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Report on the assessment in four pilot prison facilities, recommendations  
and action plans to improve the comprehensive response to HIV and  
AIDS in closed settings of Ukraine

**UNODC Regional Project XCEA01:** Partnership on effective HIV prevention and  
care among vulnerable groups in Central Asia and Eastern Europe, Phase II

*“Penitentiary, Law Enforcement and Drugs sectors’ Government Efficiency in HIV  
response in Ukraine” (PLEDGE)*

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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting Drug User(s)
MARP	Most-at-risk population
MOH	Ministry of Health
MOJ	Ministry of Justice
NAP	National AIDS Program
NGO	Non-Governmental Organisation(s)
OST	Opioid Substitution Therapy
PEP	Post-exposure prophylaxis
PLEDGE	Penitentiary, Law Enforcement & Drugs sectors' Government Efficiency in HIV Response
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention from Mother to Child Transmission response
PNSP	Prison Needle and Syringe Programme
PWID	People Who Inject Drugs
PWUD	People who use drugs
SIZO	Acronym used to describe pre trial or remand prison (investigation isolators)
SMT	Substitution Maintenance Treatment
SPSU	State Penitentiary Service of Ukraine
STI	Sexually Transmitted Infection(s)
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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## Summary

United Nations Office on Drugs and Crime (UNODC) is implementing *the Penitentiary, Law Enforcement and Drugs Sectors Government Efficiency in HIV response (PLEDGE) project* (2011-2016, United States Agency for International Development (USAID) funding) in Ukraine, in order to reduce HIV transmission among most-at-risk populations (MARPs) through increased access to HIV, AIDS and drug abuse services, including service delivery within pre-, in-, and post- detention settings.

In close cooperation with the UNODC office team in Kyiv, the international consultant Catherine Ritter (Switzerland) conducted an assessment (2013 and 2014) in four selected pilot prison facilities involved in the PLEDGE project. This document presents the key results from the assessment and recommendations to implement a comprehensive programme of HIV prevention, treatment, care and support services in closed settings.

The four pilot facilities cover different groups of detainees: men in pre-trial centre (Kyiv SIZO #13) and in prison (Bila Tserkva #35), women (Kharkiv prison for women #54) and young adults (Kremenchuk prison for adolescents).

The assessment showed an absence of HIV policy within the prison environment. The various actions regarding prevention, diagnosis and treatment of HIV/AIDS, as well as the related legal issues are spread over separated documents without a general overarching concept. The funding is multiple, with the major threat being the absence of sufficient sustainable long-term sustainability.

With regard to medical aspects, guidelines for both HIV and drug use in prisons are needed. One fifth to one third (depending on the source of data) of new HIV infections in Ukraine are diagnosed yearly in the prison system. This confirms that prisons are highly contributing to the HIV situation at a national level. However, access to antiretroviral therapy (ART) is clearly insufficient. HBV and HCV infections are not detected routinely. Neither opioid substitution therapy (OST), nor needles and syringes exchange programs (NSP) are available. HIV prevalence varies across the studies and sources of data. Approximately 15% to 31% of detainees are HIV infected, the prevalence being higher among people injecting drugs (30%) and among women (one in every three; one to two out of ten men). Occupational health is almost inexistent and does not consider HIV.

Given the high number of detainees in the Ukrainian penitentiary service (over 100'000), their turn over and the proportions of PWID and PLHIV among them, closed settings are a fundamental place to intervene in order to (1) ensure that the health needs of people in prisons (inmates and staff) are addressed and (2) have an impact on the HIV epidemic in Ukraine as a whole.

Change is an absolute necessity. As a response to such a situation, the 15 key interventions of the "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" (UNODC, ILO et al. 2013) need to be reinforced globally. However, priorities were defined, and action plans represent models of in depth development of particular aspects of the 15 interventions in the four settings. They are meant to bring up changes locally at first,

and at the same time are examples of possible developments for other detention places in Ukraine.

In addition to the action plans at regional and local levels, aims at a central level (State Penitentiary Service of Ukraine - SPSU and other key actors intervening within the HIV/AIDS epidemic in Ukraine) are included here, given the fact that SPSU has to be considered as a major actor within the National AIDS Program (NAP). At the same time SPSU needs to adopt a completely different attitude towards acknowledgment of the situation, openness, transparency and readiness to cooperate with external partners.

Core components of the action plans are: training; cooperation (i.e. joint work of prison services with the health services available for society at large for HIV); occupational health (development of a "Comprehensive HIV workplace Policy"); HIV prison policy and HIV and drug use professional guidelines for the prison environment.

In all four pilot settings, common aims of the action plans comprise the design of a HIV and drug use plan of activities (this lists the different tasks related to HIV prevention treatment and care that are being carried out yearly); the dissemination of educational materials; voluntary HIV testing and counselling, and prevention of STI.

Specific interventions are also needed.

In Kyiv SIZO, designing the path (or trajectory) of detainees upon admission going through the different steps of HIV (testing and counselling, diagnosis, treatment and care) and the organisation of SIZO as a "diagnosis and initiation of ART centre" allows the modelling of care between pre-trial SIZO and the prisons within Kyiv's region. The male prison Bila Tserkva (also in Kyiv's 's region) is part of this intervention, with additional attention given to education (design of an educational leaflet for male detainees), condom provision, sexual violence, and to the treatment of drug abuse (explore the possibility to cooperate with partners such as Narcotic or Alcoholic Anonymous for example).

In Kharkiv, female prison, greater attention will be given to women using drugs, and in particular their treatment and preparation before release (follow-up and prevention of overdose). There will also be a design of an educational leaflet for female detainees. In the prison for young detainees, it is proposed to include the prevention of sexual violence in the educative program and to provide hepatitis B vaccines for detainees and staff.

## 1 Background

The work reported here regarding assessments and action plans in four pilot settings is part of a broader commitment of the United Nations Office on Drugs and Crime (UNODC) in the prison environment of Ukraine: *the Penitentiary, Law Enforcement and Drugs Sectors Government Efficiency in HIV response (PLEDGE) project* (2011-2016, United States Agency for International Development (USAID) funding) to reduce HIV transmission among most-at-risk populations (MARPs) through increased access to HIV, AIDS and drug abuse services, including service delivery within pre-, in-, and post-detention settings. More specifically, one objective (2) of the project is aiming at strengthening capacities of the State Penitentiary Service of Ukraine (SPSU), public health and social services and civil society organizations to provide evidence and human-rights based comprehensive HIV prevention, treatment and care services, as well as drug dependence treatment in closed settings (including pre-trial detention settings and post-release stages).

In close cooperation with SPSU, UNODC provides several activities related to the prison environment, such as: advocacy, workshops, support to the participation of prison partners in international forums and conferences; technical assistance to improve the legal framework, protocols and clinical guidelines, as well as monitoring and evaluation regarding HIV in prisons.

After SPSU's formal approval of the recommendations and action plans issued here, the PLEDGE project will support their implementation in the four selected facilities through a competitive process of awarded grants. Furthermore, training events and production of training materials for management, medical and non-medical staff of the selected prisons, as well as their partners from civil society sector will be provided in close cooperation with Ukrainian public partners, in particular prison staff training centres (Chernihiv Law College).

## 2 Method

Numerous guidelines or key recommendations regarding prisoners' health are available (WHO/UNODC/UNAIDS). They are usually based on the best evidence available, and written by highly qualified experts. However, important barriers (political, structural, absence of appropriate training, etc.) still limit the practical implementation of those guidelines. Two frequent additional factors are the lack of knowledge on how to proceed locally with international recommendations and how to prioritize during implementation

The aim of this assignment is to promote the implementation of the 15 key interventions of the comprehensive "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" (UNODC, ILO et al. 2013). It counts 50 working days over a period of two years. The process includes: providing technical support on a longer term basis, setting recommendations, developing action plans to implement comprehensive HIV/AIDS services and follow-up on their operationalization. A consultant supporting field practitioners, conducting regular field visits and communicating with key stakeholders permits to progressively build the capacity of public health in prison.

### 2.1 *Data collection and analysis*

The consultant created a specific tool to collect and organise the data necessary to describe the situation at the beginning of the project (assessment guide, see copy used in the annexes for the four settings). The items cover the content of the 15 interventions "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" (UNODC, ILO et al. 2013).

In November 2013, a first visit to the four penitentiary settings participating in the project was organised. The aims were to initiate contacts with prison professionals, to collect data to describe the situation regarding HIV and drug use, and to allow professionals to reflect on their own situation.

The visit included meeting with a team composed of various professionals: health staff (i.e. doctors and nurses) in charge of both addiction (sometimes it is a psychiatrist or psychologist depending on the services that are provided) and infectious diseases in the setting; social workers; non governmental organisation(s) (NGO), local hospital cooperating actively, prison administrators and prison staff. Meeting people together as a group, and not individually one after the other allows a process of "thinking together" and also, one professional can learn from each other. However, this method might have had one negative consequence, which is impeding the freedom individual people will feel when expressing their opinion when their hierarchical superior is present.

Regarding meeting with detainees, it was left open to the organisers to make this possible at an early stage. The aim was first, to try to build up confidence with prison staff and then, during following occasions, to eventually meet with detainees.

Based on this visit, a first draft assessment report was delivered to UNODC at the beginning of January 2014.

The political situation in Ukraine at the beginning of 2014 impeded to follow the steps of the project as initially planned and among them, travelling to the country and proceed with further visits and meetings with prison staff and partners. In order to not cause long delays, Valerii Lazebnyi (UNODC) was increasingly involved as the link between the consultant (C.Ritter) and the partners in Ukraine.

A strategy to collect more information was then designed. This included (1) searching through available literature; (2) meetings over skype with UNODC consultants in Ukraine (Nikolai Gagarkin, Iryna Iakovets) and professionals of the penitentiary environment (Sergii Kravchenko); (3) the preparation of questionnaires addressed at NGO, prison authorities and field professionals. The questionnaires were sent by post/fax and filled in by oral exchange over the phone with UNODC. As some of the 15 key interventions of the comprehensive “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions” (UNODC, ILO et al. 2013), have been given less attention so far, written information is sometime unavailable. We nevertheless included those qualitative data collected during interviews or meetings in the visits of the four pilot settings. This is particularly the case for issues such as occupational health or confidentiality of data.

At the beginning of July 2014, it was possible to organise a second visit to the four pilot settings. The drafts of action plans were discussed with the contact partners working in each of them, as well as consultants in Ukraine, in order to further specify the interventions to implement, to define the need for technical support and possible schedules. The drafts of action plans were also presented to the prison staff and central authorities (July 4). A former version of this document (dated 22 May 2014) and a summary of data (power point) were translated in Russian and presented to them. This was made to involve prison authorities in the decision making process regarding the action plans. At this stage, central penitentiary authorities still have to approve some components of the action plans. Interventions will be allowed to start after their formal approval.

Communicating the results of the assessment in the four pilot prisons (collected at the field level) to central key actors will increase their awareness with regards to the reality of HIV prevention and care in the field (bottom up intervention). This is expected to promote changes in national regulations and protocols regarding HIV, which would then be ordered to the settings (bottom down), before being more specifically adapted to the local context. This is necessary, since during field visit it has been reported that protocols issued centrally can show a discrepancy with the local reality (interviews with medical doctors working in Kharkiv’s region).

This document contains the information that is available at this date (assessments are updated with more recent information), and the drafts of four action plans. Some interventions will still bring up more information by allowing a deeper comprehension of the reality. The data collection, the design of the action plans, and the implementation process have to be considered as an interrelated process.

The following elements were included in the analysis of the situation: comparison of data regarding the prisons with those available for the Ukrainian society in general, inconsistencies between implemented solutions, and comparisons of the data

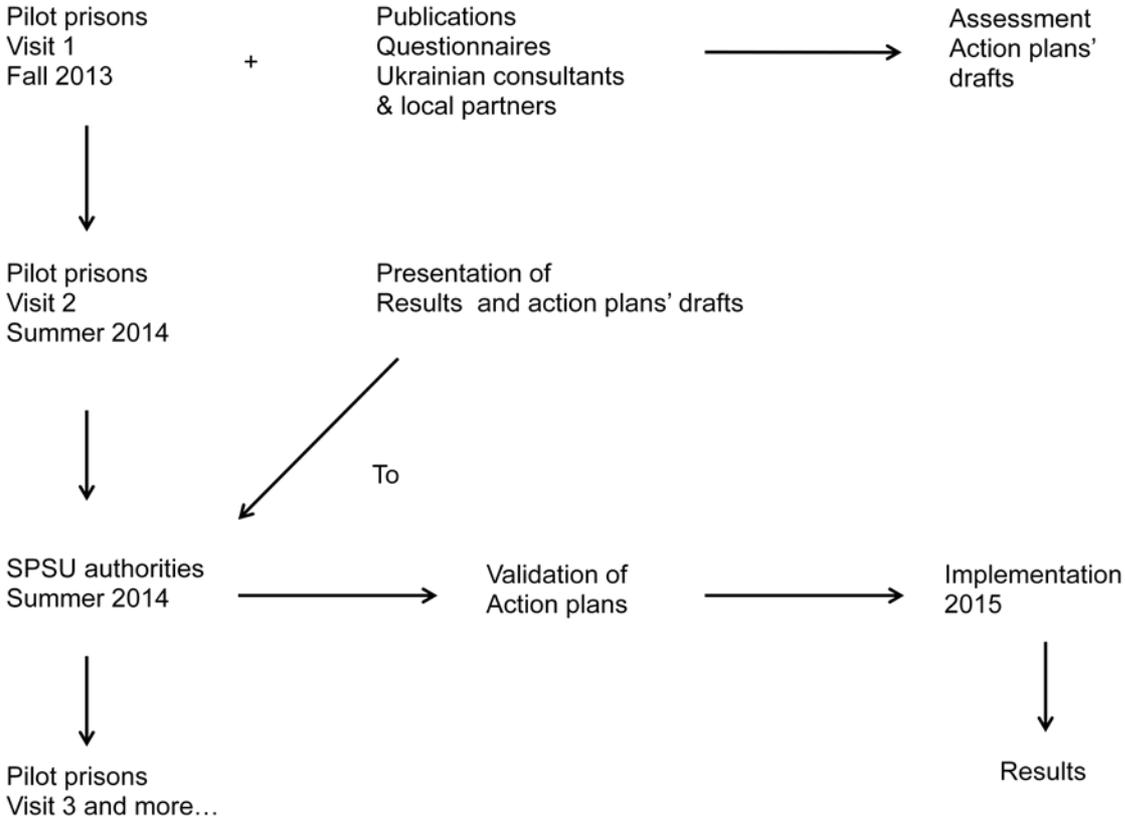
available in the literature with relation to the situation described in each of the four settings.

### 2.2 Design of the action plans

Regarding action plans, the following key words summarise the principles of the strategy that were used to design them: cooperation (with penitentiary authorities, regional partners, professionals in prison, NGO), communication (regarding the different steps of the work, between central and regional penitentiary authorities), transparency (sharing of results obtained during the assessment, translation of important documents into Ukrainian), and “bottom up methodology”. In fact they represent values of the action plans that are important in a context characterised by a highly hierarchical system such as the one prevailing in closed settings.

Allowing each professional to express his/her proposals and solutions to a given situation facilitates long-term changes, since changes cannot be implemented successfully unless actors master their complexity. Indeed, this method contributes to progressively build capacity and empower field professionals. Drug use, human rights based drug policy, HIV infection, diversity of treatment and harm reduction are highly complex issues. The need to create space for reflecting, exchanging doubts and learning are necessary. Professionals will not take part in interventions they do neither understand nor accept.

The different steps regarding the method are summarised in the following scheme:



### 3 Contextual assessment

This chapter gives a general overview of the elements to be taken into account, in particular: numbers related to prisons, drug use and treatment, HIV infection and treatment, and co infections (hepatitis and tuberculosis).

According to the most recent data available from the SPSU, there are 122,150 people detained (SPSU website, April 2014) across 181 remand detention facilities and colonies. In 2013 they were 138'000 (ICPS). During the field visits in July 2014, the number of detainees was reported to have decreased in the four pilot settings (ranging from 100 to 200, depending on the settings, information communicated during interviews), due to the armistice given after the presidential elections in May 2014. In 2010, 37'500 detainees were released (UNODC 2013). The average duration of staying is 2.6 years (Azbel, Wickersham et al. 2013).

A summary of the main data is presented below in a comparative overview between closed settings and Ukraine in general. Detailed and specific data for each setting is also available in the assessment guide (see annexes).

#### 3.1 Aims regarding HIV infection within the penitentiary service

Prisoners are briefly mentioned in the National AIDS Program (NAP) (Law of Ukraine 2009), under: *“Prevention activities include the following: “enhancing prevention activities among vulnerable groups (IDUs; prisoners and those released from prison;...)”*

A template developing specific aspects of the NAP for prisons was written in 2009 (State Penitentiary Service of Ukraine 2009) (SPSU). It has not been approved so far.

The goals are:

*“The goals of the “Program on Preventing HIV Spread, Care, treatment and Support to People Living with HIV/AIDS in pre-detention settings and prisons in 2009-2013” (hereinafter “Program”) include: stabilization of epidemic situation, decrease HIV/AIDS related mortality and morbidity by means of implementing the national policy on ensuring access to wide-scale preventive measures, treatment services, care and support to people living with HIV/AIDS, and provision of sterile disposable medical means, which are domestically produced.”*

More precisely, expected outcomes were:

*“The implementation of activities under the Programme will enable:*

- *to cover by HIV/AIDS prevention services about 60% of inmates;*
- *to train regular staff members and managerial staff on healthy lifestyle and HIV/AIDS prevention;*
- *to provide antiretroviral therapy for not less than 80% of people living with HIV/AIDS who are in need;*
- *to decrease mortality rate among people with HIV/AIDS by 10%;*
- *to prevent development of HIV strains resistant to antiretroviral medications for;*

- *to improve the system of laboratory control for quality of diagnostics and treatment of people living with HIV/AIDS.*

A conjoint and recent Order of the Ministry of Justice (MOJ) and of the Ministry of Health (MOH) (Registered in the Ministry of Justice of Ukraine 20 August 2014 # 990/25767) is addressing the organisation of health care to inmates. The procedure mentions various aspects regarding registration of PLHIV; prevention and voluntary HIV testing; diagnosis and access to treatment. Further and numerous orders regulating those different steps are linked to this document. Cooperation between the medical worker in charge of pre- and post-test consultation, the head of the medical unit and an infection disease specialist are mentioned.

### *3.2 Access to antiretroviral therapy (ART)*

Formally the SPSU is responsible for the health care of detainees. However, the full diagnostic procedure and access to ART in prisons relies on the cooperation with local AIDS Centres, affiliated to the Ministry of Health. The level of cooperation with this external partner to the prison health staff varies across the different regions. This is important because medical doctors within the prison system cannot initiate any ART on their own (UNODC 2013, WHO Regional office 2013).

Serious concerns regarding the access to HIV treatment in Ukraine are summarised in a recent document considering the consequences of the political and economical situation on HIV, tuberculosis and hepatitis (AFEW 2014). The importance of coordinated reflection and intervention between the civil society and the prison service can only be emphasized, since changes in the civil society will have repercussion on prisons too.

### *3.3 Funding*

Both national and external funding was foreseen to support the HIV prevention and care in close settings. In fact, the funding for HIV testing and treatment in prisons is entirely from GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria) (WHO Regional office for Europe 2013). This is a constant threat to long-term sustainability and also, because of the high prevalence of HIV infected detainees, this represents a high burden for the prison service.

### *3.4 Gender related issues*

A recent policy on the main issues to address women using drugs and HIV infected in prisons highlights how to integrate gender specificities (example of good practice) within key harm reduction interventions to ensure gender equality (UNODC 2014).

In the assessments of the female prison (in Kharkiv) interventions responding to the needs of women were examined. In particular: sexual and reproductive health & STI; prevention of mother-to-child transmission response (PMTCT). Mother and child units exist in Odessa and Chernihiv, and pregnant women living with HIV are transferred there. In the interviews during field visits, psychologists reported to address gender-based violence and counselling for couples (preparation for release) in their assistance. Other consideration to take into account for women who inject drugs is their engagement in sex work and the need for parental support when they have

children (UNODC 2014). In Ukrainian prisons, 70 to 100% of incarcerated women are mothers (Open Society Institute 2010), and as HIV infection rates are higher among women (prevalence 32%) than men (12%), as well as drug use (41% of women and 17% of men) (IBBS 2013) (see more details below), it is of high importance to consider any interventions with a gender-sensitive perspective.

### 3.5 Occupational health

The expression “occupational health” is used to describe “*Health services which have an essentially preventative function and which are responsible for advising the employer, as well as workers and their representatives, on the requirements for establishing and maintaining a safe and healthy working environment and work methods to facilitate optimal physical and mental health in relation to work.*” (ILO 2001).

The information regarding occupational health is almost inexistent in a written form. Most of the elements reported here were provided during the interviews with professionals working in the four pilot settings.

The SPSU counts with approximately 44'300 employees (Source SPSU website <http://www.kvs.gov.ua/peniten/control/main/uk/publish/article/628075>).

Prison staff's health care is officially provided outside of the prison system and within policlinics of the nearest city. However unofficially, prison staff get care from the doctors and medical staff working within the prison, whom they are familiar with. (Source: interview with medical doctor working in prison). According to the penitentiary trade union, health resorts for recovery are available (source: SPSU website <http://www.kvs.gov.ua/peniten/control/main/uk/publish/article/628125> and <http://www.kvs.gov.ua/peniten/control/main/uk/publish/article/670050>)

Health is considered to be the worker's personal responsibility. Health promotion or occupational health is not an employer's issue. However, prevention has been reported to be included in trainings or within limited information campaigns promoting healthy life-style (Source: interview with medical doctor working in prison; SPSU website <http://www.kvs.gov.ua/peniten/control/main/uk/publish/article/755959>).

As medical check-ups are done before employment, once a year and upon retirement, this could represent suitable moments to address issues related to prevention and to provide hepatitis B vaccine for example. The latter is currently not available free of charge on a regular basis, except within the frame of specific programs offering vaccination to staff within local hospitals (2012-2013). Those so called “vaccination campaigns” have been reported to be partially successful (Source: interview by SPSU medical authorities).

Prison staff infected with tuberculosis while at work can get support for treatment. If the disease is proven not to have occurred in the professional environment, the working contract gets interrupted. Given the exactness of this procedure, it is impeding early diagnosis and treatment of tuberculosis. This is troublesome from a public health point of view. No current numbers regarding tuberculosis diagnosis among prison staff have been provided; only a broad cumulative total of 600 prison

staff diagnosed during the last ten years. (Source: interview with medical doctor working in prison).

Regarding HIV or the transmission of other blood borne virus, issues such as the use of protective equipment (glove use and post-exposure prophylaxis (PEP) for example) are considered below in the specific assessments of pilot settings. There is no HIV workplace policy in the prison environment (Source: interview with medical doctor working in prison).

### *3.6 Data comparing the penitentiary system and Ukraine in general*

#### **3.6.1 Epidemiological data**

The table below presents key figures and compares the situation in the general population with those in the closed settings. They were gathered through literature review and official statistics. Sources are indicated and classified in a chronological way when different numbers were available. This is actually the case for most items, since various studies and evaluation were done among different groups of detained people.

Generally, people who use drugs (PWUD) and/or people living with HIV (PLHIV) are overrepresented in closed settings, and the situation in Ukraine is no exception. This is even of higher importance in a country where people who inject drugs (PWID) are fuelling the HIV epidemic (Bojko, Dvoriak et al. 2013). 70% of cumulative HIV infections are due to HIV transmission among PWID (UNAIDS, reported by Izenberg, Bachireddy et al. 2014). Even if the available numbers are not necessarily representing all the detention facilities, they provide important benchmarks to be kept in mind when working in this context.

#### **3.6.2 Integrated bio behavioural studies**

Several integrated bio-behavioural studies (IBBS) provide additional and valuable information to the tables below.

(1) In 2009; conducted among 1300 convicts (20 male, four female and two juvenile facilities) (Demchenko, Kostyuchok et al. 2010).

Detainees represented 12% of all new HIV cases officially registered in Ukraine in 2009. This proportion illustrates again that prisons are important places to diagnose HIV infection. In 2005 4058 inmates living with HIV were registered, in 2007 4702, and in 2009 6069. Detailed numbers across Ukraine were: Donetsk oblast (1649), Dnipropetrovsk (403), Kherson (387), Mykolaiv (381), Lugansk (372), Odessa (366), Chernihiv (292) and Kharkiv (291) oblasts (p 7).

Information on HIV/AIDS is more frequently made accessible in female colonies (79% of women and 68% of men were provided with information), and in juvenile facilities (up to 87%). It occurs on a regular basis, and is mainly provided by health care workers of the colonies, with an increasing participation of NGO in this activity (approximately one third – 34% of respondents had been provided information by NGO too). Other prisoners and prison staff (heads, social and psychological) count for 19% and 18% respectively of information providers. In juvenile colonies, the

diverse sources of information available are used more (p 14-15). Content of information provided is also available (p 17).

22% of respondents reported to have been provided with condoms (25% men and 15% women). The availability increases with the length of incarceration. They are exceptionally handed out in juvenile facilities. Usually, condoms are available in medical units (35%), handed out by NGO representatives (31%), staff (18%) or other detainees (12%), and in the bath/toilet area (10%) or in places for intimate visits (2%). In female colonies, condoms are mostly provided by NGO.

More data on private visits indicate that prisoners either ignore that condoms are provided in such places or deny that they are actually available. Condoms are provided to people having no sexual intercourse, and not to those who actually need them (p 20).

Disinfectants (p 23) should be provided in all facilities according to departmental documents. One third only of respondents consider that this is the case. In juvenile facilities, disinfectants are reported as more available (50%).

55% of PWID in the past 12 months used non-sterile equipment (p 39).

(1) In 2011 the study was repeated see results below (UNAIDS 2012). The report also includes achievements since 2009 and remaining difficulties.

Prevention programs were considered as insufficient. The treatment of opportunistic infection improved, bed wards for HIV infected detainees were created in 2012 (in Donetsk and Zhytomyr oblasts). Joint orders regarding OST (p 115) were mentioned.

(1) In 2013 again, the IBBS was repeated among 1471 detainees (1000 men, 300 women and 1701 minors).

In line with the previous studies, risk behaviours are reported, in particular: injecting drugs (opioids, stimulants and amphetamines) (8-12%), and needle and syringes exchange (4%); tattooing (reported by 13-20% of participants); unprotected sexual relations during private visits (32% of respondents) (Demchenko 2014).

For the first time, CD4 were measured among 126 of the HIV infected participants (162). Nearly half of them (44%) have counts below 350 cells/ml, *i.e.* need ART. The study confirms that the high needs of access to ART remain uncovered since 25% of PLWH who need ART actually have access to it.

Regarding prevention programs, the coverage is measured with two indicators (awareness of access to HIV testing and access to free condoms). The coverage for men remains stable between 2009 and 2013, but decreases among women, in particular their access to condoms.

(2) In 2011, a nationwide study among 402 participants (men, women, first timers and recidivists) (Azbel, Wickersham et al. 2013)

One third (34.4%) of the 56.6% detainees absorbing substances in the month preceding the arrest used opioids (mainly intravenously), 21.1% amphetamines, and 17.9% sedatives. These data are important to keep in mind since during the field visits other numbers were reported (the predominant substance used being

amphetamine), either due to the absence of precise data or to regional differences (mentioned in this study as well). Alcohol abuse is high, since 18.2% of participants were dependent, as well as multiple substances use among opioid users (82.6%).

The authors also estimated (based on the reported number of released people during six months of 18,304 and the results of the study) that 592 inmates living with HIV were released each month. In relation with the fact that half of the people diagnosed with HIV infection in the study ignored their status, it underlines the importance both of testing and prevention of HIV transmission to the community after release (in particular by education and condoms provision).

### **1.1.1 Drug use during incarceration**

A recent study conducted among nearly 100 PLHIV (88% male) recently released from prison (in Kiev and Odessa) examined drug use during incarceration. 56.8% of participants reported drug injection during incarceration, and among them 74.1% shared their injecting equipment with a mean of 4.4 other users. Opioid use in the 30 days before incarceration was strongly correlated to injecting drugs while incarcerated. The results of a study done within a group presenting actually being able to transmit the virus highlight again the need to tackle drug use among prisoners, and in particular to provide efficient treatment such as OST (Izenberg, Bachireddy et al. 2014).

Table: Comparison of data between the general population and prisons in Ukraine

	<b>General Population</b>	<b>SPSU - 181 remand detention facilities or colonies</b> 13 for women (5.5%), 7 for young adults > 14 years (0.7%)
Population	45 633 600	122'150 (SPSU site 01.04 2014) 138'000 (ICPS 01.09 2013) 134'957 (01.08.2013) (WHO Regional office for Europe 2014)
Drug use	To be completed	56% of population (Demchenko, Kostyuchok et al. 2010) 56.6% (Azbel, Wickersham et al. 2013) 70% of people on probation (Demchenko, Kostyuchok et al. 2010)
PWID	310'000 / 0.7% (WHO Regional office for Europe 2014) 375'000-425'000 (Bojko, Dvoriak et al. 2013)  290'000 (Izenberg, Bachireddy et al. 2014)	Use in previous 12 months 35%; 2% in juvenile facilities 7-10% during incarceration, but not in juvenile facilities 62% shared equipment in the last 12 months (Demchenko, Kostyuchok et al. 2010) 48.7% (life time prevalence) (Azbel, Wickersham et al. 2013) 37% (experience in injecting drugs) BBS 2013 (Demchenko 2014)
Opioid users	256'060 / 82.6% of PWID above Usually 40% in need of treatment (WHO Regional office for Europe 2014)	34.3% in the 30 days before incarceration (Azbel, Wickersham et al. 2013) 84.2% dependant (among 100 PLHIV released from prison (Izenberg, Bachireddy et al. 2014)
OST patients	9000 (March 2014) (Kazatchkine 2014) 7594 (WHO Regional office for Europe 2014) Less than 2% of PWID are receiving OST (Bojko, Dvoriak et al. 2013)	0 (not available at all)
VCT		72261 (57,8% of all detainees) (2013) (SPSU) 36'053 in 2012 (25.1% of all detainees) (Iakovets 2014)

	<b>General Population</b>	<b>SPSU - 181 remand detention facilities or colonies</b>
Prevalence of HIV infection	0.9% general population 0.5% women and 0.4% men aged 15-24 years old living with HIV+ (UNAIDS 2013)	<p><b>2009:</b> 15% (CI 13-17) (p 26 (UNAIDS 2012) Women 32%; men 12%. 63% are aged between 26 to 35 years old. No infection among respondents in juvenile facilities (Demchenko, Kostyuchok et al. 2010)</p> <p>In case of history of drug use 31% No drug use 6% (Demchenko, Kostyuchok et al. 2010) 10.4% in 2011 (2463 out of 23 779 tested) (Ukrainian centre for AIDS) (WHO Regional office for Europe 2013)</p> <p><b>2011:</b> (IBBS among 1300 inmates): 13.7% (CI 11.8-15.6%) (values of the national report, indicator 1.21 p 26 (UNAIDS 2012) In case of history of drug use: 22.9% (CI 19.5 -26.7%) No drug use: 8.1% (6-10.5%) Women 33%; Men 10.1% &lt; 25 years old 6.4%; 25 years and above 17.3%<sup>1</sup></p> <p><b>2011:</b> 19.4% (CI 15.5–23.3%), 22% (Kiev, pretrial) Women 28.4%; men 17.3%. 50.7% unaware of their status (Azbel, Wickersham et al. 2013) In 2012: 15-30% (International HIV/AIDS Alliance in Ukraine 2012)</p> <p>4.8% (SPSU) (cited in (UNODC 2013) 5.8% in 2013 (SPSU) 36% in Dnepropetrovsk oblast (NGO Way of life, reported by (Iakovets 2014)</p> <p><b>2013:</b> IBBS among 1471 detainees HIV prevalence 11% Women: 18%; men: 10%; no infection in juvenile colonies (Demchenko 2014)</p>

<sup>1</sup> List of regions participating in the survey on page 26



	<b>General Population</b>	<b>SPSU - 181 remand detention facilities or colonies</b>
HIV infections among PWID	21.6% (24% Women – 21% Men) (WHO Regional office for Europe 2014) 21.3-41.8%; 70% of cumulative PLHIV and 56% of new infections are PWID (Bojko, Dvoriak et al. 2013)	2009 31% (Demchenko, Kostyuchok et al. 2010) 2011 22.9% (UNAIDS 2012)  2013 22% (IBBS) (Demchenko 2014) Women 41%; men 17%
New infections / year	21'631 (2013) 11'000 (2012) 6000-7000/ year among those who inject drugs, relatively stable (UNAIDS 2013)	3772 in 2013 (SPSU) 3847 in 2012 (Iakovets 2014) 2464 in 2011 (Ukrainian centre for AIDS) 2819 (out of 28'181 tested in 2011, SPSU)
Cumulative number of HIV infection detected	196'623 (total 2002-2013) (MOH, statistics comparing Ukraine and penitentiary services)	24'980 (total 2002-2013) (MOH, statistics comparing Ukraine and penitentiary services) 27'017 (1987-2009) (Programme of measures to prevent HIV In prisons, 2009)
PLHIV	129'136 registered in January 2013, but actual number is 220'000 (WHO Regional office for Europe 2014) 230'000 (UNAIDS 2013) 139'573 registered (2013)	7299 (925 women) (2013) 6571 in 2013 (Iakovets 2014) 6069 registered (Demchenko, Kostyuchok et al. 2010) 6900 registered (Balakireva 2012)
AIDS related deaths/year	3870 in 2012 (WHO Regional office for Europe 2014) 18'000 (UNAIDS 2013)	273 (2013) (SPSU) 313 (2012) (SPSU) 388 in 2011 (UNODC 2013)

	<b>General Population</b>	<b>SPSU - 181 remand detention facilities or colonies</b>
PLHIV in need of ART	117'000 (WHO Regional office for Europe 2014) 120'000 (WHO Regional office for Europe 2013) 100'000 with WHO 2010 treatment guidelines 230'000 with WHO 2013 treatment guidelines (UNAIDS 2013)	56% according to 2010 WHO treatment guideline (Azbel, Wickersham et al. 2013)  44% (BBS 2013) (Demchenko 2014)
PLHIV currently on ART	43'959 (1. June 2014 UNAIDS) 38'082 (UNAIDS 2013) 34'323 (01.08.12) (WHO Regional office for Europe 2014)	2844 (2013) (SPSU) 1358 under treatment 01.01. 2013 (Iakovets 2014) 1236 (end June 2012) (UNODC 2013)
Proportion of PLHIV on ART among those who need it	22-28% (WHO Regional office for Europe 2013) 39% (UNAIDS 2013)	6.4% (Azbel, Wickersham et al. 2013)
Hepatitis C virus infection	To be completed	In 2011: 60.2% (95% CI = 55.1%–65.4% (Azbel, Wickersham et al. 2013) Co-infection HIV/HC: 92% (Altice 2012)
Hepatitis B	To be completed	5.2% (CI 3.3–7.2%) (Azbel, Wickersham et al. 2013)
Syphilis	To be completed	10% (CI 7.4–13.2%) (Azbel, Wickersham et al. 2013)
Tuberculosis Incidence / year	100/100'000	4111 people under treatment in 2013 (SPSU) 4834 people under treatment in 2012
Proportion of HIV + among TB	To be completed	To be completed
Proportion of TB among PLHIV	60% among people registered for HIV care (WHO Regional office for Europe 2013)	To be completed

### 3.7 Statistics regarding the four pilot settings

This table presents numbers for each of the settings (2013) that local partners working in the pilot settings or NGO provided.

n/n	Description	Kyiv pre-trial centre SIZO #13 <sup>2</sup>	Bila Tserkva prison men #35 <sup>3</sup>	Kharkiv prison women #54 <sup>4</sup>	Kremen chuk prison adolesc ents <sup>5</sup>
1	Number of convicts/detainees	≈ 2600 (turnover per year ≈ 5000 under investigation and ≈ 50000 transferred)	≈ 800 (turnover per year ≈ 150)	840	175
2	Number of beds in prison hospitals (all profiles)	49 - in tuberculosis isolation cell and 37 – in usual cells	9	24	4
3	Number of persons who received treatment in prison hospitals	354	48	8	33
4	Number of consultations on HIV prevention	2500	800	383	663
5	Number of HIV tests done	2500	800	378	663
5A	Proportion of detainees undergoing testing upon admission (%)	$2500/5000 = 50$	$800/800 = 100$	$378/840 = 45$	0
6	New HIV infections	297 <sup>6</sup>	18	17	0
6A	Incidence PLHIV (%)	$297/5000 = 5.9$	$18/150 = 12$	$17/? = ?$	0
7	Number of HIV-infected detainees	184	96	62	0
7A	Prevalence HIV infection (%)	$184/2600 = 6.9$	$96/800 = 12$	$62/840 = 7.4$	
8	Number of detainees on ART	64	24	40	0
9	Number of TB	46 119?	8	0	0
10	Hepatitis B infections	0	0	0	0
11	Hepatitis C infections	0	0	0	0
12	STI (syphilis) infections	22	0	5	0
13	Number of detainees with AIDS	47	6	0	0
14	Number of AIDS-related deaths	8	0	0	0
15	Number of drug users identified before imprisonment	≈ 2500	≈ 500	107	4
16	Number of IDU before imprisonment	≈ 2000	≈ 400	91	0
17	Number of condoms given	≈ 2500	≈ 800	120	27
18	Number of registered cases	0	0	0	-

<sup>2</sup> Лук'янівська Лук'янівська в'язниця Slidchyi izolyator Слідчий ізолятор - СІЗО

<sup>3</sup> БВК-35 - Біла Церква

<sup>4</sup> Качанівська жіноча колонія №54

<sup>5</sup> Кременчуцька виховна колонія для неповнолітніх/Кременчуцкая воспитательная колонія для несовершеннолетних

<sup>6</sup> The number of new infections is higher than that of infected people (184), due to incomplete diagnosis procedure and transfer to colonies.

	of violence				
19	Number of registered cases of sexual violence	0	0	0	-
20	Number of PEP use	0	0	0	-

### 3.8 Key issues in the four pilot settings

#### 3.8.1 Kyiv pre-trial centre SIZO #13

Lukyanivsky is a male and female pre-trial setting detaining 3100 people (2012) and 2800 people in 2014 (according to field visit). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) describes the conditions of detention as appalling (up to 40 people sharing one dormitory).

50% of the health staff jobs are vacant (due to low salaries and difficult working conditions).

HIV testing is voluntary. Medical staff reported that only 2-3% of detainees are refusing it, which is an inconsistent data with relation to the numbers provided by medical staff to fill in the table above. According to the number of detainees being investigated yearly, 50% are estimated to actually do the testing. If considering the turnover of detainees in the pre-trial centre, this coverage is lower. The diagnosis is confirmed at the AIDS centre who will determine the need for ART. The whole process of testing, diagnosis and infectious diseases specialist consultation up to the beginning of the treatment lasts between one to two months. Therefore, some detainees are transferred before the diagnosis of HIV infection is confirmed.

Another inconsistency lies in the proportion of PLHIV who need ART according to medical criteria and who actually get it in reality. With regards to the number of PLHIV under treatment that was transmitted, it cannot be confirmed that all people needing the treatment actually receive it. However, due to the important size of this setting, and its central place in the country, it has to be considered as a true platform for testing, diagnosing HIV and starting ART. Approximately one fifth of HIV infections of the SPSU system are diagnosed yearly in this setting, and this with only 50% of detainees actually getting the testing. Thus a focus on voluntary HIV testing and counselling and initiation of ART at the pre-trial centre could ease the process of PLHIV care in the colonies.

According to medical staff, 30-40% of detainees use drugs, and 99% of PLHIV. Treatment for drug dependence is oriented towards abstinence, with no substitution available. According to the current legal framework, opioids could be used with the aim of detoxification. This is not provided so far.

#### 3.8.2 Bila Tserkva prison for men #35

Bila Tserkva is a male middle security prison (800 people), with an important number of recidivists. In 2000, this setting was provided with support from the Swiss Agency for Development and Cooperation (SDC, Federal Department of Foreign affairs<sup>7</sup>).

<sup>7</sup> <http://www.ddc.admin.ch/en/Home>

The project included the creation of a training center in Bila Tserkva (Bila Tserkva College for the Training and Re-training of Prison Staff).

Most detainees stay first at the pre-trial centre in Kiev, which provides the opportunity to consider this aspect of continuity of care within the suggested action plan.

The HIV testing is voluntary (rapid testing) and then confirmed in Kiev. Since Bila Tserkva is a prison, overtesting (testing without new risk exposure since the last testing in the pre-trial centre) happens. Apparently few PLHIV start ART, since most do not meet the criteria and the access to infectious diseases specialist has been reported to be insufficient during the second field visit. Continuity of treatment upon release of PLHIV is considered as satisfactory, but at the same time staff expresses the need for a better orientation of detainees within the health care network. Adherence to ART is reported as unproblematic. That aspect has to be examined further since detainees are provided with monthly treatment in their cells. This might also cause difficulties in ensuring confidentiality of infections status.

Drug use is acknowledged as a reality in this setting; the number of users is estimated to be around 62%, with 50% of them intravenous users. Most are described as not wanting to cease the use. Searches done by security staff bring up needles and syringes. The prison director considers that his intervention to tackle the drug-related issues is insufficient. He is open to cooperation with NGO in general.

Sexual risk behaviour is also acknowledged as a reality in the setting, without being able to have any control/influence on it. 25 people sleep in one dormitory. It is reported not to be quiet in the night.

### **3.8.3 Kharkiv prison for women #54**

This setting for female prisoners has a capacity to host 1200 women; 800 were present in November 2013, and 506 in July 2014. This decrease is due to the release of 300 women following the presidential elections in May 2014 and the armistice. The release included detainees with drug dependence and PLHIV.

100% of women are being tested for HIV upon incarceration. Since all are first incarcerated in pre-trial centres, over-testing cannot be excluded. The diagnosis is confirmed at the AIDS Centre in Kharkiv. The cooperation between the prison and the AIDS Centre is described as good. The NGO PLHIV is playing an important role in transmission of information to HIV infected women and ensuring the continuity of treatment upon release. Access to ART is ensured. At the same time, the confidentiality of HIV status is not guaranteed. Also the various actions regarding HIV prevention, testing and treatment, as well as legal issues, are spread over separated documents, a situation that impedes an optimal coordination of the persons involved (NGO, prison staff).

Drug use is one of the main problems that women are facing upon release (difficulties related to work, housing, rehabilitation). However, it is not considered as a problem during incarceration or before release. The prison system gives a false impression that “there is no problem related to drugs”, since women are reported not to use drugs during the incarceration. This end up in the absence of appropriate treatment to drug abuse during incarceration and impedes a proper preparation for

release. The narcologist in Kharkiv's oblast are reported to be experimented and could be involved as trainers or cooperation partners in this process. Also, a regional working group is currently developing a protocol to ensure continuity of OST treatment in closed settings. This is a promising experience.

Staff requires help to purchase medical equipment to increase the quality of follow-up of women with ART (Haemoglobin testing and other basic laboratory tests) within the prison.

### **3.8.4 Kremenchuk prison for adolescents**

After approximately two months of pre-trial detention, adolescents spend 3 to 4 years in average in a prison. Kremenchuk houses 180 young men (out of 1000 young detainees in Ukraine, out of them 80 young women). In July 2014 96 young detainees only were present. This is again due to the release following the presidential elections in May 2014 and the armistice, and because of a higher number of detainees on probation.

Apparently, there is a close interdisciplinary cooperation on a regular basis among prison officers, teachers, and psychologists. When first arriving, the young people are isolated and go through 15 days of assessment. School is mandatory.

Drug use is not considered as a problem in the setting.

Condoms are not available during the incarceration, since sexual relation among men is considered taboo. Education, and inclusive health education regarding prevention during sexual intercourse are clearly presented as a priority in this setting. This can be used as a way to reflect on a program regarding prevention of sexual violence.

No vaccination against Hepatitis B is available. Testing has recently been made possible, following the donation of tests (50) by the NGO PLHIV.

HIV testing is done systematically upon admission (analysis are done in Kiev); no infection has been detected. It is voluntary, and no one declines it. Again, given the pre trial detention at first, one can wonder if there is overtesting. Also, the number of tests done is (more than three times) higher than the number of detainees, which can also be related to a high turnover of young detainees. Some staff is in favour of HIV screening (mandatory for all detainees), as PLHIV are considered as being a "menace". The emphasis on this potential "dangerous person" is rather surprising in a setting where no young detainee with HIV infection has been incarcerated. According to IBBS conducted in different juvenile detention in Ukraine, no HIV infection has been detected in juvenile detention facility (Demchenko 2014).

The prison director welcomes the proposal of vaccination against Hepatitis B, both for staff and detainees. A former campaign was organised in 2013 by SPSU, their protocol can be used as a reference.

Prison staff requires support to organise and provide equipment for a room that can be used for health education activities and counselling.

## 4 Analysis

### 4.1 Main findings and weaknesses

Regarding the epidemiological situation, collected data might not reflect the situation in the field. Data is scarce, inconsistent and variable according to sources.

Although there was a general welcoming attitude towards the UNODC team during the visits, and apparent readiness to cooperate, a defensive attitude could also be observed. Stakeholders might have given satisfactory answers to experts, but that do not necessarily correspond to the reality in which detainees are living. Furthermore, as information reported orally could generally not be corroborated by direct observation in the pilot settings, different aspects regarding current intervention remain unexplained. Even though incoherencies of data could usually not be fully explained, they are an indicator for the need to examine more in depth some areas (HIV testing for example).

The gaps regarding the general context and specific settings are:

#### **Work-related issues**

Working conditions for health staff are described to be poor. Health staff reports to be overworked and underpaid. Medical units are understaffed and show a high turn over. Therefore, access to key specialists in infectious diseases' and drug abuse can be lacking.

Doctors express needs in training and hope for better salaries.

#### **HIV policy in prison**

- There is no HIV specific policy within the prison environment. The various actions regarding HIV prevention, diagnosis and treatment, as well as the related legal issues are spread over separated documents without a general overarching concept. This impedes an optimal coordination of the various persons involved (prison health staff, NGO).
- The funding for those different activities is provided by different donors, with the threat of absence of sustainable long-term domestic funding, which in turn questions the sustainability of the service provision.
- There is no comprehensive response integrating both HIV infection (and co-infections) and drug use related issues.

#### **Gender related issues**

In Ukrainian prisons, 70 to 100% of incarcerated women are mothers (Open Society Institute 2010). HIV infection rates are higher among women (prevalence 32%) than men (12%), as well as drug use (41% of women and 17% of men) (IBBS 2013).

According to the data from the pilot settings, the proportion of women on ART (one out of two HIV infected) is higher than among men (one out of three or four).

#### **Information, education and communication** (Key intervention 1)

Activities related to information and education are reported to be conducted in all pilot settings. Information material is provided by NGO. This aspect is given a higher importance in the prison for adolescents where leaflets have been shown during the

field visits. In general, there are no information posters on the walls. Both in male and female prisons support to design specific leaflets for detainees has been demanded.

### **Condom programmes** (Key intervention 2)

When talking about sexual relations in prison and condoms availability, the interlocutors understand “private visits”. Condoms are available within this context, but not necessarily at a larger scale in order to be used in dormitories for example. In SIZO condoms were reported to be available in the shower area and in the medical consultation room (also in Bila Tserkva). This could not be observed directly. Condoms are not available in Kremenchuk prison for adolescents

### **Prevention of sexual violence** (Key intervention 3)

Sexual violence is recognised as being a reality in one of the pilot settings (male prison of Bila Tserkva). In the prison for adolescents, this matter seems to be addressed through communication of information to detainees. In the female prison, psychologists are considering this issue within individual therapies.

### **Prevention of transmission through medical or dental services** (Key intervention 6)

Use of protective equipment during dental procedures has been reported to be systematic in all pilot settings. This could not be observed directly though.

### **HIV testing and counselling** (Key intervention 9)

HIV testing is available, and approximately 57% of detainees undergo voluntary counselling and testing (VCT) according to official statistics provided by SPSU. The exact process of VCT could not be defined though.

SIZO pre-trial centre is a determinant place to diagnose new HIV infections. When considering the number of detainees undergoing investigations in SIZO with relation to the number of tests done yearly, 50% of people are actually tested. At the same time, medical staff reports that acceptance of the test is good, since less than 5% decline it.

Half of detainees were reported to be unaware of their HIV status (Azbel, Wickersham et al. 2013).

### **HIV prevalence**

In general across the Ukrainian prison system, 20% of detainees are PLHIV (Azbel, Wickersham et al. 2013). The number is higher among PWID (30%) and among women (one in every three; one to two out of ten men). The group aged between 26-35 years is most affected: two thirds of them are PLHIV. The prevalence is lower in the younger age group (Demchenko, Kostyuchok et al. 2010).

According to numbers provided by medical staff in the pilot settings, the prevalence of HIV can be estimated to be around 6.9% in SIZO, 7.4% among women in Kharkiv and 12% among men in Bila Tserkva. In general prevalence reported by SPSU is lower than numbers communicated by other sources.

10% of AIDS related deaths occur in penitentiary facilities of Ukraine (Source SPSU).

### **HIV treatment, care and support - Access to ART (Key intervention 10)**

ART can be provided in prisons, but the number of people who are treated is insufficient, and the process of access is long and complex. It involves external partners such as AIDS centres. The cooperation is variable across regions. Infectious diseases specialists are habilitated to initiate ART.

Only about 1500 PLHIV are currently under ART in the Ukrainian prison system (coverage of 6.4%, Azbel, Wickersham et al. 2013).

### **Drug dependence treatment (Key intervention 4)**

One half to two thirds of detained people have a history of drug use (Azbel, Wickersham et al. 2013). One third of detained people have a history of injecting drug use (Demchenko, Kostyuchok et al. 2010). One third of drug users are opioid users (Azbel, Wickersham et al. 2013).

OST is not available in the prison system. The matter has been raised in the female prison in Kharkiv where a regional working group is currently developing a protocol to ensure continuity of OST treatment. In the pre-trial context, according to the current legal framework of SIZO in Kyiv, opioids could be used with the aim of detoxification (currently not the case).

### **Needles & syringes programmes (Key intervention 5)**

NSP is not available in the prison system.

### **Prevention of transmission through tattooing, piercing and other forms of skin penetration (Key intervention 7)**

This is not considered here, since tattooing is fully prohibited in the prison system. No bleach is available.

Upon entry, people undergo a “full body check” and tattoos re recorded in the files. Detainees with new tattoos observed later during incarceration are sanctioned.

### **Vaccination, diagnosis and treatment of viral hepatitis (Key intervention 14)**

Hepatitis B and C testing are not done routinely. The literature reported a prevalence of 60% for Hepatitis C infection and 5% for Hepatitis B (Azbel, Wickersham et al. 2013). No vaccination against Hepatitis B is available.

### **Prevention, diagnosis and treatment of tuberculosis (Key intervention 11)**

Partners in the pilot prisons have provided the few numbers regarding tuberculosis that are available so far in the assessment. Annual screening has been reported to be regular and done with chest X-rays. All patients are treated at the Interregional tuberculosis hospital prison Nr 17 in Kharkiv’s Oblast.

### **Prevention of mother-to-child transmission of HIV (Key intervention 12)**

Less of concern in this project since pregnant women living with HIV are transferred to mother and child units (Odessa and Chernihiv).

### **Prevention and treatment of sexually transmitted infections (STI) (Key intervention 13)**

Treatment of STI has been reported to be available in all settings, except in the prison for adolescents.

Prevention is however incomplete, since condoms are not available in all contexts.

The number of diagnosed STI is low. Systematic testing for all detainees (syphilis) has been reported in SIZO.

**Post-exposure prophylaxis (PEP) (Key intervention 8)**

PEP has been reported to be easily available in all pilot settings, except in the prison for adolescents. The treatment is not necessarily available within the prison medical service, but in case of need, contact with the regional AIDS centre are made. No case of accident or PEP use has been reported.

**Protecting staff from occupational hazards - Occupational health (Key intervention 15)**

In general this is a neglected area, although the number of employees across Ukraine is high (44'300, SPSU source). There is no HIV workplace policy in the prison environment. No vaccination against Hepatitis B is available systematically, occasionally through campaigns.

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## 4.2 Current responses

The responses that currently exist to face the HIV situation in Ukrainian prisons are clearly insufficient.

However, every year, one fifth to one third of new HIV infections are diagnosed in the prison system (according to official statistics comparing the whole society of Ukraine to SPSU, the proportion is lower at 12.7%). The data confirm that diagnosing HIV infection during detention is a key action with regards to the situation in Ukraine.

The following table summarises to what extent the 15 key interventions (UNODC, ILO et al. 2013) have been implemented so far in the four penitentiary settings involved in the project. This has been determined according to the information available at the time of preparing the action plans. The main sources of information are interviews with professionals working in the four settings.

		Kyiv pre-trial centre SIZO #13	Bila Tserkva prison men #35	Kharkiv prison women #54	Kremenchuk prison – adolescents
	Number of detained people	3100	800	800-1200	180
1	Information/Education	+	+	+	+
2	Condom programs <sup>8</sup>	+	+	+	-
3	Prevention of sexual violence	-	-	+	-
4	Drug dependence treatment / OST	+	-	-	-
5	Needles & syringes programmes	-	-	-	-
6	Prevention of transmission through medical & dental services	+	+	+	+
7	Prevention of transmission through tattooing, piercing	-	-	-	-
8	Post-exposure prophylaxis <sup>9</sup>	+	+	+	-
9	HIV testing and counselling	+	+	+	+
10	HIV treatment, care and support	+	+	+	- (no infection)
11	Prevention, diagnosis and treatment of tuberculosis	+	+	+	+
12	Prevention of mother-to-child transmission of HIV	+	-	+	-
13	Prevention & treatment STI	+	+	+	-
14	Vaccination, diagnosis and treatment of viral hepatitis	-	-	-	-
15	Protecting staff from occupational hazards	+	+	+	-

<sup>8</sup> Mostly available for private visits

<sup>9</sup> Available at the closest Aids centre

## 5 Key recommendations

Prisons are part of the solutions in the context of HIV situation in Ukraine, with a sound proportion of people being tested annually during incarceration. At the same time, they contribute to the failure of an appropriate and global response to this situation, since far too few PLHIV have access to ART while they are incarcerated. Prevention of HIV infection is insufficient, as well as drug dependence treatment and harm reduction.

Given the high number of detainees, their turn over, the proportions of drug use and HIV infection, closed settings have to be considered as a fundamental place to intervene in order to: (1) ensure that the health needs of people in prisons (inmates and staff) are addressed and (2) have an impact on the HIV epidemic in Ukraine as a whole.

Closed settings have to be included as a major component of NAP (see 3.1 Aims regarding HIV infection within the penitentiary service). Actions at a central level with SPSU and other essential actors involved in the HIV/AIDS epidemic in Ukraine are essential. In that sense, UNODC takes a leading role in advocacy and mediation of HIV related issues for detained people.

The aims regarding HIV in prison should include: early diagnosis, treatment and retention in the treatment of HIV, and consideration of additional factors acknowledged to influence outcomes and having an impact on retention in the treatment and relapses of incarceration, such as combined HIV and drug dependence treatment, as well as prevention and educational measures (addressed both to detainees and staff).

Key recommendations to SPSU are:

- **General attitude:**
  - Acknowledge that the situation regarding HIV in prison settings is problematic.
  - Adopt a transparent communication strategy, showing the real situation in prisons associated to openness and readiness to cooperate with external health partners (involved in the treatment of drug abuse, HIV infection for example).
  - Position themselves as major actors contributing to improve the HIV situation in Ukraine on a global level.
- **HIV:**
  - Promote networking and cooperation with national and regional AIDS centre to ensure sufficient access to infectious diseases specialists and increase the access to ART.
  - Promote the creation of a national HIV prison policy
  - Promote the creation of HIV and drug use professional guidelines for the prison environment (including quality standards criteria).

- **Drug dependence treatment:**
  - Promote the development of integrated care possibilities for detainees using drugs and living with HIV, including the possibility to implement OST.
- **Education and training:**
  - Develop information materials for detainees.
  - Train medical staff on prison health.
- **Occupational health:** Develop a HIV workplace policy (addressing staff).

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## 6 Action plans

### 6.1 Core components of the action plans

The HIV PLEDGE project focuses on actions to be taken within prisons. Even though health is under the administration of penitentiary services, the various components of HIV prevention, and care are subdivided among different partners not depending on penitentiary administration, such as the (regional) AIDS centres (MOH), as well as NGO. The particularities and their degree of cooperation with the prison services are variable in the different oblasts.

A second key factor in the Ukrainian context is the centralised and strongly hierarchical administrative organisation, as well as highly detailed regulations that define very precisely the frame of organisation, functioning and working of the services provided to detainees. Initiating change at the field level is only possible in accordance with this administrative and legal context, which slows down the process. No change can be made locally without formal approval by central prison authorities.

For those two reasons, the action plans proposed here include not only elements related to the four settings, but also at a central level (see chapter 5 Key recommendations); with professionals involved within prisons, and outside (see chapter 6.1.2 Networking).

Core components of action plans are:

- Training: Any intervention in prisons requires changes of practices (see chapter 6.1.1 Training).
- Occupational health: Prison staff are considered as a recipient of the action plans' activities too (see chapter 6.1.3 Occupational health), not only contributing to their implementation.
- Design of a HIV & drug use plan of activities adapted to each setting. This lists the different tasks related to HIV prevention treatment and care that are being carried out yearly within the prison, such as: educational activities with detainees; meeting with AIDS Centres, NGO or narcologists; trainings; protocol update, etc. This is also a way to keep the subjects "HIV and drug use" as issues to work on constantly.
- Dissemination of educational materials (hepatitis, occupational risks) (Key intervention 1)
- HIV testing and counselling (Key intervention 9)
- STI prevention (Key intervention 13).

#### 6.1.1 Training

During the field visit and the meetings with the numerous professionals working in the penitentiary service, two statements were apparent: professionals are willing to discuss matters related to HIV and drug use/treatment, and they need time and a specific space for it. Training can provide both and is an essential part of the action plans.

At the same time, the awareness that can be raised through training is insufficient to bring desired changes. Indeed, decisions such as introducing OST in a given prison

are being taken at a central level. Training might be related to additional tasks for health staff and this will create reluctance to change.

At the end of the training, professionals working in prison should be able to:

- Describe the 15 interventions “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions” (UNODC, ILO et al. 2013)
- Distinguish the interrelation between the 15 interventions (for example between drug use treatment and HIV treatment or substitution treatment and harm reduction)
- Assess and analyse some aspects of their own context of work by using self-evaluation checklists; they will be designed according to the specific needs of the setting and the priorities of action plan.
- Practice interdisciplinary way of working together towards a common aim to implement a comprehensive package against HIV transmission in the prison environment (role play method).
- Help participants to create concrete tools or protocols they can use directly in their place of work (transfer of theoretical knowledge of the 15 interventions into daily work).
- Ensure continuity of training abilities within the training centres of prison staff (“training of trainers”).
- Design a manual of training containing the objectives, contents, and methods of the training delivered regarding during each training session.
- Adopt a non-discriminative attitude towards PLHIV.

Training will partially be based on a multiprofessional concept (*i.e.* specifically designed to address various professionals tackling the same matter through different angles). Other sessions will be more specifically designed for a given profession (health staff, or security personal for example).

The conceptual framework of the training is based on the 15 key interventions. Each session (duration two days) will include: theoretical introduction regarding the specific components addressed during the session, self-evaluation of their practice (with checklists or self-assessment tools), design by the participants themselves of concrete protocols they can use directly in their place of work, and draft of the implementation of this protocol (thus facilitating the transfer of theoretical knowledge to professional and practice-oriented use).

The design of a manual containing learning objectives, contents, and methods of the training sessions is planned, in order to create tools that can be used on a long-term. With regards to continuity too, each training session will involve one pedagogical representative from staff training centres (Kiev, Chernihiv, Bila Tserkva).

Trainers will be both national and international experts.

Participants of the trainings here are working in the four pilot institutions of the project.

### **6.1.2 Networking**

Involve national experts in trainings will reinforce mutual knowledge of existing networks, among partners (penitentiary professionals, NOG, AIDS centres), and contribute to building long-term cooperation.

As AIDS centres and prison medical services are not reporting to the same administration, developing cooperation between them is necessary to ensure proper access to full HIV testing, diagnosis and treatment. The degree and the quality of cooperation vary across regions. Therefore, networking with the regional centres will have to be repeatedly explored and developed separately for the four pilot settings. Increasing the cooperation with AIDS centres should consider prisons health staff as a partner of health care services in general.

The goal of this cooperation is to make prison health services the same as public health for the greater society with regard to HIV services. This example around one health condition can potentially be very valuable with regards to the long-term perspective of transferring prison health services to health authorities.

In general, prison medicine and health professionals working in prison do not benefit the same consideration as other medical specialties and places of work. This discrimination towards health staff in prison has to be addressed at. The first step is bringing professionals from both parts (in and outside prisons) together, to increase mutual knowledge and sharing of experience. Meetings, workshops and trainings are all appropriate to achieve this.

### **6.1.3 Occupational health**

The HIV workplace policy is addressing staff. It can be conceived (according to key principles described in ILO 2001 and ILO 2010) complementary to a global HIV and drug policy for detainees.

In a context of a very poor concern regarding occupational health (key intervention 15), the fear raised by a detainee potentially HIV infected is striking. Generally, upon incarceration, detainees are kept in a different area for 15 days for medical examination and blood testing.

This of course makes sense from a public health point of view, and can certainly be justified with regards to the organisation within the prison. However, the HIV testing during this period is to ensure that people are “*clean*” (according to the words used by prison staff during the interview) before joining the other detainees. Staff expresses reassurance towards this procedure.

Such a delicate subject is of course a matter to be addressed throughout the training (see objectives listed above).

The development of a proper HIV prevention program in the working area or a “Comprehensive HIV workplace Policy” is another possibility. This legitimates any debate regarding HIV among prison staff, with the goal of improving atmosphere for prisoners. The recognition of HIV infection as a workplace issue is generally seen as playing a role in the struggle to limit the effects of HIV epidemic within a country (ILO 2001). At this stage, we ignore any epidemiological data regarding HIV infection

among staff. In this context, the recognition is rather used as a lever to reach non-discrimination towards HIV infected people, *i.e.* staff and detainees, by raising key principles such as confidentiality, voluntary testing, etc. regarding staff.

It is a tricky task to make understandable to staff that PLHIV are not “dangerous people”, neither in prisons, nor outside prisons. This challenge has to be thoroughly reflected on, and be put in practice on a long-term. The hypothesis is that if key principles of HIV workplace policy, such as confidentiality or non-discrimination are understood and made feasible for staff, the same will be possible and applied for detainees too.

From the methodological point of view, rational arguments are usually insufficient, and other techniques involving emotional aspects are required, such as role-play method, or group discussions with psychologists.

In a more pragmatic way, occupational health here also considers PEP (Key intervention 8). A protocol regarding accidental hazards with a clear description of actions in such a situation is essential in each setting. Other elements to be included in the HIV workplace policy will be brought up by staff themselves, during meetings within a specific working group. The creation of such a group is suggested in each of the settings, in order to collect relevant information from people working directly in the field and to sensitize them to principles of the policy during the process.

#### **6.1.4 National prison HIV policy and HIV & drug use guidelines**

This is based on the finding that the various actions regarding HIV prevention, diagnosis and treatment, as well as the related legal issues are spread over separated documents without a general overarching concept.

Rather than being one more legal act added to the prison environment, this has to be considered as an opportunity to formulate an overarching concept that integrates both HIV infection and drug use. It should present the multiple responses health professionals develop in order to face both health conditions. In other words, based on the 15 interventions, activities that need to be implemented or reinforced within the prisons of Ukraine will be detailed. This can include clinical protocols, models of PEP protocols or elements to consider during the pre release period.

The national guidelines will be developed (in a form that needs to be defined; examples from other countries are available and can be inspiring) at a central level, and thus respecting the hierarchical procedure and organisation of the prison administration. At the same time it has to allow some flexibility. Some of the core parts need to be adapted to more specific groups of population (women, young detainees, drug users, etc.) and local particularities (regarding cooperation, testing for example). Education materials or leaflets to be handed out to detainees can also be included (addendum).

Again, the work to realise the guidelines will be done in cooperation with different professionals and partners, both from prisons and the general health services (AIDS Centres, drug treatment centres, and NGO). This is another model of cooperation that can be very useful for the long-term perspective of transferring prison health services to health authorities.

## 6.2 Action plans in the four settings – specific aims

Even though the full list of the 15 interventions of a comprehensive HIV prevention and care policy in prisons (UNODC, ILO et al. 2013) usually needs to be reinforced in all the settings, and could constitute as such a full action plan, specific focus were chosen and are emphasised for each of them. In that sense, the action plans represent models of in depth development of particular aspects of the 15 interventions. Promoting change in prison can be a very long and slow process. The option taken here is to try to gain a few concrete results at first. This will capacitate and stimulate staff to bring up further improvements.

Specific focus were defined according to the findings of the assessments, and keeping as a main goal the need to reinforce the access to early diagnosis, treatment and retention in the treatment of HIV.

The focus (coloured in blue) are summarised in the following table:

Table: Priorities of the 15 interventions in the four pilot prisons

		Kyiv pre-trial centre SIZO #13	Bila Tserkva prison men #35	Kharkiv prison women #54	Kremenchuk prison – adolescents
1	Information/Education				
2	Condom programs				
3	Prevention of sexual violence				
4	Drug dependence treatment / OST				
5	Needles & syringes programmes				
6	Prevention of transmission through medical & dental services				
7	Prevention of transmission through tattooing, piercing				
8	Post-exposure prophylaxis				
9	HIV testing and counselling				
10	HIV treatment, care and support				
11	Prevention, diagnosis and treatment of tuberculosis				
12	Prevention of mother-to-child transmission of HIV				
13	Prevention & treatment STI				
14	Vaccination, diagnosis and treatment of viral hepatitis				
15	Protecting staff from occupational hazards				

Some aims are common to all four settings, such as:

- Design a specific plan of activities regarding HIV and drug use.
- Improve staffs' competencies with relation to HIV and drug use in prison.
- Develop occupational health (inclusive PEP).
- Reinforce cooperation with civil society (NGO).

They are repeated under the specific sections to make the presentation easier.

### **6.2.1 Kyiv pre-trial centre SIZO #13**

#### **Aims of the action plan:**

1. Design a specific plan of activities regarding HIV and drug use.
2. Design an adequate and ethically acceptable path or trajectory describing the different steps of HIV testing, diagnosis, treatment and care within SIZO; this includes the incarceration of PLHIV and continuity of treatment (Key intervention Nr 9, 10).
3. Organise SIZO as a “diagnosis and initiation of ART centre” for HIV infection within Kyiv Oblast (Key intervention Nr 9, 10). This allows the modelling of care (transmission, follow-up, cooperation) of patients diagnosed with HIV in SIZO and then transferred to colonies.
4. Improve staffs’ competencies with relation to HIV and drug use in prison.
5. Develop occupational health, including PEP (Key intervention 8).
6. Reinforce cooperation with civil society (NGO).
7. Reflect on the use of OST in SIZO (Key intervention 4).

See appendix for tasks and activities regarding implementation.

### **6.2.2 Bila Tserkva prison for men #35**

#### **Aims of the action plan:**

1. Design a specific plan of activities regarding HIV and drug use.
2. Design an adequate and ethically acceptable path or trajectory including the different steps of HIV testing (protocol of VCT, indication), diagnosis, treatment (in particular adherence) and care within Bila Tserkva; this includes the incarceration of PLHIV and continuity of treatment when referred from SIZO in Kyiv and before release (Key intervention Nr 9, 10)
3. Ensure easy access to condoms (define where) (Key intervention 2, 13).
4. Provide information leaflets for male detainees upon release, with health information and addresses for follow-up care (Key intervention 1).
5. Improve staffs’ competencies with relation to HIV and drug use in prison.
6. Develop occupational health, including PEP (Key intervention 8)
7. Reinforce cooperation with civil society (NGO), for example Narcotic Anonymous/Alcoholic Anonymous and invite them to propose activities in this setting.
8. Consider developing prevention of sexual violence.

See appendix for tasks and activities regarding implementation.

### **6.2.3 Kharkiv prison for women #54**

#### **Aims of the action plan:**

1. Design a specific plan of activities regarding HIV and drug use.
2. Design an adequate and ethically acceptable path or trajectory including the different steps of HIV testing (protocol of VCT, indication), diagnosis, treatment (in particular adherence) and care within Kharkiv’s prison; this includes the incarceration of PLHIV and continuity of treatment (Key intervention Nr 9, 10)
3. Provide / create information leaflets for female detainees upon release, with health information and addresses for follow-up care (Key intervention 1).

4. Develop treatments for women using drugs, with a particular focus on overdose prevention upon release (Key intervention 4)
5. Improve staffs' competencies with relation to HIV (aspects related to discrimination, confidentiality) and drug abuse / treatment related issues (OST and pre-release).
6. Develop occupational health, including PEP (Key intervention 8)
7. Reinforce cooperation with civil society (NGO) to ensure regular and coordinated intervention regarding HIV

See appendix for tasks and activities regarding implementation.

#### **6.2.4 Kremenchuk prison for adolescents**

##### **Aims of the action plan:**

1. Design a plan of activities regarding prevention.
2. Reinforce VCT, in particular the indication of the testing (Key intervention 9)
3. Ensure easy access to condoms (define where), at least upon release (Key intervention 2, 13).
4. Develop prevention of sexual violence
5. Introduce vaccination against Hepatitis B for detainees (given their age) (Key intervention 14).
6. Develop occupational health, in particular provide vaccination against Hepatitis B for staff (Key intervention 15)
7. Improve staff competencies to promote greater prevention of HIV/STI, in particular to discuss the following topics with detainees: sexual relationships and violence, condom use, stigmatisation (Key intervention 1, 2, 3).
8. Reinforce cooperation with civil society.

See appendix for tasks and activities regarding implementation.

## 7 Conclusion

This document is a guide to implement key international recommendations in Ukraine regarding prison health and HIV. The action plans are meant to bring up changes locally in the four settings of the project at first, and at the same time are examples of possible developments extended to other detention places of Ukraine. Promoting change in prison can be a long and slow ongoing process. Hopefully, the option taken here to try to gain a few concrete results will avoid the whole process to remain theoretical without bringing up concrete changes with regards to detainees' health.

PWID play a major role with regards to the HIV situation in Ukraine. They are overrepresented in penitentiary institutions and should have more attention. In that context, HIV services for detainees provide examples of cooperation (between numerous partners, drug treatment centres, as well as ministries of justice and health). This can potentially be very valuable with regards to the long-term perspective of transferring prison health services to health authorities.

Deep changes are necessary within SPSU, but one in particular is the recognition of the difficult situation SPSU is faced with regarding HIV, and a readiness to cooperate and reform quite a high number of issues. This needs the support from other Ukrainian ministries and partners. Full implementation of prison health guidelines based on ethical values in the foreground is only possible in the broader frame of other in depth changes leading to decent conditions of work and salaries for the employees, or legal amendments that will decrease the number of incarcerated people, and thus the burden on prison services.

DRAFT

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## Annexes

### *Assessment - Kyiv pre-trial centre SIZO #13*

#### **Person of contact:**

Dr. Igor Nepecemnii

#### **Participating in the meeting 18 November 2013:**

##### **Prison:**

- Roman Grodchenko, head of the pre detention centre, 32 years in the system.
- Buryi Ivan, chief inspector of the security.
- Sergii Kravchenko head of the medical Unit for Kyiv Region.
- Natalia Kamenska head of the medical unit in the predetention centre.
- Valentina Onishuk, psychologist
- Oleksander Ovchenko, head of social and psychological unit

##### **UNODC:**

- Valerii Lazebnyi
- Dmytro Tupchiienko(translation)
- Catherine Ritter

#### **Participating in the meeting 21 May 2014**

##### **Prison:**

- Natalia Kamenska head of the medical unit in the predetention centre.
- Oleksander Ovchenko, head of social and psychological unit
- Igor Nepecemnii

##### **UNODC:**

- Valerii Lazebnyi
- Catherine Ritter

#### **General information regarding the setting**

Lukyanivsky is a male and female pretrial setting.

It was not possible to visit the prison. We were informed that 4 to 40 people were living together in one common cell. A television report illustrates those conditions of living<sup>10</sup>. Further information from the media (Kyiv Post, April 2012<sup>11</sup>) reports that the number of detainees was approximately 3100 in 2012. The overcrowding was reported to have decreased with comparison to the 3800 prisoners in 2011 (Wikipedia<sup>12</sup>).

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<sup>10</sup> <http://globalvoicesonline.org/2012/04/05/ukraine-lukyanivska-prison-where-people-are-kept-as-animals/>

<sup>11</sup> <http://www.kyivpost.com/content/ukraine/kyiv-prosecutor-vows-to-solve-the-problem-of-overc-125792.html>

<sup>12</sup> [http://en.wikipedia.org/wiki/Lukyanivska\\_Prison](http://en.wikipedia.org/wiki/Lukyanivska_Prison)

According to the CPT visit conducted at the pre-trial centre in November 2011 the situation regarding male convicted is very problematic: *“However, conditions of detention were quite simply appalling... Numerous cells were in a poor state of repair and had only very limited access to natural light. In addition, the CPT is concerned about the severe overcrowding observed in a number of detention units of both establishments. At the time of the visit, the Kyiv SIZO was accommodating 3,761 prisoners (official capacity: 2,850 places)”*. (p 24) (CPT 2012). Daily activities are limited to one hour outdoor exercise a day, playing cards, watching television. The majority of the detainees are locked up all day (p26).

All newly arrived people undergo a comprehensive medical examination and test for transmittable diseases. Regarding the conditions of testing, the report insists on the importance that all medical consultations have to be conducted *“out of the sight of prison staff”* (p 18).

In general, 50% of the health staff jobs are vacant, since working conditions in prison are not encouraging. The salaries are approximately 2500 Grivnas / month for junior medical staff and 3000-3500 for senior/hierarchical position.

The salary for security staff is 1800 Grivnas. 20% of them are women, against 40% of women in other services.

Information summarised here was produced during the meetings (18 November 2013 and 21 May 2014).

## **A. PEOPLE AND BEHAVIOUR**

**Data on drug use and risk behaviour (number of users types, amount, ways)  
How would you describe the situation regarding?**

### **a) Drug use**

Drug use does officially not happen, but it happens. 20% of prisoners are convicted for drug related crimes. A greater number of them are drug users (30-40%), particularly recidivists. Among the problems staff is facing in the setting, it is not the highest priority, but still recognised as important. Aggressive behaviour (between prisoners) is put forward as the main preoccupation for staff. Staff acknowledges the link or correlation between aggressive behaviour and drug use.

Searches upon admission (scan) detect mainly cannabis (an amount below 5 grams is apparently “tolerated”) and methadone. The consequences depend on the type and the amount of drug that is found, but can include additional term.

Searches also bring up needle & syringes, including during incarceration. This is sanctioned (various types of sanctions, no more precise information).

Synthetic drugs users are reported to present with important fatigue on admission. Abstinence syndromes are also identified, according to the substance of use.

Sanction is considered as an insufficient response to end up with drug use. The searches are more thoroughly done on people known as “heavy users”. Security staff is able to identify who is using drugs.

**b) Tattooing**

It is not allowed, but well acknowledged to happen.

**c) Sexual risk behaviour**

Reported to occur, condoms are provided. No specific intervention to prevent sexual violence exists.

**d) Prevention of transmission through medical and dental services**

No risks of transmission through those ways exist, as reported.

**B. INFECTIOUS DISEASES**

**Summary of data** (see corresponding sections for details) for this specific setting

	HIV	HIV-Aids Deaths	HCV	HBV	Syphilis	TB
<b>Prevalence</b>	6.9%		?	?		?
<b>Incidence</b>	5.9%					?
<b>Cumulative total of diagnosis</b>	?					?
<b>Number last year</b>	297-600	8			22	46
<b>Tests +/-</b>	+		-	-	+	+
<b>Number of tests done in the last year</b>	2500				All detainees upon admission	XR?
<b>Number of ongoing treatments</b>	64-150		-	-	?	?
<b>Treatments started in the previous year</b>	60		-	-	12	?

**Evolution over the last years?**

According to the medical staff present at the meeting, HIV prevalence in the general community in Ukraine is underestimated. Statistics in prison show an increase of HIV infections (not specified if those are new infections or new diagnosis among people infected over a longer period of time and not tested previously) that is closer to reality than the numbers available outside.

**Any remarkable change?**

The cooperation with an infectious diseases specialist greatly improved the access to ART and HIV care in prison.

**a) HIV**

The HIV Infection gives access to secondary benefits or “privileges”, such as better confinement conditions or lighter sentences.

Aids related deaths do occur in prison. Theoretically, it is possible to be released for medical reasons. However, this administrative procedure is very time consuming in the colonies, with the consequence that the person might die in prison, although she has already been legally freed.

## **DIAGNOSIS**

### **Testing: description**

The testing is voluntary. Only 2-3% people actually decline it. 30% of entrants have done the test before, but would not accept the result (infection). 30% think they are HIV-infected and therefore are prone to do the testing.

The diagnosis is confirmed at the Aids centre who will determine the need for ART (the AIDS centre takes the decision after CD4/viremia). The whole process of testing, diagnosis and specialist consultation up to the beginning of the treatment lasts between one to two months.

### **Who monitors the testing?**

This is centralised at the Centre for AIDS Prevention and Control.

The numbers of PLHIV detected in prisons that were provided during our visit and afterwards in written are different. During the visit, it was communicated that every month, 50 new HIV infections are diagnosed (corresponding to 1/5 of entrants per month) among the entrants. Out of them, 5 start the treatment (every month).

With relation to the 3772 new HIV infections diagnosed in prisons in 2013 (SPSU) this represents one fifth (15.9%, 600/3772) of all the people diagnosed during their incarceration in Ukraine.

Calculated over one year, 600 PLHIV are diagnosed in this setting, with 60 (10%) of them starting ART while in prison. This is under the care of the infectious diseases specialist in the prison.

50-150 PLHIV are currently under anti retroviral treatment.

## **TREATMENT RESPONSES**

### **ART**

90% of the PLHIV who need the treatment are reported to get it. This has to be correlated to the affirmation above that 10% of newly diagnosed people actually do receive it, that is 60 out of the 600 newly diagnosed in one year. One question remains open: what happen to the 90% who do not start treatment?

One reason for the absence of treatment for the majority of the people diagnosed with HIV in this prison can be the absence of medical indication. But other reasons, in particular the poor access to treatment has to be considered.

### **Regimen?**

Virocomb (composed of Lamivudin 150 mg and Zidovudine 300 mg: Combivir®<sup>13</sup>) and Efavirenz (Sustiva®, non nucleoside reverse transcriptase inhibitor - NNRTI)

Truvada® and Aluvia (lopinavir and ritonavir<sup>14</sup>: Kaletra®, protease inhibitor - PI). This second scheme was not easily accessed so far, but this is apparently changing. It is prescribed for people with hepatitis B / C, or pregnancy.

**How many are they?** Two regimens are available. Some patients do not start the treatment, due to the absence of the specific regimen for them.

**Number of people on ART?**

50 are currently on ART. 150 started the treatment since January (18 November).

**Delivery and access**

**Are there waiting lists for the ART initiation?** No

**What are the criteria for initiating, not initiating treatment?**

350 CD4 is the current criteria for initiating ART. This might be changed to a new cut-off number of 500 CD4.

**Continuity of treatment:**

- **Upon incarceration**
- **After incarceration:** Interruption of treatment occurs upon release. Usually, 2 months of treatment are provided upon release and transfer. Also, the treatment is provided when going to the court (one set of daily treatment).

**HUMAN RESOURCES for medical care and HIV**

**Staff in the medical service**

There is only one general practitioner (Natalia in the meeting).

There is a general lack of specialised staff and a great turnover of infectious diseases specialists, due to the fact that this is not considered as an attractive job in prison. Consultancies from the AIDS centre are less satisfying than as an infectious diseases specialist among staff, in particular the number of PLHIV under ART increased with the specialist who is regularly present. In the absence of infectious diseases specialist, ART is not started.

Other medical staff: neurologist, gynaecologist, surgeon (100%).

**Networking**

**Which is the AIDS reference centre?**

**CO-MORBIDITY**

<sup>13</sup> [http://www.vidal.ru/poisk\\_preparatov/virocomb.htm](http://www.vidal.ru/poisk_preparatov/virocomb.htm)

<sup>14</sup> <http://hivinsite.ucsf.edu/in-site?page=ar-03-06>

**What is the situation of PLHA with co morbidity? Are they integrated services?**

There is no dedicated person to HIV/drug use related issue, but the need is acknowledged, since this integrated service addressing both HIV infection and drug use exists in the general community.

**TB?**

10-15% of TB patients are HIV infected.  
20% of TB patients are HBV or HCV infected.

**Hepatitis?**

No specific data reported for this prison.

**Drug use?**

99% of HIV infected in this setting are reported to be drug users. A minority use opioids.

**b) STI**

**Epidemiology**

Syphilis is rarely diagnosed: approximately 12 people a year.

**Testing**

All tested

**Treatment**

Injectable antibiotics

**c) HEPATITIS B**

**Epidemiology**

No specific data reported for this prison.

**Testing**

Not done

**Treatment**

Not done

**d) HEPATITIS C**

**Epidemiology**

No specific data reported for this prison.

**Testing**

Not done. Testing without treatment is considered as not appropriate. This could even be sanctioned as a wrong procedure within the regular controls that penitentiary system is conducting.

**Treatment**

The pre-trial centre is considered as inappropriate place to treat or start the treatment against Hepatitis C. This should be done in colonies

## e) TUBERCULOSIS

### Epidemiology

50 active TB, 20% are resistant

### Testing

XR upon arrival, and again once a year

### Treatment

DOTS

## C. PROBLEMATIC DRUG USE

	Number of people opioid dependent /year	Non fatal overdose /year	Deaths from drug use - overdose /year
2013	2500	-	-

**Evolution over the last years?** Not discussed

### Any remarkable change?

Thanks to early intervention, no fatal overdose was reported to occur.

## TREATMENT RESPONSES

### Description of services

	OST	Naloxone	Others
<b>Present Yes/No</b>	-	-	
<b>Number</b>			

Officially, no naltrexone is available, since no drug use should occur, and methadone is not used. Staff is clearly in favour of abstinence-oriented therapies.

### What is used to relieve withdrawal / detoxification?

Non sedative medication is available, i.e. analgesia for withdrawal symptoms. Detoxification is only provided in specialised centres. Detoxification is the aim, since there is no continuation of treatment in colonies.

**Obstacles and possibilities to introduce OST:** not discussed during this meeting

**Ways to induce changes?** Not discussed during this meeting

### Psychiatric patients (double diagnosis) included in OST?

Not discussed during this meeting

### Continuity of treatment, including OST

- **Upon incarceration** no continuation of OST
- **After incarceration:** possible for OST; organised in cooperation with specialised centres

**Referral to treatment services as an alternative to prosecution of drug dependent offenders**

Not discussed in this meeting

**HUMAN RESOURCES for drug use**

**Staff in the medical service**

Vacancy for psychiatrist.

**Networking? Addiction centre? Psychiatrists, other**

No

**D. HARM REDUCTION**

**Description of services**

	<b>CONDOMS</b>	<b>Bleach</b>	<b>Tattoo</b>
<b>Present Yes/no</b>	<b>+</b>	<b>-</b>	<b>-</b>
<b>Numbers delivered / year</b>	2500		

Condoms are provided in the bathroom (shower area) and in the consultation room.

**Obstacles?**

Not discussed

**Possibilities?**

Not discussed

**Ways to induce changes?**

Not discussed

**E. NETWORKING**

**Actors involved (governmental and NGO)**

In general, the pretrial centre limits the contacts with the outside community, however the NGO People Living with Aids is involved. There is no cooperation with churches.

**Existence of an informal but efficient cooperation among (list of people, of services cooperating...**

Not specified in this meeting, except the cooperation with infectious diseases specialist within the prison and the Aids centre.

**F. ETHICAL ISSUES**

**Confidentiality of testing & treatment**

There is a written permission to inform about HIV status.

## **Discrimination of HIV, HCV infected people**

### **G. FUNDING**

#### **Funding from state budgets**

#### **Funding from international and bilateral donor organizations**

#### **Sustainability of funding the treatments (drug and infectious diseases)**

Not presented as a main preoccupation.

### **H. INFORMATION & EDUCATION**

#### **Subjects covered**

STI prevention and condom use

#### **Staff involved**

- **Prison staff**
- **NGO**

#### **Information materials**

Provided by NGO in important amounts

### **I. OCCUPATIONAL HEALTH**

No need of PEP use reported.

Prevention of HIV transmission during dental care is being done (sterilisation of equipment and use of gloves).

### **SUMMARY**

- The fact that this large pre-trial centre is actually participating in the HIV- PLEDGE project is very positive.
- According to the numbers provided, almost one fifth of new HIV infections in the Ukrainian prison penitentiary system are diagnosed in this centre.
- The number of PLHIV starting ART is low (10% of newly diagnosed). The reasons for this have to be better explored.
- Some data has to be more detailed in particular the co morbidity between HIV infection and drug use. Again this might define one key priority for the action plan.
- When trying to understand the reality of the practitioners' field and to discuss possible solutions, human resources issues are emphasised, in particular the low consideration of the work in prison and the extremely low salaries.
- Any possible solution is felt as an increase in already overwhelmed jobs
- There is no integration of the various and separated problems. For instance, drug use treatment is not put in relation with HIV infection. This could be the task of the general practitioner, but this job is already overwhelmed with work.

#### **Specific aim for the second meeting**

- Validate the findings
- Explore the reasons for low HIV treatment initiation
- Examine the possibility of cooperation with Bila Tserkva prison

## *Assessment - Bila Tserkva prison for men #35*

### **Participating in the meeting 22 November 2013:**

#### **Prison**

- Sergii Kravchenko, head of the medical Unit for Kyiv Region.
- Kaminatrus Andrei Nikolaevitch, prison director
- General practitioner
- Psychiatrist (present a few minutes only)

#### **UNODC**

- Valerii Lazebnyi
- Dmytro Tupchiienko(translation)
- Catherine Ritter

### **Participating in the meeting 1 July 2014**

#### **Prison**

- Kaminatrus Andrei Nikolaevitch, prison director
- General practitioner
- Psychologist

#### **UNODC**

- Georgi Eremin (translator)
- Valerii Lazebnyi
- Catherine Ritter

### **General information on the setting**

Bila Tserkva is a male middle security prison (800 people), with an important number of recidivists. It also houses migrants (10 people from Georgia, Africa, Azerbaijan, Russia, Latvia, Lithuania, Israel the day of our visit). This is apparently not presenting any difficulty such as racism.

In 2000, this setting was provided with support from the Swiss Agency for Development and Cooperation SDC (Hans Jürg Bühlmann), part of the Federal Department of Foreign affairs<sup>15</sup>. As reported by media at that time<sup>16,17</sup>, the project included restoring the building (dormitories with 100 detainees were transformed to lodge 25), and the creation of a prison staff training center in Bila Tserkva (Bila Tserkva College for the Training and Re-training of Prison Staff).

Relatives/friends are not allowed to send money to prisoners who can only use their own earnings (through work) in the prison's canteen. Changing this would make the control of drug trafficking easier, but apparently such a decision is not an easy administrative process, and cannot be taken at the level of the prison director.

<sup>15</sup> <http://www.ddc.admin.ch/en/Home>

<sup>16</sup> <http://www.kyivpost.com/content/ukraine/bila-tserkva-colony-drives-prison-reform-11395.html>

<sup>17</sup>

[http://www.swissinfo.ch/eng/archive/Switzerland\\_helps\\_Ukraine\\_update\\_its\\_prisons.html?cid=4965010](http://www.swissinfo.ch/eng/archive/Switzerland_helps_Ukraine_update_its_prisons.html?cid=4965010)

There is 50% of attendance in the occupational activities that are available: religious group, culture in the evenings, painting, singing, church for different confession.

25 people sleep in one dormitory. It is reported not to be quiet in the night.

A better integration of health and justice systems is expected.

Training for doctors and better salaries are hoped for.

Most detainees in Bila Tserkva are transferred from SIZO with their medical files (no difficulties reported). This can be useful with regards to the action plans, especially considering continuity of treatment of drug abuse.

The prison administrator was present during both meetings and the visit of the setting. Medical staff was not present the whole time, therefore medical data regarding the situation in this setting is incomplete. Sergii Kravchenko provided additional information.

A brief encounter (few minutes only) with a group of prisoners was possible during the first visit. This was not required for this first contact visit, and was spontaneously organized by the prison administrators.

Drug use is acknowledged as a reality in this setting; the number of users is estimated to be around 62%, with 50% of them intravenous users. Most are described as not wanting to cease the use. Searches done by security staff bring up needles and syringes. The prison director considers that his intervention to tackle the drug-related issues is insufficient. He is open to cooperation with NGO in general.

Note: spaces without information were not covered in the meeting (missing data).

## **A. PEOPLE AND BEHAVIOUR**

### **Data on drug use and risk behaviour (number of users types, amount, ways)**

#### **How would you describe the situation regarding?**

##### **a) Drug use**

Drug use is acknowledged as a reality in this setting; however, it is difficult to define exactly the number of drug users. Around 50% are estimated to be using drugs, with the remaining being drinking alcohol. The craving to use drugs is even greater in prisons than outside. Apparently most users are described as not wanting to cease the use (*precontemplation level*).

Some substances increase the aggressiveness and others ease relationships between prisoners. Drugs are smuggled in by relatives, and hidden into food for example. They are also thrown in from outside. Currently, drugs of interest are synthetic drugs, cannabis, and "krokodile", used as an alternate of heroine. Searches bring up needles and syringes.

The prison director considers that his intervention to tackle the drug-related issues in this setting is insufficient. He is unsatisfied with the whole situation, but at the same time considers that the person who uses drugs has to be sanctioned. The prolongation of prison term is also a “prevention tool” for other prisoners.

Urine testing is part of the routine in the medical care of drug users, but not done as often as required, since it is not always available.

**b) Tattooing**

Not a priority in this setting. It is prohibited and reported not to be as frequent as in the past. A full body examination is done upon entry, and the occurrence of an additional tattoo is sanctioned.

**c) Sexual risk behaviour**

Acknowledged as a reality in the setting, without being able to have any control/influence on it. No complaints regarding rape have come up to administration. Apparently prisoners resolve such situations among themselves “like in a large family”. Sexual relations are reported to occur only with consent of both partners. When talking about sexual relations and condoms availability, the interlocutors understand “private visits”.

**d) Prevention of transmission through medical and dental services**

Prevention of HIV transmission during dental care is being done (sterilisation of equipment and use of gloves).

**B. INFECTIOUS DISEASES**

There is a medical visit for all entrants (150 a year approximately)

	HIV	HIV-Aids Deaths	HCV	HBV	Syphilis	TB
<b>Prevalence</b>	12%		?	?		
<b>Incidence</b>	(18/150) 12%					?
<b>Cumulative total of diagnosis</b>	86 - 96 registered					
<b>Number last year</b>	18- 26	In hospital			4	1 - 8
<b>Tests +/-</b>	+		-	-	+	+ XR
<b>Number of tests done in the last year</b>	800		-	-	?	?
<b>Number of ongoing treatments</b>	17-24		-	-		?
<b>Treatments started in the previous year</b>	3-4		-	-		?

## **a) HIV**

### **DIAGNOSIS**

86- 96 (there is a difference in the numbers provided during the visit and afterwards in the tables sent in written) people registered as PLHIV.

#### **Testing: description**

The testing is voluntary. Rapid testing is done among all detainees upon admission. Since Bila Tserkva is a prison, overtesting has been recognised as a reality. Tests are confirmed in Kiev.

#### **Who monitors the testing?**

Results are registered centrally in Kiev.

### **TREATMENT RESPONSES**

#### **ART**

Very few patients (3-4) initiated ART in this setting last year. Apparently it was not indicated for the others. During the second visit, this low number was also reported to be due to insufficient visits by the infectious diseases specialist (once every three months, contradiction with the information regarding the frequency of the visit for patients already under treatment, see below). ART is not taken under supervision. Detainees are provided with one month of treatment in their cell. Apparently, adherence is ensured. No interruption of treatment is reported.

#### **Regimen?**

#### **How many are they?**

#### **Number of people on ART?**

17-24 (there is a difference in the numbers provided during the visit and afterwards in the tables sent in written) PLHIV are currently under treatment. They disclose their status/treatment to other prisoners. This is reported to be without negative consequences (discrimination).

#### **Delivery and access**

**Are there waiting lists for the ART initiation?** 0

**What are the criteria for initiating, not initiating treatment?**

#### **Continuity of treatment**

- **Upon incarceration**
- **After incarceration**

### **HUMAN RESOURCES for medical care and HIV**

#### **Staff in the medical service**

General practitioner, nurse, dentist

## Networking

### Which is the AIDS reference centre?

Infectious diseases specialist from the local Aids centre visits once-twice a month the patients in the medical unit.

## CO-MORBIDITY

### What is the situation of PLHA with co morbidity? Are they integrated services

#### TB?

PLHIV with TB are treated for both infection in Kharkiv (prison hospital Interregional TB hospital prison Nr 17)

#### Hepatitis?

#### Drug use?

100%: All 86 people registered as PLHIV are PWID, mostly synthetic drug users.

#### b) STI

##### Epidemiology

4 tested positive for syphilis

##### Testing

Treatment unknown

#### c) HEPATITIS B

##### Epidemiology

##### Testing

##### Treatment

#### d) HEPATITIS C

##### Epidemiology

Only chronic hepatitis are diagnosed.

##### Testing

The testing is only done when symptomatic liver conditions appear. The patient is referred, as the testing is not done in the setting itself.

##### Treatment

None available

## e) TUBERCULOSIS

### Epidemiology

1 – 8 (there is a difference in the numbers provided during the visit and afterwards in the tables sent in written) active tuberculosis were diagnosed in 2013.

### Testing

XR is done once a year.

### Treatment

## C. PROBLEMATIC DRUG USE

	Number of people opioid dependent	Non fatal overdose /year	Deaths from drug use -overdosis /year
2013	62.5% 500/800 50% (400/800) iv users	?	0

Evolution over the last years? Not discussed

Any remarkable change? Not discussed

## TREATMENT RESPONSES

### Description of services

	OST	Naloxone	Others
Present Yes/No		Yes	
Number		Rarely used	

OST is presented as an illicit treatment. There is no detoxification treatment. Treatment is oriented towards abstinence.

There are no drug free wings, but some people want to get isolated from drug users. There is no more mandatory drug/alcohol treatment anymore. The decision to treat is made by the user himself.

### What is used to relieve withdrawal / detoxification?

Sedatives are used to treat epilepsy, not to release withdrawal.

### Obstacles?

### Possibilities?

The discussion is considering drug policy as such, in general for Ukraine and in prisons too. For example, to increase access to drug treatment, there is a need for another policy, since repression alone has a limited impact. The following aspects have to be included in it: prohibit selling synthetic drug components in the pharmacy; reintroduce mandatory drug treatment; consider detoxification, but not substitution. There is currently a generation of drug users that is dying from drug use related causes, which allows the public to start to build its own opinion.

## Ways to induce changes?

### Psychiatric patients (double diagnosis) included in OST?

### Continuity of treatment, including OST

- Upon incarceration
- After incarceration

### Referral to treatment services as an alternative to prosecution of drug dependent offenders

## HUMAN RESOURCES for drug use

### Staff in the medical service

Psychiatrist 50%, and narcologist 50%. The latter is reported to be insufficient with relation to the important number of detainees with a problematic drug use.

### Networking

### Addiction centre? Psychiatrists, other

One NGO is promoting sport instead of drug use. Neither NA nor AA is visiting the detainees.

## D. HARM REDUCTION

### Description of services

	<b>CONDOMS</b>	<b>Bleach</b>	<b>Tattoo</b>
<b>Present Yes/No</b>	Yes	-	-
<b>Numbers delivered / year</b>	500-800		

Condoms are available for free (Network of PLWHA) in the medical unit. They are currently thinking of making them available in other areas. They can also be purchased at the canteen. The number communicated is high in comparison with the other settings.

### Obstacles?

### Possibilities?

### Ways to induce changes?

## E. NETWORKING

### **Actors involved (governmental and NGO)**

No currently developed, but the NGO "People living with AIDS" has the possibility to work in cooperation with the prison system. The prison director is open to cooperating with NGO.

### **Existence of an informal but efficient cooperation among (list of people, of services cooperating)**

## **F. ETHICAL ISSUES**

### **Confidentiality of testing & treatment**

### **Discrimination of HIV, HCV infected people**

In the past, prisoners were avoiding contact with PLHIV, this seems not to be the case anymore.

## **G. FUNDING**

### **Funding from state budgets**

HIV tests are funded by state (30%) and GFATM (70%).

### **Funding from international and bilateral donor organizations**

### **Sustainability of funding the treatments (drug and infectious diseases)**

Yes.

## **H. INFORMATION & EDUCATION**

School and vocational training are available. Before rehabilitating, the aim is to show that another life is possible.

A lot of information is reported to be available on various health related issues. Detainees apparently understand it. Information leaflets providing addresses or important contacts for treatment upon release that can be handed out to detainees are however reported to be missing.

### **Subjects covered**

STI prevention and condom use

### **Staff involved**

- **Prison staff**
- **NGO**

## **I. OCCUPATIONAL HEALTH**

PEP prophylaxis is available at the AIDS centre and a protocol of steps to follow in case of accident is available. As the proportion of intravenous drug users is reported to be 50%, it is still considered as one important point for the action plan. No case of accident or PEP use has been reported. No vaccination for hepatitis B vaccine is available. An agreement with the local military hospital has been signed. One case of tuberculosis has been reported for 2012.

## SUMMARY

- This prison has already been provided with support regarding prison staff training (and restoration of dormitories).
- The dialogue during the visit was reasonably honest regarding the situation of drug related matters in the setting.
- Drug related issues are frankly acknowledged as an important problem in this setting. Our visit is taken as an opportunity to discuss drug policy and drug related issues in general. This shows the need to promote spaces and opportunities for staff to address this important matter. Currently, there is no training on addiction at the medical faculty.
- Training in drug policy and drug related issues is welcome and needed. This training could address staff from the pretrial centre in Kyiv too, as there is continuity between both institutions and geographical closeness.
- Contacts with Narcotic or Alcoholic Anonymous are suggested

DRAFT

## *Assessment Kharkiv Prison for women #54*

Person of contact: Alexei Tsura, general practitioner, head of the prison medical unit

### **Participating in the meeting 19 November 2013:**

#### **Prison:**

- Alexei Tsural, general practitioner, head of the prison medical unit
- Olexander Bortchan, chief medical officer, head of the regional medical department
- Svitlana Malaeva, psychologist\*
- Tetiana Korh, nurse\*
- Vitalii Samohin, narcologist\*
- One member of the NGO Network of PLWHI ("The Net")\*

\*Attending the end of the meeting

#### **UNODC:**

- Valerii Lazebnyi
- Dmytro Tupchiienko(translation)
- Catherine Ritter

### **Participating in the meeting 3 July 2014**

#### **Prison:**

- Alexei Tsural
- Social worker
- Svitlana Malaeva, psychologist
- Regional head of medical department
- Substitute of prison director

#### **UNODC**

- Georgi Eremin (translator)
- Valerii Lazebnyi
- Catherine Ritter

### **General information regarding the setting**

This setting for female prisoners has a capacity to host 1200 women; 800 were incarcerated at the time of our visit.

The CPT has visited the Kachanivska Correctional Prison No. 54 in 2012. The report mentions an official capacity of 820 people (p8). 22 women are under life sentences (between 25-74 years old). Their conditions of detention have been examined by the CPT and described as improving, although matters related to restricted space in the cells and video surveillance remain of concern. Regarding ill treatments, the delegation mentions "*It received no complaints from life-sentenced women about staff behavior in the medium-security unit and only heard very few individual accounts of ill-treatment of women serving fixed-term sentences in the other parts of the establishment. These cases mainly involved verbal abuse and slaps by male*

*members of staff in the main courtyard or in a holding room.”* (p 14). Detainees can be designated to assist prison staff (CPT 2013)<sup>18</sup>

On the contrary to important difficulties related to the level of local cooperation mentioned by the delegation (p 10) which visited the setting (including detainees), the general atmosphere of the meeting was very welcoming.

A visit of the setting was possible, but without direct contacts with the women in detention, according to our objectives for this first visit.

The meeting started with a discussion regarding health care in prison in general, around issues such as separation of health and penal administrations, function of a prison medical service, organization of health care and the comparison of prison doctor and family doctor. Although not directly related to the issues we wanted to raise in this first visit, time was given to this exchange, due to the importance of the issues, and also because such visits are good opportunities to exchange about professional experiences. They help to understand the logic of different practices and to favor working contacts.

A very high level of control occurs within the medical service, for example the number of syringes used in the setting (for diverse treatment, mainly diabetes) are regularly counted.

Note: spaces left open without information were not covered in the meeting (missing data).

## **A. PEOPLE AND BEHAVIOUR**

### **Data on drug use and risk behaviour (number of users types, amount, ways) How would you describe the situation regarding?**

#### **a) Drug use**

Drug use is not considered as a problem, since the women have spent time in pre trial settings before arriving to the prison. We have been told that there is no use in the prison.

#### **b) Tattooing**

This is reported as rare in female prisons. It is prohibited. A full body examination is done upon entry, and the occurrence of an additional tattoo is sanctioned.

#### **c) Sexual risk behaviour**

Private visits are allowed every 3 months with the husband (officially designed as such). Preservatives are available. Psychologists are in charge of prevention of sexual violence.

#### **d) Prevention of transmission through medical and dental services**

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<sup>18</sup> CPT. (2013). Report to the Ukrainian Government on the visit to Ukraine carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 1 to 10 December 2012. <http://www.cpt.coe.int/en/states/ukr.htm>. Accessed 25 September 2013.

Reported to be done (sterilisation of equipment and use of gloves).

## B. INFECTIOUS DISEASES

	HIV	HIV-Aids Deaths	HCV	HBV	Syphilis	TB
<b>Prevalence</b>	7.4%	0	?	?		?
<b>Incidence</b>	4.5%					
<b>Cumulative total of diagnosis</b>	?				5	
<b>Number last year</b>	17					
<b>Tests +/-</b>	+		-	-	+	+
<b>Number of tests done in the last year</b>	378					
<b>Number under ART</b>	40					
<b>Treatments started in the previous year</b>	?					

### Evolution over the last years?

There are 62 women living with HIV in the prison. Two thirds of them undergo ART. In July 2014, following the armistice, only 39 of them were present.

#### a) HIV

### DIAGNOSIS

#### Testing: description

In the discussion during the visit, it has been reported that a 100% of women are being tested. With relation to what has been said above regarding the previous incarceration in pre trial prison, over testing cannot be excluded. However, looking at the numbers provided for 2013, 45% of women are being tested when considering the number of detainees in the setting and the number of test done. This is however very approximate, since the calculation should be based on the number of women entering the prison, not the number actually staying in it.

The diagnosis is confirmed at the Aids Centre in Kharkiv.

**Who monitors the testing?** Not specified

### TREATMENT RESPONSES

Prevention of mother to child transmission is rarely needed. One women living with HIV became pregnant during the private visit with her husband. She was then transferred to Odessa (or Chernihiv) in special units for mothers and children.

### ART

## **Regimen?**

### **How many are they?**

Various regimens are used, they are individualised.

### **Number of people on ART?**

Across all the prisons in the oblast: 65 PLHIV were treated in 2012, 122 in 2013. A total of 350 PLHIV are registered.

### **Delivery and access**

The medication is delivered through NGO or the prison itself. ART is taken under daily control in the medical unit.

### **Are there waiting lists for the ART initiation?**

### **What are the criteria for initiating, not initiating treatment?**

There are no problems regarding access to treatment. There is no waiting list. Infectious diseases specialist from Kharkiv initiates the treatment. The threshold used for ART is 350 CD4.

### **Continuity of treatment**

- **Upon incarceration**
- **After incarceration:** Contacts are made with the Aids centre from the oblast where the women is going to be living.

The psychologist, with relation to the parents or the husband/partner of the women, also considers the HIV infection. Most women will not tell the family about their status. She prepares them to share the diagnosis upon release or does it with them during the incarceration, depending on the particular situation.

## **HUMAN RESOURCES for medical care and HIV**

### **Staff in the medical service**

GP, gynaecologist, psychologist, 5 nurses. The doctor in charge of the unit (Alexey) is male. Two female doctors also work in the unit. A nurse or female colleague does not always accompany the male doctor during his consultations.

### **Networking**

NGO PLHIV is playing an important role.

**Which is the Aids reference centre?** Kharkiv's Oblast. The cooperation with the prison medical unit is described as good.

## **CO-MORBIDITY**

**What is the situation of PLHA with co morbidity? Are they integrated services**

**TB?**

**Hepatitis?**

## Drug use?

### b) STI

#### Epidemiology

##### Testing

Done for syphilis

The gynaecologist is examining each women upon admission and then once a year or more according to specific needs.

##### Treatment

Available

### c) HEPATITIS B

#### Epidemiology

?

##### Testing

None

##### Treatment

None

There is no vaccine. A negative opinion about vaccines in Ukraine is described and therefore it is not considered as a priority.

### d) HEPATITIS C

#### Epidemiology

?

##### Testing

None

##### Treatment

None

### e) TUBERCULOSIS

#### Epidemiology

##### Testing

Chest XR is done every 6 months during the incarceration.

**Treatment** is done in tuberculosis clinics

## C. PROBLEMATIC DRUG USE

	Number of people opioid dependent	Non fatal overdose /year	Deaths from drug use - overdose
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	<b>/year</b>		<b>/year</b>
<b>2013</b>	?	?	?

Women do not present with abstinence syndrome; this has been resolved in pretrial prisons. Among the 107 women reported to be presenting a problematic drug use, 91 of them are intravenous users. Drug use during incarceration is concealed and not recognised as a problem. No urine testing for drug use is done.

### **Evolution over the last years?**

In 2004, an important change occurred with the end of coercive addiction treatments in the prison system. The narcologists who were in charge of those treatments (described as a “soviet heritage”) are still working in the service, although in reduced numbers. According to staff present at the meeting, this change has worsened the situation regarding access to treatment and increased the number of drug users outside. There seems to be an absence of clear protocol on who among medical staff will now take care of drug users, and how. Indeed, other medical staff has been neither used to, nor trained to take care of drug users, since they were previously directly under the care of the narcologist.

### **Any remarkable change?**

Poor women are reported to use alcohol. Other substances are rather of use in wealthier family environment.

### **TREATMENT RESPONSES**

There is no particular treatment

#### **Description of services**

	<b>OST</b>	<b>Naloxone</b>	<b>Others</b>
<b>Present Yes/No</b>	+ ?	-	
<b>Number</b>			

#### **a) IF OST Forms available**

##### **Aims**

Methadone can apparently be prescribed at the beginning of the incarceration, with the aim of detoxification. This information reported during the visit is highly surprising given the general absence of OST in the penitentiary service.

##### **Regimen**

**Who wrote it?**

##### **Delivery and access**

#### **b) IF NO OST**

**What is used to relieve withdrawal / detoxification?** To be explored.

##### **Obstacles?**

## Possibilities?

A working group considering the implementation in Kharkiv's Oblast of a central order protocol for continuity of OST in prisons is currently run. Four colonies will be testing OST among a 120 detained people.

## Ways to induce changes?

### Psychiatric patients (double diagnosis) included in OST?

### Continuity of treatment, including OST

- Upon incarceration
- After incarceration

According to staff, drug dependence or drug use is one of the main problems that prisoners are facing upon release (difficulties related to work, housing, rehabilitation). However, drug use is not considered as a problem during incarceration, or among one of the aspects to consider before the release. The prison system gives a false impression that "there is no problem related to drugs", since women do not use drugs during the incarceration. This is probably impeding a proper preparation to release.

### Referral to treatment services as an alternative to prosecution of drug dependent offenders

## HUMAN RESOURCES for Drug use

### Staff in the medical service

Narcologist (introduced but did not participate in the meeting, unfortunately).

Psychologist

### Networking

Networking? Addiction centre? Psychiatrists, other

## D. HARM REDUCTION

### Description of services

	CONDOMS	Bleach	Tattoo
Present Yes/No	+ in private visits and upon release	-	-
Number/year	120		

Information and education include the infection risks while injecting.

OST is understood as being a harm reduction measure.

### Obstacles?

Information regarding condoms is controversial. One source indicates that they are not available at all, including during private visits, and prison health staff on the other

hand considers that the number of condoms is sufficient and informs us that they are available.

## **Possibilities?**

### **Ways to induce changes?**

As condoms are available, it is suggested to include them in a “pre release kit” containing also the information booklet (see under H).

## **E. NETWORKING**

### **Actors involved (governmental and NGO)**

NGO PLHIV is playing an important role in this prison, however the coordination could be improved. Also, the various actions regarding HIV prevention, testing and treatment, as well as legal issues, are spread over separated documents, a situation that impedes an optimal coordination of the persons involved (NGO, prison staff).

### **Existence of an informal but efficient cooperation among (list of people, of services cooperating)**

There is a HIV coordinator in the regional prison service (funded by Ukraine Alliance).

A centre for social adaptation is available for after incarceration, it is run by the NGO LIGHT OF HOPE.

## **F. ETHICAL ISSUES**

### **Confidentiality of testing & treatment**

HIV status seems difficult to hide among detainees.

Confidentiality is not respected since medical staff informs prison staff regarding HIV status.

### **Discrimination of HIV, HCV infected people**

HIV infected women are working in different areas of the prison, there seems to be no discrimination. At the same time, HIV infected detainees who are aware of their rights are said to be “abusing them”.

Other sources report that women living with HIV are suffering from isolation.

Also, the fact that infected and non-infected women have to live together is presented as a danger of being infected by staff.

## **G. FUNDING**

### **Funding from state budgets**

To treat STI (syphilis)

### **Funding from international and bilateral donor organizations**

Tests are funded by GFATM, and ART's by the NGO PLHIV. Preservatives are also provided by NGO. The proportion of international / national funding is unknown.

### **Sustainability of funding the treatments (drug and infectious diseases)**

## **H. INFORMATION & EDUCATION**

### **Subjects covered**

There is no official health education program addressed to detainees. Information materials are available though. Some subjects such as hepatitis or professional health risks are not covered. The idea of creating an information booklet containing health information (HIV and drug use mainly) and useful addresses after release is discussed. The detainee could also use it to write more specific data in it, depending on her particular health problems and the place of residence after incarceration.

### **Staff involved**

- **Prison staff**
- **NGO**

### **Information materials**

Provided by NGO PLHIV

## **I. OCCUPATIONAL HEALTH**

PEP is available at local AIDS centre. No masks nor gloves are available. One person is in charge of occupational health (profession not specified).

## **SUMMARY**

- The whole visit gives an impression of “everything is fine”, and at the same time the atmosphere is welcoming and open to discuss important matters regarding health care in closed setting
- The NGO PLHIV is working on a regular basis in this setting.
- The situation regarding drug use seems to be underestimated. This is probably impeding a proper preparation to release, where drug use is presented as one of the main difficulties women are faced with. Therefore, drug use treatment and care could be one issue to address further in this setting, in particular also since it is the first place where the consequences due to the end of coercive treatment for drug users was raised, and where a regional working group is considering OST continuity in prison
- A possible focus for action plan is the preparation for release of detainees with a problematic drug use. This includes the creation of an information booklet and the provision of condoms.

## *Assessment - Kremenchuk prison for adolescents*

### **Persons of contact:**

Yuri Velitchko, head of the prison

### **Participating in the meeting 21 November 2013:**

#### **Prison:**

- Iulia Hartchenko, chief inspector on social work (qualified as a psychologist)
- Yuri Velitchko, head of the prison
- Victor Kolesnikov, acting head of the medical unit виктор колесников  
57kolesnikov350@mail.ru
- Liubov Solomenko, acting head of secondary school
- Iana Simonova, Psychologist
- Doctor
- Teacher
- Taisia Parhomenco, Laboratory assistant

#### **UNODC:**

- Valerii Lazebnyi
- Dmytro Tupchiienko(translation)
- Catherine Ritter

### **Participating in the meeting 2 July 2014**

#### **Prison:**

- Yuri Velitchko, head of the prison (second part of the meeting)
- Head of the medical unit
- Doctor
- Iana Simonova, Psychologist
- Vice director women

#### **UNODC**

- Georgi Eremin (translator)
- Valerii Lazebnyi
- Catherine Ritter

### **General information regarding the setting**

In general, after 2 months of pretrial detention, adolescents spend 3 to 4 years in average in a prison.

The prison in Kremenchuk houses 180 young men (out of 1000 in Ukraine, among them 80 women) is apparently following the pedagogical principles of Anton Makarenko, an educator and writer (1888 – †1939)<sup>19</sup>, whose sculpture occupies a central place in the inner Ward of the prison.

When first arriving, the young people are isolated and going through 15 days of assessment. School is mandatory. During our visit, all the classrooms were empty.

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<sup>19</sup> <http://www.marxists.org/reference/archive/makarenko/works/problems-soviet-school-education.pdf>

There are no video games. Prisoners learn to use computers, without internet access. Regarding sport, football can be practiced, but the participation rate is described as poor.

Skin problems are frequent upon admission. Prisoner’s hair is cut very short. Shower is available once a week, and lavabo washing ever day (morning and evening).

The general atmosphere of the interdisciplinary meeting that was organized for our visit was agreeable and welcoming. A visit of the setting itself was also organized.

Important efforts are made to build up / keep the relation with relatives or close contacts of the detainees. There are three categories of them: orphans, with parents, with parents deprived of parental rights. 70% of the parents do not visit their son. The prison provides accommodation for family. Due to this situation, the relation among prisoner and staff are considered as particularly important. However, some aspects related to the confidence in their relationship are rather surprising at this age and in this context. For instance, the young prisoners are reported to discuss freely and with easiness with staff about some intimate subjects such as sexual life (during prevention/health education activities).

Note: spaces without information were not covered in the meeting (missing data). The larger questionnaire addressed to prison administrators is missing at this stage of reporting the situation.

**A. PEOPLE AND BEHAVIOUR**

**Data on drug use and risk behaviour (number of users types, amount, ways)  
How would you describe the situation regarding?**

**a) Drug use**

No drug use is occurring in the prison. This is not considered as a problem.

**b) Tattooing**

Not occurring at this setting but during pretrial.

**c) Sexual risk behaviour**

Sexual violence is reported to be addressed at through communication of information to detainees.

**d) Prevention of transmission through medical and dental services**

Prevention of HIV transmission during dental care is being done (sterilisation of equipment and use of gloves).

**B. INFECTIOUS DISEASES**

	HIV	HIV-Aids Deaths	HCV	HBV	Syphilis	TB
<b>Prevalence</b>	0	0	0	0	0	

<b>Incidence</b>	0					
<b>Cumulative total of diagnosis</b>	0					
<b>Number last year</b>	0					
<b>Tests +/-</b>	+		-	-	-	+
<b>Number of tests done in the last year</b>	663					
<b>Number of ongoing treatments</b>	0					
<b>Treatments started in the previous year</b>	0					

### **Evolution over the last years?**

#### **Any remarkable change?**

Given the high number of testing, one has to consider the possibility of over testing. Three reasons can explain this situation: over testing, mistake in reporting data, high turn over of young detainees in this setting.

#### **a) HIV**

No HIV infected young detainee was incarcerated at that time. Therefore this multiple aspects related to HIV are unknown to the participants of the meeting.

### **DIAGNOSIS**

#### **Testing: description**

The testing is done systematically upon admission; no infections have been detected. It is voluntary, and no one declines it. Rapid tests are done in the setting and confirmed in Kiev.

#### **Who monitors the testing?**

The setting participated in a random testing among 50 detainees, following a specific order from Kyiv. This seems to occur regularly on a one – two years basis, but the context of this testing is not clear, participants seem to ignore the purposes.

Nurses are doing the rapid test, whereas the NGO LIGHTH OF HOPE and the doctors provide the counselling.

## **TREATMENT RESPONSES**

### **ART**

**Regimen?**

**How many are they?**

**Number of people on ART?** None at that time.

### **Delivery and access**

**Are there waiting lists for the ART initiation?**

**What are the criteria for initiating, not initiating treatment?**

### **Continuity of treatment**

- **Upon incarceration**
- **After incarceration**

## **HUMAN RESOURCES for medical care and HIV**

### **Staff in the medical services**

- 2 Psychologists
- 6 Doctors
- 3 nurses
- Laboratory assistant
- 10 Teachers

Staff regularly attends training. They considerer they have a good network of professionals they can rely on in case of need.

### **Networking**

**Which is the Aids reference centre?**

## **CO-MORBIDITY**

**What is the situation of PLHA with co morbidity? Are they integrated services**

**TB?**

**Hepatitis?**

**Drug use?**

**b) STI**

**Epidemiology**

Not diagnosed

**Testing**

Not tested

**Treatment**

**c) HEPATITIS B**

**Epidemiology**

There is no vaccination.

**Testing**

Testing is available, thanks to a donation by PLHIV of 50 tests (GFATM funding). No particular counselling is provided in that context.

**Treatment**

**d) HEPATITIS C**

**Epidemiology**

**Testing**

Not done

**Treatment**

**e) TUBERCULOSIS**

**Epidemiology**

0

**Testing** XR on entry and before leaving

**Treatment**

**C. PROBLEMATIC DRUG USE**

	<b>Number of people opioid dependent /year</b>	<b>Non fatal overdosis /year</b>	<b>Deaths from drug use -overdosis /year</b>

There is no drug use among the young detainees, neither drugs nor syringes are found during searches.

**Evolution over the last years?**

4 detainees were diagnosed with problematic drug use in 2013.

**Any remarkable change?**

**TREATMENT RESPONSES**

**Description of services** not of concern in this setting

	OST	Naloxone	Others
Present Yes/No	-		
Number			

**a) IF OST**  
Forms available

**Aims**

**Regimen**  
Who wrote it?

**Delivery and access**

**b) IF NO OST**  
What is used to relieve withdrawal / detoxification?

**Obstacles?**

**Possibilities?**

**Ways to induce changes?**

**Psychiatric patients (double diagnosis) included in OST?**

**Continuity of treatment, including OST**

- Upon incarceration
- After incarceration

**Referral to treatment services as an alternative to prosecution of drug dependent offenders**

**HUMAN RESOURCES for drug use**  
Staff in the prison

**Networking? Addiction centre? Psychiatrists, other**

**D. HARM REDUCTION**

**Description of services**

	<b>CONDOMS</b>	<b>Bleach</b>	<b>Tattoo</b>
<b>Present Yes / NO</b>	-	-	-
<b>Numbers delivered</b>	27 in 2013		

### **Obstacles?**

Condoms are not available during the incarceration, since this is considered as a provocation to sexual relations among men.

### **Possibilities?**

Staff participating in the meeting is encouraged to give condoms before release, especially since there are pre release interviews.

### **Ways to induce changes?**

## **E. NETWORKING**

### **Actors involved (governmental and NGO)**

### **Existence of an informal but efficient cooperation among (list of people, of services cooperating)**

The participants of the meeting report that their work is done in close interdisciplinary cooperation among prison officers, teachers, and psychologists, and this on a regular basis.

The cooperation includes parents and NGO (not specified which, but in important numbers, up to 10).

## **F. ETHICAL ISSUES**

### **Confidentiality of testing & treatment**

### **Discrimination of HIV, HCV infected people**

## **G. FUNDING**

### **Funding from state budgets**

### **Funding from international and bilateral donor organizations**

### **Sustainability of funding the treatments (drug and infectious diseases)**

## **H. INFORMATION & EDUCATION**

### **Information activities**

Health education is apparently a central task. The young detainees do prepare themselves some illustrations for prevention materials. Leaflets shown as examples contain little images and are mainly made of written text.

A list of phone numbers and addresses they provide to detainees before release exists. A specific document regarding HIV in prisons among adolescents is being used<sup>20</sup>

### **Subjects covered**

General health, HIV, sexual intercourse.

### **Staff involved**

- **Prison staff**
- **NGO**

### **Information materials**

Available. Manuals for professionals involved in health education were shown.

## **I. OCCUPATIONAL HEALTH**

A first aid protocol is available. No testing is done in case of accident, this is relying upon a personal decision. At the same time PEP is reported to be available.

Tobacco smoking is prohibited, but nevertheless occurs.

Staff is only allowed to smoke outdoors in order not to be a negative example or to avoid raising their desire to smoke.

### **SUMMARY**

- Education is presented as a key activity. However, it is rather difficult to have an exact idea of what is actually being done and taught, since during the visit no prisoners were seen attending the class area.
- Two measures could be implemented: vaccination against Hepatitis B and the delivery of condoms before release.

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<sup>20</sup> available at

[http://elibrary.kubg.edu.ua/3493/1/T\\_LYAKH\\_T\\_ZHURAVEL\\_G\\_SKIPALSKA\\_Y.CHORNA\\_MRSOPR\\_ZPVSTRPSPTMVUDKVS\\_KSP%26SR\\_IL.PDF](http://elibrary.kubg.edu.ua/3493/1/T_LYAKH_T_ZHURAVEL_G_SKIPALSKA_Y.CHORNA_MRSOPR_ZPVSTRPSPTMVUDKVS_KSP%26SR_IL.PDF)

### *Action plan - Kyiv pre-trial centre SIZO #13*

Lukyanivsky is a male and female pre-trial setting detaining 3100 people (2012) and 2800 people in 2014 (according to field visit). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) describes the conditions of detention as appalling (up to 40 people sharing one dormitory).

50% of the health staff jobs are vacant (due to low salaries and difficult working conditions).

HIV testing is voluntary. Medical staff reported that only 2-3% of detainees are refusing it, which is an inconsistent data with relation to the numbers provided by medical staff to fill in the table above. According to the number of detainees being investigated yearly, 50% are estimated to actually do the testing. If considering the turnover of detainees in the pre-trial centre, this coverage is lower. The diagnosis is confirmed at the AIDS centre who will determine the need for ART. The whole process of testing, diagnosis and infectious diseases specialist consultation up to the beginning of the treatment lasts between one to two months. Therefore, some detainees are transferred before the diagnosis of HIV infection is confirmed.

Another inconsistency lies in the proportion of PLHIV who need ART according to medical criteria and who actually get it in reality. With regards to the number of people under treatment that was transmitted, it cannot be confirmed that all PLHIV needing the treatment actually receive it. However, due to the important size of this prison, and its central place in the country, it has to be considered as a true platform for testing, diagnosing HIV and starting ART. Approximately one fifth of HIV infections of the SPSU system are diagnosed yearly in this setting, and this with only 50% of detainees actually getting the testing. Thus a focus on voluntary HIV testing and counselling and initiation of ART at the pre-trial centre could ease the process of PLHIV care in the colonies.

According to medical staff, 30-40% of detainees use drugs, and 99% of PLHIV. Treatment for drug dependence is oriented towards abstinence, with no substitution available. According to the current legal framework, opioids could be used with the aim of detoxification. This is not provided so far.

#### **Aims of the action plan:**

1. Design a specific plan of activities regarding HIV and drug use.
2. Design an adequate and ethically acceptable path or trajectory describing the different steps of HIV testing, diagnosis, treatment and care within SIZO; this includes the incarceration of PLHIV and continuity of treatment (Key intervention Nr 9, 10).
3. Organise SIZO as a “diagnosis and initiation of ART centre” for HIV infection within Kyiv Oblast (Key intervention Nr 9, 10). This allows the modelling of care (transmission, follow-up, cooperation) of patients diagnosed with HIV in SIZO and then transferred to colonies.
4. Improve staffs’ competencies with relation to HIV and drug use in prison.
5. Develop occupational health.

6. Reinforce cooperation with civil society (NGO).
7. Reflect on the use of OST in SIZO.

DRAFT

### Tasks and activities - SIZO #13

	<b>Activity</b>	<b>In charge</b>	<b>Tasks</b>	<b>Expected results / Criteria of evaluation</b>
1	Design of HIV & drug use specific plan of activities	Consultants V. Lazebnyi	<ul style="list-style-type: none"> <li>• Prepare draft of annual plan of activities to fulfil, in particular HIV and drug use; OST</li> <li>• Discuss draft with partners involved in the activities (UNODC, prison health staff and administration, other stakeholders, AIDS centres)</li> <li>• Finalise draft</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of the plan</li> <li>• Implementation of the plan</li> <li>• Activities implemented: number, types</li> <li>• Partners involved in the activities: numbers, types</li> </ul>
2	“HIV Path”	Doctor in SIZO Consultants	<ul style="list-style-type: none"> <li>• Describe in written the path regarding HIV testing, diagnosis, treatment and care</li> <li>• Discuss draft with AIDS Centres</li> <li>• If necessary, implement changes</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of the path in a written form (manual, chart)</li> <li>• Criteria of an ethically acceptable protocol: indication of testing (voluntary), confidentiality, non-discrimination, etc.</li> </ul>
3	SIZO – HIV diagnosis and treatment centre	Consultant with inputs from I. Nepecemnii V. Lazebnyi	<ul style="list-style-type: none"> <li>• Prepare draft of health care organisation for PLHIV between SIZO and colonies</li> <li>• Discuss draft with: UNODC, health staff, Aids centre Kyiv Oblast, NGO (to identify)</li> <li>• Experiment &amp; Follow-up</li> <li>• Finalise protocol</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of protocol regarding HIV testing, diagnosis and ART initiation within SIZO, in a coordinated form with relation to colonies in Kyiv Oblast</li> <li>• Statistical changes with regards to numbers under table 2.2</li> </ul>
4	Training	V. Lazebnyi C. Ritter	<ul style="list-style-type: none"> <li>• Define training objectives</li> <li>• Organise training</li> </ul>	<ul style="list-style-type: none"> <li>• Number of trainings</li> <li>• Number of participants</li> <li>• Evaluation questionnaire by participants</li> <li>• Availability of a manual regarding the subjects covered in the training</li> <li>• Variety of professionals participating</li> <li>• Content of training</li> <li>• Creation of network with partners</li> </ul>
	Training	C Ritter	<ul style="list-style-type: none"> <li>• Prepare checklists (self assessment by participants) according to objectives</li> </ul>	<ul style="list-style-type: none"> <li>• Checklists available</li> </ul>

5	Occupational health	Consultant	<ul style="list-style-type: none"> <li>• Create a working group addressing HIV related issues regarding staff, including PEP</li> <li>• Conduct an assessment of HIV related activities regarding staff working in prison (prevention, testing, treatment)</li> <li>• Summarise and draft plan of HIV workplace activities</li> </ul>	<ul style="list-style-type: none"> <li>• Working group</li> <li>• Results of the assessment</li> <li>• Number and types of activities considered</li> <li>• Feed-back of staff involved in the assessment</li> <li>• Draft of plan for activities to be implemented</li> <li>• Protocol regarding accidental hazards available and yearly updated</li> </ul>
6	Cooperation with civil society	Consultant from civil society V. Lazebyni	<ul style="list-style-type: none"> <li>• Identification of possible partners involved within prisons, as well as outside, taking into account pre and post release period</li> <li>• Meeting among partners</li> </ul>	<ul style="list-style-type: none"> <li>• Number of partners involved</li> <li>• Meetings with partners</li> <li>• Activities (numbers and types) carried out by civil society</li> <li>• Formal agreements with partners</li> </ul>
7	Reflection on OST	Expert in drug dependence treatment and OST prescription	<ul style="list-style-type: none"> <li>• Identify professionals that can reflect upon the introduction of OST within SIZO.</li> <li>• Define criteria for treatment</li> <li>• Identify protocols</li> </ul>	<ul style="list-style-type: none"> <li>• Cooperation with experts and colleagues experimented in drug dependence treatment, and OST</li> <li>• Treatment criteria are in line with national protocols</li> <li>• Continuity of treatment</li> <li>• Number of people treated</li> </ul>

### Schedule 2015 - SIZO #13

	Activity	January	Feb	March	April	May	June	July	August	Sept	October	Nov	Dec
1.	HIV & drug plan of activities	Draft	Draft	Discuss draft			Prepare new draft and discuss again with partners				Finalise		
2.	"HIV Path"		Describe path	Discuss with AIDS centres	Modify and experiment new path							Evaluate Finalise	
3.	SIZO - HIV diagnosis & treatment		Prepare protocol Make necessary contacts Discuss draft			Implement new organisation Experiment protocol over 6 months period					Evaluate Finalise organisation		
4.	Training	Prepare schedule			Train							Evaluate	
	Training	Prepare content			Use in training							Finalise	
5.	Occupational health	Create working group		Assessment during meetings			Assessment during meetings			Assessment during meetings		Summarise Draft plan	
6.	Cooperation	Create contacts										Formalise Cooperation	

DRAFT

### *Action plan Bila Tserkva prison for men #35*

Bila Tserkva is a male middle security prison (800 people), with an important number of recidivists. In 2000, this setting was provided with support from the Swiss Agency for Development and Cooperation (SDC, Federal Department of Foreign affairs<sup>21</sup>). The project included the creation of a training center in Bila Tserkva (Bila Tserkva College for the Training and Re-training of Prison Staff).

Most detainees stay first at the pre-trial centre in Kiev, which provides the opportunity to consider this aspect of continuity of care within the suggested action plan.

The HIV testing is voluntary (rapid testing) and then confirmed in Kiev. Since Bila Tserkva is a prison, overtesting (testing without new risk exposure since the last testing in the pre-trial centre) happens. Apparently few PLHIV start the ART treatment, since most do not meet the criteria and the access to infectious diseases specialist has been reported to be insufficient during the second field visit. Continuity of treatment upon release of PLHIV is considered as satisfactory, but at the same time staff expresses the need for a better orientation of detainees within the health care network. Adherence to ART is reported as unproblematic. That aspect has to be examined further since detainees are provided with monthly treatment in their cells. This might also cause difficulties in ensuring confidentiality of infections status.

Drug use is acknowledged as a reality in this setting; the number of users is estimated to be around 62%, with 50% of them intravenous users. Most are described as not wanting to cease the use. Searches done by security staff bring up needles and syringes. The prison director considers that his intervention to tackle the drug-related issues is insufficient. He is open to cooperation with NGO in general.

Sexual risk behaviour is acknowledged as a reality in the setting, without being able to have any control/influence on it.

#### **Aims of the action plan:**

1. Design a specific plan of activities regarding HIV and drug use.
2. Design an adequate and ethically acceptable path or trajectory including the different steps of HIV testing (protocol of VCT, indication), diagnosis, treatment (in particular adherence) and care within Bila Tserkva; this includes the incarceration of PLHIV and continuity of treatment when referred from SIZO in Kyiv and before release (Key intervention Nr 9, 10)
3. Ensure easy access to condoms (define where) (Key intervention 2, 13).
4. Provide information leaflets for male detainees upon release, with health information and addresses for follow-up care (Key intervention 1).
5. Improve staffs' competencies with relation to HIV and drug use in prison.
6. Develop occupational health, including PEP (Key intervention 8)
7. Reinforce cooperation with civil society (NGO), for example Narcotic Anonymous/Alcoholic Anonymous and invite them to propose activities in this setting.
8. Consider developing prevention of sexual violence.

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<sup>21</sup> <http://www.ddc.admin.ch/en/Home>

### Tasks and activities - Bila Tserkva prison for men #35

	<b>Activity</b>	<b>In charge</b>	<b>Tasks</b>	<b>Expected results / Criteria of evaluation</b>
1	Design of HIV & drug use specific plan of activities	Consultants V. Lazebnyi	<ul style="list-style-type: none"> <li>• Prepare draft of annual plan of activities to fulfil, examining in particular:               <ul style="list-style-type: none"> <li>○ protocol of access to condoms</li> <li>○ prevention of sexual violence</li> </ul> </li> <li>• Discuss draft with partners involved in the activities (UNODC, prison health staff and administration, other stakeholders, AIDS centres)</li> <li>• Finalise draft</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of the plan</li> <li>• Implementation of the plan</li> <li>• Activities implemented: number, types</li> <li>• Partners involved in the activities: numbers, types</li> </ul>
2	“HIV Path”	Doctor in Bila Tserkva Consultants	<ul style="list-style-type: none"> <li>• Describe in written the path regarding HIV testing, diagnosis, treatment and care (in particular adherence)</li> <li>• Discuss draft with AIDS Centres</li> <li>• If necessary, implement changes</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of the path in a written form (manual, chart)</li> <li>• Criteria of an ethically acceptable protocol: indication of testing (voluntary), confidentiality, discrimination, etc.</li> </ul>
3	Cooperation with SIZO regarding PLHIV	Consultant with inputs from I. Nepecemnii V. Lazebnyi	<ul style="list-style-type: none"> <li>• Prepare draft of health care organisation for PLHIV between SIZO and Bila Tserkva</li> <li>• Discuss draft with: UNODC, health staff, AIDS centre Kyiv Oblast, NGO (to identify)</li> <li>• Experiment &amp; Follow-up</li> <li>• Finalise protocol</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of a protocol regarding HIV testing and counselling (who, where, when), diagnosis and ART initiation in a coordinated way with SIZO, as well as transfer from SIZO and follow-up upon release</li> <li>• Statistical changes with regards to numbers under table 2.2</li> </ul>
4	Information leaflet	V. Lazebnyi Civil society	<ul style="list-style-type: none"> <li>• Design an information leaflet for male detainees (with key information regarding HIV, and addresses for follow-up care for example)</li> <li>• Validate with prison administrators</li> </ul>	<ul style="list-style-type: none"> <li>• Leaflet available</li> </ul>
5	Training	V. Lazebnyi C. Ritter	<ul style="list-style-type: none"> <li>• Define training objectives</li> </ul>	<ul style="list-style-type: none"> <li>• Number of trainings</li> </ul>

			<ul style="list-style-type: none"> <li>Organise training</li> </ul>	<ul style="list-style-type: none"> <li>Number of participants</li> <li>Evaluation questionnaire by participants</li> <li>Availability of a manual regarding the subjects covered in the training</li> <li>Variety of professionals participating</li> <li>Content of training</li> <li>Creation of network with partners</li> </ul>
	Training	C Ritter	<ul style="list-style-type: none"> <li>Prepare checklists (self assessment by participants) according to objectives</li> </ul>	<ul style="list-style-type: none"> <li>Checklists available</li> </ul>
6	Occupational health	Consultant	<ul style="list-style-type: none"> <li>Create a working group addressing HIV related issues regarding staff, including PEP</li> <li>Conduct an assessment of HIV related activities regarding staff working in prison (prevention, testing, treatment)</li> <li>Summarise and draft plan of HIV workplace activities</li> </ul>	<ul style="list-style-type: none"> <li>Working group</li> <li>Results of the assessment</li> <li>Number and types of activities considered</li> <li>Feed-back of staff involved in the assessment</li> <li>Draft of plan for activities to be implemented</li> <li>Protocol regarding accidental hazards available and yearly updated</li> </ul>
7	Cooperation with civil society	Consultant from civil society V. Lazebnyi	<ul style="list-style-type: none"> <li>Identification of possible partners involved within prisons, as well as outside, taking into account pre and post release period</li> <li>Meeting among partners</li> </ul>	<ul style="list-style-type: none"> <li>Number of partners involved</li> <li>Meetings with partners</li> <li>Activities (numbers and types) carried out by civil society</li> <li>Formal agreements with partners</li> </ul>
8	Prevention of sexual violence	Expert	<ul style="list-style-type: none"> <li>Discuss the matter among prison professionals, with the aim of preventing sexual violence</li> </ul>	<ul style="list-style-type: none"> <li>Meetings addressing this issue</li> <li>Monitoring sexual violence</li> <li>Prevention activities</li> </ul>

Note: activity 3 be partially developed in cooperation with SIZO

### Schedule 2015 - Bila Tserkva prison for men #35

	Activity	January	Feb	March	April	May	June	July	August	Sept	October	Nov	Dec
1.	HIV & drug plan of activities	Draft	Draft	Discuss draft			Prepare new draft and discuss again with partners					Finalise	
2.	"HIV Path"		Describe path	Discuss with AIDS centres	Modify and experiment new path							Evaluate Finalise	
3.	HIV diagnosis & treatment - cooperation with SIZO		Prepare protocol Make necessary contacts Discuss draft			Implement new organisation Experiment protocol over 6 months period					Evaluate Finalise organisation		
4.	Information leaflet				Present model and adapt locally			Experiment				Evaluate Finalise	
5.	Training	Prepare schedule			Train							Evaluate	
	Training	Prepare content			Use in training							Finalise	
6.	Occupational health	Create working group		Assessment during meetings		Assessment during meetings			Assessment during meetings		Summarise Draft plan		
7.	Cooperation	Create contacts									Formalise cooperation		

### *Action plan - Kharkiv prison for women #54*

This setting for female prisoners has a capacity to host 1200 women; 800 were present in November 2013, and 506 in July 2014. This decrease is due to the release of 300 women following the presidential elections in May 2014 and the armistice, including detainees with drug dependence and living with HIV.

100% of women are being tested for HIV upon incarceration. Since all are first incarcerated in pre-trial centres, over-testing cannot be excluded. The diagnosis is confirmed at the AIDS Centre in Kharkiv. The cooperation between the prison and the AIDS Centre is described as good. The NGO PLHIV is playing an important role in transmission of information to HIV positive women and ensuring the continuity of treatment upon release. Access to ART is ensured. At the same time, the confidentiality of HIV status is not guaranteed. Also the various actions regarding HIV prevention, testing and treatment, as well as legal issues, are spread over separated documents, a situation that impedes an optimal coordination of the persons involved (NGO, prison staff).

Drug use is one of the main problems that women are facing upon release (difficulties related to work, housing, rehabilitation). However, it is not considered as a problem during incarceration or before release. The prison system gives a false impression that “there is no problem related to drugs”, since women are reported not to use drugs during the incarceration. This results in the absence of appropriate treatment to drug abuse during incarceration and impedes a proper preparation for release. The narcologist in Kharkiv’s oblast are reported to be experimented and could be involved as trainers or cooperation partners in this process. Also, a regional working group is currently developing a protocol to ensure continuity of OST treatment in closed settings. This is a promising experience.

Staff requires help to purchase medical equipment to increase the quality of follow-up of women with ART (Haemoglobin testing and other basic laboratory tests) within the prison.

#### **Aims of the action plan:**

1. Design a specific plan of activities regarding HIV and drug use.
2. Design an adequate and ethically acceptable path or trajectory including the different steps of HIV testing (protocol of VCT, indication), diagnosis, treatment (in particular adherence) and care within Kharkiv’s prison; this includes the incarceration of PLHIV and continuity of treatment (Key intervention Nr 9, 10)
3. Provide / create information leaflets for female detainees upon release, with health information and addresses for follow-up care (Key intervention 1).
4. Develop treatments for women using drugs, with a particular focus on overdose prevention upon release (Key intervention 4)
5. Improve staffs’ competencies with relation to HIV (aspects related to discrimination, confidentiality) and drug abuse / treatment related issues (OST and pre-release).
6. Develop occupational health, including PEP (Key intervention 8)
7. Reinforce cooperation with civil society (NGO) to ensure regular and coordinated intervention regarding HIV

### Tasks and activities - Kharkiv prison for women #54

	<b>Activity</b>	<b>In charge</b>	<b>Tasks</b>	<b>Expected results / Criteria of evaluation</b>
1	Design of HIV & drug use specific plan of activities	Consultants V. Lazebnyi	<ul style="list-style-type: none"> <li>• Prepare draft of annual plan of activities to fulfil (HIV and drug use)</li> <li>• Discuss draft with partners involved in the activities (UNODC, prison health staff and administration, other stakeholders, AIDS centres)</li> <li>• Finalise draft</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of the plan</li> <li>• Implementation of the plan</li> <li>• Activities implemented: number, types</li> <li>• Partners involved in the activities: numbers, types</li> </ul>
2	“HIV Path”	Doctor in Kharkiv Consultants	<ul style="list-style-type: none"> <li>• Describe in written the path regarding HIV testing, diagnosis, treatment and care (in particular adherence)</li> <li>• Discuss draft with AIDS Centres</li> <li>• If necessary, implement changes</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of the path in a written form (manual, chart)</li> <li>• Criteria of an ethically acceptable protocol: indication of testing (voluntary), confidentiality, discrimination, etc.</li> </ul>
3	Information leaflet	V. Lazebnyi Civil society	<ul style="list-style-type: none"> <li>• Design an information leaflet for female detainees (with key information regarding HIV, and addresses for follow-up care for example)</li> <li>• Validate with prison administrators</li> </ul>	<ul style="list-style-type: none"> <li>• Leaflet available</li> <li>• Cooperation with civil society</li> </ul>
4	Treatment for PWUD	I. Iakovets	<ul style="list-style-type: none"> <li>• Participate in the working group regarding the continuity of OST in prisons</li> <li>• Follow-up experimentation of change (if occurring)</li> <li>• Create working group with regional specialists with the aim of improving the care of incarcerated women using drugs</li> <li>• Develop prevention of overdoses before release</li> </ul>	<ul style="list-style-type: none"> <li>• Protocol available</li> <li>• Working group</li> <li>• Cooperation with regional specialists</li> </ul>
5	Training	V. Lazebnyi C. Ritter	<ul style="list-style-type: none"> <li>• Define training objectives</li> <li>• Organise training</li> </ul>	<ul style="list-style-type: none"> <li>• Number of trainings</li> <li>• Number of participants</li> </ul>

				<ul style="list-style-type: none"> <li>• Evaluation questionnaire by participants</li> <li>• Availability of a manual regarding the subjects covered in the training</li> <li>• Variety of professionals participating</li> <li>• Content of training</li> <li>• Creation of network with partners</li> </ul>
5	Training	C Ritter	<ul style="list-style-type: none"> <li>• Prepare checklists (self assessment by participants) according to objectives</li> </ul>	<ul style="list-style-type: none"> <li>• Checklists available</li> </ul>
6	Occupational health	Consultant	<ul style="list-style-type: none"> <li>• Create a working group addressing HIV related issues regarding staff, including PEP</li> <li>• Conduct an assessment of HIV related activities regarding staff working in prison (prevention, testing, treatment)</li> <li>• Summarise and draft plan of HIV workplace activities</li> </ul>	<ul style="list-style-type: none"> <li>• Working group</li> <li>• Results of the assessment</li> <li>• Number and types of activities considered</li> <li>• Feed-back of staff involved in the assessment</li> <li>• Draft of plan for activities to be implemented</li> <li>• Protocol regarding accidental hazards available and yearly updated</li> </ul>
7	Cooperation with civil society	Consultant from civil society V. Lazebnyi	<ul style="list-style-type: none"> <li>• Identification of possible partners involved within prisons, as well as outside, taking into account pre and post release period</li> <li>• Meeting among partners</li> </ul>	<ul style="list-style-type: none"> <li>• Number of partners involved</li> <li>• Meetings with partners</li> <li>• Activities (numbers and types) carried out by civil society</li> <li>• Formal agreements with partners</li> </ul>

### Schedule 2015 - Kharkiv prison for women #54

	Activity	January	Feb	March	April	May	June	July	August	Sept	October	Nov	Dec
1.	HIV & drug plan of activities	Draft	Draft	Discuss draft			Prepare new draft and discuss again with partners					Finalise	
2.	"HIV Path"		Describe path	Discuss with AIDS centres	Modify and experiment new path							Evaluate Finalise	
3.	Information leaflet				Present model and adapt locally			Experiment				Evaluate Finalise	
4.	Drug treatment		Create working group		Meeting working group		Meeting working group		Meeting working group		Meeting working group	Evaluate, draft aims	
5.	Training	Prepare schedule			Train							Evaluate	
	Training	Prepare content			Use in training							Finalise	
6.	Occupational health	Create working group		Assessment during meetings			Assessment during meetings			Assessment during meetings		Summarise Draft plan	
7.	Cooperation	Create contacts										Formalise cooperation	

### *Action plan - Kremenchuk prison for adolescents*

After approximately two months of pre-trial detention, adolescents spend 3 to 4 years in average in a prison. Kremenchuk houses 180 young men (out of 1000 young detainees in Ukraine, out of them 80 young women). In July 2014 96 young detainees only were present. This is again due to the release following the presidential elections in May 2014 and the armistice, and because of a higher number of detainees on probation.

Apparently, there is a close interdisciplinary cooperation on a regular basis among prison officers, teachers, and psychologists. When first arriving, the young people are isolated and go through 15 days of assessment. School is mandatory.

Drug use is not considered as a problem in the setting.

Condoms are not available during the incarceration, since sexual relation among men is considered taboo. Education, and inclusive health education regarding prevention during sexual intercourse are clearly presented as a priority in this setting. This can be used as a way to reflect on a program regarding prevention of sexual violence.

No vaccination against Hepatitis B is available. Testing has recently been made possible, following the donation of tests (50) by the NGO PLHIV.

HIV testing is done systematically upon admission (analysis are done in Kiev); no infection has been detected. It is voluntary, and no one declines it. Again, given the pre trial detention at first, one can wonder if there is over testing. Also, the number of tests done is (more than three times) higher than the number of detainees, which can also be related to a high turnover of young detainees.

Some staff is in favour of HIV screening (mandatory for all detainees), as PLHIV are considered as being a “menace”. The emphasis on this potential “dangerous person” is rather surprising in a setting where no young detainee with HIV infection has been incarcerated. According to BBS conducted in different juvenile detention in Ukraine, no HIV infection has been detected in juvenile detention facility (Demchenko 2014).

Training is an absolute necessity when such representations are present.

The prison director welcomes the proposal of vaccination against Hepatitis B, both for staff and detainees. A former campaign was organised in 2013 by SPSU, their protocol can be used as a reference.

Prison staff requires support to organise and provide equipment for a room that can be used for health education activities and counselling.

#### **Aims of the action plan:**

1. Design a plan of activities regarding prevention.
2. Reinforce VCT, in particular the indication of the testing (Key intervention 9)

3. Ensure easy access to condoms (define where), at least upon release (Key intervention 2, 13).
4. Develop prevention of sexual violence
5. Introduce vaccination against Hepatitis B for detainees (given their age) (Key intervention 14).
6. Develop occupational health, in particular provide vaccination against Hepatitis B for staff (Key intervention 15)
7. Improve staff competencies to promote greater prevention of HIV/STI, in particular to discuss the following topics with detainees: sexual relationships and violence, condom use, stigmatisation (Key intervention 1, 2, 3).
8. Reinforce cooperation with civil society (NGO).

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### Tasks and activities - Kremenchuk prison for adolescents

	Activity	In charge	Tasks	Expected results / Criteria of evaluation
1	Design plan regarding prevention activities	Consultants V. Lazebnyi	<ul style="list-style-type: none"> <li>• Prepare draft of annual plan of prevention activities to fulfil, examining in particular:                             <ul style="list-style-type: none"> <li>○ protocol of access to condoms</li> <li>○ prevention of sexual violence</li> <li>○ hepatitis B vaccination</li> </ul> </li> <li>• Discuss draft with partners involved in the activities</li> <li>• Finalise draft</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of the plan</li> <li>• Implementation of the plan</li> <li>• Activities implemented: number, types:                             <ul style="list-style-type: none"> <li>○ Revision of protocol regarding condoms</li> <li>○ Working group regarding prevention of sexual violence</li> <li>○ Access to Hepatitis B vaccination</li> </ul> </li> <li>• Partners involved in the activities: numbers, types</li> </ul>
2	VCT	V. Lazebnyi	<ul style="list-style-type: none"> <li>• Examine indication of HIV testing and counselling</li> </ul>	<ul style="list-style-type: none"> <li>• Criteria of testing</li> <li>• Number of tests</li> </ul>
3	Training	V. Lazebnyi C. Ritter	<ul style="list-style-type: none"> <li>• Define training objectives</li> <li>• Organise training</li> </ul>	<ul style="list-style-type: none"> <li>• Number of trainings</li> <li>• Number of participants</li> <li>• Evaluation questionnaire by participants</li> <li>• Availability of a manual regarding the subjects covered in the training</li> <li>• Variety of professionals participating</li> <li>• Content of training</li> <li>• Creation of network with partners</li> </ul>
	Training	C Ritter	<ul style="list-style-type: none"> <li>• Prepare checklists (self assessment by participants) according to objectives</li> </ul>	<ul style="list-style-type: none"> <li>• Checklists available</li> </ul>
4	Occupational health	Consultant	<ul style="list-style-type: none"> <li>• Create a working group addressing HIV related issues regarding staff, including PEP</li> <li>• Conduct an assessment of HIV related activities regarding staff working in prison</li> </ul>	<ul style="list-style-type: none"> <li>• Working group</li> <li>• Results of the assessment</li> <li>• Number and types of activities considered</li> <li>• Feed-back of staff involved in the</li> </ul>

			<p>(prevention, testing, treatment)</p> <ul style="list-style-type: none"> <li>Summarise and draft plan of HIV workplace activities</li> </ul>	<p>assessment</p> <ul style="list-style-type: none"> <li>Draft of plan for activities to be implemented</li> <li>Protocol regarding accidental hazards available and yearly updated</li> </ul>
	Occupational health: Vaccination against Hepatitis B	Consultant	<ul style="list-style-type: none"> <li>Examine protocols used by SPSU in a previous campaign</li> <li>Initiate vaccination both for detainees and staff</li> <li>Follow-up</li> </ul>	<ul style="list-style-type: none"> <li>Vaccination protocol</li> <li>Number of people vaccinated</li> </ul>
5	Cooperation with civil society	Consultant from civil society V. Lazebnyi	<ul style="list-style-type: none"> <li>Identification of possible partners involved within prisons, as well as outside</li> <li>Meeting among partners</li> </ul>	<ul style="list-style-type: none"> <li>Number of partners involved</li> <li>Meetings with partners</li> <li>Activities (numbers and types) carried out by civil society</li> <li>Formal agreements with partners</li> </ul>

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### Schedule 2015 - Kremenchuk prison for adolescents

Activity	January	Feb	March	April	May	June	July	August	Sept	October	Nov	Dec
1. Prevention plan	Draft	Draft	Discuss draft			Prepare new draft and discuss again with partners					Finalise	
2. VCT		Describe current procedure	Train staff in charge of VCT	Apply new procedure			Evaluate					
3. Training	Prepare schedule			Train							Evaluate	
	Prepare content			Use in training							Finalise	
4. Occupational health	Create working group		Assessment during meetings			Assessment during meetings			Assessment during meetings		Summarise Draft plan	
	Set Hepatitis B vaccination protocol Examine provision of vaccines					Vaccinate staff			Vaccinate staff		Evaluate	
5. Cooperation	Create contacts										Formalise cooperation	

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