CDs with presentations for use during training sessions and an anthology of materials that can be used in the prevention education of prisoners. All correctional facilities in Ukraine have been equipped with these materials. A national team of 27 trainers is now qualified to conduct training of prison staff on issues such as health promotion in prisons and the prevention of HIV, STIs and tuberculosis.
8. Development of the procedure of social supervision, providing of medical care and social support to children born by HIV-infected mothers who are currently in penitentiary institutions, as well as HIV-infected children under age who are currently in penitentiary institutions and investigation jails	One order in 2009 (TB)
9. Establishment of infectious disease departments for the treatment of people living with HIV/AIDS in the settings of the State Penitentiary Service of Ukraine	One clinic in Donetsk has been established within the National Program, a HIV-clinic in the Kherson region was established earlier, and received just some funding within NAP. Unclear how much money has been spent.
10. Infection control within the health care institutions of the State Penitentiary Service of Ukraine	No. of HIV tests in 2009: 24,099 (HIV-positive prisoners 2,902 = 12%); 2010: 24 371 tests, 2 738 were detected HIV +, - 11,23%; 2011: 23 779 tests, 2 463 were detected HIV +, - 10,36%
11. Promotion of tolerant attitude towards people living with HIV/AIDS	No objectives and indicators. Trainings (see below, chapter 2.3)

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12. Development and implementation of HIV/AIDS preventive methods at working places and elimination of discrimination practices in labour relations	No objectives and indicators. Trainings (see below, chapter 2.3)
13. Implementation of activities on identification and preventive treatment of sexually transmitted infections in risk groups	No specific information available.
14. Delivery of HIV prevention services to convicted and inmates (condoms, disinfectants)	No information available regarding accessibility of condoms and disinfectants. SPSU provided condoms only within conjugal visits. According to information gathered during field visits, the provision of condoms to prisoners by NGOs (financed by GFATM funds) not being allowed to have conjugal visits, varied widely across the country.
15. Ensuring access to counseling and free of charge testing for HIV for convicted persons and inmates	No. of HIV tests (see No. 10), according to SPSU almost each new incoming prisoner is offered a VCT, which is also being taken by the prisoner. Counseling is provided by trained doctors and supported by peer educators (mostly on the post testing stage). Annual targets of coverage according to SPSU Action Plan have been reached in 2009, but not in 2010 and 2011: 2009 2010 2011 15% 20% 30% 16,28% (24,099) 16,46% (24 371) 16,06% (23 779)
16. Provide preventive and antiviral medicines against HIV-infection (PCP) to the persons who have contacted with biological liquids, especially for the medical staff and social workers	PEP kits are stored at local AIDS Centers, procured within MoH procurement.
17. Provide access for HIV infected inmates to sustained ARV by means of ensuring centralized procurement of ARVs (to a large extent covered by GFATM funds – almost. 80%)	The number of persons receiving ARV therapy has been increased from 205 (1.1.2009) to 1,026 (1.4.2012). The target number of 1,200 will certainly be reached at the end of 2012. This number meets the goal for 2012 that 17% of officially known HIV-infected prisoners should receive ARV.
18. Ensure treatment of opportunistic infections among people living with HIV/AIDS	In 2010 the amount of 10 million UAH was provided. This was enough to cover the costs of opportunistic infections. In 2011, the sum of 5 million UAH was transferred. There are no data related to the real needs of fund for treating OI.
19. To ensure confidentiality of pre- and post-testing counseling while conducting a voluntary testing for HIV	VCT has been introduced in 1998, it is unclear to which degree HIV-testing is offered proactively. VCT is offered to all incoming inmates. According to information from some prisoners the quality of pre- and post testing counseling is very variable, especially with regard to ARV initiation.
20. Ensure CD4 testing among convicted persons and inmates receiving ARV	CD4 testing for prisoners receiving ARV is procured mostly within GF RD6 project. According to reports from facilities there is no possibility to provide testing quarterly according to National guidelines. Unclear, whether the planned CD4 test kits have been procured.
21. Ensure HIV viral load testing among convicted and inmates receiving ARV	Viral load testing for inmates receiving ARV is provided mostly within the GF RD6 project or provided at Regional AIDS Centers. SPSU does not procure test kits and have no laboratory to do tests.
22. Ensure that biochemical analyses are provided	Range of provision is unclear.
23. Ensure diagnostics of opportunistic infections markers	No information available, whether the target numbers have been met.
24. Ensure hepatitis diagnostics	To our knowledge hepatitis infection testing is not being done on any regular basis, no program is being launched
25. Provide medical equipment for health facilities of the SPSU	No information available on the expenditures
26. Ensure an ongoing monitoring of Program execution	No information available, no objectives and targets.

27. Ensure timely statistic reporting on HIV/AIDS (2 – on HIV/AIDS, 3 - on HIV/AIDS/ARV, and a report on utilization of medical means)	Reporting is provided according to MoH statistics forms. According to Kryvoruk (SPSU – personal communication during field visit) reporting is done on a monthly basis.
B. Other programs (outside NAP 2009 - 2013)	
a). GFATM	
Prevention	Preventive activities (group counseling, lecturing or handing out information, partly condom distribution) are mainly carried out by NGOs. The targets are not been reached (only 15-20% have been reached – personal communication during field visits; see Annex 5). However, NGOs publish important information in form of manuals or videos (for example: AFEW or International HIV/AIDS Alliance in Ukraine). Condom/lubricant distribution is mostly project driven, therefore penitentiary facilities not cooperating with NGOs are lacking condoms.
Care and support for prisoners	The data on care and support activities show that the original targets for each time period have been met and even exceeded. However, little is known about the activities as such and the quality of services. During field visits it did not become clear how these services with what contents and methods have been delivered. Additional clarification from service providing institutions is needed (see Annex 4).
Procurement of CD4 testing for prisoners	CD4 testing for prisoners under ARV is procured mostly within GF RD6 project.
b). Governance of HIV/AIDS in Ukraine - 01.01.2005 - 29.02.2012 – implemented by UNDP	The manual on HIV and human rights for penitentiary system of Ukraine was published and distributed. Manual was approved for publication Scientific Expert Council of the State Penitentiary Service of Ukraine, protocol number 2/3 September 23, 2011. Guide is designed for professionals of the State Penitentiary Service, health workers, teachers and students of educational institutions, professionals involved in the organization and conduct of health care to persons who are in penal institutions. Guide aims to raise awareness about HIV / AIDS, explanation rights, social security, duties and responsibilities of personnel and penal institutions, as well as prisoners and persons in custody. About 80 penitentiary staff were trained at Chernigiv collage of Penitentiary System (2009) - http://www.undp.org.ua/en/projects-list-all/38-prosperity-poverty-reduction-and-mdgs-/627-governance-of-hiv-aids-in-ukraine
c). Institutionalisation of Health Promotion and HIV Prevention in the Educational System of the Ukraine State Department of Corrections – donors MATRA Programme funded by the Ministry of Foreign Affairs of the Netherlands – implemented by AIDS Foundation East-West (AFEW) (Partners: Mainline Foundation (The Netherlands), Ukrainian State Department of Corrections, Project Duration: 01.07.2007-01.08.2011	A training program was developed and incorporated into the state department's obligatory training program for all prison staff A resource Center on the premises of the Correctional Department was established and equipped An educational manual 'Health Promotion in the State Department of Corrections' was developed together with prison staff. It is accompanied with a series of posters, CDs with presentations for use during training sessions and an anthology of materials that can be used in the prevention education of prisoners. All correctional facilities in Ukraine have been equipped with these materials A national team of 27 trainers is now qualified to conduct training of prison staff on issues such as health promotion in prisons and the prevention of HIV, STIs and tuberculosis. Some members of the team took part in a study tour to Amsterdam in Oct. 2008 Local teams of trainers are now based in 4 regional Centers – Zaporozhye, Lugansk, Odessa and Ternopil. To date, 84 trainers have attended preparatory courses and 68 people have received training certificates Across all regions 140 specialists were trained to conduct educational sessions for other personnel Altogether , 281 employees of the State Department of Corrections participated in this project

In Ukrainian penitentiary system the services regarding prevention, treatment, care and support of HIV-infected prisoners are provided and efforts to implement structures to spread professional expertise on HIV/AIDS are being undertaken. However, the responses to the dramatic situation in prisons are still insufficient. Those services, although they might appear disproportional regarding the size and dynamic of the epidemic (for example access to ARV), do still represent first steps to build on further developments, as much in the amount than in the content of the services. At least, they create opportunities to raise important matters among the staff of the prison system and to experiment the implementation of new services. Changes in prisons are slow; usually to be faced with very high resistance towards changes in general. Therefore the existence of some responses, even on a small scale can be considered as a starting point to provide important information for further improvements and implementations on a larger scale. Relevant strengths are:

Existence of a sectoral program for prisons

In line with the National AIDS Program (National Program for the Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients for 2009–2013), a relevant sectoral program for prisons entitled “Program to Ensure Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients in Penitentiary facilities and Remand Prisons of the State Criminal Execution Service of Ukraine for 2009-2013” is currently operating. The existence of such a program targeted to the situation in prisons is a strength, although it shows some limits in the conception and implementation. Its main goals are centered on HIV/AIDS, neither TB, screening and treatment nor opiate substitution treatment is mentioned. However, the provision of condoms and disinfectants are mentioned.

Cooperation with NGOs

Although variable in proportions and types, cooperation with and involvement of NGO’s is a second important strength. This can ensure a greater equity in accesses to services, sustains the prisons in their work and supply of services addressed to IDUs or HIV-positive prisoners, etc. Often NGO’s are also a way to experiment new services that prisons usually are not used to do. Indeed, NGOs are substantially involved in prevention for prisoners and prison staff (information, provision of hygienic materials) (Balakireva, Sudakova et al. 2012) and care and support for HIV-positive prisoners and prisoners in ARV.

Cooperation with National AIDS Center (NAC) consultants at the regional level

Efforts made to delocalize and spread the expertise necessary to provide complex treatments such as ARV are a third strength. Although, as with regards to NGO’s the degree of cooperation is substantially varying across the regions, one model of development is represented that allows the NAC to be directly in contact with prisons and avoids the further isolation of prisons of the general health system. The existence of another civil society representative, the AIDS coordination councils, goes in the same direction and has to be positively underlined also.

Improved access to ARV

The number of ARV treatments has been increased within the GFATM funding period, and has reached its target numbers. This demonstrates that the system is capable to manage the envisaged goals. However, the number of ARVs is below the calculated needs of HIV-infected prisoners.

3. WEAKNESSES AND CHALLENGES

Regarding the current responses to the situation, some of the reported weaknesses and key challenges are: insufficient funding and transfer of State budget's allocation for prisons, permanent lack of qualified staff, insufficient or irregular procurement of treatments, shortages of information materials and individual protection means, unregulated cooperation with partners, inequity in the access to those services. Health staff both doctors and nurses is insufficient.

3.1. Absence of sustainable funding

The HIV/AIDS response in prisons is still mostly project driven. The majority of prevention activities, VCT, ARV, CD4 testing, care and support programs are funded from GFATM Rd6 project (2007 -2012) and will be continued and extended within GFATM Rd10 project (2012 -2016).

With GFATM ending in 2017, sustainability can only be reached by integrating the funds of the GFATM into the State budget.

3.2. Insufficient coverage of ARV needs

SPSU is lacking proactive ARV management based on epidemiological and clinical monitoring, which impedes a realistic planning for the next years.

There are 183 penal institutions across Ukraine, some in very remote areas. This represents highly complex organizational matters in terms of access to treatment, quality of trained staff, and equity of access. One major gap is the absence of proper reporting and estimation of HIV/AIDS needs to apply for adequate funding in those matters.

3.3. Insufficient coverage of prevention and absence of harm reduction measures

Mostly NGOs are delivering preventive activities in prisons, which consist mainly of group counseling, lecturing or handing out information (see Annex 7). After a few years of intervention in prisons, there is an important interest for volunteer trainings and self-help group developments. SPSU agreed to the involvement of NGOs in the training of prisoners (peer education based programs; field visit). Manuals addressing this issue are available (see <http://www.aidsalliance.org.ua/ru/library/our/2011/module.pdf>). NGOs publish important information in form of manuals or videos (for example: AFEW or International HIV/AIDS Alliance in Ukraine).

Prevention was assessed as being insufficient (UNAIDS 2012) since its scale was limited to the available funds within GFATM Rd6 Project. The targets of preventive measures have not been reached (only 15-20% have been reached – personal communication during field visits).

Prison authorities have been reported to be reluctant to recognize the existence of male to male sex/contextual homosexuality (UNAIDS 2009). This has been confirmed at prison/field visits in 2012.

Condoms provision is reported to be irregular (UNAIDS 2009). Condoms are available only for conjugal visits. Private visits are allowed three to four times a year, but only a minority does use them or are allowed to use them (14%). In the women's prison visited only 10% of the female prisoners receive conjugal visits. Therefore, even if it is indicated to provide condoms in this context, the impact on HIV/STI-related prevention in prisons seems to be not very significant.

When NGOs are present in the penitentiary institutions condoms availability is greater, and HIV awareness is more raised (EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol And Drugs of the Ministry of Health of Ukraine 2011).

Harm reduction measures virtually do not exist at the moment in Ukrainian prisons. Prison authorities remain opposed to it (UNAIDS 2009; UNAIDS 2012). Prison-based needle syringe program (PNSP) has been planned in 2005, it was ready to work, a Memorandum of Understanding has been signed, 3 pilot sites had already been selected, training has been carried out, a full algorithm has been elaborated, a PNSP order was drafted, but in the last moment the pilot has been rejected. All planned activities were stopped.

3.4. Lack of drug dependence treatment and in particular of OST

Drug dependence is not considered as an illness but as an offence. This is the main obstacle for treating drug dependent prisoners. According to experts there is a certain amount of denial to treat addiction in prison pretending officially that "these (drug) problems don't exist". The almost complete absence of any form of drug dependence treatment (e.g. OST) is clearly contributing to a high risk situation in Ukrainian prisons. The underlying assumption is that during imprisonment

no drug use is happening (although seizures suggest that there are numerous attempts to smuggle drugs in). Based on seizures the control measures are perceived as being very effective (field visits). However, the fact that drugs are coming in via different ways shows that control strategies remain partly unsuccessful.

There is a high turnover of prisoners going through the prison system yearly and there is a high number of IDU inside the prisons. The impact of measures or absence of measures is therefore of utmost importance for the prisoners and for public health.

Although buprenorphine has been provided since 2004 and methadone since 2008 in the community in Ukraine, OST is inexistent at the moment in prisons, which is unethical (UNAIDS 2009; Balakireva, Sudakova et al. 2012). It has been reported that in a few cases in police arrest stations OST can be continued if provided by the doctor in the community, mainly on initiative and by payment of the detainee him/herself.

In general, fear of stigma is associated with delay in access to treatment among IDU (Wolfe, Carrieri et al. 2010). The prison services do not facilitate the access to treatment; on the contrary, prisoners face severe inequity. Prisons lack qualified staff and means to diagnose and treat people who need it (p 108 (UNAIDS 2009). In Ukraine, IDU and prisoners are the groups who have the most difficult access to prevention, care and support services (p.139 (UNAIDS 2012).

OST that was begun in the community is interrupted on imprisonment. The absence of continuity of OST therefore might result in abrupt detoxification in either police arrest or pre-detention, which again is a health burden for those IDUs suffering from BBVs (EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol And Drugs of the Ministry of Health of Ukraine 2011). A working group including members of the Ministry of Internal Affairs, State Service on Drug Control, Ministry of Health, Ministry of Justice and the State Penitentiary Service of Ukraine is tackling the issue of opioid substitution treatment. A draft order has been elaborated by all the four Ministries in May 2011, which foresees that in police detention and then pre-trial prisons a continuation of OST should be done (in individual cases it is partly done in police detention, depends on the case). It has been submitted to the MoJ, and had been returned to MoH for reconsideration (November 2011). But one and a half year after first submission (October 2012), this order is still under consideration.

Also there is a lack of any other form of drug treatment. Preparatory work to pilot 'Atlantis' (12-step Minnesota model) in prisons has been done, but was stopped later. However, these approaches are not considered to be evidence-based.

All in all IDUs in prisons do not benefit from the achievements and the progress of services that can be observed in the community.

3.5. Absence of collaborative, intersectoral strategies

3.5.1. HIV/AIDS, TB

The prevalence of HIV-infection and TB are high in prisons. People die of both diseases in prisons. The "Program to Ensure Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients in Penitentiary facilities and Remand Prisons of the State Criminal Execution Service of Ukraine for 2009-2013" is solely concentrating on HIV/AIDS. It insufficiently addresses key cooperation or necessary bridges with other national programs tackling addiction issues, TB or STIs. This results in an absence of integrated services that include the main issues prisoners are confronted with (drug use; harm reduction, HIV/AIDS, hepatitis, TB and other MARP services (e.g. MSM) (UNAIDS 2009).

3.5.2. Hepatitis/STI

Hepatitis has not been addressed at all in prisons yet, although the majority of HIV-positive prisoners are co-infected with hepatitis (Altice & Dvoryak, 2012), and it contributes substantially to an increase in the health burden of those prisoners already infected with either HIV, already suffering from AIDS, and or TB.

The high rates of STIs make it necessary to address these topics much more intensive in order to raise awareness and educate about risk behavior. Rapid testing for STIs, with a follow-up referral to the health unit providing free diagnostic and treatment will lead to reduced incidences among prisoners.

3.5.3. Drug dependence treatments

Modeling of services to address the HIV epidemic in Ukraine have shown that the most efficient way was to achieve a high level of access to opioid substitution maintenance therapy and to ARV (p 84 (UNAIDS 2012). This is currently not possible in prisons or other custodial settings.

4. KEY BOTTLENECKS AND SOLUTIONS

Alongside the 15 recommendations to fight HIV in the comprehensive package (UNODC/ILO 2012) the key bottlenecks addressing HIV prevention, screening and treatment and solutions are discussed in the following.

4.1. Prison isolation and lack of inter-sectoral cooperation with other actors involved in NAP

Prisons are environments where efforts made in the NAP in general to decrease HIV transmission, or to implement treatment and care are undermined by insufficient service delivery in prevention, testing, treatment of HIV, and absence of drug treatment and harm reduction. According to the high number of prisoners that go through the prison/penitentiary system annually, this mechanism of disruption and negative consequences for public health after release of prisoners cannot be neglected. Prison staff and administrative are isolated and lacking competences that service providers in the general community have developed.

Solutions consist in creating bridges among prison representatives and stakeholders in the general community, at various levels:

- Re-vitalize the pre-existing intersectoral Technical Working Group (TWG) on HIV/AIDS and prisons (2007-2009) that included representatives of the central Management of SPSU, UNODC, UNDP, AFEW, USAID, HIV/AIDS Alliance in Ukraine, MOH, State AIDS Service (field visit).
- Link SPSU and State budgets / MOH in order to apply for appropriate funding.

4.2. Absence of equivalence of health care in prisons compared to the community

The principle of equivalence of health care in the community and in custodial settings is international standard also acknowledged by the Ukraine. The high AIDS-related morbidity and mortality in prisons is an indicator for improvement of services that should be equivalent with regards to guidelines, standards and protocols to those in the community.

Prison authorities should ensure that prisoners receive care, support (including adequate food and 509 nutritional supplements, if needed) and treatment equivalent to that available to people living with 510 HIV in the community, including ART.

Solution: Adjust all HIV (and other BBV) and TB-prevention and treatment strategies to those applied in the community. With regard to the internationally demanded equivalence of health care services in the community and in prisons, coverage, size and quality of services should be complementary and moving along the same line.

4.3. Absence of a comprehensive strategy to address HIV, TB and co-infections (hepatitis and STIs) together

Hepatitis, HIV, STIs and TB are closely interlinked, especially in prisons due to a complex interaction of factors: high rates of TB in prisons, poor adherence to TB treatments, poor infection control in prisons and health facilities, insufficient supply and prescription of TB drugs, lack of adequate government support for opioid substitution treatment. Early detection and treatment of STIs is important because these infections increase the chances of an individual transmitting and acquiring HIV. STIs that disrupt the integrity of the skin or mucous membranes can bleed easily, increasing the infectiousness and susceptibility to HIV. Monitoring, screening and treatment therefore need to be closely connected in order to tackle the diseases together effectively.

Solution: Promote collaboration among HIV and TB programs to ensure adequate services in prisons: "Prisons should ensure that integrated services are available to deliver effective prevention, including TB infection control measures, diagnosis and treatment of HIV, TB and hepatitis as well as harm reduction services." (WHO/HTM/TB 2012). A detailed strategy on the management of HIV/AIDS and co-infections (TB, hepatitis, and STIs) associated with the common elaboration of target indicators, standards, guidelines and protocols should be developed. Implement an integrated approach to tackle HIV/AIDS and TB together (organizational, professional level). Members of both HIV and TB national programs can use "WHO policy on collaborative TB/HIV activities" to implement the best country-specific management for providing collaborative activities to reduce HIV-associated TB mortality and morbidity, according to the Ukrainian epidemiology of both infections.

4.4. Lack of VCT

Prisons are a central and important place to undergo screening and VCT, since one tenth to one sixth of new HIV infections are detected among incarcerated people. However, due to reports not all prisoners requiring HIV testing and VCT were provided due a limited number of test kits. VCT give a deeper insight of dynamics of the epidemic and allow further planning and follow-up of testing and treatment commencing.

All forms of coercion must be avoided and HIV testing must always be done with informed consent, adequate pre-test information or counseling, post-test counseling, protection of confidentiality, and referral to services

Solutions: Access to, coverage and quality of VCT should be enhanced in the near future in order to improve diagnosis and entry into treatment if the prisoners are HIV-positive or if HIV-negative prevention through counseling. With regard to the quality of pre- and post test counseling the focus should be put on (1) knowledge about risk behavior and preventive measures, (2) life with HIV infection; (3) possibilities for diagnostics and treatment, especially ARV. The means VCT and its quality should be substantially increased. An urgently needed expansion will only be possible the use of rapid tests.

4.5. Limited access to ARV and follow up

ARV coverage in relation to treatment needs is extremely low. There is no management of proactively planning of the treatment needs. Closely related to the prescription of ARV, insufficient provisions of pre-treatment and follow up laboratory testing (in particular CD4 count and viral load) have been reported to impede the access to ARV.

Solutions: Access to ARV needs to be drastically expanded and be of comparable size and quality than in the community. Based on the number of PLWHA in prisons, the average estimation of indication for ARV (approx. 57%), the length of the sentence could be calculated in order to have a baseline for covering the testing and treatment needs. More prison staff has to be trained in administrative issues in order to apply for proper funding that will be in line with the needs.

The issue of providing ARV in the context of scarce access to laboratory follow up (based on a thorough clinical evaluation of the patients) could be studied more in depth to facilitate a greater access to ARV. However, such an issue could only be approached in line with the care of HIV in the general community, in order to keep the same protocol in different contexts (for more information see (WHO 2010).

Two more solutions could be explored:

- Study the possibility to delegate testing, counseling and ARV to RAC staff and train them accordingly

Use "success stories" that have been applied in the general community for Ukraine also in prisons, for example: community-based services; advocacy for reducing the costs of ARV (both reported in (UNAIDS 2012) pp 60 and 91).

4.6. Insufficient number of prevention activities

Preventive activities (group counseling, lecturing or handing out information, partly condom/lubricant distribution, IEC distribution and development) are mainly carried out by NGOs. The targets are not been reached (only 15-20% have been reached – personal communication during field visits; see Annex 5). However, NGOs publish important information in form of manuals or videos (for example: AFEW or International HIV/AIDS Alliance in Ukraine).

The provision of condoms is feasible in a wide range of prison settings, including in countries in which same-sex activity is criminalized. Condom access is unobtrusive to the prison routine, represents no threat to security or operations and is accepted by most prisoners and prison staff once it is introduced. Condom/lubricant distribution at the moment is mostly project driven; therefore penitentiary facilities not cooperating with NGOs are lacking condoms.

Solutions: Improve scope and quality of prevention activities. Make use of existing manuals, strategies. Use interactive ways, use peer-to-peer approaches and involvement of community services. IEC programs for both prisoners and staff about HIV and other infectious diseases, well-designed programs should be implemented in all prisons and other closed settings. Written materials should be appropriate for the educational level in the population in prisons and other closed settings. Furthermore, prisoners and staff should participate in the development of educational materials.

Condoms, lubricants as well as disinfectants need to be made accessible in a low threshold manner, which allows an easy, decent and discrete access for all prisoners.

The recommendations are prioritized on the basis of the data gathered within this and previous assessments, evaluations, international standards (e.g. comprehensive package of the UNODC 2012), and personal experience.

4.7. Absence of treatment and harm reduction measures (including OST) for IDUs

Considering the substantial number of estimated IDU on the one side in Ukraine (approx. 310,000) and the total number of prisoners (approx. 150,000) on the other, and the fact that four out of 10 prisoners have been or still are involved with injecting drug use, prisons represent one major place where to implement treatment for IDU on a large scale. The figures presented could even be higher considering prisoners' turnover rate. Solutions: Implement thoroughly OST in prisons and other custodial settings, as well as non-medication assisted treatment (e.g. 12 step Minnesota program, self help groups etc.), which partly could be even linked with each other. In a first step the draft order to introduce OST in police arrest and pre-detention centers needs to be signed urgently by the ministries in charge.

Harm Reduction measures have to be elaborated and urgently introduced. Existing plans for PNSP (in three pilot sites) need to be re-considered. Study visits to countries with comparable penitentiary system structures, where PNSP already have been introduced (e.g. Moldova, Kyrgyzstan) should be planned.

4.8. Lack of training for staff of different levels

Although trainings have been increased, still a clear lack of staff training has been noticed during field visits (e.g. prevention, VCT, clinical monitoring, ARV). Partly this is due to the high turnover rate among prison staff. This development leads to the fact that to high degree knowledge and experiences regarding everyday management of HIV/AIDS, STIs and TB issues get lost and require new capacity building.

Solutions:

- Provide training both for health care professionals and prison staff (especially health in prisons, drug nature and dynamic of dependence and related infectious diseases).
- Expand peer-education based programs in cooperation with NGOs.
- Increase cooperation with NGO and NAC to increase the presence of qualified HIV/AIDS doctors in prisons.
- Develop a mobile group of prison experts in HIV.

4.9. Absence of addressing hepatitis infections and STIs

Hepatitis B is easily spread in prisons. HCV is even much more easily spread among prisoners than HIV, including through sharing of shavers and toothbrushes, as well as through tattooing and body piercing. In contrast to HIV, the risk of infection can be reduced through the administration of a vaccine. All staff and prisoners should have easy access to free hepatitis B vaccination. In addition, consideration should be given to providing hepatitis A vaccination to prisoners at risk.

Although data on hepatitis is scarce in Ukraine the high rate of HIV and HBV/HCV co-infections is an alarming signal, which urges hepatitis testing, vaccination (HAV and HBV), and HBV and HCV treatment.

Solutions: It is therefore important that all prisoners and staff should be provided with information about the risks of HCV and HBV transmissions in custodial settings, and educate them about the ways to reduce the risks. In addition, shavers and toothbrushes should be made available to prisoners so that they do not have to share them with fellow prisoners. Hepatitis tests and STI tests should be offered proactively and pre- and post test counseling should inform prisoners about risks associated with risk behavior.

5. CROSS CUTTING ISSUES

5.1. Legal and human rights aspects

Like all persons, prisoners are entitled to be provided with the highest attainable standard of health, as guaranteed under national and international law. Key international instruments reveal a general consensus that the standard of health care provided to prisoners must be equivalent to that available in the general community. Principle 9 of the Basic Principles for the Treatment of Prisoners of the UN General Assembly (1990) states: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."

The principle of equivalence should play the guiding role in the organization of prison health care. Taken the existence of opiate substitution treatment, needle/syringe exchange projects and condom/lubricant availability in the community in Ukraine, equivalence of harm reduction in prison does not exist with the exception of condom availability in a few pre-trial detention centers and in conjugal visits.

Regarding people who are incarcerated, who are often MARP's in several perspectives, there are insufficient attention and means made available. Due to this, the professionals involved can only partly reach their targets.

The degree to which prisoners are equipped with passport and "propiska" (residency registration) after incarceration varies and depends very much on the commitment of prisons and NGO policies. During prison visits it became clear that some prisons explicitly focus on this support. Both are necessary for access to healthcare after release. Their absence on prison's release can impede access to health care following incarceration.

Police can detain IDU in police arrest up to 72 hrs without charge. Opioid withdrawals or threats of it have been reported to be used to obtain confessions. IDU can be sentenced up to three years for possessing a single dose of narcotic. Such severe law enforcements increase the tension with public health approaches aiming at treating IDU and represent barriers to treatment (Wolfe, Carrieri et al. 2010). In 2010, the legal threshold of illegal drugs have been reduced, increasing therewith the negative impact of criminalization even further (Resolution 634 reported by (Country Report Task Force for the adoption of lists of issues on Ukraine 2012). Poor prison conditions and abusive police practices have been considered to hamper prevention and harm reduction measures (UNAIDS 2009).

The narcological register is non-anonymous and implies observance periods (1 to 5 years depending on the treatment's issue). One can wonder if this restrains IDU from treatments, fearing to be registered, in particular since police has been reported to be using the register to fill their arrest quota (example of Nikopol, p 24 (Open Society Institute 2010). Registers are shared with police (Wolfe, Carrieri et al. 2010). Incarceration that can include unofficial police detention and harassment in up to 55.7% creates adverse effects on IDU (interruption of OST and ARV, confiscation of clean needles). Opioid substitution treatment was predicting police detention in a regression analysis model (Izenberg, Bachiredy et al. 2012).

PLWHA can be released due to their condition, according Art. 408 of the Criminal Code of Ukraine (354 prisoners in 2011, 5% of the registered HIV positive inmates in 2011) (Kryvoruk 2012). One has to wonder if this release is motivated by a condition near to death and what the future of those people is made of. During our prison visits negative consequences of such procedure have been reported in terms of self-neglect in the demand of treatment and follow-up in order to see one owns condition deteriorate and benefit from release.

Release or admission of prisoners PLWHA from and in the penal institution can influence the AIDS related deaths in prisons. Usually, prisons are not well rated if death rates are too high.

The same question relates to TB diseases. According to a specific order TB patients benefit from food supplement. While there is no doubt about the needs of such measures, one has to be aware that in some contexts, where food supply is particularly insufficient or unsatisfying in general, this can signify a secondary benefit to prisoners. This might impede their adherence to treatment, or even bring some to willingness of being sick, in order to benefit from such advantages.

During its visits to Ukraine penitentiary institution the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has stressed repeatedly on the importance of confidential medical care that often was not respected, in particular, when police officers are present during medical examination in pre-trial centers. Such practices have to be abandoned (CPT 2012). However, this issue has not been raised during prison visits.

Health staff is bound to military hierarchy and not health administration. The system will have to go through a deep reform in order to guarantee the independence of health care. In the everyday life of prisoners it can easily be identified if a prisoner is HIV-infected or not (e.g. daily appearance at the provision of medications, as in the women's prison – field

visit).

5.2. Gender issues

There is a specific response to incarcerated women and in case of pregnancy. In case of pregnancy, women in prisons are provided with services of preventing mother to child transmission (PMTCT) of HIV, according to the joint order (Nr. 740/1030/4154/321/614a; ed. 23. 11 2007) of the MOH, MOES, MOFYS, State Department of Ukraine of Execution of Punishment, and MoLabour and Social Policy Ukraine. The algorithm of services includes access to gynecologist, ARV for mother and child and decision on placement or adoption of the child (Personal communication during visits). The latter has been described as a longstanding problem in Ukraine for infants born to women drug users. Between 70% to 100% of female IDU clients have children (Open Society Institute 2010). Therefore, parenthood is a central issue in the care of IDU in prisons also and this opportunity to bring up positive changes in the women's life has to be seized whenever possible. ARV treatment is prescribed by infectiologist at the AIDS Centers, medications are provided by the AIDS Center of the oblast. Women inmates are transferred to local pre-natal hospitals for delivery, new borne are tested for HIV at AIDS Center (ELISA and PCR).

Even if women are a minority among detained people, the prevalence of HIV infection and drug dependence among them is substantially higher than in men. It remained unclear if, apart from efforts with regard to PMTCT, there are other specific strategies applied (e.g. easier access to treatment).

In general, experts pointed out that the needs of female prisoners especially in case of addiction, pregnancy, HIV infection and with children have to be much more specifically addressed. Regarding preparation for release, the need of much more psychologists and psychotherapists was claimed as well as closer cooperation with NGOs. Health care facilities as well as psychosocial and educational care need to be more intensive for women than outside prison walls because 85% of female prisoners come from socially deprived groups of the community.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions

Due to numerous risks for prisoners (high likelihood of BBV and TB transmissions due to high number of members of risk groups, poor living conditions, absence of many evidence –based preventive means and treatments) prisoners need to be addressed in the NAP along the line with other key populations. In public health terms the absence or insufficiency, or poor coverage of services addressing HIV/AIDS, other BBVs and TB among prisoners will slow down the achievements and efforts being made in the general community (see SR “People who inject drugs (PWIDs) - prevention, treatment, care and support”). Only a close connection between health care and especially HIV/AIDS/TB/STI services in the prison setting and the larger community is the guarantee for continuity of care (prisoners cycling in and out of penitentiary institutions several times), comparable size and quality of care, which contributes substantially to an effective and efficient response.

6.2. Recommendations

The recommendations are prioritized on the basis of the data gathered within this and previous assessments, evaluations, international standards (e.g. comprehensive package of the UNODC 2012), and personal experiences.

Recommendations made here cannot be realized in an isolated way in prisons only. Certain issues are also relevant in the general community (sustainability of funding; inter sectoral work or cooperation with NGO).

Table 1: Main bottlenecks, recommendations and expected results

Main bottlenecks	Recommendations	Expected results
1. Prison isolation and lack of inter-sectoral cooperation with other actors involved in NAP.	Develop networking, coordination, and cooperation of institutions and staff from prison administration, prisons and the community Revitalize the steady Technical Working Group (TWG) on HIV/AIDS and Prisons (2007-2009).	Improved access to and quality of health services for prisoners. Decrease in the interruption of continuity of care either on entry or release from prison. Reinforcement of NAP in the general community through appropriate interventions in prisons
2. Absence of equivalence of health care in prisons compared to the community	Adjust all HIV (and other BBV)-preventive strategies applied in the community to custodial settings	Improved prisoners health. Decrease in HIV/AIDS mortality and morbidity. Alignment of HIV/AIDS policy with international standards (principle of equivalence).
3. Absence of a comprehensive strategy to address HIV, TB and co-infections (hepatitis and STIs) together.	A detailed strategy on the management of HIV/AIDS and co-infections (TB, hepatitis, and STIs) associated with the common elaboration of standards, guidelines and protocols should be developed. Implement an integrated approach to tackle HIV/AIDS and TB together (organizational, professional level). Members of both HIV and TB national programs can use “WHO policy on collaborative TB/HIV activities” to implement the best country-specific management for providing collaborative activities to reduce HIV-associated TB mortality and morbidity, according to the Ukrainian epidemiology of both infections. (WHO/HTM/TB 2012).	.Improved prisoners health. Decrease in HIV/AIDS mortality and morbidity Decrease in co-infections morbidity and mortality

4. Lack of VCT	Increase the number and quality of VCTs. Expand VCTs by using rapid tests.	Improved prevention of HIV transmission. Improved diagnosis of HIV. Improved access to ARV-treatment. Improved knowledge of the epidemiological situation in custodial settings, information for prisoner's health (HIV status) and basis for ARV planning.
5. Limited access to ARV and follow-up	Increase access to ARV, improve clinical monitoring, staff quality, needs forecasting. Improve continuation of ARV at the interface of imprisonment and on release	Better monitoring and preparation for ARV, stabilization of prisoner's health, decrease of AIDS-related morbidity and mortality.
6. Insufficient number of prevention activities	Improve scope and quality of prevention activities. Make use of existing manuals, strategies. Use interactive ways, use peer-to-peer approaches and involvement of community services Make condoms, lubricants and disinfectants available in a low threshold manner, which allows an easy, decent and discrete access for all prisoners.	Improved knowledge of prisoners on HIV/Aids and BBVs. Decrease in the transmission of HIV
7. Absence of treatment and harm reduction measures (including OST) for IDUs and other drug users	Raise awareness for evidence-based treatment of IDUs, especially OST among management, prison doctors, nurses by close cooperation with community services providing OST. Discuss evidence-based harm reduction measures. Start with existing draft order for needle exchange programs and extension of condom provision in prisons. Introduce PNSP at least in two selected prisons (women, men)	Decrease in the transmission of HIV Reduction of risk behavior Improvement in the continuation of treatment Deeper understanding of the interrelation between risk behavior, and opioid dependence and prevention of HIV/Aids transmission
8. Insufficient training of staff of different levels	Train staff on the interaction among drug dependence and infectious diseases. Adapt the training to the various professionals involved (management, guards, health professionals).	Greater knowledge among prison staff leads to improved response towards the challenges of BBVs, TB and STIs and less discrimination towards infected people/IDU.
9. Absence of addressing hepatitis infections and STIs	Provide information about the risks of HCV and HBV transmissions in custodial settings, and how to avoid them. Provide individual shavers and toothbrushes Organize screening of hepatitis with pre- and post test counseling Provide vaccination	Prisoners are aware of hepatitis and STIs and can protect themselves accordingly. Decrease in the transmission of hepatitis Up-to-date perception of the situation from the epidemiological point of view, as a starting point for an appropriate public health response to it

7. ACTION PLAN

The action plan is framed according to the 15 components of UNODC Comprehensive package and adapted to the Ukrainian context.

Table 2: Action Plan for Prevention and treatment at Penitentiary System

Main recommendation	Recommended activities by responsible agency		
	Immediate term (3-6 months)	Short term (6-12 months)	Medium term (12-24 months)
1. Develop networking, coordination, and cooperation of institutions and staff from prison administration, prisons and the community	<p>Revitalize the steady Technical Working Group (TWG) on HIV/AIDS and Prisons (2007-2009). This TWG should take the lead in managing the problem</p> <p><i>Responsible agency:</i> UNODC¹, SPSU and others</p>	<p>Quarterly meetings to discuss needs and progress.</p> <p>Small working groups are responsible for technical/practical issues.</p> <p>Develop a strategy for the next 2 years with the goal to harmonize policies and practices regarding HIV/AIDS in custodial settings and the community.</p> <p><i>Responsible agency:</i> UNODC</p>	<p>Organize study tours to countries with similar HIV/AIDS and drug use-related problems and examples of good practices (e.g. Moldova, Kyrgyzstan, Estonia for needle exchange and OST). Progress report in 2014.</p> <p><i>Responsible agency:</i> UNODC, SPSU, OSI (?)</p>
2. Adjust all HIV-preventive strategies applied in the community to custodial settings	<p>The TWG should assess all inequalities with regard to HIV-preventive strategies on a national level.</p> <p><i>Responsible agency:</i> SPSU with UNODC Technical support</p>	<p>Working groups (see above) should discuss and write standards, guidelines and protocols of prevention, screening and care guidelines in prisons</p> <p><i>Responsible agency:</i> SPSU with UNODC Technical support</p>	<p>Standards, guidelines and protocols are available in written form and are published. Staff of different levels will be informed and trained</p> <p><i>Responsible agency:</i> SPSU with UNODC Technical support</p>

<p>3. Develop a detailed strategy on the management of HIV/AIDS and co-infections (TB, hepatitis, and STIs) associated with the common elaboration of standards, guidelines and protocols</p>	<p>A working group (see above) consisting of HIV and TB programs representatives and prison health staff should be implemented to the management of HIV/AIDS and co-infections (inter-sectoral). The goal of this group will be to assess the situation and develop a detailed strategy of how cooperation could be improved in the near future. Use "WHO policy on collaborative TB/HIV activities" (WHO/HTM/TB 2012) to implement the best country-specific management for providing collaborative activities to reduce HIV-associated TB mortality and morbidity, according to the Ukrainian epidemiology of both infections.</p> <p><i>Responsible agency: SPSU, WHO, TB national program</i></p>	<p>Interim report will be ready 6 months after implementation of the group. Write standards of HIV/TB treatment in prisons. Develop networking activities in order to ensure follow-up of co-infected persons upon release.</p> <p><i>Responsible agency: SPSU, State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases</i></p>	<p>The detailed strategy is developed and all relevant actors are informed and trained.</p> <p><i>Responsible agency: SPSU</i></p>
<p>4. Increase the number and quality of VCTs</p>	<p>a. Increase contacts with NGO providing VCT b. Make use of existing manuals</p> <p><i>Responsible agency: SPSU, Network, UAC, UNODC? WHO?</i></p>	<p>a. Facilitate NGO in providing VCT's in prisons b. Train health prison staff in VCT</p> <p><i>Responsible agency: SPSU, Network UAC</i></p>	<p>a. Implement peer-to-peer approaches with NGO</p> <p><i>Responsible agency: SPSU, Network</i></p>

<p>5. Increase access to ARV, improving clinical monitoring, staff quality, needs forecasting. Improve continuation of ARV at the interface of imprisonment and on release</p>	<p>Expand the share of ARV for prisons within the budget procurement at the end of 2012 (of the 44,000 ARV at the end of the year). The centralized procurement should stay. Specialists of the AIDS Centers should be motivated to treat PLWH in prisons</p> <p><i>Responsible agency: SPSU, State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases (UNODC and/or USAID)</i></p>	<p>Cooperate with regional AIDS Centers to ensure the continuation of ARV at the interface of imprisonment and on release</p> <p><i>Responsible agency: SPSU, UAC</i></p>	<p>Increase the number of infectiologists in prisons, who can either initiate ARV or treat under the supervision of specialized staff of AIDS Centers.</p> <p><i>Responsible agency: SPSU, State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases</i></p>
<p>6. Improve the scope and quality of prevention activities.</p>	<p>Develop a cooperation with NGO's active in educational issues. Make use of existing manuals, strategies. Use interactive ways, use peer-to-peer approaches and involvement of community services</p> <p><i>Responsible agency: SPSU, UNODC?</i></p>	<p>Development of interactive ways, use peer-to-peer approaches and involvement of community services</p> <p><i>Responsible agency: SPSU, Network</i></p>	

<p>7. Implement evidence-based harm reduction measures.</p>	<p>Discuss draft order for PNSP and extension of condom provision in prisons (e.g. how and where could they made accessible?). Sign and introduce order to start OST in police arrest and pre-detention Centers. Make sure that OST provider from the community have information and training sessions with doctors from custodial settings (police arrest, pre-trial detention Center and prisons/colonies). Use also non-pharmacological forms of drug treatment (self help, 12 – step Minnesota program).</p> <p><i>Responsible agency: SPSU with UNODC Technical Assistance</i></p>	<p>Make condoms available not only for conjugal visits but for any same-sex activities. Plan the process of introduction of OST in prisons as a one-year pilot project (one large men’s and one large women’s prison) Write standards of screening and treatment guidelines regarding drug abuse in prisons</p> <p>Invite self help groups/ ex-prisoners groups to intervene in prisons also.</p> <p><i>Responsible agency: SPSU</i></p>	<p>Introduction of OST in prisons Include condoms and for women hygienic set. Pilot project of needle exchange programs.</p> <p><i>Responsible agency: SPSU</i></p>
<p>8. Train staff on HIV and drug dependence</p>	<p>Assess the current situation related to training of prison staff regarding HIV</p> <p>Develop networking with NGO and training centers involved</p> <p>Assess the current situation related to training of prison staff regarding drug abuse</p> <p><i>Responsible agency: SPSU with UNODC Technical Assistance</i></p>	<p>Train medical staff with regards to HIV/AIDS issues</p> <p>Train medical staff with regards to OST.</p> <p><i>Responsible agency: SPSU with UNODC Technical Assistance</i></p>	<p>Organize an Ukrainian conference on prison health, which is aiming at getting together prison health specialists and professionals from the community involved in prevention, treatment and/or care of prisoners. On this conference the above mentioned strategies, standards, guidelines and protocols will be presented, discussed on national level.</p> <p><i>Responsible agency: SPSU, State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases, Network</i></p>
<p>9. Implement hepatitis testing and vaccination, along with pre- and post test counseling</p>		<p>Develop a modality of addressing Hepatitis and STI. <i>Responsible agency: SPSU, State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases</i></p>	<p>HIV-positive prisoners should be offered Hepatitis-B-vaccination. Based on cooperation and networking developed with actors involved in HIV issues, implement Hepatitis and STI testing</p> <p><i>Responsible agency: SPSU, State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases</i></p>

ANNEXES

Annex 1: Prisoners under ARV at the expense of the GF funds

Reporting period	Expected	Actual number
GF 6		
January-March 2009	250	234
April-July 2009	300	301
August-September 2009	300	322
October-December 2009	300	347
January-March 2010	350	376
April-June 2010	350	534
July-September 2010	400	533
October-December 2010	400	681
January-March 2011	500	750
April-June 2011	500	797
July-September 2011	800	728
October-December 2011	800	822
January-March 2012	900	861
April-July 2012	1000	1.029
GF 10		
August-December 2012	1200	1103

Number of CD4 cells tests done within GF project

Data provided by PLWH Network

Project Year	Number of tests
August 2009 - June 2010	4378
July 2010- June 2011	8229
July 2011- July 2012	8371
Total	20978

Annex 2: HIV and TB in a men’s prison in Bucha (field visit)

At the time of the visit the prison was holding 1,000 men (capacity for 1,200 prisoners) and 120 places in hospital (from 4 oblast). The prison is specialized on urology surgery for all prisoners in the Ukraine.

Prisoners usually live in dormitories of partly more than 30 persons. Also in the hospital ward approx. 6-8 patients live together in one room. HIV/AIDS and TB are the number one problems of the prison.

The situation of infectious diseases is as follows over the recent years:

Infectious disease	2009**	2010**	2011**	2012 (until 1st Sept.)
HIV prisoner	76 HIV-tests/16 HIV+	122/12	70/18	50/2
HIV prisoner UA*	364/73	569/136	575/138	535/116 (22%)
TB	14/-	19/3	9/3	7/-

* from all UA to undergo surgery, observation etc.

** all years the first 8 months

Annex 3: Coverage of care and support services among prisoners**(August 2009 - 1 August 2012; reported by NGOs):**

Reporting period	Expected	Actual number
2009-2010		
August-September 2009	750	1.182
October-December 2009	1600	2.345
January-March 2010	2500	3.259
April-June 2010	3200	4.030
2010-2011		
July-September 2010	1100	1884
October-December 2010	2250	3089
January-March 2011	3400	4.022
April-June 2011	4400	4.851
2011-2012		
July-September 2011	1300	1.744
October-December 2011	2250	2.689
January-March 2012	3500	4.481
April-July 2012	4400	5.921

Annex 4: Reported data correspond to data from Prisons IBBS-2011

Proportion of prisoners reached with prevention: approx. 15-20%.

	2009	2010	2011
Coverage of prisoners with prevention (GFATM RD6 – Alliance Ukraine program reporting)	27372	32341	25497
Male	26028	28588	22866
Female	1344	3783	2631

Annex 5: List of informants during field visits (23-29 September 2012)

Name	Position	Institution
Mr. Eugen Polyakov,	Head of Department of Health and Medical-sanitary Provision	State Penitentiary Service of Ukraine
Zurab Malazoniya	Deputy Head of Department of Health and Medical-sanitary Provision	State Penitentiary Service of Ukraine
Mr Igor Pechenogo	Deputy Head of Department of Health and Medical-sanitary Provision	State Penitentiary Service of Ukraine
Anatoliy Kryvoruk	Head of the Department of Treatment and Prevention Activities, coordination of all HIV-related activities	State Penitentiary Service of Ukraine
Victor Nakonechni and other medical staff, social-psychological service	Leading specialist-doctor of Health Care Unit (Former Head of Medical Service of colony #85)	Kyiv City and Kyiv Oblast Penitentiary Department
Bereznetsky Leonid	Acting governor	Chernigiv colony #44
Volkova Svetlana	Head of Health care Unit	Chernigiv Oblast Penitentiary Department
Guzhva Olexandrovich	Head of Social and Correctional Unit	Chernigiv Oblast Penitentiary Department
Lyudmila Storozhuk	Head of Department for medical and Social Care	State Service of Ukraine on HIV/AIDS and other Socially Dangerous Diseases
Professor Nataliya Nizova	Director of Ukrainian AIDS Center	Ukrainian AIDS Center
Inna Tovkach	Deputy Director (coordination of Torment activities)	Ukrainian AIDS Center
Ksenia Voronova	Officer at Department for Medical care planning and delivery	Ukrainian AIDS Center
Lyudmila Shurpach	Senior program officer	HIV/AIDS Alliance in Ukraine
Olena Kucheruk	IHRD Policy Officer in Ukraine	Renaissance foundation (OSI)
Olga Gvozdetska	Program Director	All Ukrainian Network of PLWH
Angela Skopenko	Head of grant management Unit	All Ukrainian Network of PLWH
Petro Kochegan	Head of Unit for Interaction with State Penitentiary Service	All Ukrainian Network of PLWH
Sergei Ivanov		Podolannya – representation of former Prisoners
Denis Kudelya	Director	NGO Vertical
Anzela Moiseenko	Head	Chernigiv Branch of All-Ukrainian Network of PLWH
Svitlana Valko	Manager	AFEW (AIDS Foundation East-West)
Natalija Kozhan	Head of Treatment Unit	'Development of Ukraine' Foundation
Olena German	Director	NGO "Youth movement – penitentiary initiative"

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Footnotes)

1 UNODC is standing here as for the UN-family, which comprises of many specific organisations, such as WHO, UNFPA etc. Partly also other UN-organisations should be involved on their area of expertise.

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