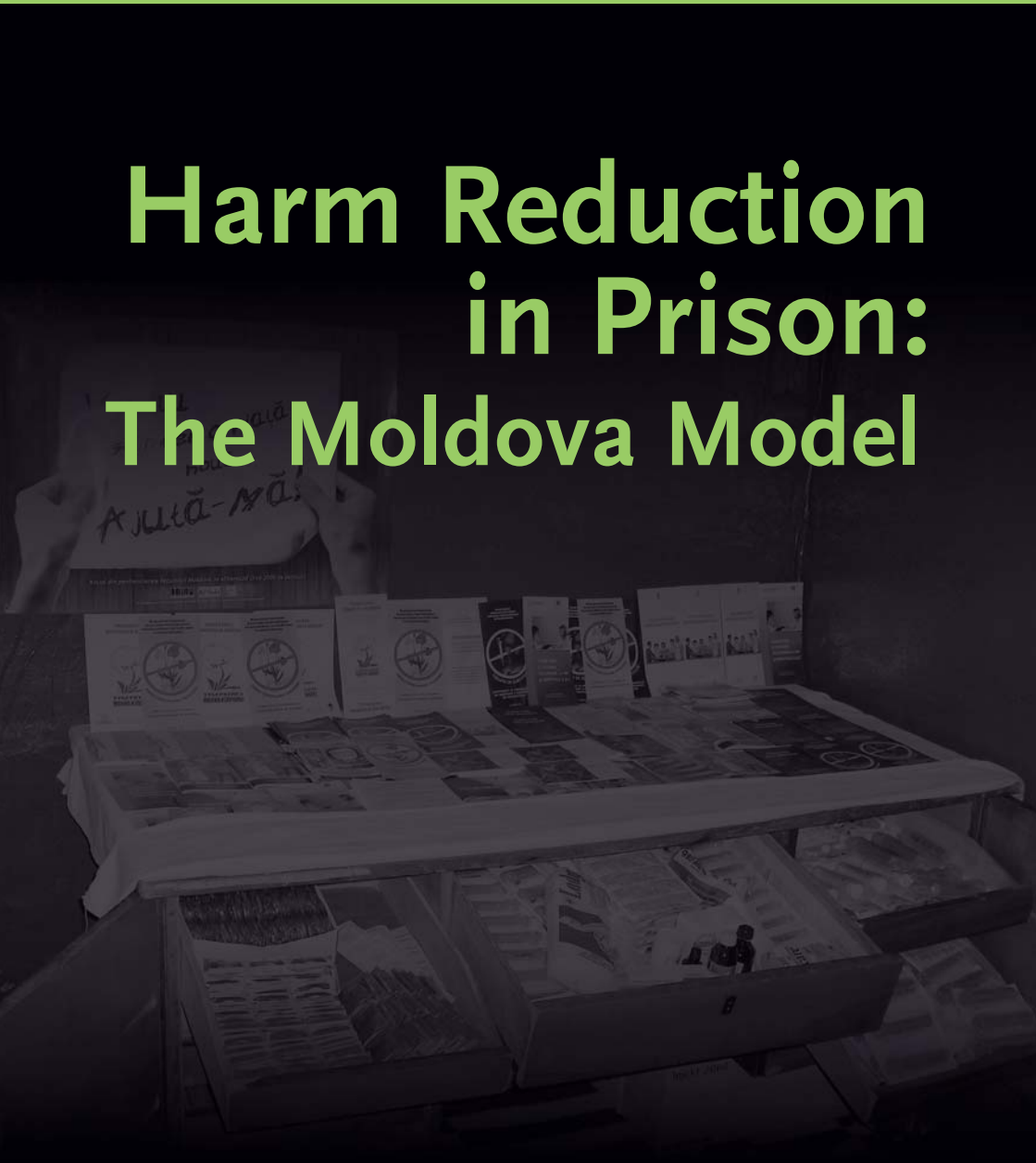
Harm Reduction in Prison: The Moldova Model



INTERNATIONAL HARM REDUCTION DEVELOPMENT PROGRAM

OPEN SOCIETY INSTITUTE
Public Health Program

Harm Reduction in Prison: The Moldova Model

By Jeff Hoover and Ralf Jürgens

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Public Health Program

The Open Society Institute's Public Health Program aims to build societies committed to inclusion, human rights, and justice, in which health-related laws, policies, and practices are evidence-based and reflect these values. The program works to advance the health and human rights of marginalized people by building the capacity of civil society leaders and organizations, and by advocating for greater accountability and transparency in health policy and practice. The Public Health Program engages in five core strategies to advance its mission and goals: grantmaking, capacity building, advocacy, strategic convening, and mobilizing and leveraging funding. The Public Health Program works in Central and Eastern Europe, Southern and Eastern Africa, Southeast Asia, and China.

International Harm Reduction Development Program

The International Harm Reduction Development Program (IHRD), part of the Open Society Institute's Public Health Program, works to reduce HIV and other harms related to injecting drug use and to press for policies that reduce stigmatization of illicit drug users and protect their human rights. Since 1995 IHRD has supported more than 200 programs in Central and Eastern Europe and Asia, and bases its activities on the philosophy that people unable or unwilling to abstain from drug use can make positive changes to protect their health and the health of others. Since 2001, IHRD has prioritized advocacy to expand availability and quality of needle exchange, drug dependence treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the participation of people who use drugs and those living with HIV in shaping policies that affect their lives.

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About this Report

This report focuses on the introduction of harm reduction programs in Moldovan prisons and describes successes achieved as well as remaining challenges. Research was conducted in Moldova in August 2007 and October 2008, with seven site visits to prisons and one site visit to a pretrial detention facility, as well as visits to the headquarters of the penitentiary system and Innovative Projects in Prisons—a non-governmental organization (NGO) that provides harm reduction services in prisons. The authors interviewed prisoners and pretrial detainees, NGO staff, and penitentiary system officials and employees at both the national and local levels.

The extent of research conducted at each prison and pretrial detention facility varied due to several factors, including: length and timing of visit; staff responsibilities and availability at the time; and access to prisoners and their ability and willingness to talk. Citations are provided when appropriate to identify the sources of information, observations, opinions, and direct quotes. Any errors are the fault of the authors.

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1. Introduction

Prevalence of HIV infection among prisoners in many countries is significantly higher than in the general population.[1] Hepatitis C virus prevalence is even higher.[2] Most prisoners living with HIV contract their infection prior to imprisonment. However, the risk of being infected in prison, specifically through the sharing of contaminated injecting equipment, is high. Even countries that have invested heavily in drug demand and drug supply reduction efforts in prisons have not been able to stop injecting drug use.[3] Outbreaks of HIV infection caused by sharing injection equipment in prisons demonstrate how rapidly HIV can spread in detention settings unless effective action is taken to prevent transmission.[4]

Internationally, the importance of implementing comprehensive HIV interventions, including needle exchange and methadone maintenance programs, in prisons was recognized early in the epidemic. After holding its first consultation on prevention and control of HIV in prisons in 1987, the World Health Organization responded to growing evidence and issued guidelines on HIV infection and AIDS in prisons in 1993. With regard to health care and prevention of HIV, the guidelines emphasize that "all prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality."[5]

An increasing number of countries have introduced HIV programs in prisons since the early 1990s. However, many of these programs exclude necessary interventions such as needle exchange and methadone treatment. Not so in Moldova, whose experience with introducing and expanding a comprehensive HIV program, including such interventions, is described in this report.

Nearly a decade ago, top officials in Moldova's penitentiary system acknowledged that, as in prisons worldwide,[6] it was impossible to prevent illegal drugs from entering their facilities and stop prisoners from having sex with one another. They realized that measures to prevent drugs from coming into prisons could reduce the flow of drugs, but would never fully stamp out the illicit drug trade. They also realized that pretending that drug use is not occurring would only increase the spread of HIV infection among prisoners.

In Moldova as in other countries, many people sentenced to prison are dependent on drugs, and will continue to use drugs in prison. Some people begin using drugs only after they come to prison, often as a means to release tensions and to cope with being in an overcrowded and often-violent environment.[7] Studies show that people in prisons are typically much more likely to share injecting equipment than those outside of prison.[8] Because it is more difficult to smuggle needles and syringes into prisons than it is to smuggle drugs, needles and syringes are often in short supply. At the same time, sexual activity, including rape and other forms of sexual violence, also occur in prisons and can result in transmission of HIV and other sexually transmitted infections (STIs) when condoms are not provided and measures to prevent sexual violence are not taken.[9]

Moldovan authorities have demonstrated leadership, and pragmatism, in adopting evidence-based HIV prevention programs. Since 1999, local NGOs have provided prisoners with HIV/AIDS education and a wide range of harm reduction services, including psychological support, counseling, and distribution of clean injection equipment and condoms. Ten years later, Moldova remains one of only a few countries in the world where comprehensive harm reduction services are available in prisons. Few other countries—and almost none in the former Soviet Union[10]—grant prisoners free, anonymous, and confidential access to such an extensive range of materials and supplies that can greatly reduce risks to their health and, ultimately, save their lives.

The NGOs that provide education and harm reduction services are unusual in that they are essentially single-purpose NGOs. The organization Medical Reforms in Penitentiary Institutions, with the help of several key individuals (including Alexei Ledora and Dumitru Laticevschi), started the programs and administered them until another organization, Innovative Projects in Prisons (IPP), was founded in 2002 and took over the programs. Both NGOs work exclusively in prisons and their only focus is to help prisoners involved in risky behaviors to protect their health. NGO staff

members say that they hope their clients will ultimately stop using drugs, but they recognize that many people are unable or unwilling to quit drug use in prison, and harm reduction measures are the most practical and effective way of stemming the spread of HIV.

In 2005 the Department of Penitentiary Institutions expanded the range of prevention services in prisons and introduced a methadone program. Neither the harm reduction program nor the methadone program, which is run by the Department of Penitentiary Institutions, has had an easy road to follow. Among other things, the programs have faced severe funding constraints. As of October 2008, IPP had been unable to expand its harm reduction project to all prisons and pretrial detention institutions. Meanwhile, the number of prisoners benefiting from the methadone program, although growing, remains small (see Box 4).

Therefore, many challenges remain and will have to be addressed in order to guarantee comprehensive access to education and harm reduction services for all prisoners and pretrial detainees in Moldova. But they cannot and do not detract from the positive developments that began when the first prisoner in need received a clean needle in 1999. More than two-thirds of adult prisoners sentenced in Moldova are incarcerated in facilities where they have access to harm reduction services. In all the prisons where harm reduction services are provided, the experience has been overwhelmingly positive—needles have never been used as weapons against prison staff or fellow prisoners, drug use has not increased, and available data suggest a reduction in HIV and hepatitis C incidence.

Because of the training that has preceded and accompanied service delivery, awareness about HIV and risk behaviors is now nearly universal among prisoners and prison staff, from guards to administrators. The awareness has helped reduce HIV-related discrimination and stigma, thereby improving the lives of prisoners living with HIV.

The introduction and expansion of harm reduction measures in Moldova's prisons have attracted significant international attention over the years. Officials from penitentiary systems in a number of countries—including Azerbaijan, Bulgaria, Canada, Lithuania, Poland, and Ukraine—have visited Moldova and toured the prisons where harm reduction services are offered. They have talked to administrators, medical personnel, the prisoners who serve as outreach volunteers, and prisoners who use the services. They have seen the data and heard the observations, all of which point to success of varying degrees in the project's primary purpose: improving prisoners' health,

and doing so *without* prompting commensurate negative changes such as increased drug use.

Importantly, the introduction of harm reduction measures has in recent years been accompanied by a drastic reduction in the number of prisoners and pretrial detainees; it has also been accompanied by other prison reform initiatives aimed at improving conditions for both prisoners and staff. Such measures, including reduction of overcrowding, increased work activities for prisoners, better food, and better pay for prison staff, have long been recognized as essential—although often neglected—components of the overall effort to reduce the spread of infectious diseases in places of detention and to improve the health of prisoners and pretrial detainees.[11]

Moldova's efforts should be examined closely by other prison systems, and adapted wherever possible. Ultimately, the health and well-being of all members of society, prisoners or not, are improved by virtue of pragmatic and comprehensive interventions in places of detention.

One of the most important lessons from the Moldova experience is that success of harm reduction initiatives can be greatly enhanced when top-level staff are engaged and proactive from the start. Both the director general and medical director of Moldova's Department of Penitentiary Institutions have been strong supporters of the needle and syringe and methadone programs from early on. They were not afraid to use their authority to remove potential and existing obstacles. They ordered officials at local prisons to implement the needle and syringe project and cooperate fully with those providing the services—even if the officials opposed the project. This determination proved fortuitous; as positive results emerged from the project, attitudes among resistant staff moved from opposition to acceptance to support.

2. Background and Roll-out

The introduction of harm reduction in Moldovan prisons was a joint initiative on the part of prison staff and civil society. In 1997 the Department of Penitentiary Institutions, in cooperation with the NGO Medical Reforms in Penitentiary Institutions, developed a project proposal on prevention of HIV/AIDS and STIs in penitentiary institutions. The proposal was funded by the Soros Foundation–Moldova and the Open Society Institute's International Harm Reduction Development Program.[12] Its goal was to identify and initiate appropriate strategies to combat HIV in prisons. While supportive of HIV prevention programs, some of the prison officials, including Veaceslav Toncoglaz (the former deputy director of the Department of Penitentiary Institutions who now serves as a consultant to IPP) were initially opposed to the concept of harm reduction: "I thought the idea was strange. It sounded as though we'd be accepting and facilitating the use of drugs in prison."[13]

However, Toncoglaz and his colleagues changed their minds after reading the results of the NGO's first activity, an anonymous survey conducted among prisoners in 1999, the year that HIV first became a serious health concern in Moldova. Prisons were already heavily affected: The first case of HIV infection in the prisons of Moldova had been registered in October 1996,[14] but a 1999 report stated that a total of 47 HIV-positive prisoners were in just one prison, Branesti Prison Colony 18. All of them were people who inject drugs who had been incarcerated on drug-related charges. Meanwhile, HIV-related stigma and discrimination reportedly were rampant, with many Moldovans believing it was possible to contract the disease merely by touching someone infected with HIV.

According to the survey, injecting drug use was widespread throughout the prison system. Individual needles and syringes were shared by as many as 12 different prisoners, and some prisoners were using homemade equipment to inject drugs. The survey found that the majority of illegal drugs were smuggled into the prison either during visits or by guards and other staff members. The survey also revealed that sex between prisoners was common, as was the resulting spread of STIs.[15]

Armed with the survey results and information about how and why harm reduction measures could work, the NGO approached top-level officials at the Department of Penitentiary Institutions and proposed to initiate a harm reduction pilot project in one facility. The survey results helped counter initial skepticism about the project. According to Toncoglaz, the survey's results were important because they "reinforced reality. Although prison workers are reluctant to admit it, drugs are in prison…and people will use them when they are. We suggested that they now think about reducing HIV prevalence and risk."[16]

2.1 Needle Exchange Begins

Criteria for Site Selection

NGO and penitentiary officials agreed to implement an initial harm reduction project at Branesti prison, a medium and maximum-security prison with a population at that time of approximately 1,000 men. They chose that facility because it housed the largest number of prisoners known to be HIV-positive, had the largest number of people incarcerated for drug-related offenses, was the prison with the lowest average age (mid-20s) and where a significant majority were imprisoned for the first time. Need was greatest in Branesti due to the relatively high levels of HIV and drug use, and authorities assumed the project would have a greater opportunity for success because the youth and "newness" of the prisoners meant they were less hardened than those elsewhere.

Trainings on Safety and Legality

The decision was conveyed to local prison officials. The NGO then organized a series of trainings with prisoners and with prison staff at all levels. The trainings had two

main prongs—to inform and educate about HIV, and to explain the harm reduction philosophy and how it would actually work in practice.

Larisa Pintilei, IPP's project coordinator, said that most staff and prisoners knew little if anything about HIV or hepatitis C, neither how they were transmitted nor how infection could be prevented. The only certainty was fear. Prisoners, for example, were ignoring, avoiding, and isolating other prisoners they knew or suspected had HIV. Prison guards and other staff also avoided those they thought to be HIV-infected. At the same, staff were initially almost uniformly hostile to the concept of harm reduction. They were worried about their personal safety, fearing that they could be accidentally stuck by dirty needles or that prisoners would use the needles as weapons. They also believed that distributing safer-injecting materials would encourage illegal drug use.

Vitaly Morozan, the interim director of the Branesti prison, was responsible for issues related to security and safety at the facility when the project started in 1999. He said, "I had never heard of harm reduction. But I did know I was against it. We were frightened of giving needles to convicts...we thought it was like giving a knife to them. We also thought we were facilitating drug smuggling. Almost everyone felt this way. Only the medical unit was supportive, and that's because they had done some research in advance and were more open in general about health issues."[17]

During trainings, the NGO addressed the two main concerns—safety and legality—head on. Harm reduction would actually improve safety, they said, because it would reduce the number of used and potentially contaminated needles in circulation and help prevent HIV infections. They added that there would be no change in official policy regarding use of illegal drugs.

Both prisoners and guards were reminded that prisoners found with illegal drugs would be disciplined and likely face additional criminal charges. At the same time, prison staff were reminded that both Moldovan law and prison policy already allowed prisoners to have needles and syringes in their possession.[18] After all, such items were also used to inject legal substances (such as insulin for diabetics).

On December 3, 1999, order 115 "On a harm reduction pilot program to be implemented in penitentiary institutions" was enacted, authorizing the needle and syringe pilot project in the prison. The project was originally run by staff from the medical unit. Prisoners were required to visit the medical facility to receive safer-injection materials, condoms, and all available informational materials.

Project Revision to Increase Reach

Uptake was slow, however; during the approximate five months that this initial distribution system was in place, less than 50 syringes were exchanged and fewer than a third of the prisoners known to inject drugs were accessing the project.[19] Staff from the NGO and the medical unit spoke to numerous prisoners to find out why. They discovered that many prisoners were reluctant to access the services because they did not believe the program was truly anonymous and confidential. Nicolae Bodrug, the head of Branesti's medical unit since 1999, said, "Clients originally thought, when staff were running the project, that they would get into trouble if they participated."[20] Prisoners were concerned that they would be harassed or detained when seeking needles and syringes because drug use remained illegal.

Another obstacle was that medical personnel were not always available when prisoners needed them. The project's services were usually available only when the majority of medical staff were present—perhaps eight hours during the day, from Monday through Friday. That meant access was nonexistent or limited in the evenings and on the weekends.

Peer-based Exchange

NGO staff and Branesti officials came up with a plan to change the project. They decided that select prisoners should be trained as outreach volunteers to provide services to fellow prisoners. According to Dr. Bodrug, "To make the needle exchange genuinely anonymous, we recruited eight secondary exchange volunteers to work throughout the penal colony. The advantage was a much higher degree of trust and confidentiality." This decision inaugurated stage two of the project.

The peer volunteers provided harm reduction services in four different sites within the prison living units (barracks-style accommodations, with 70 or more men living and sleeping in the same large room at that time). Two peer volunteers were assigned to each site, where they distributed all relevant supplies from a designated cabinet or closet near their living space. The project became accessible 24 hours a day, seven days a week because clients and direct service providers lived with and near each other. Interviews with the peer volunteers revealed that most prisoners access the project during the day and evening. One volunteer said: "I need to sleep too, and people respect that and come while I am around and awake." Most importantly, prisoners trust that the peer volunteers would never reveal the identity of fellow prisoners

accessing the project.[21] Volunteers do not register names or last names; they collect no information other than writing down the number of syringes and condoms distributed. This basic data is then given to the medical unit staff supervisor. (See Boxes 1 and 2 for more information about and observations from volunteers.) The activities are carried out in cooperation with the prison physician. The role of the physician is to act as project supervisor and as a link between the peer volunteers, prison staff, and the NGO staff.

Larisa Pintilei speaks with a volunteer at the prison in Cricova

According to the NGO project coordinator, Larisa Pintilei, after this change was made uptake increased dramatically. Soon, 65 to 70 percent of people known to inject drugs in the prison were accessing the project through the peer volunteers. Between December 1999 and December 2000, the peer volunteers in Branesti exchanged 2,840 syringes.[22] And, she said, nearly 100 percent of all syringes and needles distributed were returned. Prisoners said they were much more satisfied and comfortable with the new system.

2.2 Moving Out of Pilot Phase

As restructured, the project moved out of pilot phase when it was implemented in a second prison, Cricova Prison Colony 4, in 2002. By 2008, the NGO was providing harm reduction services in seven prisons—six men's prisons and one women's prison. The NGO hopes to move into an eighth prison, but funding constraints have prevented further expansion. According to Vladimir Trofim, former director general of the Department of Penitentiary Institutions, "we would like to cover 100 percent of sentenced prisoners."[23] (See Box 3 for more information about the prisons in which the NGO operates.)

Decisions about starting a project in a particular institution are made by the director general in consultation with the NGO. The NGO first does needs assessments to determine if services are needed and likely to be used. Among the most important criteria are the number and percentage of prisoners convicted on drug-related charges. Another key part of the assessments are anonymous surveys conducted among the prison population; prisoners are asked about type and frequency of drug use, awareness of HIV, and HIV-related discrimination.

Once a decision is made, the order to start the project at the institution is issued. As it did in Branesti, the NGO then organizes special trainings for staff and prisoners.

For many years, the department and the NGO were reluctant to expand the project to pretrial detention facilities (so-called SIZOs or "investigative isolators"). Reasons included the overcrowding and often worse overall conditions in these facilities and the difficulties of implementing peer-based services given the rapid turnover of detainees. However, officials recognize that risk behaviors occur also in pretrial detention facilities and that it may now be more feasible to implement the project, or at least some of its components, due to the fact that overcrowding has drastically decreased and conditions have improved in pretrial detention facilities. As of October 2008, there were a little more than 1,000 detainees in all five SIZO facilities, compared to nearly 3,000 in 2005. According to Trofim, introducing the project in SIZOs would be much easier now "because there is so much support for the project and little resistance because everyone knows the project is good." He said that the department "would be receptive" to advice about expanding the project to these pretrial detention facilities.

During a visit to a pretrial detention isolator in Balti in October 2008, the director of the institution, Tudor Pascaru, said that he had not been able to participate in

BOX 1.

How Volunteers Are Identified

Prisoners are more than just clients of the harm reduction program in prisons in Moldova. Some of them are also at the frontline of service delivery itself. The actual supplies—needles, syringes, condoms, alcohol wipes, creams, lubricants, information booklets—are distributed by prisoners, who work as volunteers and are specifically trained by Innovative Projects in Prison, the NGO that provides the harm reduction services.

NGO staff identifies prisoners who might be willing to participate. The first step is generally taken during large group meetings prior to the project's launch at a facility. Such meetings and trainings focus on introducing and explaining the project to all prisoners. At the conclusion of those meetings, presenters urge interested prisoners to consider being volunteers and direct them to indicate interest to the prison medical unit director and NGO staff.

The NGO relies on local staff to play major roles in helping find appropriate volunteers at the beginning and on an as-needed basis as the project continues. NGO personnel note that the medical unit directors interact regularly with the prisoners and thus are best placed to recognize suitable candidates. In some cases, this means having their own formal or informal criteria. Nataliya Cioran, the director of medical services at Rusca prison (interviewed August 23, 2007), said she and her colleagues originally approached prisoners they knew were HIV-positive and asked them to be involved as volunteers. Their rationale was that such prisoners are more inclined to pay close attention to health issues and risk factors and are more likely to have direct knowledge, as people with a history of drug use, about behaviors targeted by the project. In addition, Cioran said they sought prisoners with "good personalities" who are "open" and "friendly."

Larisa Pintilei, the NGO's coordinator, said that only prisoners who have the absolute trust of their fellow prisoners can be selected as volunteers—otherwise, the project's services would not be used. In addition, she said that volunteers "must be willing to do this work and strictly obey the rules."

The prisoners do not get paid for their volunteer work. The NGO does, however, provide them with "gift bags" on a regular basis, usually once or twice a month. The bags generally contain items such as cigarettes, food packages, and other hygiene supplies. The provision of these gifts is considered a major incentive for participation, given that such items are often in short supply in the facilities. At the same time, volunteers are clearly proud of what they are doing. Asked why he had been doing this work for more than three years already, one volunteer said: "I do this because it is a good thing to do. It helps prevent infections and saves lives."

any trainings on HIV and harm reduction delivered by the NGO and therefore knows very little about the harm reduction project. "The only thing we do here is provide condoms and information leaflets, as well as hair cutting implements for people who are HIV-positive," he added.[24] He pointed out that drug use is a much rarer occurrence in pretrial detention isolators than in prisons, due to the fact that detainees are only allowed to receive one monthly short-term visit, which is supervised, and that staff who were detected bringing drugs into the institution were dismissed immediately, charged with a criminal offence, and sentenced. However, he admitted that drug use still occurs and said that "it would be good to have the [harm reduction] project" "because it is a positive project" that, as far as he had heard from his colleagues, "has many positive outcomes not only for prisoners, but also for staff and ultimately, for everyone in Moldovan society."

This openness reflects the fact that, over the past ten years, the project has become broadly accepted by the prison department and the Moldovan government more broadly, and is viewed as a best practice of sorts. Although the department does not fund IPP directly, the organization has always been housed in the department's headquarters in Chisinau, and the government provides that space free of charge. Local prisons also provide space to house harm reduction materials, and the prison medical directors receive funds from the NGO to allocate part of their working hours to the project.

In 1998–1999, the first harm reduction project outside of the Moldovan penitentiary system was initiated in the city of Soroka; by October 2008, harm reduction projects were operating in 20 locations across the country. Harm reduction is considered a major component of the government's most recent anti-HIV strategy, the National Program for Prevention and Control of HIV/AIDS/STIs 2006–2010,[25] which stipulates that needle exchange and methadone are important elements of a comprehensive response and explicitly says that the Ministry of Justice has to "ensure the development of activities and measures to prevent and control HIV/AIDS and STIs in penitentiary institutions through extending harm reduction programmes and substitution treatment." The new "Law on HIV/AIDS Infection Prevention" of 2007 also contains an article on prevention activities in penitentiary institutions, which stipulates:

"The Ministry of Justice ensures:

a) education and training of staff and inmates, with the purpose to develop skills and knowledge on HIV/AIDS prevention, safe and responsible behaviors, pre and post voluntary testing [sic], consent for HIV testing;

b) harm reduction programs, including providing bleach and needle exchange supported free of charge and condom distribution in all prisons;

c) access to free-of-charge ARV treatment and treatment for opportunistic infections."[26]

The government's efforts are funded partially by the Global Fund to Fight AIDS, Tuberculosis and Malaria.[27] (See Box 4 for information about the methadone program in Moldovan prisons.)

2.3 Overcoming Opposition

Opposition to harm reduction in general, and to distribution of syringes specifically, was initially widespread at all prisons. As at Branesti, most local administrators and staff had never heard of such a strategy. Their first (and strong) reaction was that it ran counter to their long-held primary objective: to uphold laws and punish prisoners who violated them.

For example, Gheorghe Chirila, the director of the women's prison at Rusca, said that opposition was particularly high among security guards in the run-up to the project's launch there in 2003. "One of their responsibilities is to prevent smuggling drugs into prison," Chirila said, "so they asked, 'Why would we do this? The next thing you know, we'll be giving them drugs.'"[28]

In most cases, there was significantly less opposition, if any, among directors of medical units. The main reason is that prisoners' health is their primary responsibility. They see firsthand the effects on prisoners of HIV, hepatitis, and STIs, not to mention wounds and abscesses related to injecting with dull or unclean needles or substitutes such as pens.

One notable exception was Nataliya Cioran, the director of Rusca's medical unit. She said she was against the project from the very beginning out of concern that access to harm reduction services would lead to an increase in overdoses and "crazy" and "dangerous" behavior.[29] Cioran added that she would not have implemented it in the absence of an order to do so.

When interviewed in 2007, Cioran had completely changed her mind. For one thing, she said, her fears were not realized—there had been no increase in overdoses or "dangerous" behavior. Instead, there was an increase in knowledge and awareness

about HIV among both staff and prisoners and a decline in the number of HIV cases. She noted that the safety of both staff and prisoners improved in the wake of those key developments.[30]

Cioran is not alone in having initially resisted harm reduction before ultimately embracing it. Vitaly Morozan, the interim director of Branesti prison, said: "We had an order from the director general to initiate the project, so we did it. I'll admit I was still opposed when it began. But over time, I saw that the number of HIV cases was decreasing…and that trend has continued."[31]

Morozan added that he has since become a willing and constant advocate of the project, and he said he tries to use his influence on its behalf whenever possible: "We were the test case because our facility was the first one and the project has been here the longest. We're visited by staff from other prisons where the project will be launched. They are always apprehensive, even when I discuss the stages of the project and why it works well. The most convincing way to reduce their fear and opposition is to have them talk to prison staff and prisoners. Just about all of them are in favor of the project."

Anatolii Vizitiu, head of the medical unit at the Cricova prison, acknowledged the importance of positive results and feedback from Branesti. He said he visited Branesti and subsequently urged the then-head of his prison to welcome the project. Vizitiu said the director and other staff members were swayed by reports from Branesti of, among other things, lower rates of hepatitis C and the fact that the project had not led to an increase of used injecting materials discarded throughout the facility. He added that he tried to focus on practical elements in discussions with both prison staff and prisoners. "After all," Vizitiu said, "they [guards and prisoners] must understand that it's not necessarily advisable but much more reasonable to use new needles and syringes."[32]

Similarly, Eduard Timofei, the interim director in Cricova in October 2008, said that when he started working at the prison in 2005—three years after the project started there—he did not agree with it.[33] "But after discussing it with others and after receiving more information and training, I understood why it was important." Timofei confirmed that "initially there were some problems, but today all staff accept and support the program." He added: "Staff know why they need to leave the project sites alone—if they tried to supervise them and find out who exchanges injecting equipment, prisoners would soon stop using the project and infection rates would go up. Our main purpose must be to prevent the spread of HIV and hepatitis C." When asked about the level of drug use in the prison, he said that it was difficult to assess exactly how prevalent drug use is, but highlighted that

prisoners who want to use drugs or are dependent on drugs will use them regardless of whether clean injecting equipment is available. "The fact that we make needles and other injecting equipment available does not increase drug use, it only reduces its harms." However, Timofei said he wished the methadone program was available at Cricova prison. Vizitiu, head of the medical unit, agreed, saying that it would "reduce drug smuggling and make prisoners who receive treatment with methadone less aggressive." Prisoners in Cricova have already asked to be on methadone treatment, Vizitiu added.

Both NGO and prison staff stress the importance of training and education on a regular basis, not only when a project begins. That is because turnover of prisoners and personnel is high in all prisons. Staff who are new to prisons tend to know little about HIV and nothing about harm reduction—and are instinctively suspicious of the project. Personnel's safety concerns vis-à-vis HIV are addressed by providing extensive information about transmission and protection. Staff are also generally told to act as though all prisoners are HIV-positive. That means, for example, that they should always use rubber gloves when in contact with any blood and other bodily fluids. Efforts to reassure personnel about their safety tend to reduce not only their distrust and fear, but also limit instances of abuse and discrimination based on real or perceived HIV status.

Branesti's director, Morozan, described his approach as follows: "We start off by telling all new personnel that they must comply with internal orders. No question. And then we get the head of the medical unit to explain how the project works and how staff should behave in regard to it. Each staff member, old or new, is encouraged to raise any problems or concerns about the project or anything else with his superior. Those concerns are usually then brought to the attention of top staff during our weekly meeting. Any responses, comments or decisions made are then conveyed to all staff by their superiors." The NGO's project coordinator Larisa Pintilei added that staff are told that the project's activities are not illegal and that the volunteers are not to be sanctioned for the work they do but should be rewarded so that they can do their work, for the benefit for prisoners, but also of staff."[34]

2.4 Current HIV Situation

It has been estimated that there are 77,000 to 116,000 people who inject drugs in the Republic of Moldova.[35] From 1987 (when the first case of HIV in Moldova was registered) to January 1, 2007, 2,527 HIV-positive cases were registered, plus 873 in Transnistria, for a total of 3,400 cases.[36]

As in other countries of the region, the HIV epidemic has been driven primarily by injecting drug use. An outbreak of HIV among people who injected drugs occurred in 1997 and 1998, when respectively 404 and 408 new HIV cases were detected, of which 87.9 and 84.8 percent respectively were among people who injected drugs. In recent years, the proportion of people with a history of drug injection among new HIV cases has been steadily decreasing, to 38.2 percent in 2006, with a corresponding increase of the number of HIV cases contracted sexually. The total number of new HIV cases has been steadily and rapidly increasing, from 356 in 2004 to 535 in 2005 and 616 in 2006.[37]

According to Pintilei, the most popular drug among people who inject drugs in Moldova (including those incarcerated) is a homemade opiate made from acetylated extract of poppy straw. That drug, known locally as *shirka*, is more common than either heroin or amphetamines, both of which are more expensive.

National laws regarding drug use have been relaxed in recent years as part of an effort to focus on dealers. Simple drug use is not a crime, but it is an administrative offence according to Article 44 of the Administrative Code.[38]

Vladimir Tsaranu, the head of medical services in the Department of Penitentiary Institutions until 2008, estimated that each year some 400 to 600 individuals newly entering the penitentiary system were people who injected drugs. That number includes both those convicted and sent to a prison colony and those in pretrial detention. Tsaranu said that according to official data, about 120 individuals incarcerated at the end of 2006 were officially identified as people who used drugs. He added, "Multiply by 10 to get the real number."[39]

Tsaranu said the number of HIV-positive prisoners fluctuates constantly, but that the overall trend had been down. In 2002, he said, there were "maybe" 200 prisoners with HIV; five years later he estimated the total to be about 160. In October 2008, the new interim head of medical services, Victor Vovc, estimated the number of HIV-positive prisoners to be 145.[40] He reported that the number of prisoners requesting an HIV test is increasing and said that the department was now undertaking a major effort to

ensure that "every prisoner who wants an HIV test can get it."

Until recently, prisoners' access to HIV testing was limited. Testing campaigns were only offered on an occasional basis at each facility, with limited slots available. Demand nearly always exceeded supply. One volunteer at Rusca prison, interviewed on August 23, 2007, said, "I haven't had an opportunity to take a blood test for three years. I know I have hepatitis C, so it may be that I have HIV also." Another volunteer at Rusca said she wished the Ministry of Health's AIDS center would visit each prison regularly and provide prisoners an opportunity to take an HIV test. According to Oleg Borduja, medical director at Cricova Prison Colony 15 at the time of the first series of interviews in 2007, he was only able to accommodate prisoners' requests for an HIV test—outside of a special testing campaign—if they told him they'd recently engaged in risky behavior, such as unprotected sex or using a dirty needle to inject. In such cases the prisoner was referred to the penitentiary system's main hospital at Pruncul. Borduja noted that he rarely received such special requests, at least in part because prisoners were understandably reluctant to divulge such behavior.[41]

The penitentiary health system's inability to provide sufficient HIV testing services was indicative of longstanding resource constraints. As of August 2007, for example, Vladimir Tsaranu, then head of the penitentiary system's medical services, estimated that the system was receiving "just 40 percent of the funds that we really need" to provide an adequate level of care.[42] He was hopeful that the situation would improve with an infusion of new funds in 2008.

With Global Fund assistance, antiretroviral treatment (ART) first became available in Moldova in 2004. It is now available both outside and inside the penitentiary system. According to Vovc, as of October 2008, a cumulative total of 89 prisoners had received ART since 2004, with 30 currently on ART. Both he and his predecessor said that the department was "able to cover all who want or need ART when they are in prison."

The NGO's project coordinator Pintilei and other health advocates reported that, as in other countries,[43] the prevalence of hepatitis C among prisoners is far higher than HIV prevalence. In 2006, for example, hepatitis C was detected in nearly two-thirds (62 percent) of 70 prisoners whose blood was tested at the women's prison at Rusca.[44] As of October 2008, however, the high costs of medicines to treat hepatitis C precluded their availability in both the penitentiary system and in Moldova in general.[45] Testing for hepatitis C (and hepatitis B) virus was also not available to prisoners; it was, one of the "many things we would like to be able to do, but cannot because we do not

have sufficient financial resources."[46] Caregivers in the separate health systems (for the general public and within the penitentiary system) are only able to provide medicines to treat hepatitis C symptoms.

2.5 Staffing of Prison Harm Reduction

As of October 2008, there were harm reduction projects in 20 locations all over Moldova. The majority were run by NGOs with support from the Global Fund (through Soros Foundation–Moldova). The foundation also supported local government officials involved in providing harm reduction services. IPP's project was the only harm reduction project in the penitentiary system. The organization has a small number of employees working out of its offices located within the Department of Penitentiary Institutions in Chisinau (a coordinator, assistants, and an accountant).

BOX 2.

Voices of Volunteers at Prisons in Branesti and Cricova

The staff at Innovative Projects in Prisons said they greatly value stability and consistency when it comes to actual service delivery. They are particularly proud of their success in this regard in Branesti prison, the first facility in which the project began operating (in 1999). In August 2007, each of the four prisoners overseeing the individual harm reduction points in Branesti prison had been volunteers for the project for at least two years. One had been volunteering for four years. Their ages ranged from 28 to 45.

Prison officials allowed one of the researchers to interview the four volunteers in a semi-private manner during a visit to the facility on August 21, 2007. Although the interview was conducted jointly, no guards or other prison authorities were in the room at the time with the prisoners, the researcher, and two translators.

During a second visit to prisons and pretrial detention facilities in Moldova in October 2008, the second researcher was allowed to interview three volunteers in Cricova prison #15 privately, in the presence of only one of the translators.

Some of the more notable bits of information, observations, and comments from the interviews are listed below. To ensure confidentiality, identifying information about individual prisoners (including sources of quotes) has not been included:

- Four of the seven volunteers said they had histories of injecting drug use. They acknowledged as well that they had engaged in unsafe behaviors at various times in the past, even at times when they knew the risks involved. Sometimes they had no choice. According to one volunteer, "I was in a different prison for a few years before I came here. The project wasn't there yet, so it was necessary to share needles all the time. We would sharpen them ourselves if they went dull." One of them said he had never used drugs before coming to prison and added: "Now I am spending half of my life with people who use drugs—the temptation was simply too great and there was nothing else to do." He continued by saying: "The best solution clearly is not to use. When someone comes to me for the first time and asks for a needle, I usually try to talk them out of injecting drugs. But in the end, if they are going to inject, it is better if they at least do it with clean equipment." Another volunteer said that "people use or do not use, for a wide number of reasons. The fact that clean injecting equipment is available does not make it more likely they will use."
- "There's an attitude that everything coming from the authorities must be bad," said a volunteer. "That's why it's better that they come to us if they want anything. Some of them are our friends...and even those we don't know well aren't strangers. Usually we've seen them, and they've seen us, for a long time. They trust us. They know we won't tell anyone that they come to us or what they want. If I said anything, I'd get beaten up at the very least." Another volunteer acknowledged that, nevertheless, some prisoners will be reluctant to come themselves. "That is why prisoners can come and exchange many needles and syringes, not just their own. They can bring the equipment used by others, and exchange for them."
- Some of the volunteers talked about the need to also provide methadone treatment, saying that many of the prisoners would like to be on treatment, rather than continuing to use. "I know 30 people who would like to be on methadone," said a volunteer.
- Three of the volunteers—all with histories of injecting drug use—said they had tested positive for HIV. All said that they were open about being HIV-positive in the prison, adding that they rarely if ever experienced any open discrimination because of their HIV status. They believe the lack of discrimination from prison staff and other prisoners is a result of the project's indirect awareness-raising impact.

One volunteer said his openness about having HIV meant that other prisoners listen to him when they visit and he talks about how and why to protect themselves when injecting drugs or having sex. He added that he encourages them to get tested for HIV if and when possible.

In addition, the organization contracts the medical directors at the facilities where the project operates to oversee the activities of volunteers and outreach workers on a daily basis and to ensure sufficient supplies and collect data on a regular basis. The medical directors are regularly in contact with the NGO staff by telephone; the NGO's coordinator or an assistant visit each facility at least once a month.

The NGO also hires consultants on an as-needed basis. Most of them are social workers who help run trainings on HIV, injecting drug use, and other issues of direct interest to the prisoners.

Finally, the organization works with more than 20 volunteers and outreach workers from among the prisoners. They deliver direct harm reduction services from dedicated points near their living spaces in facilities. Most are thought to be people who use or have used drugs, although direct questions about such activities are frowned upon due to confidentiality and anonymity considerations. In some facilities, volunteers have been involved for up to four years. (See Box 1 for information about how volunteers are selected, and Box 2 about volunteers' viewpoints.)

It is worth noting that there are numerous other NGOs that provide social support to prisoners with TB and other services such as education assistance, legal assistance, and religious guidance. Foreign as well as local NGOs are involved in such efforts. For example, during research for this publication, one of the authors visited one prison (Cricova #15) the same day that a group of 60 doctors were also visiting. They were members of a U.S. faith-based organization that provides free eye examinations to all prisoners who want them. The organization reportedly arranges such visits two or three times a year.[47]

3. Service Provision

3.1 Peer Outreach

As noted previously, the NGO's project is structured so that harm reduction materials are provided by prison outreach volunteers to other prisoners on a peer-to-peer basis, allowing clients to participate without fear of disclosure to prison authorities. Prisoners trust each other (within reason) more than they do prison personnel, regardless of position or department. Also, a volunteer who "rats" on another prisoner—by, say, disclosing that he or she exchanges needles or syringes—risks being beaten if found out.

The NGO and prison medical staff collaborate in identifying potential volunteers and training them (see Box 1). There is no formal monitoring system in place for volunteers. However, the heads of prison medical units, who are paid by the NGO to oversee the individual projects, often find indirect ways to determine the quality of direct service delivery. At Cricova prison #4, for example, Anatol Vizitiu, the head of medical services, said he occasionally discusses the project with prisoners in private and tells them he is collecting confidential observations. He asks prisoners about their impression of the project and its volunteers, with a goal of determining whether clients are getting what they need and in the most convenient and appropriate manner possible. Vizitiu also makes a point to ask a number of prisoners if the volunteers are providing information about HIV and safer-injection practices.[48]

The number of harm reduction points staffed by volunteers ranges from two to four, depending on the prison. The points are located near the volunteers' living spaces, which might be as large as a room with up to 100 other prisoners or as small

as one room with just two beds. The supplies are stored in small metal or wooden cabinets lined with shelves. Each cabinet has a door that is kept closed when supplies are not being distributed. The cabinets are locked only in Rusca, the women's prison, where only the volunteer has the key to open her cabinet. The cabinets are locked there to prevent theft, according to the medical director.[49] Volunteers interviewed elsewhere said they and the medical staff had determined that locking the cabinets was a disincentive to project participation because it indicated that other prisoners could not be trusted. None of the volunteers interviewed in the men's prison colonies said they had ever seen evidence of theft. One added simply, "I'm always here anyway." Another said: "Our internal rules are very strict. Nobody touches anything unless I am here."

Volunteers provide information about HIV and health in addition to supplies

BOX 3.
Detention Facilities in Moldova

There are 17 facilities within Moldova's penitentiary system: eight prisons, a prison hospital, a detention center for juveniles, five pretrial detention facilities; and two "suspended" (i.e., not currently open) prisons. As of October 30, 2008, there were 6,986 prisoners in the eight prisons, and "a little more than 1,000 detainees"[i] in the five investigative isolator (pretrial detention) facilities. This represents a substantial decrease from recent years, as shown below.[ii]

Recent prison population trend

Year	*Prison population total, including pretrial detainees*[iii]
1992	**10,258**
1995	**9,781**
1998	**10,521**
2001	**10,037**
2004	**10,591**

The NGO that provides harm reduction services and trainings has been active in six prisons for several years and more recently began working in a seventh prison. Once funding will allow it, the NGO plans to expand the project to the last prison for adults. After that, the next challenge will be to expand it to pretrial detention facilities.

Research conducted in August 2007 included site visits to five of the six prisons in which the project was operating at the time. In October 2008 site visits were undertaken to two of the prisons (Cricova #4 and Cricova #15) also visited in 2007, and to an investigative isolator facility.

Four of the five prisons visited are classified as "semi-enclosed", which means that prisoners are generally not locked in cells and can walk around the facility on their own. The fifth prison, Cricova #15, is a "closed" facility in which prisoners face far greater restrictions on activities. According to Ruslan Galupa, director of regime and surveillance at that facility (interviewed August 24, 2007), it is for prisoners convicted numerous times as well as those who have committed "exceptionally serious" crimes such as murder.

Snapshots of the five prisons visited are included below:

1) **Branesti #18**
   - Location: 50 km (31 miles) from Chisinau
   - Number of prisoners (all men): about 1,000 (August 2007); 521 (October 30, 2008)
   - Type of facility: "semi-enclosed"
   - Year harm reduction project began: 1999
   - Number of separate harm reduction points: 4

2) **Cricova #4**
   - Location: 20 km (12 miles) from Chisinau
   - Number of prisoners (all men): about 1,000 (August 2007); 802 (October 30, 2008)
   - Type of facility: "semi-enclosed"
   - Year harm reduction project began: 2002
   - Number of separate harm reduction points: 3

3) **Pruncul #9**
   - Location: outskirts of Chisinau
   - Type of facility: "semi-enclosed"
   - Number of prisoners (all men): 675 (August 2007)
   - Year harm reduction project began: 2005
   - Number of separate harm reduction points: 2

4) **Rusca #7**
   - Location: 60 km (37 miles) from Chisinau
   - Type of facility: "semi-enclosed"
   - Number of prisoners (all women): 280 (August 2007)
   - Year harm reduction project began: 2003
   - Number of separate harm reduction points: 3

5) **Cricova #15**
   - Location: 20 km (12 miles) from Chisinau
   - Type of facility: "closed"
   - Number of prisoners (all men): 571 (August 2007)
   - Year harm reduction project began: 2005
   - Number of separate harm reduction points: 2

About the Facilities

Five of the six prisons in which the project operated in August 2007 were for male prisoners. All six differ in how prisoners are housed. In some, the majority of prisoners sleep in large, communal rooms with up to 100 individual cots, often crammed close together (although the recent decrease in the number of prisoners has resulted in less overcrowded situations particularly in these communal rooms). Each prison

also tends to have a few smaller rooms with beds for two to 15 prisoners. Prisoners typically are not segregated by reason for incarceration or length of sentence.[iv] HIV-positive prisoners are not segregated either, unless they have active TB, in which case they are required (as are all prisoners with active TB) to be treated in the penitentiary system's main hospital. However, in one of the prisons visited, HIV-positive prisoners did live together in one room, allegedly because they preferred this to being placed with other prisoners.[v]

All five prisons have some sort of work program for prisoners. Facility administrators and staff interviewed in August 2007 said that work is voluntary—prisoners can choose to participate in work programs. In most cases, prisoners who wish to participate are required to apply for the jobs, many of which (for all but those in the "closed" prison) are not on facilities' premises. Among the jobs available are: shoemaking, construction, wood-carving, and agricultural work (i.e., planting and picking crops). Prison officials stressed that prisoners are paid for their work, with the money deposited into an individual account. As observed during site visits in August 2007, participation in work programs in some facilities was as high as 50 percent of all prisoners. According to then Director General Vladimir Trofim, "prisoners are very interested in working because of recent changes to the legislation—now one day of work counts for three days of imprisonment and the salary is attractive."[vi] Trofim spoke with passion about the increased efforts to offer more work and training opportunities, and more interesting work, to prisoners. He said that, as of October 30, 2008, there was work for almost 4,000 prisoners.

The investigative isolator facility visited in October 2008 was facility #11 in Balti, Moldova's oldest institution, built in 1812. It has three sectors (closed, semi-closed, and open), with a total of 409 detainees as of October 31, 2008, including 16 women and eight minors (compared to 1,000 male, 60 female, and 50 minors on average in 2002).

Notes

i. Interview with Vladimir Trofim, October 30, 2008.

ii. International Centre for Prison Studies. Prison Brief for Moldova. London: King's College, 2008. At http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=155 (accessed on January 16, 2009).

iii. Data from Prison Brief Moldova, supra, note 1.

iv. One important exception was noted in Branesti prison. A separate living space there was reserved for "lower hierarchy" prisoners.

v. Interview in Cricova #15, October 30, 2008.

vi. Interview with Vladimir Trofim, October 30, 2008.

Some volunteers personalize their cabinets by displaying brochures, booklets, or posters on adjacent walls or on top of their cabinets. Every cabinet contains needles, syringes of varying sizes, condoms, alcohol wipes, basic medicines such as troxevasin (for collapsed veins), and booklets and pamphlets containing information about HIV and safer-injection practices. Until 2007 (when this practice was discontinued because of lack of funding) razor blades were also provided, since sharing of razor blades is a common occurrence in prisons in low- and middle-income countries, and puts prisoners at risk of contracting blood-borne infections.[50] In addition to reducing the risk of blood-borne infections—in particular, hepatitis C—there is another important reason to make razor blades available through harm reduction projects: every prisoner has an incentive to visit the volunteers, not only those engaging in illegal or forbidden and stigmatized behaviors. This normalizes the project and makes it much easier for those who might otherwise avoid the visit for fear of being identified as engaging in such behaviors.

Every 10 days or so, the volunteers bring a bucket full of used materials to the medical unit director. They sign a form on which is noted the number of used syringes and needles in the bucket. Volunteers receive clean syringes and needles in return. However, they may request and receive larger or smaller amounts depending on demand and trends. Also, medical directors are instructed to be open to providing additional needles and syringes to volunteers should they run out suddenly before they are scheduled to return the used supplies. Used syringes and needles are incinerated on the facilities' grounds.

Used syringes are collected in disinfectant liquid and then incinerated

During their regular visits to the medical unit with the used syringes and needles, volunteers also provide information as to the number and type of other materials distributed, including condoms, medicines, alcohol wipes, booklets, etc. Their supply of such materials is replenished as needed, based primarily on demand and usage trends.

It is important to note that the only information exchanged during these interactions refers to the number of needles, syringes, condoms, booklets, etc. that have been distributed. No names, codes or other data are provided. Medical directors subsequently provide the data to the NGO, which uses it to help plan future supply orders. The NGO also adds the data to regular reports it shares with funders and penitentiary system officials.

Some volunteers and local prison staff were able to provide information and estimates regarding clients served and materials distributed. A sampling of responses is noted below:

- Average number of clients (includes prisoners who do not need needles or syringes, but may want condoms or information booklets only):
  - — Cricova #4 (August 20, 2007): about 10 per day (as per volunteer)
  - — Branesti (August 21, 2007): four volunteers estimated 50 to 60 per day, 30 per day, 70 to 80 per day, and 40 to 50 per day, respectively
  - — Pruncul (August 22, 2007): 700 a month (as per volunteer)
  - — Cricova #15 (October 30, 2008): one of the volunteers estimated that he had 15 to 20 per day, while another estimated he had up to 40, "but rarely less than 30."
- Average number of supplies distributed:
  - — Branesti (August 21, 2007): 800 needles and syringes each throughout the facility, on weekly basis (as per volunteers)
  - — Pruncul (August 22, 2007): 600 syringes and 600 condoms distributed each month at one point (as per volunteer)
  - — Rusca (August 23, 2007): 1,100 needles exchanged in July 2007 throughout the entire facility (as per medical unit director)
  - — Cricova #15: two volunteers estimated 400 to 500 syringes and needles a month, and 200 syringes and needles a month, respectively. One volunteer estimated he distributed 400 condoms a month, while the other said he distributed perhaps 50 to 60 a month.

All points offer a wide range of syringe sizes. The most popular, according to Larisa Pintilei and volunteers asked, are 1, 2, and 5cc. Providing a wide range of syringe sizes is important since evaluation of a needle and syringe program in a prison in Germany showed that many prisoners did not access that program because it did not provide the sizes that were most in demand.[51]

Separately, Pintilei said that, as of August 2007, on average the NGO distributed a total of 7,600 needles and syringes each month across all six prison colonies. The number of condoms distributed ranged from 1,500 to 3,000 a month, she said. Pintilei noted significant differences among prisons, with demand being highest in Branesti

(where prisoners are younger and more likely to be incarcerated for drug use-related convictions). She also said that demand for syringes in general tended to be higher in spring and summer.[52] The total number of needles and syringes exchanged in prisons in Moldova increased from 3,650 in 2000/2001 when the project was running only in Branesti prison to 84,280 in 2006/2007.

3.2 Training

Training has been a major part of the NGO's work from the very beginning, as noted previously. The NGO offers training on a regular basis in all of the facilities in which it operates, with the primary focus being on new prisoners and prison personnel. The trainings address all aspects of HIV, including transmission and prevention, as well as other relevant conditions such as hepatitis and STIs. Presenters then explain how the harm reduction project works and what it intends to achieve. They also seek to reinforce the confidential aspects of the project; to encourage prisoners to utilize the services; and to explain relevant legal and policy issues, such as the fact that the volunteers do not engage in any illegal activity by distributing needles and syringes and that prisoners can legally possess injecting equipment but can still be charged if found in possession of an illegal substance.

Trainings are conducted by consultants as well as by NGO staff. For the first several years, up to six trainings a month were held at each facility. While funding constraints have forced the NGO to reduce the number of trainings, they are considered vital by both the NGO and prison staff. As observed by Gheorghe Chirila, the director of Rusca prison, "It's much better to work with those who are well-informed, both staff and prisoners."[53]

3.3 Budget

In November 2008, Pintilei provided the overall budget for the NGO's activities in seven penitentiaries.[54] Of an overall annual budget of US$37,541, $12,650 went to staff salaries; $9,240 to condoms, syringes, and other harm reduction supplies; $2,244 to administrative expenses; and $13,407 to "other expenses" of the project, of which $2,200 were for rewards to volunteers.

4. Project Evaluation

In some ways it is difficult to gauge the impact of these harm reduction efforts. Prisons are not static environments; prisoners move in and out on a regular basis, hampering efforts to collect statistically relevant information. In the absence of rigorous statistics, it is tempting to view anecdotal evidence and perceived general trends as sufficient basis on which to base evaluations. That temptation should be resisted in the interests of accuracy and project replicability. When asked, Pintilei acknowledged that the NGO and prison administration had collected much persuasive data over the years, demonstrating the positive impact of the project. "Every time we start the program in a new prison, we see a reduction in new cases of HIV and hepatitis B and C. The main goal of the project is achieved: in the prisons where the project is run, every prisoner has access to sterile injection equipment, condoms, information materials, HIV testing, ART, or methadone. Discrimination against HIV-positive prisoners is almost absent in the Moldovan prisons. At the same time, we know there are limitations of our data and that we cannot scientifically prove that the reduction in infections is due to the project. We would be interested in getting funding and assistance for a more rigorous evaluation."[55]

A review of studies and other available information on all needle and syringe programs in prisons worldwide noted that randomized clinical trials, often regarded as the gold standard for tests of efficacy, would be difficult, if not impossible, to conduct in prisons.[56] Indeed, in all countries in which studies on needle and syringe programs in prisons have been undertaken, ethical committees rejected proposals to undertake randomized clinical trials, finding that—in light of the large body of evidence of the effectiveness of needle and syringe programs outside prison and other factors—

a comparison of outcomes among comparable groups of prisoners with and without access to needle and syringe programs would be unethical. The review of studies found that, "[w]ith the exception of one prison in which sharing continued because of insufficient supply with needles and syringes, all available evaluations have shown that sharing of injecting equipment either ceased after implementation of the NSP [needle and syringe program], or significantly dropped."[57] It continued by saying:

> *No new cases of HIV were reported in any evaluation. In five of the six prisons in which blood tests were performed for HIV or hepatitis infection, no seroconversion was observed, and self-reports in other prisons also indicated no new cases of infection. In another prison in which the incidence of HIV, HBV, and HCV was determined through repeated testing, no HIV and HBV seroconversions were observed, but four HCV seroconversions, one of which had definitely occurred in prison.*[58]

The review further noted:

> *In addition, there is evidence of ancillary benefits associated with the implementation of NSPs, including: a reduction of overdose incidents and deaths; facilitation of greater prisoner contact with drug treatment programmes; reduction in abscesses, improved relationships between prisoners and staff, and increased awareness of infection transmission and risk behaviours; and increased staff safety, because accidental injuries from hidden injecting equipment during cell searches decreased.*[59]

Finally, it found that "[t]here have been no reports of syringes having been used as weapons in any prison with an operating NSP" and that "[t]he availability of sterile injecting equipment has not resulted in an increased number of prisoners injecting drugs, an increase in overall drug use or an increase in the amount of drugs in prisons."[60]

Such positive results have been documented, although sometimes less rigorously, also in prisons in Moldova.

Declines in HIV Cases

Several seroprevalence studies undertaken in prisons in Moldova since the project began have shown that the percentage of prisoners living with HIV has declined over the years. In addition, Pintilei and the medical directors in the prisons in which the project has been active report that the number of new cases of HIV, hepatitis C, and STIs has also been declining.

- Branesti #18: Nicolai Bodrug, the head of the prison's medical unit, cited several blood testing campaigns conducted since the project began in Branesti colony in 1999. He said that one early campaign indicated that "one of every nine" prisoners had HIV, but that the most recent campaign indicated that just "one of every 17 prisoners" was HIV-positive.[61]
- Pruncul #9: Igor Jalba, the head of the prison's medical unit, said a testing campaign conducted in 2005, the year the project was initiated in his colony, found eight HIV cases among 128 prisoners tested. A year later, no HIV cases were found among 35 prisoners tested. Jalba added that five cases of syphilis were found among the 35 prisoners tested in 2006. He said he did not have comparative data on hand for 2005, but that "there were definitely more cases [of syphilis] then."[62]
- Rusca #7: According to the prison's director, Gheorghe Chirila, his facility had the highest percentage of HIV-positive prisoners in the entire system—12 percent, or 24 prisoners—when the project began in 2003. That figure was based on blood tests conducted, voluntarily he said, among all prisoners. Two years later, the total number of HIV-positive prisoners was 11. That figure was also based on a testing campaign that reached all prisoners, according to Chirila.[63]
- Cricova #15: Oleg Borduja, then head of the prison's medical unit, said a testing campaign in 2005 revealed 16 HIV cases. Two years later, he said, just seven cases were found in another testing campaign. Borduja said that each testing campaign reached about one-tenth of all prisoners at the time.[64]

While such declines could be due to a number of factors, the vast majority of prisoners who inject drugs in Moldovan prisons report never sharing injecting equipment.[65] Coupled with evidence of extensive injecting drug use in prisons, and

data showing that the number of people who inject drugs in the community outside prisons who contract HIV has continued to increase in recent years,[66] evidence suggests that the harm reduction program has been successful in its primary goal of limiting risk behaviors and helping prisoners protect themselves from harm.

Equally important, consistent with the experience in other prison systems with needle and syringe programs, penitentiary system staff point out that the project has had no negative consequences, and prisoners, prison staff, and medical personnel report positive impacts.

Decrease in Discarded Injection Paraphernalia

Chirila, the director of the Rusca prison, said that since the project began in 2003, no used needles were found on the grounds of his facility. As a result, he said, the environment was safer for both prisoners and staff.[67]

Prisoner Empowerment

Chirila said the project had helped motivate prisoners to focus on and take greater care of their own health. One reason, he claimed, was that prisoners were more inclined to believe that the administration was willing and able to support and help them. According to Chirila, "They now have the information they need to ask for and demand help" in protecting their health in general, not just in regard to drug use and HIV.[68]Chirila's observations were echoed by Oleg Borduja, then medical director at Cricova prison #15. He noted that as "guards and prisoners learn more about HIV, they are more likely to take measures to protect themselves."[69]

Reduction in STIs Among Prisoners

According to Borduja, "We've observed, from our medical records, that the number of cases of syphilis and other STIs, including trichomoniasis, has decreased." He attributed such trends to the availability of condoms through the harm reduction project.[70]

Reduced Safety Risks for Prison Personnel

Ruslan Galupa, the head of security services at Cricova prison #15, said the project's implementation had helped improve the safety and security of guards and other prison staff. He cited three main reasons:[71]

- Prior to the project's initiation, most staff knew nothing about HIV. Project-related training sessions have given personnel extensive information regarding HIV transmission and protection. Such knowledge has helped them make smarter decisions and reduced fear based on the unknown.
- Guards come across far fewer discarded needles and syringes. And those that they do find are less likely to contain HIV or hepatitis C because, given prisoners' easy and consistent access to clean needles, they have probably been used by just one person.
- Before the project began, prisoners who injected drugs were often forced to reuse and share injecting supplies. They frequently hid needles and syringes in places such as their clothes or under their beds. That greatly increased the risk of needle sticks and other harms for prison staff who searched prisoners and/or their living areas. With the advent of the project, however, prisoners can dispose of their used needles relatively quickly and safely because they know they can get new ones if needed. Prison staff are at a much lesser risk of harming themselves as a result.

It should be noted that, unlike the needle and syringe programs in prisons in Western Europe,[72] the project in Moldova does not provide plastic storage cases to prisoners for disposing injecting equipment. There are no regulations requiring prisoners to store their injecting equipment in such cases, or in particular locations in their living quarters. Initially, the decision against providing plastic cases was made on economic grounds. Later, it became clear that the projects were working well and safely without such storage cases and it was therefore decided they were unnecessary.[73]

Reduction in HIV-related Stigma and Discrimination

Two respondents—Oleg Borduja in Cricova and Gheorghe Chirila in Rusca—said the project's implementation had helped reduce stigma and discrimination by both prison staff and prisoners toward prisoners known or thought to be HIV-positive. The reason, they both claimed, was improved knowledge and awareness. As a result of trainings and extensive access to booklets and other informational materials, prisoners and staff are more likely to know how and why HIV can actually be

transmitted—and that, for example, it cannot be contracted merely by touching someone or sharing utensils.

Borduja said that HIV-positive prisoners in his facility often were ignored and isolated by other prisoners. He added that prisoners with HIV had become far more integrated into the community since 2005, when the project was implemented.

Borduja also said that the clear reduction in HIV-related stigma and discrimination pointed to the need for training and education to be conducted on a regular basis. That was the only way for the benefits to continue, he said, given that new prisoners were arriving constantly and new guards were hired almost as frequently. Most newcomers, he observed, were inclined to discriminate and stigmatize on the basis of real or perceived HIV status because they are mostly ignorant about the disease.

Influence on society in general

Pintilei noted that the project's awareness-raising elements cannot help but have a positive impact on society in general.[74] "Prisoners are released regularly. Those with awareness of HIV and an appreciation of harm reduction are more likely to continue taking measures to protect their own health and the health of those around them even outside of prison walls. Their examples and explanations have a ripple effect among their family, friends, and drug-use and sex partners. Significant benefits accrue not just to their individual health, but to public health in general."

The benefits to public health are likely to be magnified, according to Pintilei, because prisons are disproportionately high risk environments for HIV, hepatitis C, TB, and STIs. Reducing the prevalence of such diseases in prisons is an important step toward reducing their prevalence throughout the general population.

5. Challenges

The NGO and its allies have faced, and continue to face, numerous challenges to their efforts to provide consistent, reliable, and comprehensive harm reduction services to as many prisoners as possible. They have been able to identify solutions to address some of them, especially those related specifically to the project's structure. The more intractable obstacles tend to stem from one main problem: a chronic lack of sufficient funds at both the NGO and its government sector partners.

Some of the most notable past, present, and ongoing challenges are listed in this section. All individuals involved in the project agreed that the challenge discussed first, in Section 5.1, has proved to be the most persistent and thus the most important to address appropriately.

5.1 Resistance from Prison Staff

As noted throughout this report, prison personnel at all levels are nearly always opposed to the project at first. This obstacle has been approached via a dual strategy of "command and education." The command element is simple: An order to start the project is issued to heads of individual prisons and their medical departments' supervisors. They have had no choice but to act on the department's order and allow the project to operate in their facilities.

However, Trofim, the department's former director general, emphasized that such a command must be accompanied by a clear and immediate commitment to education. Trainings for all prison staff, from directors to guards, must focus on raising

awareness about HIV and other relevant health issues. The project must be explained both in concept as well as in execution. Trofim observed from experience that "guards want to know *exactly* how to act and respond in individual situations...such as what they should do if they see a needle or a syringe on a prisoner."[75]

He added that both prison staff and prisoners must be aware of and understand the specific legal issues and contexts as well. Prison staff, he said, are particularly reassured when "we make it clear that there is a disciplinary element. We tell prisoners that in exchange for the help we offer them, they must abide by all relevant rules, policies, and regulations. For example, they must know that if caught with illegal drugs, they will be disciplined...that's the law. This is important for the guards to understand as well because it helps them see that they aren't giving everything away by accepting the harm reduction project and helping it operate smoothly."[76]

Another key step in overcoming staff opposition, according to Trofim, has been to provide them with specific health safety information. He said, "Trainers explain the type and scope of risks to staff, regarding HIV in particular. Guards are much more relaxed and open once they recognize such risks are minimal if they take basic precautions." One key policy that has been effective, he added, is to "make it clear that all staff should adopt a rule of treating every prisoner as if he or she is HIV-positive. That doesn't mean be afraid of them or discriminate against them. It just means that you should, for example, wear gloves when patting down prisoners and when touching bodily fluids. We remind them that they should always do so in a respectful manner."[77]

Trofim reinforced the importance of providing training on an ongoing and regular basis, not just prior to the project's initiation in a specific facility: "Training has to continue all the time because there are always new people coming into institutions, both new prisoners and new guards. It's rare that any of them have ever heard of harm reduction, so they are naturally suspicious. The cycle repeats itself, with those who are trained sufficiently nearly always accepting the project."[78]

The NGO's coordinator, Larisa Pintilei, was adamant in echoing Trofim's comments on the need for training to be ongoing. "Regular training," she said, "is vital to limit potential problems and to ensure the projects' effectiveness. There have been instances when guards' personal attitudes have been negative toward the project. They will comply with orders, but not always happily. They won't go out of their way to help the project proceed effectively, as they should."[79]

Pintilei cited one case when a guard seized a volunteer after he left the medical unit with new supplies for his harm reduction point. The guard reportedly locked the

volunteer in an isolated cell for several hours. He was released only after the head of the medical unit was informed. When questioned, the guard, who was newly hired, said he did not know about the project and assumed the volunteer was involved in illegal activities.

Pintilei added that such instances are rare. However, she said, they would likely be more common in the absence of extensive and ongoing training for both staff and prisoners. She said she was increasingly concerned about the impact of recent cutbacks in trainings, due to funding constraints, on the project's ability to provide both staff and prisoners with as much information and support as possible.

When financing was better, Pintilei said, "we had up to four trainings a month, maybe, in each facility—two for prisoners and two for employees." With funding shortfalls forcing decreases in training, some of the prisoners have been complaining about the lack of specialized support. "The state-provided psychologists and social workers in prison tend to focus on general issues regarding health and well-being, but the project psychologists and social workers have always focused on issues specifically related to drug use and HIV," she added.[80]

One casualty of funding problems has been the NGO's service focusing on preparing drug dependent and HIV-positive prisoners for release. According to Pintilei, "the consultants offered advice on how to establish social connections with relatives, to interact with others, find housing, and make connections with harm reduction projects outside if necessary. We invited all prisoners to participate, but indicated that the services would be particularly useful for people who use drugs and people with HIV."[81]

5.2 Funding Constraints

As noted, funding levels have been insufficient to provide all services and all the trainings that are needed. Liliana Gherman at Soros Foundation-Moldova acknowledged that it is "difficult to raise funds in and for Moldova" in addition to the funds provided by the Global Fund.[82] She noted that the Department of Penitentiary Institutions, despite a severe lack of funding for its activities, is co-funding harm reduction activities and has made a US$5,000 contribution. In 2008, Soros Foundation–Moldova provided some additional funds of its own to IPP for a training for penitentiary staff, and funded two evaluations of the substitution treatment program in Moldova, including in prisons.[83]

According to Pintilei, the budget deficit for 2008 amounted to approximately $14,000.

One outcome of the funding deficit is that the NGO was forced to put on hold plans to expand the project to additional prisons. Pintilei added that in the meantime, "We never will stop the project...although we do worry about having to decrease volume, in terms of some services."

The availability of "core" materials—condoms, syringes, needles, and other safer-injection items—has not changed, though it will be important to ensure that razor blades will become available to prisoners again soon.

The NGO regularly faces requests and pleas for additional assistance from both prisoners and prison officials, including for nutritional supplies for HIV-positive prisoners, especially those who do not receive supplementary food from relatives or friends on the outside.

Igor Jalba, the head of the medical unit at Pruncul prison, said his facility was in great need of additional vitamins, razor blades, and medicines to treat liver conditions. He said that budget cuts in the penitentiary health system had greatly reduced the quantity of such medicines, which were commonly needed by prisoners due to the high prevalence of hepatitis C.[84]

Expansion to Pretrial Detention Facilities

Additional funding will also be needed to expand the project to pretrial detention facilities. This will raise additional challenges, as the project relies on volunteers who often work for it for years. Rapid turnover of prisoners in pretrial detention facilities, as well as the particular conditions in these facilities, mean that the project will have to devise innovative ways of delivering its services. Despite some initial reservations, both Trofim and Pintilei were open to expanding the project to pretrial detention facilities, provided additional funding could be secured. In particular, they acknowledged that some of the project's activities, such as providing trainings for staff and detainees and undertaking a survey of HIV prevalence, risk behaviors, and detainees' knowledge, attitudes and needs with regard to HIV and other infectious diseases, could and should start soon. As Trofim said, "now is a good time to start this," and this was confirmed by the fact that the director of the pretrial detention facility in Beltsi, Tudor Pascaru, said that he would welcome the project's activities in his facility.

Limitations on Data Collection

As noted by the head of the medical unit in Branesti, Nicolae Bodrug, one negative element of the peer-to-peer approach is that it limits project administrators' ability to collect certain kinds of data. He noted, for example, that the strict confidentiality policy precludes more precise determination of the number of people who inject drugs in a prison. "We can only make a slight estimation based on the number of syringes distributed," he said. Bodrug added, however, that such a limitation should be accepted as is. The important thing, he said, is to "diminish risk and improve prisoners' health, not to collect exact information as to the number of prisoners who use drugs."[85]

Expanding Methadone in Prisons and Pretrial Detention Facilities

As discussed in greater detail in Box 4, methadone has more recently become available in some prisons in Moldova, complementing the harm reduction services provided and offering another important alternative to prisoners with severe opioid dependence to decrease their risk of contracting HIV, hepatitis C, and other infections, and to achieve other positive outcomes. International recommendations urge prison systems to make both needle and syringe programs and other harm reduction interventions, including methadone, available to all prisoners in need.[86] Those interviewed for this study agreed that greater access to methadone in prisons in Moldova and outside is needed, and that increasing the number of prisoners on methadone would benefit not only individual prisoners, but also lead to a better environment in the prisons. Another challenge will be to ensure that people on methadone in the community can continue treatment in pretrial detention facilities. Because of the many positive developments in the Department of Penitentiary Institutions in recent years, and the great leadership provided by its senior staff, now would be a good time to plan for the needed expansion and scale up, and to secure the necessary funding.

BOX 4.
Methadone Treatment for Drug-dependent Prisoners

Moldova initiated methadone treatment in October 2004 and was the first among the countries of the former Soviet Union to introduce methadone in penitentiary institutions in July 2005.

The benefits of providing methadone treatment (also known as opiate substitution treatment or OST) in prisons have been well documented.[i] International organizations, including the United Nations Office of Drugs and Crime (UNODC), the World Health Organization, and UNAIDS have recommended that "[p]rison authorities in countries in which OST is available in the community should introduce OST programmes urgently and expand implementation to scale as soon as possible."[ii]

According to Victor Vovc the recently appointed head of medical services in the national Department of Penitentiary Institutions, on October 1, 2008, 40 prisoners were enrolled in methadone treatment in prisons in Moldova, compared to 22 prisoners in August 2007.[iii] A cumulative total of 120 prisoners have received methadone while incarcerated since the program began in 2005.

Vovc said that the number of prisoners benefiting from the program has been increasing slowly since eligibility criteria have been relaxed and the program has been expanded to a greater number of facilities, including the women's prison in Rusca.[iv]

History of the Methadone Program in Prison

The first step toward methadone in prisons began in 2003, when staff from Soros Foundation–Moldova approached the Department of Penitentiary Institutions about initiating methadone in prisons at the same time, or shortly after, its introduction in the community in Moldova. Among other things, foundation staff pointed to the success of IPP's harm reduction project and suggested that methadone would complement that project's efforts by providing even more options for prisoners seeking to limit drug use-related risks to their health.

The department agreed in principle, but said that decision makers needed more information about how such a program might operate. In May 2004, Vladimir Tsaranu, then head of medical services in the department, together with Vladimir Trofim, the department's director general, and Dumitru Laticevschi,[v] went on a study tour to Canada, funded by OSI's International Harm Reduction Development Program and organized by the Canadian HIV/AIDS Legal Network. They visited OST programs in several prisons and in the community, spent time with the experts who had designed and implemented the prison system's OST program, and spoke to prisoners on OST. They also met with prison staff who said that, while they had initially been skeptical about the program, they now fully supported it,

having seen the positive impact it has not only on the health of prisoners, but also on the prison environment. Tsaranu also had an opportunity to meet expert consultants from the Netherlands who toured several Moldovan prisons with him and other colleagues.

Shortly after the visit to Canada, the program received the green light from all relevant government officials. Before leaving Canada, Trofim had said to his Canadian colleagues that he had been convinced of the benefits of the program, and would start it as soon as possible in his prisons. Tsaranu's department explained the program to prison administrators and staff, notably those from local medical units (which would be in charge of administering methadone). Leaflets about the program, with particular focus on the health benefits of methadone treatment, were then distributed throughout several prisons. Potentially eligible prisoners were urged to apply to participate in the program.

The criteria for inclusion, inside and outside prisons, initially were very strict, severely limiting access to the program. They included the following: 1) drug dependent for at least two years, with injecting being the main method of drug delivery; 2) HIV-positive; 3) on ART; and 4) clear evidence of the individual's strong desire to participate and, especially, to stop using drugs. A prisoner could meet the fourth criterion by, for example, writing a letter to prison administrators stating how and why drug use had caused destruction and havoc in his life.

A total of 10 prisoners applied during the initial application period. In July 2005, four of them were selected by a special commission comprising penitentiary system administrators. At the beginning, the four participants were isolated at a special prison hospital so officials could monitor the program closely. Within a year, however, medical staff at individual prisons were given responsibility for administering methadone on-site.

Admission criteria have since been relaxed, and an evaluation undertaken by an international expert documented other positive developments that have led to increased access to, and quality of, methadone treatment in prisons.[vi] The main document which regulates methadone in Moldova, "The Order of the Ministry of Health on the OST" (2003), was modified in 2008. In order to be included in the methadone treatment program, now only the informed consent of a patient with opioid dependence is required. Patients must be 18 years or older. HIV, TB, and hepatitis C are additional indications for methadone treatment.[vii] Among the most important other positive developments is the possibility to continue methadone with maintenance doses in prisons beyond six months. Previously, patients had to gradually reduce their methadone dose during a period of six months.[viii]

Despite the positive changes, the overall number of prisoners in the methadone treatment program remains very low. Victor Vovc noted that, while it was initially hard to convince prison directors of the need to start OST at their institutions, "this has changed and staff are now more tolerant and understanding."[ix] He added:

"Today, many chiefs of prisons would like to open an OST program in their prisons. We have all seen the good results. Prisoners now also know the program and many are eager and willing to start the treatment." One of the people who witnessed the positive results of the program is Constantin Birca, who has been responsible for the program at prison #15 in Cricova since 2007. According to him, "the program should have been introduced a long time ago. Many problems have decreased for us. Prisoners on methadone are doing much better and they are much more disciplined—not always seeking to find drugs as before, but really trying to get well."[x]

Prisoners on methadone who spoke with one of the researchers semi-privately[xi] discussed at great lengths the positive impact the treatment has on their health and general well-being. One prisoner, who is living with HIV, said: "Before I started [the treatment], I was in the medical unit most of the time. Now I am well." Another said: "I used to be nervous, unstable, always thinking about how to get drugs. Now I am more quiet and confident, and able to make the right decisions for myself and think about the future." A third prisoner added: "Methadone treatment is a big relief. I can concentrate on my needs now, not only on drug use as before. My mother, my brothers and sisters, are all very happy, and I know I will be able to help them when I will be released, rather than being a burden all the time."

Challenges and Obstacles

The current and former heads of medical services in the national Department of Penitentiary Institutions acknowledged that there have been numerous challenges since the program began. Among them are the following:

Limited Availability of Methadone Treatment in the Community Outside Prisons

Despite a recent marked increase in patients on methadone in the community (from 17 in July 2007 to around 140 in August 2008) and despite many other substantial improvements to methadone provision in Moldova,[xii] the overall coverage in the country remains very low, with less than one percent of the estimated number of people who inject opioids on methadone. As of August 2008, methadone programs were available only in the capital, Chisinau, and in one other major center, Balti.

While the Ministry of Health and Department of Penitentiary Institutions offer separate methadone programs, limited access to methadone in the community affects access to, and continuation of, methadone in prisons. The heads of medical services and their staff have worked closely with the Ministry of Health to ensure that prisoners on methadone are automatically eligible for programs outside of prison once they are released. "We work hard to ensure continuity of treatment. We give them [prisoners on methadone about to be released] a certificate specifying their dose and they can be on a program outside within one hour of their release,"[xiii] said

Birca. "If problems arise we resolve them working with our colleagues in community programs. But prisoners who are not from Chisinau or Balti have a problem."

Continued Limited Methadone Availability in Penitentiary Institutions

Everyone agreed that there was a need to vastly increase the number of treatment places and to increase the number of institutions with a methadone treatment program: prisoners and staff in prisons with an existing methadone treatment program said that many other prisoners would like to be on the program; prisoners or staff in prisons without a methadone program said it was time that the program be expanded to include their institution; and the international expert who evaluated the methadone program in Moldova also called for greater access.[xiv]

Another priority should be to make the program available in at least some of the pretrial detention facilities and to ensure that detainees who are on methadone treatment at the time of their arrest and pretrial detention can continue the treatment without interruption. Unassisted withdrawal from methadone constitutes cruel and unusual punishment, and patients who are not able to continue treatment upon detention often return to injecting drug use.[xv] During the visit to the pretrial detention facility in Balti, one of the researchers had a semi-private interview with a detainee living with HIV who had been a client of a methadone program on the outside. He had been transferred to the facility the day before and was starting to experience withdrawal from methadone; the detainee was in a panic and asked for help. Clearly, he should have been able to continue his treatment without interruption.

Opposition from Other Government Officials

According to Tsaranu, one major early problem stemmed directly from the easy and regular availability of media originating from Russia, where methadone treatment is banned. It is difficult for Moldovans—nearly all of whom speak Russian—to avoid anti-methadone stories that regularly appear in Russian media outlets. Tsaranu said that such stories greatly influenced the Moldovan Ministry of Justice, whose strong opposition to methadone was only overcome by successful advocacy by the Ministry of Health. Justice officials eventually were ordered to accept the legal use of methadone to treat drug dependence. The main battle, Tsaranu said, was fought by the Ministry of Health as it sought permission to launch OST through the main healthcare system. The battle had largely been won by the time the Department of Penitentiary Institutions became involved.

Diversion of Methadone

Both the current and former heads of medical services in the Department of Penitentiary Institutions said there had initially been concerns about diversion of methadone. Tsaranu spoke of prisoners in the methadone program attempting to

bribe medical personnel so they could take the methadone to prisoners not in the program. He also mentioned instances when participants had been forced by other prisoners to vomit upon returning from drinking their daily methadone dose. The vomit would then be dried by another prisoner, who would ingest the remains.

Tsaranu and Vovc however reported that these concerns had been successfully addressed, following the example of other prison systems with methadone programs.[xvi] Methadone is now administered under strict supervision, in the presence of three people observing the intake: a doctor, a medical assistant, and a security guard. Clients also have to stay for at least 10 minutes after drinking their dose, and are asked to speak to ensure they swallow their dose. Vovc added that another reason why diversion is no longer an issue is that, as soon as there are several people on the methadone program in a particular prison, the group auto-regulates itself and its members protect themselves. "If someone is pressured by another prisoner, the group protects him. If the group cannot manage the problem, it informs the medical personnel and we help the person. This works well and diversion is no longer an issue."[xvii]

Supply Limitations

Methadone is kept in the prison's pharmacies where there is an alarm and a safe to securely store the methadone. The program's guidelines stipulate that local prison authorities can have on hand a maximum of 10 days' supply of methadone at any given time. That rule was imposed, according to Tsaranu, because methadone remains technically illegal in Moldova and is officially considered a dangerous narcotic. The rule is a hassle, he added, because it can be hard to move supplies around the country so frequently on a regular basis. He said he hoped it would be possible for the policy to be relaxed once the program becomes more entrenched and key people are more accustomed to it, especially opponents in law enforcement agencies.

Notes

i. Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. *Lancet Infectious Diseases* 2009; 9: 57-66; WHO, UNODC, UNAIDS. *Interventions to Address HIV in Prisons: Drug Dependence Treatments. Evidence for Action Technical Papers*. At www.who.int/hiv/idu/prison/en/index.html or www.unodc.org/unodc/en/hiv-aids/publications.html.

ii. Ibid.

iii. The interview with Vovc was conducted on October 30, 2008.

iv. Since the program was first introduced in colony #16 in 2005, as of October 2008, it had become available in another four facilities: prison colonies 6, 7, 15, and 18.

v. A health professional who, working in various positions over the years, greatly contributed to the establishment of various health programs in prisons in Moldova, and now is portfolio manager for the GFATM in Geneva.

vi. Subata E. *Evaluation of Opioid Substitution Therapy in the Republic of Moldova*. Vilnius: Vilnius Centre for Addictive Disorders, 2008.

vii. Ibid.

viii. Ibid.

ix. Interview with Victor Vovc, October 30, 2008.

x. Interview in Cricova, October 30, 2008.

xi. In the presence of only the interpreters and other prisoners on methadone.

xii. Subata, supra, note 6.

xiii. Interview in Cricova, October 30, 2008.

xiv. Ibid.

xv. WHO, UNODC, UNAIDS, supra, note 1, with reference to Gruer L, Macleod J (1997). Interruption of methadone treatment by imprisonment [letter]. *British Medical Journal*, 314: 1691; Shewan D, Gemmell M, Davies JB (1994). Behavioural change amongst drug injectors in Scottish prisons. Soc Sci Med, 39(11): 1585–1586.

xvi. Canadian HIV/AIDS Legal Network. Opioid Substitution Therapy in Prisons: Reviewing the Evidence. Toronto, 2008. Available in English at http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=163 and in Russian at http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=164.

xvii. Interview with Victor Vovc, October 30, 2008.

6. Advice from Program Implementers

Over the last ten years, Moldova has shown that comprehensive harm reduction services and methadone programs can successfully be implemented in prisons, even in a resource-poor country. While challenges remain, the work undertaken by the Department of Penitentiary Institutions, the NGO, and others who made implementation of the programs possible, represents international best practice that can and should help and inspire other countries and their prison systems.

Staff at both the NGO and the Moldovan penitentiary system consistently expressed the view that the benefits of provision of comprehensive harm reduction services and methadone, for individual prisoners' health, for the prison system, and for public health, far outweigh concerns that, for example, needle exchange and condom distribution could promote illegal or immoral behavior. They pointed out that there is no evidence from Moldovan prisons that illegal drug use increased in the wake of the implementation of the needle and syringe program, and that it is impossible to completely stop illegal drugs from entering prisons or prisoners from using them. According to them, the "immoral" response is therefore one that denies prisoners the means to protect themselves from harm.

Several people interviewed for this report offered advice for individuals, organizations, and prison systems committed to following international recommendations by implementing comprehensive HIV programs in prisons, including needle and syringe programs and methadone maintenance treatment.

Below are some of those observations.

Vladimir Trofim, Department of Penitentiary Institutions[87]

- Advice for penitentiary officials: "The most important thing is to learn to take responsibility for the things you do. If your fate is to be a decision-maker, you should do it in the most realistic way possible. You must help people if you can. Helping them doesn't require a big technical background...just a commitment."
- Advice for NGOs: "Convince someone like myself, a government official in a decision-making post, of the merits and importance of your project. Often your ability to move forward can depend on the will of one person. Persistence is key. NGOs must not be afraid, especially if they have statistics that prove their case. For example, I was convinced by the results of the first anonymous survey done by the NGO in 1999. The extent and type of drug use in prisons were shocking to me, and I knew we had to do something very different in response."

Oleg Borduja, Cricova Prison Colony 15[88]

- "I'd advise prison medical staff, especially directors, to research and find numerous examples of the positive impact of harm reduction programs. The positive effect should be evident both in terms of the health of prisoners and safety of staff. Armed with this data, you can then explain why harm reduction leads to these outcomes. And don't forget that a person who is well-informed is well-protected."

Larisa Pintilei, Innovative Projects in Prisons[89]

- "My advice is for other NGOs, and it has several parts:

    1. Realize and accept that harm reduction must be done. This must be the first step.

    2. When you provide harm reduction services, you must ensure that as many people as possible have consistent and easy access to them.

3. If possible, approach and convince top-level officials at first. Our ability to do this is perhaps the single most important factor behind our success in covering the majority of facilities and reaching several thousand prisoners.

4. Provide training on an ongoing basis for administrative staff at all levels, from top to bottom. If possible, we regularly train prison staff at all our facilities. And we brief the senior administration of the penitentiary department on our activities, achievements and challenges on a regular basis. We even invited senior administration staff to international conferences on harm reduction so they could see for themselves what's being done elsewhere and what's possible.

5. Regularly monitor and evaluate your activities so that you can demonstrate that you are achieving good results.

6. Don't be afraid to start new initiatives—you will be successful! Good luck!"

Notes

1. Dolan J, Kite B, Aceijas C, Stimson GV. HIV in prison in low-income and middle-income countries. *Lancet Infectious Diseases* 2007; 7 : 32-43; WHO/UNODC/UNAIDS. *Evidence for Action Technical Papers - Interventions to Address HIV in Prisons. Comprehensive Review*. Geneva: WHO, 2007). At www.who.int/hiv/idu/prison/en/index.html.
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3. WHO/UNODC/UNAIDS. *Evidence for Action Technical Papers—Interventions to Address HIV in Prisons. Comprehensive Review*. Supra, note 1.
4. Taylor A et al. (1995). Outbreak of HIV infection in a Scottish prison. *British Medical Journal*, 310(6975): 289-292; Taylor A, Goldberg D (1996). Outbreak of HIV infection in a Scottish prison: why did it happen? *Canadian HIV/AIDS Policy & Law Newsletter*, 2(3): 13-14; Dolan K, Wodak A (1999). HIV transmission in a prison system in an Australian State. *Medical Journal of Australia*, 171(1): 14-17; MacDonald M (2005). *A Study of Health Care Provision, Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe*. Finland: Heuni; Bobrik, A., Danishevski, K., Eroshina, K., McKee, M. (2005). Prison health in Russia: the larger picture. *Journal of Public Health Policy*, 26: 30–59.
5. World Health Organization (1993). *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva: WHO (WHO/GPA/DIR/93.3).
6. For information about the extent to which drugs are being used in prisons around the world, see: Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. *Lancet Infectious Diseases* 2009; 9: 57-66; WHO/UNODC/UNAIDS. *Evidence for Action Technical Papers - Interventions to Address HIV in Prisons. Comprehensive Review*. Geneva: WHO, 2007). At www.who.int/hiv/idu/prison/en/index.html.
7. Calzavara L et al. (1997). *Understanding HIV-Related Risk Behaviour in Prisons: The Inmates' Perspective*. Toronto: HIV Social, Behavioural and Epidemiological Studies Unit, Faculty of Medicine, University of Toronto; Hughes RA (2003). Illicit drug and injecting equipment markets inside English prisons: a qualitative study. *Journal of Offender Rehabilitation*, 37(3/4): 47–64.
8. WHO, UNODC, UNAIDS, supra, note 1.

9. WHO, UNODC, UNAIDS. *Interventions to Address HIV in Prisons: Prevention of Sexual Transmission. Evidence for Action Technical Papers.* At www.who.int/hiv/idu/prison/en/index.html or www.unodc.org/unodc/en/hiv-aids/publications.html.

10. Kyrgyzstan initiated a pilot prison needle and syringe program in October 2002 and has since vastly scaled up access to harm reduction measures in its prisons. See: Lines R et al. *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*. Toronto: Canadian HIV/AIDS Legal Network, 2005. At http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=184 (English version) or http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=186 (Russian version); Wolfe D. *Pointing the Way: Harm Reduction in Kyrgyz Republik*. Bishkek: Harm Reduction Association of Kyrgyzstan "Partners' network", 2005. Available in Russian and English at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/pointing_20050523

11. UNODC, WHO, UNAIDS. *HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response*. United Nations: New York & Vienna, 2006, Available in English, Russian, and other languages at www.unodc.org/unodc/en/hiv-aids/publications.html; WHO. *Health in Prisons. A Guide to the Essentials in Prison Health*. WHO Europe: Copenhagen, 2007. Available in English and Russian at http://www.euro.who.int/InformationSources/Publications/Catalogue/20070521_1; UNODC, WHO, UNAIDS. HIV and AIDS in places of detention. A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings. United Nations: New York & Vienna, 2008. Available at http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf.

12. Although the Department of Penitentiary Institutions is providing some co-funding, harm reduction programs have continued to be funded predominantly by donors, including the Open Society Institute, Soros Foundation–Moldova, the World Bank, the Swedish International Development Cooperation Agency and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

13. Interview in Chisinau, August 20, 2007.

14. UNAIDS Moldova—Best practices: Prevention of HIV/AIDS in Prisons. At http://www.aids.md/information/best-practices/prevention-hiv-aids-prisons/ (accessed May 28, 2009).

15. In 1996, an outbreak of syphilis occurred in one prison where over 50 new cases were documented. See UNAIDS Moldova, supra.

16. Interview in Chisinau, August 20, 2007.

17. Interview in Branesti, August 21, 2007.

18. In many other countries, prison regulations do not allow prisoners to have needles in their possession and these regulations need to be amended before needle and syringe programs can be introduced.

19. Lines et al., supra, note 10,

20. Interview in Branesti, August 21, 2007.

21. Interview in Cricova, October 30, 2008.

22. Correspondence between Larisa Pintilei and Rick Lines, dated May 13, 2003, cited in Lines et al, supra, note 10.

23. Interview in Chisinau, October 30, 2008.

24. Interview in Balti, October 31, 2008.

25. Available via the site of UNAIDS in Moldova, at http://www.aids.md/coordination/national-aids-program/.
26. Law number 23-XVI "On HIV/AIDS Infection Prevention" adopted by the Parliament of the Republic of Moldova on February 16, 2007, and published in the official law register *Monitorul Oficial* on April 20, 2007. Available in English and Russian at http://www.aids.md/information/library/d1084/ (accessed on January 13, 2009).
27. The Global Fund has provided support for HIV/AIDS and harm reduction activities in Moldova, through the Ministry of Health, since issuing a five-year HIV/TB grant in 2003. A total of US$11.7 million was disbursed through the grant. The Global Fund approved a subsequent grant of $6.4 million for 2008 and 2009. As of May 2009, the Global Fund had approved a new proposal from Moldova for $22.1 million, and the grant will be presented to the Global Fund board for funding approval when funds are available. Additional information may be found at http://www.theglobalfund.org/programs/country/?countryid=MOL&lang=en (accessed May 28, 2009).
28. Interview in Rusca, August 23, 2007.
29. Interview in Rusca, August 23, 2007.
30. Ibid.
31. Interview in Branesti, August 21, 2007.
32. Interview in Cricova, August 20, 2007.
33. Interview in Cricova, October 30, 2008.
34. Interview in Cricova, October 30, 2008.
35. Subata E. Evaluation of Methadone Maintenance Therapy in the Republic of Moldova. Vilnius: Vilnius Centre for Addictive Disorders, 2007, with reference to WHO, *HIV/AIDS in Europe. Moving from the death sentence to chronic disease management*. Edited by: Matic S., Lazarus J.V., Donoghoe M.C. WHO Regional Office for Europe, 2006. See also the 2008 follow-up evaluation: Subata E. Evaluation of Opioid Substitution Therapy in the Republic of Moldova. Vilnius: Vilnius Centre for Addictive Disorders, 2008.
36. UNAIDS Moldova. New HIV cases per year.
37. Ibid.
38. *Annual Report 2007. Drug Situation in the Republic of Moldova*. Chisinau: Ministry of Health, National Centre of Health Management, Monitoring and Evaluation of National Health Programmes, National Drug Observatory, 2007. At http://www.observator.mednet.md/eng/documente/pub_nationale/ (accessed January 13, 2008). See also the Moldova country overview of the European Monitoring Centre for Drugs and Drug Addiction: http://www.emcdda.europa.eu/publications/country-overviews/md (accessed January 13, 2008).
39. Interview in Chisinau, August 22, 2007.
40. Interview with Victor Vovc at the Department of Penitentiary Institutions, October 30, 2008.
41. Interview in Cricova, August 24, 2007.
42. Interview in Chisinau, August 22, 2007.
43. Macalino GE et al. Hepatitis C infection and incarcerated populations. *International Journal of Drug Policy* 2004; 15: 103–114.

44. Interview with Gheorghe Chirila, director of the Rusca prison, August 23, 2007.
45. The only effective treatment for hepatitis C is a combination of two expensive drugs, interferon and ribavirin. The high costs of these drugs limit access to them in all but the wealthiest countries in the world.
46. Interview with Victor Vovc, supra.
47. Interview with Oleg Borduja, head of the medical unit at Cricova #15 prison, August 24, 2007.
48. Interview in Cricova, August 20, 2007.
49. Interview with Nataliya Cioran in Rusca, August 23, 2007.
50. WHO, UNODC, UNAIDS, Comprehensive review, supra, note 1. This review reports that sharing of razor blades is common in prisons in developing countries and countries in transition, such as in Zambia, where 63% of 1,566 prisoners reported sharing razor blades, and in Thailand and Armenia (22.6%).
51. WHO, UNODC, UNAIDS. *Interventions to Address HIV in Prisons: Needle and syringe programmes and decontamination strategies. Evidence for Action Technical Papers.* Geneva: WHO, 2007 (at www.who.int/hiv/idu/prison/en/index.html or www.unodc.org/unodc/en/hiv-aids/publications.html), with reference to Heinemann A, Gross U (2001). Prevention of blood-borne virus infections among drug users in an open prison by vending machines. *Sucht* 2001; 47(1): 57–65.
52. Interview in Chisinau, August 22, 2007.
53. Interview in Rusca, August 23, 2007.
54. Email correspondence from Larisa Pintilei, dated November 6, 2008.
55. Interview in Chisinau, October 30, 2008.
56. WHO, UNODC, UNAIDS. *Interventions to Address HIV in Prisons: Needle and syringe programmes and decontamination strategies.* Supra
57. Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. Supra, note 6.
58. Ibid.
59. Ibid.
60. Ibid.
61. Interview in Branesti, August 21, 2007.
62. Interview in Pruncul, August 22, 2007.
63. Interview in Rusca, August 23, 2007.
64. Interview in Cricova, August 24, 2007.
65. In a 2004 survey, 98.4 percent of 124 respondents (prisoners who inject drugs in prisons with needle and syringe programs) reported that they had easy access to clean injecting material when they need it, 94 percent reported never having shared injecting equipment in the last month, and only 4 percent reported sharing at their most recent injection. See: HIV/AIDS Surveillance Moldova 2004. Injecting drug users, commercial sex workers, inmates. Chisinau: Editura "Tehnica-Info", 2004. Available via the UNAIDS Moldova website at http://www.aids.md/information/library/d73/ (accessed January 14, 2009).

66. Subata, supra.
67. Interview in Rusca, August 23, 2007.
68. Ibid.
69. Interview in Cricova, August 24, 2007.
70. Ibid.
71. Interview in Cricova, August 24, 2007.
72. WHO, UNODC, UNAIDS. *Interventions to Address HIV in Prisons: Needle and syringe programmes and decontamination strategies. Evidence for Action Technical Papers*. Supra.
73. Lines et al., supra, note 10.
74. Interview in Chisinau, August 22, 2007.
75. Interview in Chisinau, August 20, 2007.
76. Ibid.
77. Ibid.
78. Ibid.
79. Interview in Chisinau, August 22, 2007.
80. Ibid.
81. Ibid.
82. Interview with Liliana Gherman, October 30, 2008.
83. See Subata.
84. Interview in Pruncul, August 22, 2007.
85. Interview in Branesti, August 21, 2007.
86. UNODC, WHO, UNAIDS. *Evidence for action technical papers - Interventions to address HIV in prisons. Comprehensive review*. Supra, note 1; Jürgens, Ball, Verster, supra, note 6; and the documents cited supra, note XX. (UNODC, WHO, UNAIDS. *HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response*; WHO. *Health in Prisons. A Guide to the Essentials in Prison* Health; UNODC, WHO, UNAIDS. HIV and AIDS in places of detention. A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings).
87. Interview in Chisinau, August 20, 2007.
88. Interview in Cricova, August 24, 2007.
89. Interview in Chisinau, August 24, 2007.

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