

PENAL REFORM INTERNATIONAL  
ROYAL NETHERLANDS TUBERCULOSIS FOUNDATION

HUMAN RIGHTS AND HEALTH IN PRISONS:

A REVIEW OF STRATEGY AND PRACTICE

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## CONTENTS

<b>Acknowledgments</b>	5
<b>Acronyms and Abbreviations</b>	6
<b>CHAPTER 1: CONTEXT</b>	8
<b>1. Introduction</b>	8
<b>2. Kazakhstan: Background</b>	10
<b>3. Moldova: Background</b>	12
<b>CHAPTER 2: GENERAL PRINCIPLES, POLICIES, STRATEGIES AND TOOLS</b>	13
<b>1. Principles of PRI/KNCV Approach</b>	13
<b>2. An Integrated Approach to Human Rights and Health in Prisons</b>	13
2.1 TB Epidemiology and Prisons	15
2.1.1 Prisons	16
2.1.2 Prisoners	16
<b>3. Reducing Overcrowding in Prisons</b>	17
3.1 Legislation	18
3.1.1 Pre-trial detention	18
3.1.2 Diversion from Prosecution	19
3.1.3 Sentencing: Non-custodial sanctions	19
3.1.4 Post-sentencing	21
3.2 Alternatives in Practice	22
3.3 Alternatives: One Model	23
<b>4. Management of Prisons based on a Human Rights Approach</b>	24
4.1 Strategic Planning: A Method	27
4.2 Why Strategic Planning?	27
4.3 What is Strategic Planning?	28
4.4 Strategic Management Cycle	30
4.4.1 The “Continuous Improvement” Cycle	31
4.5 Stages of the Strategic Planning Process in the Penal System	32
4.6 Strategic Planning Tables	33
4.7 Prison Management with Strategic Planning	36
<b>5. TB/HIV Control Strategies in Prisons</b>	37
5.1 Reasons of High Levels of TB in the Prison Population	38
5.2 DOTS Strategy	39
5.3 Goals of Tuberculosis Control Programmes	39
5.3.1 Early Diagnosis (Case-finding)	40
5.3.2 Effective Treatment	41
<b>6. Policies to be Considered in TB/HIV Control</b>	42
6.1 Decrease of Overcrowding in Prisons	43
6.2 Access to Early and Effective Diagnosis and Treatment	44
6.3 Standardised Treatment under DOT and Compliance to Treatment	44
6.4 Effective HIV Control in Prisons	46
6.4.1 HIV Background	46
6.4.2 Impact of HIV in Prisons	47
6.5 Staff Management in Prison TB/HIV Control	48
6.6 Efficient Drug Management	49
6.7 Infection Control for Reduction of the Risk of Infection among Inmates,	

Visitors and Staff	50
6.7.1 Administrative Measures	51
6.7.2 Environmental Measures	51
6.7.3 Personal Respiratory Protection	51
6.7.4 Other Measures	52
6.8 Integration of Civilian and Prison Health Services	52
6.9 Increasing TB/HIV Awareness /Common Unhealthy Behavioural Patterns and Ways to Change Them	57
6.10 Monitoring and Evaluation of TB/HIV Control Programmes	58
6.11 Reviewing Legislation to Avoid Double Standards and Discrimination	58
<b>CHAPTER 3: KAZAKHSTAN: ACHIEVEMENTS</b>	60
<b>1. Prison Reform Programme</b>	60
1.1 Structural and Legislative Developments	60
1.2 Strategic Planning Training and Practice	62
1.3 Changes on the Ground	64
1.4 Public Monitoring of Places of Detention	71
<b>2. Alternatives Programme</b>	74
2.1 Structural and Legislative Outcomes	74
2.1.1 Parole (Early Conditional Release)	75
2.1.2 Sentencing	76
2.1.3 Diversion from Prosecution	76
2.2 Alternatives: Pilot Projects	79
<b>3. TB/HIV Management Programme</b>	82
3.1 DOTS Strategy	83
3.2 Early Case Finding	85
3.3 Effective Treatment	86
3.4 Standardised Treatment under DOT and Ensuring Compliance to Treatment	87
3.5 Staff Management	88
3.6 Double Standards	89
3.7 Integration of TB Services	90
3.8 Infection Control	92
3.9 HIV Control	92
3.10 Palliative Treatment	96
3.11 Legislation in TB/HIV Control	96
<b>CHAPTER 4: KAZAKSHTAN: PROCESS</b>	100
<b>1. Prison Reform Programme</b>	100
1.1 Pavlodar Project (1998-2000)	100
1.1.1 Training: Strategic Planning/Human Rights	100
1.1.2 Study Visit to Poland, 1999	100
1.1.3 Prison Refurbishment	100
1.2 Kazakhstan II Project (2000-2004)	101
1.2.1 Training: Strategic Planning/Human Rights	101
1.2.2 Study Visit to Poland, 2001	101
1.2.3 Training of Trainers and Advanced Training of Trainers	101
1.2.4 Dissemination of Training at National Level (Roll-out Programme)	101
1.3 Public Monitoring	102

1.4 Conclusions	103
<b>2. Alternatives Programme</b>	105
2.1 Alternatives Conference	105
2.2 Working Group on Alternatives	106
2.3 Key Legislative Changes	106
2.4 Piloting Alternatives	108
2.5 Public Awareness Raising	109
2.6 Conclusions	110
<b>3. TB/HIV Management Programme</b>	110
<b>4. Integration of Prison Reform and Health Interventions</b>	111
<b>CHAPTER 5: MOLDOVA</b>	113
<b>1. Prison Reform Programme</b>	113
1.1 Prison Reform Programme: Achievements	113
1.2 Prison Reform Programme: Process	114
<b>2. Alternatives Programme</b>	115
2.1 Community Service: Achievements	115
2.2 Community Service: Process	117
2.2.1 Legislative Framework	117
2.2.2 Public Awareness Activities	117
2.2.3 Piloting Community Service	117
2.2.4 Extension of Piloting	120
2.3 Probation System: Achievements	120
2.4 Probation System: Process	123
2.5 Mediation	124
<b>3. TB/HIV Control in Prisons</b>	125
3.1 TB/HIV Control: Achievements	125
3.2 Other Policies and Organisational Aspects of TB/HIV Control in Prisons of Moldova	128
3.3 Preparation for Release	128
3.4 TB Monitoring	129
<b>4. Integration of Prison Reform and Health Interventions</b>	130
<b>CHAPTER 6: KAZAKHSTAN: SUSTAINABILITY</b>	131
<b>1. Positive Factors</b>	131
<b>2. Main Concerns and Recommendations</b>	133
2.1 Prison Reform and Alternatives Programmes	133
2.2 TB/HIV Management Programme	138
<b>Bibliography</b>	143

## APPENDICES

1. Model of Strategic Planning Tables used for Prison Management in Kazakhstan
2. UN Manual Headings
3. SWOT Analysis on the Strategic Planning Element of the Project.

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## ACRONYMS AND ABBREVIATIONS

AFEW	AIDS Foundation East West
AIHA	American International Health Alliance
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCG	Bacille Calmette-Guérin (TB vaccination)
CEI	Criminal Executive Inspection
CL	Caritas Luxembourg
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DIZO	Disciplinary Segregation Cell (Distsiplinarnyi izoliator)
DOTS	Directly Observed Therapy Short-Course
DST	Drug Susceptibility Test
FCO	Foreign and Commonwealth Office of UK
GDF	Global Drug Facility
GFATM	Global Fund to Fight AIDS, TB & Malaria
GMP	Good Manufacturing Practices
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
ICCO	Interchurch Organisation for Development Cooperation
ICPS	International Centre for Prison Studies, King's College, University of London
IDA	International Development Association
IDU	Injecting Drug User
IRP	Institute for Penal Reform
KNCV	Royal Netherlands Tuberculosis Foundation
KUIS	Committee of the Criminal Executive System (Central Administration of the Penal System)
LQAS	Lot Quality Assurance System
MDR-TB	Multi-Drug Resistant Tuberculosis
MSH	Management Sciences for Health
NTP	National Tuberculosis Programme
Oblast'	Region (Region and oblast' are used to refer to the same geographical subdivision in this review)
OSCE	Organisation for Security and Co-operation in Europe
OSI	Open Society Institute
PAL	Practical Approach to Lung Health
PKT	Long-term punishment cell (Pomeshchenie Kamernogo Tipa)
PLWHA	People Living with HIV/AIDS
PRI	Penal Reform International
ShIZO	Short-term punishment cell (Shtrafnoi izoliator)
SIZO	Pre-trial detention establishment
SOH	Stichting Oecumenische Hulp (Dutch Interchurch Aid)
STI	Sexually Transmitted Infection
TB	Tuberculosis
UIS	Regional Administrative Unit of the Criminal Executive System
UNODC	UN Office for Drug Control and Crime Prevention
WHO	World Health Organisation

## **CHAPTER 1**

### **CONTEXT**

#### **1. INTRODUCTION**

The main part of this document is an outcome of the practical experiences of Penal Reform International (PRI) and Royal Netherlands Tuberculosis Foundation's (KNCV) programmes aiming to improve tuberculosis (TB)/HIV management and human rights in prisons. The focus is Kazakhstan, where the largest and longest running joint project was implemented (1998-2004). Brief information is given also about the programme in Moldova (2003-2006).

The rationale of adopting a joint strategy when dealing with penal reform and health in prisons is now accepted by an increasing number of stakeholders in the fields of prison health and criminal justice in the region.

There is growing recognition that:

- Health is an integral element of human rights in prisons;
- Improving prison conditions and developing a positive prison environment have a significant impact on the success of health interventions;
- An integrated approach to health and human rights is more cost effective in the long term, when compared to programmes focusing exclusively on health;
- Joint strategies lead to more sustainable change;
- Prison health is an integral part of public health, and improving prison health is crucial for the success of public health policies.

Nevertheless, many policy makers, experts and practitioners still perceive the two areas of health and human rights in prisons as separate issues, which hinders the development of effective and sustainable policies and programmes, aiming to achieve comprehensive improvements in either of these two areas. PRI and KNCV therefore believe that it is essential to broaden and strengthen the recognition of the need for an integrated approach to penal and prison health reform among decision makers and practitioners. It was felt that the best way to achieve this would be to demonstrate the success of a particular programme, which from the very beginning was developed on the basis of this understanding. The result is this review, which in many ways is a case study of the PRI/KNCV programme in Kazakhstan, with limited information on Moldova, though it begins by providing an overview of the general principles that have guided the programmes and the methods and tools that were used to implement them. These are applicable to any country with similar problems.

However, this document is not just a review of best practice. It includes information on the impressive achievements and the process of reaching them, but also highlights problem areas and new challenges. It is hoped that this approach, deriving from practice and experience in two particular countries, will be helpful to those who are trying to achieve lasting change in similar and difficult circumstances.

This review attempts to:

- Explain the overriding principles and rationale of PRI and KNCV's approach to penal reform and management of TB and HIV/AIDS in prisons;
- Provide an overview of internationally accepted principles, strategies, methods and tools relating to penal reform, TB and HIV/AIDS management in prisons, which have provided guidance for PRI/KNCV's programmes;
- Demonstrate the results of this approach in two countries, with similar problems, drawing attention to successes as well as weak points;
- Provide recommendations to address main challenges in Kazakhstan.

It is hoped that this will:

- Assist authorities and NGOs involved in penal reform in Kazakhstan and Moldova to strengthen their understanding of the main principles and approaches of the PRI/KNCV projects, in order to enable them to build on achievements;
- Complement the Manual on Strategic Planning<sup>1</sup> in trainings, to give information about the place of strategic planning in a wider penal reform and health context. Thus build the capacity of trainers and trainees in the area of penal reform and health in prisons;
- Introduce the concept of integrating human rights and health to achieve penal reform and a healthier society to a wide audience in Central Asia and beyond. This may help with the replication of the project, or elements of the project in other countries;
- Help convince authorities to adopt or improve the integrated approach to prison and civil healthcare;
- Provide accessible information to non-medical, as well as medical prison staff, on the principles of TB and HIV/AIDS management in prisons, within a broad penal reform context.

The primary target audience of the review comprise all persons and organisations involved in penal reform and prison health in the Central Asia region. They include policy makers, prison managers, medical and other prison personnel, managers of civil health services, members of civil society organisations, independent penal and prison health experts and others. However, it is felt that this document is relevant to decision makers and practitioners well beyond the region, as challenges encountered in this field in countries from different regions around the world bear many similarities. Thus it is hoped that the information provided in this document may have a positive impact on the development of more effective and sustainable penal and prison health reform strategies worldwide.

In preparing the review extensive use was made of a number of evaluations of the programme in Kazakhstan, undertaken by independent consultants. Recent data was

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<sup>1</sup> A separate training manual developed by PRI.



gathered, interviews and prison visits conducted during a mission in October 2005, by the authors of this document, which enabled a thorough and updated review of outcomes. Evaluation reports and recent information from PRI and KNCV's project partners have been used for information relating to Moldova.

The programmes have been implemented with the contribution of a variety of partners, taking responsibility for different activities. The main partners have always been and continue to be the Ministries of Justice and prison authorities (the Ministry of Interior, Kazakhstan, before the transfer of the prison administration to the responsibility of the Ministry of Justice on 1 January 2002) and National TB Centres in both countries, together with the Oblast TB Dispensaries in Kazakhstan. International Centre for Prison Studies, King's College London (ICPS) provided valuable expertise and training during the first phase of the project (Pavlodar Project, 1998-2000) and in the initial stage of the second phase (Kazakhstan II Project, 2000-2004). The prison service of Poland acted as close partner at various times, both by providing expertise for activities in Kazakhstan, and by hosting study visits by Kazakh prison service staff to Poland. Project Hope has contributed with training for the TB element of the Kazakhstan II project. Recently close partnership and a joint strategy has been developed with Aids Foundation East West (AFEW) in Kazakhstan. A considerable number of local NGOs in Kazakhstan have played a crucial role, Kazakhstan International Bureau for Human Rights and the Rule of Law, being a constant partner. In Moldova, Caritas Luxembourg (CL) and Institute for Penal Reform (IRP) are working in partnership with PRI/KNCV in the implementation of the health and human rights elements of the project respectively. The efforts of committed and enthusiastic individuals among senior and junior prison service personnel and civil society (e.g. members of monitoring committees and NGOs), who were often working in very difficult conditions, was essential for the success of the programmes.

Donors have also acted as partners, and are listed under the different programmes.

## **2. KAZAKHSTAN: BACKGROUND**

### **Prison Reform, Alternatives to Imprisonment and TB Control Programme**

#### **Pavlodar Project (1998-2000)**

PRI and KNCV first started working in Kazakhstan in 1998, following a request for assistance from the Pavlodar Oblast' prison authorities in combating the acute problem of TB in the oblast's prisons. Convinced that treatment of TB alone would not guarantee long-term success in reducing the rate of tuberculosis infection in prisons, PRI and KNCV decided to work in partnership, implementing a project involving TB prevention and treatment, staff training and improvement of physical conditions in prisons, based on strategic planning. The programme also aimed to achieve a reduction in the prison population by encouraging the use of alternatives to imprisonment.

The outcome of the project was intended to be a prison system, which had embarked willingly on a process of change, which would lead it eventually to achievement of international human rights standards. There was also a hope that the project in Pavlodar, which is a relatively small region within Kazakhstan, would become a model for prison reform in the rest of the country and the region.

## **Kazakhstan II Project (2000-2004)**

On the basis of the encouraging results of the Pavlodar project and following a request from the Committee of the Criminal Executive System (KUIS), a new project was implemented in three pilot oblasts (Akmola, East Kazakhstan and Karaganda) between 2000 and 2004, which expanded the positive changes that had already taken place. The project included staff training, alternatives to imprisonment and tuberculosis management, as its main components.

The training element included a series of training seminars on “Human Rights in Prison Management and Strategic Planning” for selected staff in the three pilot oblasts and the establishment of strategic planning teams at regional and colony level in these oblasts. At the same time training for medical personnel in pilot oblasts was conducted on international standards relating to medical services in prisons, DOTS and TB control, while assistance was provided for the establishment of a laboratory network. A training of national trainers and a roll-out programme started the process of prison staff training in the remaining ten oblasts of Kazakhstan. Project activities were undertaken in a way that increasingly strengthened the links between the two elements of the project, as well as between prison and civil healthcare services.

The Alternatives Programme complemented the prison staff training and TB management programmes, based on the understanding that penal and prison health reform efforts have little chance of success unless the problem of overcrowding is resolved.

Four public monitoring committees in Pavlodar, Akmola, East Kazakhstan and Karaganda oblasts were supported and trained to monitor conditions and TB control activities in the prisons of these oblasts. Such committees were completely new to Kazakhstan (although active human rights NGOs existed) and were based on the initiative of PRI and KNCV, starting with Pavlodar Oblast’ in 1998. The transparency of the prison system was increased not only through support given to monitoring committees, but also through a successful public awareness campaign.

## **Third Phase: 2004 – present**

The responsibility for continuing the programme has been handed over to KUIS, Ministry of Justice, Kazakhstan, together with recommendations for future implementation. PRI and KNCV continue to play a consultative role and to support initiatives by NGOs which are building on achievements. Due to a number of senior level changes in the Kazakhstan prison administration, since the project formally finished at the end of 2004, this latest phase has proven to be slow. However, progress continues to be made.

Funding for the programme has been received from the following:

## **Pavlodar Project (1998-2000)**

- The Ministry of Foreign Affairs of the Netherlands
- Stichting Oecumenische Hulp (SOH, Dutch Interchurch Aid)
- The Interchurch Organisation for Development Co-operation (ICCO)
- Caritas Netherlands.

## **Kazakhstan II Project (2000 – 2004)**

- Cordaid, the Netherlands
- ICCO
- The Ministry of Foreign Affairs of the Netherlands

## **3. MOLDOVA: BACKGROUND**

### **Strengthening Civil Society, Health and Human Rights in Prisons (2003-2006)**

Based on a partnership between the Luxembourg prison in Givenich and the prison in Pruncul, Moldova, the director of Givenich suggested collecting data on TB in the penitentiary institutions in Moldova. Medical Mission Institute Wurzburg was asked to perform an assessment mission in 1997. Based on the recommendations of this assessment Caritas Luxembourg managed a TB control pilot project in Moldova in Bender Tuberculosis and Pruncul Prison Hospitals over a period of two years.

As a follow up, ICCO asked KNCV to formulate a project proposal for tuberculosis control in prisons in Moldova. Since combining TB control with the introduction of international prison and human rights standards in the co-coordinated KNCV/PRI project in the Kazakhstan penitentiary system had proven to be more sustainable than TB control measures alone, it was decided to adopt a similar approach in Moldova. A joint project was developed, implemented by KNCV and PRI. The 3-year project started in 2003.

The project aims to:

- Contribute to the development of sustainable health conditions in prisons
- Create a continuum of care and support for prisoners with TB before and after release through the establishment of a functioning referral system between the prisons and the community; strengthen cooperation between the prison and civil health services, involving local NGOs;
- Decrease overcrowding by introducing alternatives measures to imprisonment;
- Assist with the introduction of international human rights standards in prisons;
- Enable one local NGO to take over the project after the defined project period, through systematic capacity building, and assist in facilitating cooperation between government institutions and NGOs.

The project is funded by ICCO and Cordaid.

## CHAPTER 2

### GENERAL PRINCIPLES, POLICIES, STRATEGIES AND TOOLS

#### 1. PRINCIPLES OF PRI/KNCV APPROACH

- Prison reform and management of TB, HIV/AIDS in prisons cannot be successful and sustainable if undertaken in isolation from each other, from the criminal justice system as a whole and from the public health policies and programme of any given country. All these issues are closely interconnected, making individual elements of a reform programme dependent on the success of the others. This simple reality forms the overriding principle of PRI and KNCV's approach to penal reform and prison health programmes.
- However, recognition of the simple reality leads to the need to adopt a comprehensive, interdisciplinary strategy, with far reaching goals. Successful implementation requires the participation of all key stakeholders, necessitating close collaboration between ministries, prison authorities, prison health services, civil health authorities, the judiciary, local authorities, NGOs and civil society as a whole. Joint action, led by a clear strategy, is essential for sustainable success. It also avoids duplication of projects and wastage of valuable resources.

#### 2. AN INTEGRATED APPROACH TO HUMAN RIGHTS AND HEALTH IN PRISONS

Human rights programmes on their own can be successful in selected areas, such as the transparency of the prison system, improving complaints procedures or providing legal assistance to prisoners, as long as they form part of an integrated strategy in terms of taking prisons as part of the whole criminal justice system and therefore aiming to make changes at policy level. But a comprehensive human rights programme would include the aim to improve prisoners' right to adequate health care. The effectiveness of such a programme would then be fundamentally increased if an integrated approach is adopted, including a medical element for the prevention, treatment and management of the main problem diseases in prisons, such as TB and HIV. This is also true of some projects with narrower focus, such as programmes to prepare prisoners for release or resettlement after release. A health element, ensuring uninterrupted treatment of TB and HIV, or assisting with the care of other physical or mental ailments, would constitute an essential component of such projects.

However, adopting an integrated approach (health and human rights) is important particularly when considered from the health perspective. In general health interventions on their own will achieve limited success, unless human rights issues are addressed at the same time. Therefore, it is particularly important for those who are designing health reform projects in prisons, such as TB and HIV management programmes, to adopt a strategy that includes the improvement of human rights in prisons and to ensure that activities strengthen interaction between medical services and others.

The reasons include the following:

- The clearest of all is the obvious impact a reduced prison population will have on prisoners' health, which can be achieved by increasing alternatives to prison and

rationalising criminal justice legislation. This point is discussed in detail under 2.1, 3 and 6.1 of this chapter.

- Addressing both health and human rights concerns as part of one programme is more cost effective and sustainable than developing a programme exclusively on the control of certain diseases, such as TB and HIV in prisons. This is because costly medical interventions will have limited effect, if basic conditions relating to prisoners' access to adequate food, space, light, sanitation, ventilation and heating remain unsatisfactory. By addressing these issues, which are components of the basic human rights of prisoners, prison authorities can eliminate the underlying factors leading to and increasing the transmission of infectious diseases in prisons. As a result, there will be fewer prisoners to treat and less medication necessary, which will be a continued situation, as long as satisfactory conditions are maintained. By providing adequate human rights conditions, governments will not only comply with their international obligations relating to prisoners' rights, but also make savings on prison health programmes.
- Improving human rights in prisons include the understanding of improving the climate in prisons by encouraging a positive atmosphere and humane relationship between staff and prisoners. A positive environment decreases the stress levels both on prisoners and on prison personnel. Less stress means less mental and psychological disturbances (of which both prisoners and prison personnel are at increased risk). The result is better mental health, which in turn has an impact on physical health.
- In many countries prison health workers see their role in a very narrow light, confined to treatment of sick prisoners. Their status is not high and they are strictly subordinated to the governors or regional/central administration prison directors. More involvement in planning on a wide range of issues (which relate to both human rights and health) can gradually change this situation, by giving them more responsibility for the creation of a healthy prison and eventually raising their status. This in turn, enables medical personnel to make a more effective contribution to prison health policies.
- International instruments oblige medical staff to use their professional expertise to inspect and report on all conditions, which may affect the health of prisoners (e.g. UN Standard Minimum Rules for the Treatment of Prisoners, Rule 26). Thus, medical workers should monitor the quality and quantity of food, ventilation, access to natural light, heating, sanitary arrangements, bedding, clothing and many other elements of life in prisons in order to make sure that prison conditions do not encourage disease. Projects emphasising and increasing medical staff's active involvement in monitoring and consulting prison directors will help ensure that conditions which create a healthier prison are constantly improved and maintained.
- In parallel, joint training of healthcare workers and staff from other services establishes the concept among all staff that the role of medical services in prisons should not be confined to the treatment of sick prisoners alone. It also makes clear that effective healthcare involves creating a healthy environment in the whole prison, which depends on many factors and the cooperation of all services.

Thus the link between health and human rights is underlined and cooperation between medical and other services strengthened.

Often the starting point for reform is a particular problem that is most visible. PRI and KNCV's programmes in Kazakhstan and Moldova began with the need to address the acute problem of TB in prisons. Recognising the above principles, in both cases projects were developed that integrated TB treatment and prevention in prisons with efforts to improve general prison management and human rights in these institutions and to influence broader penal reform policies.

Looking at the need for penal reform from the perspective of TB epidemiology is useful to understand the starting point of the integrated approach to health and human rights in prisons.

## **2.1. TB Epidemiology and Prisons**

TB is an infectious disease caused by the bacterium, Mycobacterium tuberculosis. TB can affect any organ of the body, but most commonly attacks the lungs.

TB is spread through the air by droplets produced by a person suffering from pulmonary TB by coughing, sneezing or speaking.<sup>2</sup> Patients who produce sputum in which the bacteria can be seen with a light microscope are the most infectious and are called 'smear positive'. So, the source of TB is not a building by itself (let us say a prison) or country or any human made boundary, because the real source of TB is the person suffering from pulmonary TB.

The risk of infection and the development of subsequent disease depend on three main factors:

1. Factors associated with the bacteria: the size of infecting dose, viability, transmissibility, virulence.
2. Factors associated with the host (person): length and intensity of exposure, strength of immune system (HIV infection, immunosuppressive treatment, hormonal disorders), etc.
3. Factors of the host-bacteria interaction: site of involvement.

It is estimated that after infection, only 10% of infected healthy individuals will develop active TB disease throughout their lifetime, the majority within the first two years after infection.<sup>3</sup> However, co-existing infection with the human immunodeficiency virus (HIV) significantly increases the chance of a person developing active TB. The lifetime risk of persons with HIV positive status developing TB is considered to be 50%<sup>4</sup>.

If a person with active TB is not identified and treated, then he/she might infect 10-20 persons during a year. But if this smear positive TB person is staying in an unventilated room for over 8 hours a day for a few months together with another 30 (or let us say 100) persons, then we have both risk factors – the size of infecting dose and the length and intensity of exposure. In this case we might expect that most of his/her colleagues in

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<sup>2</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.13

<sup>3</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.13

<sup>4</sup> TB/HIV: a clinical manual, WHO/HTM/TB/2004.329 p. 37

that unventilated room (30 or 100) will be infected with TB. Unfortunately unventilated and overcrowded rooms are almost a usual prison environment in many countries.

### **2.1.1 Prisons**

In this context, the term “prison” is used to mean any place of detention. The term therefore includes police detention centers, pre-trial centers (SIZOs), prison colonies, closed type prisons, and all closed institutions where people are deprived of their liberty.

Prisons are often the responsibility of several government ministries within a country, most usually the Ministries of Justice, Interior, Security or Defense. Each administration may have its own rules and regulations, security problems and medical services. There may also be different levels of government responsibility at federal, state or local levels. However, there may be little coordination among these ministries, although the same prisoners will pass through a number of different centers during the judicial process. Coordination might be difficult even within different units and services of the same jurisdiction (i.e. security service and educational service, or medical service of the penitentiary departments). Sometimes administrations may even be competing because of scarcity of resources or for political reasons.<sup>5</sup>

Regimens and conditions vary within and between countries and may have a significant impact on the health of prisoners and those charged with their care. Prisoners usually return to the society after serving their sentence, or earlier because of early release or amnesties. However there is often little collaboration between detaining authorities and the civilian sectors for health care delivery or social welfare.

### **2.1.2 Prisoners**

Prisoner populations are composed predominantly of men aged 15-44 years. There is usually an over-representation of vulnerable and marginalized groups of the civilian community<sup>6</sup>, such as substance abusers, homeless, ethnic minorities, illegal immigrants, mentally ill, orphans and the poor. These groups are already considered to have a high risk of TB infection and disease.

Living conditions inside prisons are often appalling. In all countries where resources are scarce, those considered “criminals” may become the lowest priority for funds. Prisoners are often housed in overcrowded facilities with inadequate heating and ventilation systems, and with low hygiene and sanitation. Food that is provided can be unappealing and nutritionally inadequate. Even if the food respects the minimal requirements of 2000 k.kal per day, it usually does not contain the minimal required amount of proteins or fresh vegetables and fruits. Health facilities may be weak or absent, or ‘paralyzed’ by security services. Unhealthy behaviour such as the use of alcohol/drugs, or unprotected sexual activities (with or without consent) usually are not reported to the administration and medical services.

As a result of poor living conditions inside prisons, many prisoners rely on assistance provided by family members outside the prison walls. Gambling, trading in drugs or other ‘commodities’, prostitution and violence are realities in many prisons world-wide

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<sup>5</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.16

<sup>6</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.17

and in some instances may be part of an internal system which prisoners use to obtain their basic needs. Given this background and conditions of incarceration, it should not be surprising that internal groups develop in prison, adapting the criminal social order to the closed environment. These unofficial rules and hierarchy may be extremely powerful and a prisoner's position in this hierarchy is crucial for access to basic needs and protection from violence. This includes his ability to access health care and therefore impacts on TB control. Prisoners are often very resentful of the society that imprisoned them and may have little respect for figures that represent it, including prison health staff. Behavioral norms and respect for others may not necessarily apply and should not be assumed. Unwritten norms and coded behaviour are not always apparent, but easily slighted or misunderstood by the unaware.

All the above exacerbate the outbreak of epidemic diseases, including TB and HIV.

Reducing the rate of incarceration through penal reform is fundamental to improve prison health. By decreasing overcrowding, transmission of infectious disease can be reduced, living conditions can be substantially improved and some of the violence and deterioration in mental health associated with prison relieved.<sup>7</sup> In addition fewer prisoners can mean greater resources to improve prison conditions both for prisoners and staff.

### **3. REDUCING OVERCROWDING IN PRISONS**

Overcrowding in prisons can be decreased either by building new prisons or by reducing the number of people staying in them. Practice shows that trying to overcome the harmful effects of prison overcrowding through the construction of new prisons does not provide a sustainable solution. Indeed, a number of European states have embarked on extensive programmes of prison building, only to find their prison populations rising in tandem with the increased capacity acquired by their prison estates.<sup>8</sup> In addition, building new prisons and maintaining them is expensive, putting pressure on valuable resources. Instead, numerous international instruments recommend a rationalization in sentencing policy, including the wider use of alternatives to prison, aiming to reduce the number of people being isolated from society for long periods

Council of Europe, Committee of Ministers Recommendation No. R (99) 22, 1999, Rules 2, 3 and 4

The extension of the prison estate should rather be an exceptional measure, as it is generally unlikely to offer a lasting solution to the problem of overcrowding. Countries whose prison capacity may be sufficient in overall terms but poorly adapted to local needs should try to achieve a more rational distribution of prison capacity.

Provision should be made for an appropriate array of community sanctions and measures, possibly graded in terms of relative severity; prosecutors and judges should be prompted to use them as widely as possible.

Member states should consider the possibility of decriminalising certain types of offence

<sup>7</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.18

<sup>8</sup> European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (CPT) standards, Extract from the 7<sup>th</sup> General Report [CPT/Inf (97) 10], p.21



or reclassifying them so that they do not attract penalties entailing the deprivation of liberty.

### 3.1 Legislation

The starting point is legislation. In undertaking legislative reforms care needs to be taken, however, to ensure that the changes lead to a reduction in prison sentences, rather than an increase in sentences overall (i.e. prison sentences, plus non-custodial sanctions, as has happened for example, in England and Wales – where prison sentences are also on the rise<sup>9</sup>).

In order to achieve a sustained reduction in the prison population, changes to existing criminal legislation should aim to reduce the use of pre-trial detention, decriminalize certain acts, provide shorter terms of imprisonment for selected crimes, introduce a wide range of non-custodial sentences as an alternative to prison for specific offences and to ease possibilities for parole (early conditional release).

In parallel, social, psychological and medical support mechanisms for offenders should be developed to assist with their reintegration into society and to reduce the rate of recidivism.

The following is a summary of the most frequently used legislative steps available to reduce the size of the prison population.

#### 3.1.1 Pre-trial detention

Although international instruments recommend minimal use of pre-trial detention<sup>10</sup>, in countries of Eastern Europe and Central Asia this measure is used widely. Pre-trial detention facilities (SIZOs) are often overcrowded and conditions are worse in comparison to prison colonies, despite the fact that pre-trial detainees should be presumed innocent.

A reduction in the number of pre-trial detainees can be achieved by:

- a. Prohibiting the use of pre-trial detention for certain offences;
- b. Removing the obligation for pre-trial detention for others;
- c. Introducing wider possibilities for bail;
- d. Imposing supervision or certain restrictions as an alternative;
- e. Setting strict time limits on pre-trial detention.

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<sup>9</sup> Developing Alternatives to Prison in Central and Eastern Europe and Central Asia. A Guidance Handbook, ICPS, Vivien Stern, May 2002, p. 22 (electronic version).

<sup>10</sup> E.g. Article 9 (3) of the International Covenant on Civil and Political Rights, Rule 6 of the UN Standard Minimum Rules for non-custodial Measures, Rule 11 of the Council of Europe, Committee of Ministers Recommendation No. R (99) 22.

Council of Europe, Committee of Ministers Recommendation No. R (99) 22, Rule 12

The widest possible use should be made of alternatives to pre-trial detention, such as the requirement of the suspected offender to reside at a specified address, a restriction on leaving or entering a specified place without authorization, the provision of bail or supervision.

### **3.1.2 Diversion from prosecution**

It is also possible to prevent a case coming to trial, during pre-trial stage, if reconciliation between victim and offender is achieved. Special mediation programmes are used for this purpose. In order for mediation to be initiated, the accused person must admit that he/she is guilty of the offence and both parties must agree to participate in the process. This procedure may then result in an agreement where the offender undertakes to compensate for the damage done, instead of being tried and sentenced.

### **3.1.3 Sentencing: Non-custodial sanctions**

International instruments recommend the availability of a wide range of non-custodial sanctions in criminal legislation, suitable for different types of offences, and applicable to the individual circumstances of each offender.

These include:<sup>11</sup>

1. Fines: Used widely. It has the disadvantage that many people cannot afford the fines prescribed;
2. Suspended sentences, (with or without supervision): A sentence is suspended for a specific length of time, during which the convicted person must not commit any further offences;
3. Deferred sentence: A decision is taken not to pass sentence on condition that the offender undertakes some action, such as undergoing treatment for alcoholism, drug addiction or receiving psychological counsel. Depending on the result, the offender may not receive a prison sentence;
4. Removal of certain rights: Restrictions are placed on certain rights, such as the right to take up certain types of employment, to occupy certain positions in government or to travel to certain places;
5. Limitation of freedom: The offender is obliged live in a certain place (normally his/her place of residence) under the supervision of a specialized agency. The offender cannot change place of residence, work or education, without permission of the supervising body;
6. Community service: The offender undertakes unpaid work, for the benefit of society. Community service is performed in addition to any employment the convicted person may already have;
7. Correctional work: A type of sentence widely used in the CIS countries. The offender continues to work in his existing place of employment, but is obliged to

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<sup>11</sup> Developing Alternatives to Prison in Central and Eastern Europe and Central Asia. A Guidance Handbook, ICPS, Vivien Stern, May 2002, pp. 17, 18 (electronic version).

pay a certain percentage of his/her salary to the state. (In Kazakhstan this is between 5% and 25%).

A number of international instruments prescribe the ethical, legal and executive framework in which non-custodial sanctions can be applied. An underlying principle with sanctions that oblige offenders to perform certain acts is that they require the offender's consent. This is particularly relevant in the case of community service sanctions. Precautions need to be taken in order to avoid any element of forced labour, which is prohibited by international law.

UN Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules), Rule 3.4

Non-custodial measures imposing an obligation on the offender, applied before or instead of formal proceedings or trial, shall require the offender's consent.

Council of Europe, Committee of Ministers Recommendation, No. R (92) 16, Rule 35

The consent of an accused person should be obtained before the imposition of any community measure to be applied before trial or instead of a decision on a sanction.

In fact, not only is the consent of offenders necessary, but their active participation in the decision process is desirable, as set out in Rule 34 of Council of Europe, Committee of Ministers Recommendation No. R (92) 16: "Since the implementation of a community sanction or measure shall be designed to secure the co-operation of the offender and to enable him to see the sanction as a just and reasonable reaction to the offence committed, the offender should participate, as far as possible, in decision-making matters of implementation".

Since abuse of human rights can occur in the implementation of sanctions, such as community service, that require a person to perform certain acts under supervision, it is vital that offenders have recourse to a formal complaints system, set out clearly in legislation.

UN Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules), Rules 3.6 and 3.7

The offender shall be entitled to make a request or complaint to a judicial or other competent independent authority on matters affecting his or her individual rights in the implementation of non-custodial measures.

Appropriate machinery shall be provided for the recourse and, if possible, redress of any grievance related to non-compliance with internationally recognized human rights.

### **3.1.4 Post-sentencing**

At the post-sentencing stage, the most common measures used to reduce overcrowding include amnesties and conditional release (parole). (Other dispositions include furlough and half-way houses, work or educational release, remission and pardons<sup>12</sup>). Amnesties

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<sup>12</sup> UN Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules), Rule 9.2

are not considered as a sustainable measure, as they only relieve overcrowding for a limited period. Often many of those released return to prison and the cycle continues.

When correctly targeted and applied, early conditional release is considered to be the best way with which to deal with prison overcrowding at post-sentencing stage. However, while increasing possibilities for early conditional release, it is important to establish/improve mechanisms that will help offenders reintegrate to society, in order to prevent recidivism and to increase the credibility of parole with the community.

It is also vital to ensure close coordination between prison and civil health services, so that prisoners being released can continue uninterrupted treatment for diseases such as TB, in order to reduce the risk of spreading them into society and to avoid the development of drug resistance.

Council of Europe, Committee of Ministers Recommendation No. R (99) 22, Rules 23, 24 and 25.

The development of measures should be promoted which reduce the actual length of the sentence served, by giving preference to individualized measures, such as early conditional release (parole), over collective measures for the management of prison overcrowding (amnesties, collective pardons).

Parole should be regarded as one of the most effective and constructive measures, which not only reduces the length of imprisonment but also contributes substantially to a planned return of the offender to the community.

In order to promote and expand the use of parole, best conditions for offender support, assistance and supervision in the community have to be created, not least with a view to prompting the competent judicial or administrative authorities to consider this measure as a valuable and responsible option.

### **3.2 Alternatives in Practice**

Legislation on its own, however, will not achieve a sustainable reduction in the prison population and will not receive the crucial support of judges and the public.

It is essential to ensure that mechanisms for implementation, organizational aspects, including a systemized cooperation between all agencies responsible for delivering and supervising the sanctions are developed; that cooperation with social and health services established to provide care and support for offenders, and that adequate supervision staff and training for staff involved provided. Clear rules and guidelines must be made available for all agencies involved.

UN Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules), Rule 22.1

Suitable mechanisms should be evolved at various levels to facilitate the establishment of linkages between services responsible for non-custodial measures, other branches of the criminal justice system, social development and welfare agencies, both governmental and non-governmental, in such fields as health, housing, education and labour, and the mass media.

Society at all levels must be involved in the introduction of alternatives. There should be adequate understanding and commitment at the highest levels, including ministries, the parliament and executive bodies. Judges' confidence in alternatives must be secured, by ensuring that legislation can be successfully put into practice. Additional advocacy activities should also be carried out to increase judges' knowledge about alternatives and to influence their sentencing tendencies.

If there is no public support, in time this will lead to the failure of implementation. If civil society is not involved in the introduction of alternatives, reintegration of offenders into society will prove to be difficult.<sup>13</sup> Indeed in a number of countries the role of NGOs during the introductory stage of alternatives has been invaluable (e.g. Kazakhstan, Moldova and Russia).

Finally, the importance of monitoring and evaluating the outcomes of increased use of non-custodial sanctions should not be disregarded. As recommended in by the Council of Europe<sup>14</sup>, research on the effects of community sanctions and measures should not be limited to the simple recording of post-supervision convictions, but should make use of more sensitive criteria. The information is crucial to understand the circumstances which lead to re-offending and to devise more effective programmes of reintegration. It is also important to have scientific data available, in order to be in a position to respond to public criticism and to manage crises, for example when individual failures draw widespread reaction (e.g. in the extreme possibility of a person serving an alternative sentence committing a grave offence).

A change in sentencing policy and increased use of alternatives to prison is not only necessary for the reduction of the prison population. It is a result and reflection of a fundamental change in the approach to crime, offenders and their place in society, changing the focus of penitentiary measures from punishment and isolation, to restorative justice and reintegration. When accompanied by adequate support for offenders, it assists some of the most vulnerable members of society to lead a life without having to relapse back in to criminal behaviour patterns. As noted by the Council of Europe, the implementation of penal sanctions within the community, rather than through a process of isolation from it, may well offer in the long term better protection for society, including the safeguarding of the interests of victims.<sup>15</sup>

### **3.3 Alternatives: One Model**

There is no prescribed model or strategy for the introduction of alternatives, though there is substantial international experience which can guide individual countries. Successful reform programmes relating to criminal legislation and the introduction of alternatives to prison have generally followed similar lines. Problems have been encountered when a number of issues mentioned above have not been adequately taken into account, for example the lack of sufficient attention given to the public opinion factor or to the establishment of clear mechanisms for implementation.

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<sup>13</sup> See Developing Alternatives to Prison in Central and Eastern Europe and Central Asia. A Guidance Handbook, ICPS, Vivien Stern, May 2002, pp. 25-28 for a detailed discussion of the need to involve society and secure public support.

<sup>14</sup> Council of Europe, Committee of Ministers Recommendation R (2000) 22, Rule, 26.

<sup>15</sup> Council of Europe, Committee of Ministers Recommendation R (92) 16, Preamble

The model PRI used in Kazakhstan to promote alternatives to prison included a number of steps that followed a logical path from legislation to practice. The process was based on international experience, taking into account national circumstances and being guided by recommendations developed by decision makers, experts and practitioners working in the field of penal reform in Kazakhstan.

1. It started a national debate on imprisonment and alternatives with an international conference in Almaty in 1999. The subsequent programme on alternatives was guided by the recommendations of that conference, to which both national and international experts had contributed. Thus, the alternatives programme was not imposed from outside, but developed as an integral part of the reform movement in Kazakhstan, taking into account the particular needs and problems in that country.
2. Based on the recommendations of the conference, PRI facilitated the formation of a national Working Group on Alternatives. The working group included the first Vice Minister of Justice, senior members from the upper house of parliament, the Chairman and Deputy Chairman of KUIS, a representative from the Prime Minister's office, Chair of the Criminal Committee of the Supreme Court, a Supreme Court judge, a representative from the police investigation branch, a senior prosecutor and head of the National TB Centre, as well as representatives from non-governmental organizations involved in criminal justice issues.
3. Following regular meetings, and study visits to Sweden, France and Germany, it formulated recommendations to bring changes to the Criminal, Criminal Procedure and Criminal Executive Codes. Over 50% of its recommendations were reflected in new codes adopted on 21 December 2002 (which came into force on 8 January 2003).
4. Five pilot projects on alternatives, managed by non-governmental organizations and supported by PRI, were selected by the Alternatives Working Group. Some of the achievements of these projects will help develop the practical implementation of non-custodial sanctions. Problem areas that have come to light as a result of the projects will need to be taken into account in improving the system.
5. Recognizing the crucial importance of influencing public opinion, PRI accompanied all these activities with a massive public awareness campaign on the harmful effects of imprisonment and the benefits of adopting a more humane and constructive approach to sentencing, with the use of alternative measures.

So, the possible main stages of a successful programme for the introduction of alternatives may be summarized as follows:<sup>16</sup>

- The setting up of a national, high-level working group, where a wide range of decision makers and stakeholders in the criminal justice system are represented;

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<sup>16</sup> Inspired by Developing Alternatives to Prison in Central and Eastern Europe and Central Asia. A Guidance Handbook, ICPS, Vivien Stern, May 2002, p.4 (electronic version)

- Work on legislation, ensuring that measures introduced take into account recommendations of international instruments, and that they are designed and targeted in a way that will really lead to a reduction in the prison population;
- Setting up of mechanisms and introduction of new methods of implementing and supervising alternatives, and clarifying these clearly in rules and regulations;
- Initiating pilot projects to evaluate the implementation of legislation and new methods and making adjustments, where necessary;
- Accompanying all these measures with a campaign to raise awareness in society and secure public support. Involving organizations of civil society at all stages.

#### **4. MANAGEMENT OF PRISONS BASED ON A HUMAN RIGHTS APPROACH**

While reducing the prison population will help alleviate many problems, in many countries there is also a need to ensure that a fundamental change takes place in prison management, transforming the underlying approach from that of a militaristic one, based on the notions of control and punishment, to one that takes respect for human rights as its basis and aims to facilitate the integration of offenders back into society.

Ensuring that human rights considerations are an integral part of management is not only a requirement of universally accepted standards, but is also the basis for creating an environment that is safe and healthy and a system that works efficiently on the basis of fairness and justice.

Basic principles, such as the obligation of prison authorities to provide prisoners with at least minimal humane living conditions, such as a bed, clean bed linen, adequate space, hygiene and sanitation facilities, nutritious food, enough fresh air, light, adequate contact with the outside world, useful occupation, fairness in disciplinary punishments, among others, are necessary from an ethical point of view. But they are also crucial to ensure that individuals in prison (who are often from marginalized or vulnerable groups of society) are able to maintain their human dignity, are not further damaged psychologically, leading to further loss of self-esteem, further marginalization and criminalization. Experience shows that prison managers cannot expect and receive positive behaviour and cooperation from prisoners, who are not justly treated.

The principle of starting the process of rehabilitation and reintegration of offenders in prison, for example by providing education and vocational training, or by the use of special programmes to help with alcohol and drug addiction, is also essential to reduce the likelihood of offenders returning to crime after release.

#### **UN Standard Minimum Rules for the Treatment of Prisoners, Rules 65 and 66(1)**

The treatment of persons sentenced to imprisonment or a similar measure shall have as its purpose, so far as the length of the sentence permits, to establish in them the will to lead law-abiding and self-supporting lives after their release and to fit them to do so. The treatment shall be such as will encourage their self-respect and develop their sense of responsibility.

To these ends, all appropriate means shall be used, including religious care in the countries where this is possible, education, vocational guidance and training, social casework, employment counseling, physical development and strengthening of moral

character, in accordance with the individual needs of each prisoner, taking account of his social and criminal history, his physical and mental capacities and aptitudes, his personal temperament, the length of his sentence and his prospects after release.

Bringing conditions in prisons closer to the requirements of international standards is vital also for the prevention of disease and the spread of infection, as described under sections relating to the management of TB and HIV/AIDS in prisons.

Indeed, UN Standards Minimum Rules for the Treatment of Prisoners underline prison authorities' obligation to ensure that a healthy environment is established in prison.

**UN Standard Minimum Rules, 10, 13, 20 (1)**

All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation.

Adequate bathing and shower installations shall be provided so that every prisoner may be enabled and required to have a bath or shower, at a temperature suitable to the climate, as frequently as necessary for general hygiene according to season and geographical region, but at least once a week in a temperate climate.

Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served.

International instruments also stress medical doctors' role, not only in treating the sick, but also in contributing to the maintenance of healthy prison conditions, as well as the prison administration's responsibility to respond to the medical officer's advice.

**UN Standard Minimum Rules 26 (1) and 26 (2)**

The medical officer shall regularly inspect and advise the director upon:

- (a) The quantity, quality, preparation and service of food;
- (b) The hygiene and cleanliness of the institution and the prisoners;
- (c) The sanitation, heating, lighting and ventilation of the institution;
- (d) The suitability and cleanliness of the prisoners' clothing and bedding;
- (e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

Achieving a transformation in attitude within prisons is a gradual process. Success depends on the level of staff participation in bringing about change and on the existence



of a clear vision towards which to progress. The vision is provided by international standards relating to prisons, but must be supported by a leadership that is clear about its aims and encourages reform. There is also a need for a coherent strategy, as reforms cannot be sustainable if they are undertaken in an ad-hoc manner.

#### 4.1 Strategic Planning: A Method

The method that PRI used in supporting reform efforts in the penitentiary system of Kazakhstan took all these considerations into account. Strategic planning was introduced as a vehicle to help bring prison colonies in four oblasts of Kazakhstan closer to the requirements of international standards.

Strategic planning, which is used widely in business, had already been used successfully to improve the management of prison systems in a number of countries by PRI's partner, ICPS. Strategic planning in prisons comprises the same concepts and stages as those in business, but it takes as its basis the implementation of international human rights standards in prisons. Strategic planning in Kazakhstan was based on UN Standard Minimum Rules for the Treatment of Prisoners and the training tool used by PRI and ICPS was the manual produced by the United Nations, Office of the High Commissioner for Human Rights, for prison staff training<sup>17</sup> (Henceforth referred to as the UN Manual). Before introducing strategic planning to Kazakhstan, recommendations and views of the managers of Kazakhstan's penal system were taken into account.

#### 4.2 Why Strategic Planning?

The aim of the project was to ensure that the concept of human rights was ingrained in the management of the penal system of Kazakhstan. It aspired to a conceptual change that permeated the very mechanism of the system, and therefore was effective and sustainable. This objective could not be achieved by merely conducting courses on human rights to prison staff. Often such courses, though useful to raise awareness and improve knowledge, can constitute a relatively abstract exercise, with little connection to the reality that staff faces each day in its prisons. Daily battles, for example, to acquire basic needs and deal with the rapid spread of disease, such as TB, may *seem* to override considerations of international human rights standards. Plans, however, are designed to be implemented. So, when human rights considerations are used as a basis for planning and when this is undertaken without losing sight of reality and available resources, then human rights standards are brought into prison, and made to work. Then it becomes apparent that many challenges that seemed to have little connection to international human rights standards are in fact all part of the same whole, and that solutions can be found, with guidance from those very standards and with strategic planning.

As a result, management improves as well - firstly, because the concept of strategic planning itself is designed to improve management, and secondly, because managing prisons on the basis of human rights strengthens efficiency.

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<sup>17</sup> United Nations, Office of the High Commissioner for Human Rights, Professional Training Series No. 8, Human Rights in Prisons, A Manual on Human Rights Training for Prison Officials

So the project started with the assumption that, if strategic planning were to be used on a national and continued basis, with regular staff training to match, it would assist the reform process in Kazakhstan to be easier, faster and more effective. As the concept of human rights also includes the right to proper healthcare and to healthy living conditions, the process of strategic planning was expected to have a significant impact on the success of the TB and HIV management programme. Savings would also be made on resources in the long term.

### 4.3 What is Strategic Planning?

Simply put, strategic planning involves setting goals (choosing a desired future) and developing an approach and actions to achieve those goals.

The concept of strategic planning implies managing, day to day and month to month, in a way that focuses on the most important decisions and actions. This requires the kind of longer term perspective and priorities which result from strategic thinking. This concept also incorporates the assumption that the environment is always changing: thus, strategic management requires ongoing reassessment of current plans in light of long term priorities. Therefore it is a dynamic process, which is implemented in concordance with the changing environment in which it must operate.

#### STRATEGIC PLANNING IS:<sup>18</sup>

The process of identifying and establishing a connection between the organisation and its environment, working towards reaching selected goals and the desired state of relationships with the environment by resource allocation, which allows the organisation and its branches to act effectively and efficiently.

The process of management aimed at implementing the organisation's mission by managing interaction between the organisation and its environment.

Key specifications of an organisation which develops a strategy include the following:

- Mission and values of the organisation;
- Resources and possibilities of the organisation, including its capability of finding pro-active solutions to problems (leadership) and its knowledge base (intellectual capital);
- Structure and systems of the organisation;

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<sup>18</sup> Popov, S.A., Strategicheskogo upravlenie: 17 modul'naia programma dlia menedzherov "Upravlenie razvitiem organizatsii".

- Strategic alliances and its inter-organisational networks (employees, partners);
- Culture of the organisation.

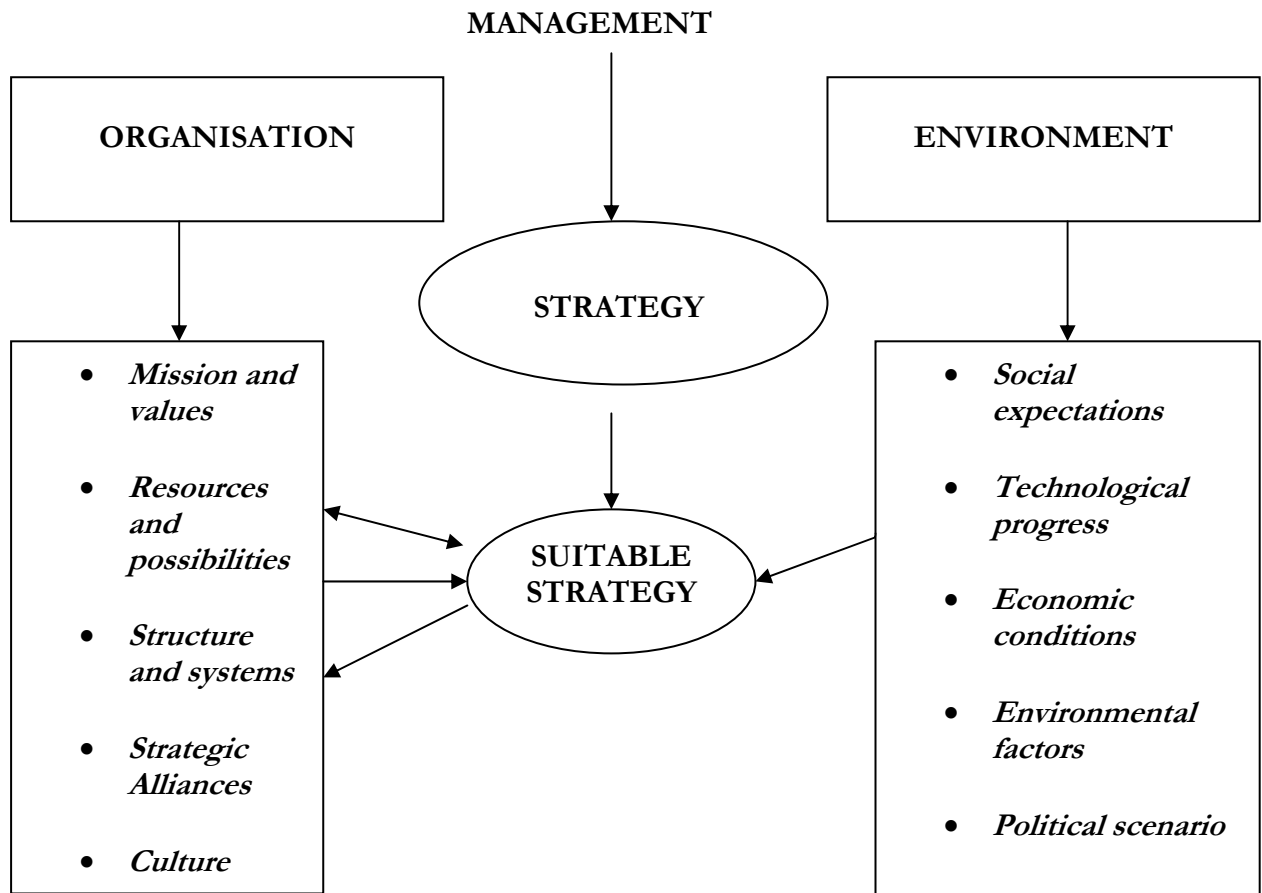


Chart 1: Strategic management in the context of internal and external conditions<sup>19</sup>

The strategic plan of an organisation reflects three basic principles:

1. Each employee must know what the organization is seeking to accomplish – the goal (mission);
2. Each employee must know how to work and behave – the values;
3. Each employee must know what is being strived towards – the vision.

While developing the strategic plan, it is important to keep in mind that:

A clear understanding of the goal (mission) gives meaning to the work of managers and other employees. It brings together the efforts of an organisation's staff.

Values and standards (“principles”) give a clear definition of how the employees should work to achieve the goal set and provide an expected pattern of behaviour for staff.

<sup>19</sup> “Vvedenie v strategicheskoe myshlenie i planirovanie”, Uchebnye materialy Kazakhstanskogo uchebnogo proekta, “Prava cheloveka v upravlenii penitentsiarnymi uchrezhdeniiami”, Programma strategicheskogo planirovaniia, Prilozheniia 4, Alistair Bailey, oktiabr’ 2001 (with minor change).

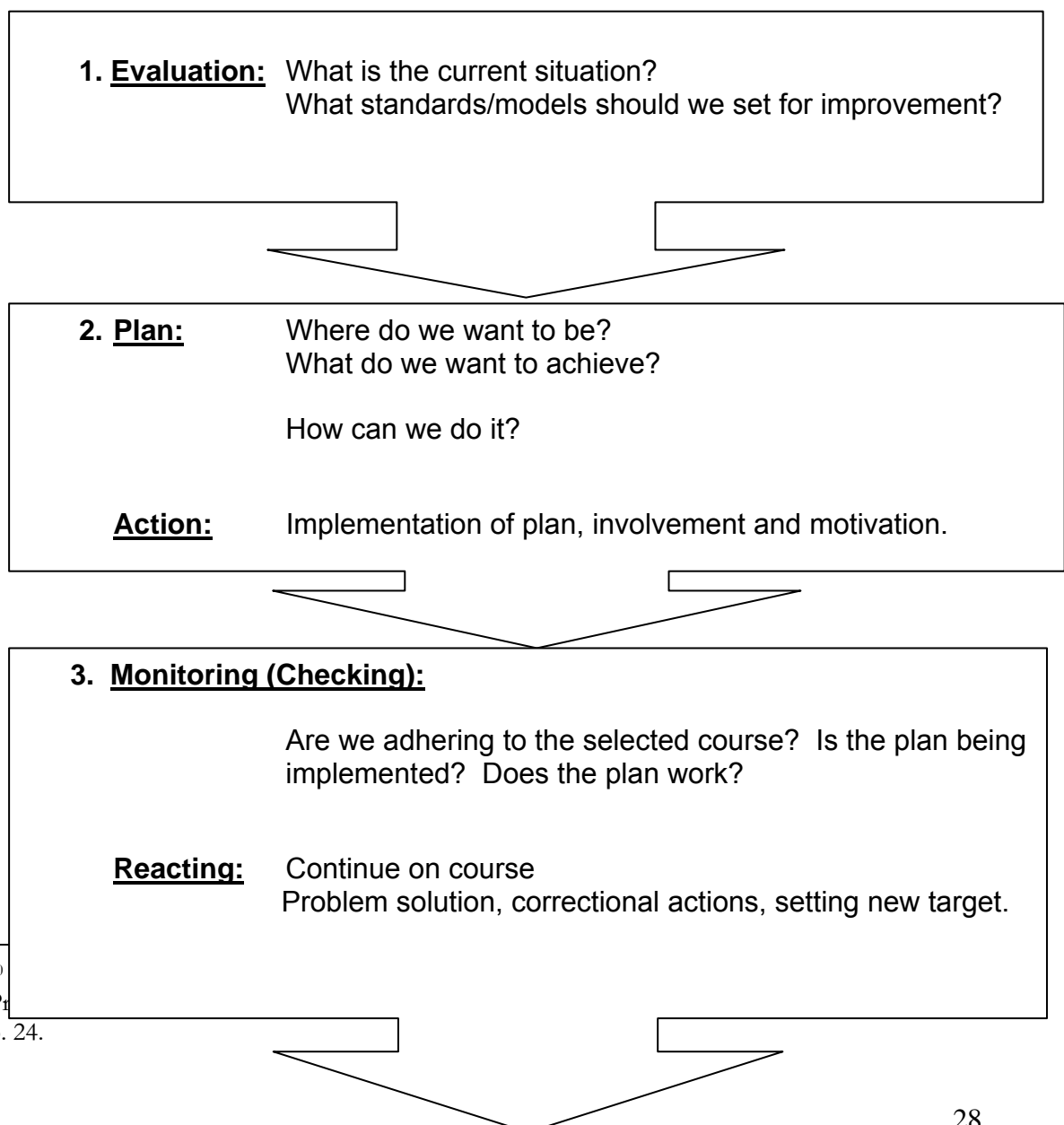
Mental image of the successful accomplishment of the mission (vision) gives a sense of direction, provides a basis for leadership, motivates people, and enhances development towards the future.

“Strategic planning” is a planning process which includes an assessment of the organisation or enterprise at a certain point and determines the direction of development for the next five years (or a different period). It clearly describes what the organisation wants to have achieved by a designated date, and develops basic stages in achieving the goal that has been set.

#### 4.4 Strategic Management Cycle

The strategic planning process follows the strategic management cycle.

Below is the international strategic management cycle aimed at ensuring a continuous improvement of an organisation’s activities.<sup>20</sup> It can be used for any business planning.



#### 4.4.1 The “Continuous Improvement” Cycle

Simple planning is generally considered to mean the development of a plan for accomplishing a goal or set of goals over a given period, with the assumption that current knowledge about future conditions is sufficiently reliable to ensure the plan's reliability over the duration of its implementation.

On the other hand, strategic planning assumes that an organization must be responsive to a dynamic, changing environment and circumstances. The environment is indeed changeable, often in unpredictable ways. Strategic planning, then, stresses the importance of making decisions that will ensure the organization's ability to successfully respond to changes in the circumstances within the organisation, as well as the environment within which it exists.

Thus, the strategic planning group must:

- “raise their heads” and look around to understand what is going on beyond the confines of their organisation (e.g. the prison institution);
- “look beyond the horizon” to see what’s going on around them in the larger organisation (e.g. the prison system), and what’s going on around them, beyond the confines of the larger organisation (e.g. the criminal justice system and society).

**Strategic planning is not a static process. It is a dynamic and continuous process: a cycle aimed at “continuous improvement”.**

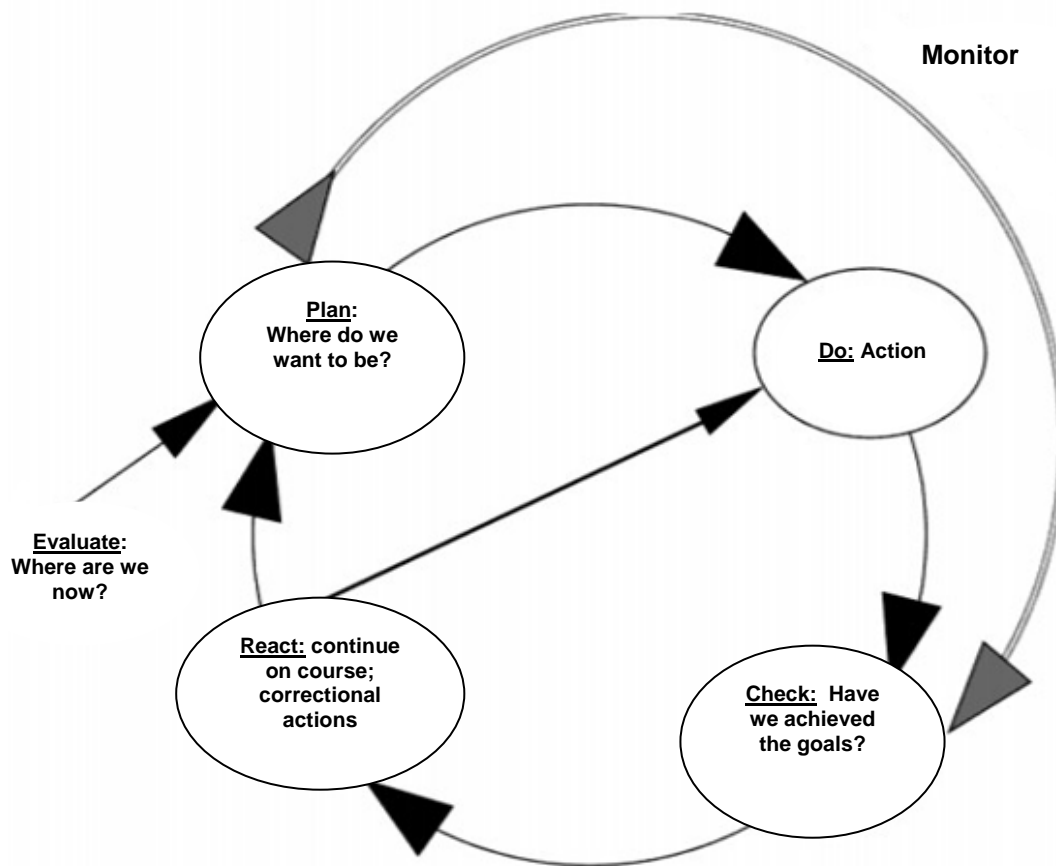


Chart 2: Strategic Management Cycle<sup>21</sup>

#### 4.5 Stages of the Strategic Planning Process in the Penal System

Strategic planning provides a general review of the upcoming activities and outlines the work areas for months and years ahead. The process may be described as follows: Assess the current situation, then plan; do; monitor; react.

**Stage 1 – The Strategic Vision: A mental image of a good prison:** For the image to involve and inspire others, it needs to be transported from thought to reality. This image must give a clear idea of what every participant of the process should strive for. It must be as close to the reality as possible, while at the same time, being based on international human rights standards for the treatment of prisoners (as set out in the UN Manual).

The process of creating an image of what has to be achieved is sometimes called creating the vision.

<sup>21</sup> Based on “Uchebnye materialy Kazakhstanskogo uchebnogo proekta ‘Prava cheloveka v upravlenii penitentsiarnymi uchrezhdeniiami’. Programma strategicheskogo planirovaniia, oktiabr’ 2001, p. E16, and “Strategicheskogo planirovanie po pravam cheloveka v penitentsiarnykh uchrezhdeniiax”, Ozzie Ffield (based on the work of A. de Friszing and A. Barclay).

**Stage 2 – Evaluation/assessment:** Participants are asked to review the existing situation at the moment strategic planning is to begin. They need to compare the current arrangements with the mental image of what the institution should be like in five years' time. For example, they compare the current practices with international standards as set out in the UN Manual. Then they assess the gaps between what is happening at the legislative level and in practice, and what should be happening, according to international standards. This process is called "gap analysis".

**Stage 3 – Strategic Planning:** A question is then asked: "What should be done to eliminate the gaps between what we are doing now and our "ideal"? This stage will identify the process of "Actions". A list of actions/steps will need to be made in priority order with timings. The implementation of actions will be in stages. This is the action plan.

To ensure execution of the action plan, the following need to be added:

- Date or event by which every stage should be completed;
- Responsible manager and other employees/departments;
- Resources.

There are sometimes restrictions hindering implementation of plans. Some staff might resist, saying, they cannot fulfil the plans due to a variety of reasons. Staff responsible for strategic planning will then need to make up a list of those restrictions to identify the underlying problem. Then they need to find a way to solve the problem and eliminate hindrances. At the same time, they should not ignore the available "positive forces", or contributing factors that they can utilise in the reform process.

All strategic planning participants should know that the plan is being implemented. For this purpose, monitoring needs to be conducted, to collect data and assess progress. This data collection system should be established at the very beginning of strategic planning.

**Stage 4 – Monitoring and Review:** Monitoring of the implementation of planned activities generates data which is used for reviewing the implementation of the plan.

The managers need to react accordingly. If the plan implementation is progressing according to schedule, then the process continues. If not, then corrective action needs to be taken. This action should concentrate on correcting the management process and the work plan, and setting a new target.

#### **4.6 Strategic Planning Tables**

The strategic planning tool includes a number of tables. The list of these tables is shown in the "Model of Strategic Planning Tables used for Prison Management in Kazakhstan", with all eight tables shown on one page. (Appendix 1)

Each part of the strategic plan has to be studied and completed to include what can be done to carry out the plan, its implementation steps, required resources, and who must do what by which deadline. This activity is carried out with respect to each heading of the UN Manual, for example "Maintaining Human Dignity", "Prisoners' Contact with the Outside World", etc. (See Appendix 2 for all UN Manual headings.)

## **Title Page**

The vision of what the penal institution will be like in a few years is at the centre of the strategic plan. The vision is an image, both visual and verbal, for each person involved in the process. International standards form its basis.

Development of the vision may pass through two stages.

Stage One: discussion of the ideal prison, the dream and the question: if we had all necessary resources, what would the ideal penal institution be like?

Stage Two: when we have to go back to reality and discuss the question: what can be realistically achieved while at the same time striving for how it should be?

## **The List of Strategic Planning Tables<sup>22</sup>**

<b><u>1. Assessment:</u></b>	What are the standards of the UN Manual?
	What are respective laws of Kazakhstan?
	Where are we on our way to achieve these standards?
	Some examples of the current positive practices.
	What are the gaps between the current practices and standards?
<b>Table 1</b>	<b>Standard from the UN Manual</b>
<b>Table 2</b>	<b>Current National Legislation, Policy and Practices</b>
<b>Table 3</b>	<b>Gap Analysis between the Current National Legislation and Policy and the UN Standards and between the Current Practices and the National Legislation and Policy</b>
<b><u>2. Plan:</u></b>	What do we want to achieve in five years? (Mental image of improvements).
	What actions need to be taken to eliminate the gap between the current state of affairs and what we want to achieve? (Our action plan)
	What constrains us?
	Who/what can help?
	Actions.

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<sup>22</sup> Programma upravleniia tiurmami na osnove strategicheskogo planirovaniia v Kazakhstane. Programma professional'noi podgotovki trenerov, Ust'-Kamenogorsk, 10-18 sentiabria 2002., Part 8, pp. 33-34, Part 9, pp. 7-8, Part 10, pp. 4-5



### Action / Implementation:

How can we involve and encourage managers and employees?

What must we start with? How?

Which monitoring data and measurements are needed to verify the progress in reaching the goal and keeping the right course to achieve the plan?

Providing this data at the very beginning.

**Table 4**                    **The vision of what should be achieved in five years and the order of steps to be taken**

**Table 5**                    **The action plan and basic stages of achieving the vision**

**Table 6**                    **Constraining and Contributing Factors**

**3. Monitoring:**            Are we moving in the right way to achieve what we want – our practices?

What does the monitoring data tell?

Is the plan implemented effectively?

**Reaction:**                    Continue on course, move to next target

Correctional actions if needed.

Correction of the plan or implementation mechanisms, setting of new target

**Table 7**                    **Progress in the course of monitoring and measuring**

**Table 8**                    **Monitoring (verification) and reaction**

This process helps each member of staff to gain:

- Increased knowledge about international and national human rights standards relating to penal institutions.
- Understanding of the possibilities to implement international and national standards relating to the treatment of prisoners in prisons, taking into account existing possibilities and practices.

### **4.7 Prison Management with Strategic Planning**

Efficiency of strategic planning in the penal system depends on the management at each level (e.g. prison establishment, regional administration, central prison administration, Ministry of Justice). It is implemented in a “top-down” manner at each level, though its

success depends on the degree of involvement of prison staff from a variety of services. The prison manager's role is to support prison staff's aspirations and encourage a sense of independence, in order to help them utilise their skills and creativity to bring changes to their prisons and to the penal system. This needs to be achieved within the limits of available resources.

Introduction of strategic planning at all levels of the penal system would consist of its use, starting at the level of individual prison establishments, and going up to the Ministry of Justice. The way the process would work, was tested in the three pilot oblasts, in Kazakhstan II project, as follows:

- Each prison establishment, regional department and central prison administration sets up a strategic planning team (of 4-5 members of prison staff from different services). This team is responsible for preparing the five year strategic plan for its prison, region or for the whole prison system.
- The process starts at the level of individual prison establishments. The strategic planning team, in consultation with all services, prepares a strategic plan for its prison covering 5 years.
- The strategic plan of each prison establishment is then submitted to the regional prison administration, which prepares a strategic plan for the region, based on plans submitted by the prison colonies and SIZOs in that oblast'.
- All regional strategic plans are then submitted to KUIS, which prepares a national strategic plan (a national plan for penal reform). This is submitted to the Ministry of Justice and from there it would be submitted, as part of the Ministry of Justice plan, for parliament for the approval of the necessary budget.
- Once the budget is allocated and implementation of plans begin, the process of monitoring and reviewing would start, using previously established measures of assessing whether plans are being successfully put into practice. Monitoring might result in readjusting some plans, due to changing circumstances, and setting new targets, or it might result in continuing the process without changes. Monitoring should be undertaken by the managers of the prison system at each level. (This is the monitoring precisely of the implementation of strategic plans). External monitoring, undertaken by public monitoring committees, is an additional safeguard.

Strategic planning differs from the planning system that is currently used by Kazakhstan's penitentiary system in a number of important ways:

1. It builds a shared vision that is values-based: Its aim is very clear and set out in internationally accepted human rights standards for prison management. Many of those aims are about changes in attitude, rather than, for example, mere physical changes to prison establishments (or, for example, the prioritization of physical changes is different).
2. It is a participatory process involving a number of different services and levels of staff. Thus, it improves contact and information exchange between staff from different services.

3. It encourages staff to think through carefully all steps that must be taken to achieve an identified target, with or without additional funding. Thus it is an educational process in itself and motivates staff.
4. It involves long-term planning (5 years), but uses action plans to achieve identified targets in the process.
5. The emphasis in strategic planning is on understanding how circumstances (the environment) are changing and will change, and in developing organizational decisions which are responsive to these changes. Thus, it's a dynamic process, which involves monitoring and reacting and setting new targets on a regular basis.

## 5. TB/HIV CONTROL STRATEGIES IN PRISONS

The goal here is to stress some of the main aspects of the TB/HIV control strategies in prisons. Additional information about public health strategies and clinical management is available in WHO guidelines for TB/HIV managers, which can be found on the official web page of WHO (see internet resources under Bibliography). Medical aspects of case management are not included in this document.

Humanity has faced TB epidemics for many centuries. Microscopy diagnosis of TB has been known over one century. When anti-TB drugs were developed in the 50s-60s there was hope that the problem could be easily solved and indeed some success was achieved. Unfortunately, the uncontrolled use of anti-TB drugs resulted in another TB epidemic – Multi Drug Resistant TB epidemic (MDR-TB) – the TB that is resistant to at least Isoniazid and Rifampicin, considered to be the most efficient anti-TB drugs. Moreover the HIV/AIDS epidemic radically transformed the “normal” TB epidemic. As a result, humanity is currently facing a TB epidemic conventionally divided into three main epidemics: TB epidemic, MDR-TB epidemic and TB/HIV epidemic.

WHO recognizes Eastern Europe and Central Asia as the region facing the most dramatic MDR-TB epidemic, with some countries reporting up to 14.1% (Estonia) of new TB cases being MDR-TB. Usually reported prison data of MDR-TB among new TB cases is at least twice as high as the civil sector (even countries with a low incidence of MDR-TB admit to high MDR-TB in prisons). Unfortunately the treatment of MDR-TB is more difficult, more expensive, and with relatively lower treatment success. It is easier to prevent MDR-TB than to treat it. And if treatment with second line drugs fail than humanity will face a supra-resistant, non-treatable TB.

The HIV/AIDS epidemic is considered to be an international threat for TB control too, and has already led to the collapse of some TB control programmes, previously considered to be successful, mostly in the Sub-Saharan Region. But Eastern Europe and Central Asia is currently facing an HIV/AIDS epidemic too, and TB/HIV has gone almost out of control in many settings, especially in prisons (in 2004 in Moldavian prisons 25% of TB patients who died were co-infected with HIV).

So, only diagnostics and availability of drugs have not stopped the TB epidemic. The creation of an MDR-TB epidemic together with the overlapping of an HIV/AIDS epidemic led to the requirement of establishing a comprehensive approach to TB

epidemics. The first (and the most important) break was the adoption of an efficient TB Control Strategy, and the most efficient was internationally recognized to be DOTS strategy. The strategy not only allows the control of TB epidemics, but also prevents any further creation of MDR-TB, and is one of the main tools in TB/HIV management.

### 5.1 Reasons for High Levels of TB in the Prison Population

WHO sets out the reasons for high levels of TB among prisoners, as follows<sup>23</sup>:

- A disproportionate number of prisoners are derived from population groups already at high risk of TB infection and disease (e.g. the homeless, those addicted to alcohol or illicit drugs, former prisoners, the mentally ill), who often do not have access to adequate treatment in civilian life.
- Prisons promote transmission of TB infection through prolonged and repeated exposure to Mycobacterium tuberculosis as a result of:
  - Poor ventilation
  - Late case detection
  - Overcrowding
  - Lack of respiratory isolation and inadequate treatment of infectious cases
  - High turnover of prisoners through repeated transfers within the prison system, default after release and recidivism.
- Prisoners are also at risk of rapid progression to TB disease following recent infection or reactivation of latent infection through:
  - Co-existing pathology, particularly HIV and intravenous drug use
  - Poor nutritional status
  - Physical/emotional stress

Additional reasons might be:

- A lower level of TB/HIV awareness along with unhealthy behaviour patterns among prisoners, visitors and staff.
- A lower access to diagnosis and treatment, insufficient amount of drugs or irregular supply of laboratory consumables and anti-TB drugs, unsupervised treatment in the past
- Sometimes TB might be 'attractive' to prisoners due to the chances of humanitarian release or amnesties or to benefit from better conditions in hospitals.

### 5.2 DOTS Strategy

DOTS is a strategy composed of five components:

1. A political and financial commitment by the government at all levels to comprehensive and sustained TB control activities.
2. Case detection by sputum smear microscopy among symptomatic patients and active case finding and screening on arrival.

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<sup>23</sup> WHO manual for Prison TB managers: Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281, p.19

3. Standardized short course chemotherapy using regimens of six to eight months, for at least all confirmed smear-positive cases. Case management includes directly observed therapy (DOT). Each time and all anti-TB drugs should be administered only under DOT.
4. A reliable and uninterrupted supply of all essential anti-tuberculosis drugs.
5. A standardized recording and reporting system that allows assessment of case-finding and treatment results for each patient and of the TB control programme overall.

### 5.3 Goals of Tuberculosis Control Programmes<sup>24</sup>

TB control programmes have three main goals. These are to:

1. Reduce morbidity and mortality from TB.
2. Prevent the development of drug-resistant TB.
3. Reduce and ultimately stop the transmission of TB infection.

The most effective strategy to achieve these three goals is to provide:

1. Early diagnosis of TB (case-finding)
2. Effective treatment

Such a strategy should be accessible to all TB cases. However, where resources are limited, the strategy must prioritize the diagnosis and treatment of infectious cases (patients with smear positive, pulmonary TB) and TB/HIV co-infected patients. This is because these cases transmit infection (drug-susceptible and drug-resistant) and therefore ultimately produce more morbidity and mortality.

#### 5.3.1 Early Diagnosis (Case-finding)

Late TB case-finding and delays in commencing treatment are common problems in many prisons. They are the most important causes of TB morbidity, mortality and transmission, and can trigger creation of drug-resistant TB.

Firstly, delaying diagnosis and treatment of highly infectious, smear-positive, pulmonary cases exposes other individuals who come into contact with the patient to TB infection.

Secondly, late treatment for active TB leads to greater tissue destruction, a weaker nutritional status and a greater likelihood of poor outcomes from treatment.

Thirdly, diagnostic and treatment delays may pressure patients into seeking their own solutions through treatment obtained via visitors or the prison black market. Such erratic, unsupervised treatment promotes the development of MDR-TB.

Infectious cases can only be diagnosed through laboratory investigations that demonstrate TB bacteria in an individual's sputum. The more bacteria present, the more infectious a case is likely to be. Light microscopy of sputum smears is quick, inexpensive and relatively easy to establish and implement. Laboratory services are therefore fundamental to the control of TB.

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<sup>24</sup> Section is cited from Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.29

Early case finding depends on two main factors: the first is access to diagnosis and the second is the timeframe between the onset of TB symptoms and the moment when the suspect is diagnosed as a TB patient. One of the most common symptoms of TB is coughing over a period of 2-3 weeks, and very often patients self-report this sign to prison staff. But very often they do not, and as a result they might be diagnosed late, especially if diagnosis of TB is not accessible all the time. This is why prison TB control programmes should establish accessibility to diagnosis (sputum smear microscopy among symptomatic patients) and effective policies of active case finding.

In populations with high incidence of TB, such as prisoners, active case finding may be composed of:

- On-entry screenings of new arrivals into prison;
- Screenings with clinical questionnaires. An example of a clinical questionnaire is presented in Annex 3a of “Tuberculosis Control in Prisons” published by WHO in 2000.
- X-ray screenings, if resources are available;
- Suspects’ registers, where suspects with coughing, pulmonary infections, low body weight index, former patients in the first few months after treatment completion, patients on immunosuppressive treatment are monitored. The status of HIV should not be mentioned in suspects’ register, because of potential stigmatization. An example of a suspects’ register is presented in Annex 3b of “Tuberculosis Control in Prisons” published by WHO in 2000.
- Identification of volunteers among prisoners, which would be attracted for TB peer education and alerting patients with coughs (and other TB related symptoms) about the necessity of a medical examination;
- Only some periodical measures in active case finding are less effective if taken alone - like only periodical x-ray screenings. It is important that early case finding is undertaken in a comprehensive way, systematically and continuously for all symptomatic patients, especially for those with coughs, which might be highly infectious, and smear positive pulmonary TB cases.

It should be mentioned that WHO suggests strengthening DOTS implementation with Practical Approach to Lung Health (PAL) strategy. According to WHO data about 20-30% of patients above five years of age visit primary health care facilities with respiratory symptoms, and approximately 5-10% are identified as possible cases of TB. PAL strategy is a syndromic approach to the management of patients who attend primary health care with respiratory symptoms. It focuses on four priority respiratory diseases among patients aged five years or more: TB, acute respiratory infections (in particular pneumonia), asthma, and chronic obstructive pulmonary disease<sup>25</sup>.

### 5.3.2 Effective Treatment

Effective treatment reduces morbidity and mortality and prevents the development of drug resistance. As smear-positive cases usually become non-infectious within 2-3 weeks of starting effective treatment (if the patient is harboring drug-susceptible bacilli), transmission of TB infection is rapidly reduced.

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<sup>25</sup> National Tuberculosis Programme Managers’ Meeting. WHO, Europe. 2004. EUR/04/5049254. p.13.

Effective treatment means providing treatment with the correct combination of anti-TB drugs for the duration necessary to ensure cure and reduce risk of relapse. It also means guaranteeing that the treatment is properly taken, its impact monitored and the treatment actually completed.

Therefore, effective treatment requires:

- An uninterrupted supply of drugs, in the correct quantities and of good quality.
- Prescription of correct drugs, in the correct dosages, for the appropriate duration of treatment.
- Patient supervision and support to ensure that the treatment prescribed is taken in the full range, with no interruptions and is directly observed.
- Monitoring of treatment efficacy through clinical and laboratory measurements.
- An effort to ensure treatment is completed and the outcome of treatment known and reported – a point where many prison and civilian TB programmes currently falter.<sup>26</sup>

## **6. POLICES TO BE CONSIDERED IN TB/HIV CONTROL**

A successful implementation of a TB Control Programme based on DOTS strategy depends on a comprehensive and active approach. Usually it is necessary to adopt and update many polices in both areas – medical and organizational. The following components are to be considered during implementation of DOTS strategy:

- Decrease of overcrowding, achievable in prisons through penal reforms, especially by alternatives to incarceration.
- Ensuring accessibility to diagnosis and treatment of all infectious TB cases.
- Standardized treatment under DOT, and ensuring compliance to treatment.
- Ensuring effective HIV prevention within the population (prison populations being one of the first target groups for HIV prevention).
- Staff management, including both training of staff and exclusion of conflicts of interest.
- Efficient drug management that provides an uninterrupted supply of all essential anti-TB drugs with an internationally acceptable quality of anti-TB drugs and laboratory consumables.
- Infection control for reduction of the risk of infection among inmates, visitors and staff.
- Integration of civilian and prison TB services and coordination of anti-TB activities performed at all levels inside and outside prisons.
- Increase of TB/HIV awareness and establishing efficient ways of educating patients and staff, establishing most common unhealthy behavioral patterns and finding ways to change them.
- Continuous monitoring and evaluation of the TB/HIV control programme, identifying weaknesses and opportunities.
- Reviewing legislation to avoid double standards in TB/HIV control and discrimination of TB/HIV patients.

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<sup>26</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.30

- Creation of decision making bodies, responsible to update required TB/HIV polices.

It should be mentioned, that medical interventions alone in TB/HIV control will be less effective (if not ineffective) without organizational interventions.

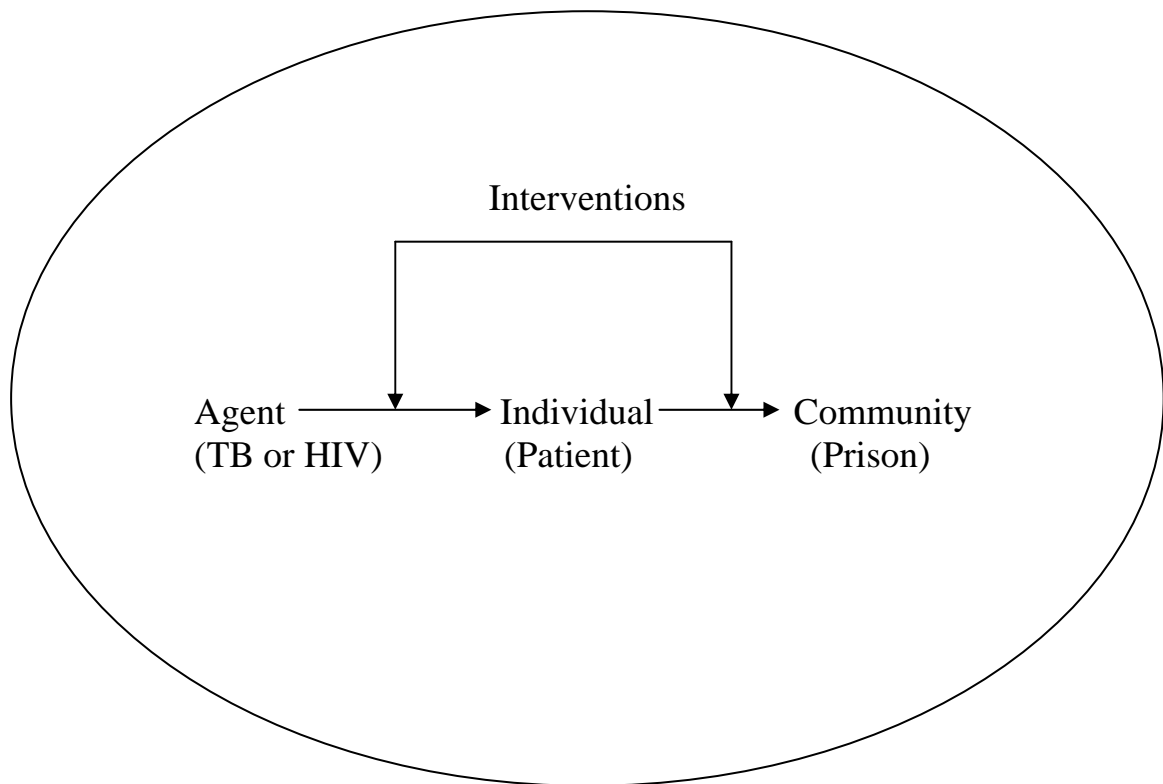


Chart 3: TB and HIV Control<sup>27</sup>

### 6.1 Decrease of Overcrowding in Prisons

TB is spread through the air by droplets produced by a person suffering from pulmonary TB by coughing, sneezing or speaking. Persons who are in contact with a TB patient might be infected by the source of infection. So there are two main aspects of TB in overcrowded facilities: first of all a person with TB might infect more persons who are detained in the same facility, and secondly in an overcrowded facility more than one person might be the source of TB.

An aspect to be taken into account is the definition of overcrowding. Some countries establish a “legal capacity” of facilities, and report data about overcrowding according to that “legal capacity”, that is based on the calculation of how many square meters are established per person. This limit varies between countries. In some countries (former Soviet Union) this limit is only 2-2.5 sq. meters per person, while the minimal surface for a prisoner according to European standards is 4 sq. meters per person. There is a

<sup>27</sup> Adapted from Hans L. Rieder, *Epidemiologic Basis of Tuberculosis Control*, Paris: International Union Against Tuberculosis and Lung Disease, 1999, Figure 1



substantial difference when twice as many people are detained in one facility, although it is considered to be “normal” because local standards allow it.

Another aspect of overcrowding is the number of prisoners detained in a room, particularly in colonies, where large numbers (60-100) of prisoners stay all together in a dormitory.

There are two main ways to decrease overcrowding in prisons: by building new penitentiaries and by decreasing the incarceration rate through penal reforms (described in Chapter 2, Section 2).

If a TB control programme is implemented efficiently, but the problem of overcrowding is not resolved, then the TB epidemic will decrease to a certain level, when overcrowding will become the main weakness of the programme and will fuel a TB epidemic continuously.

If a TB/HIV control programme is implemented with a clear strategy of decreasing overcrowding, through penal reforms targeting decrease of incarceration rate, then this approach will be more effective and long lasting. This is because not only is the risk of infection thereby decreased, but also resources received (e.g. medication, food, medical equipment) are distributed to a less number of patients. Some countries, such as Kazakhstan, have achieved stronger prison TB control with the help of penal reforms leading to a decreased incarceration rate and parallel improvements made in prisons, including the training of staff.

## **6.2 Access to Early and Effective Diagnosis and Treatment<sup>28</sup>**

According to WHO guidelines all infectious TB cases should have the same level of access to early and effective diagnosis and treatment of TB whether they are inside or outside the prison walls. In the same way, all prisoners should have the same level of access to TB care regardless of their gender, crime, prison regime, and remaining time of incarceration. As well as being important from an individual ethical and human rights point of view, this principle is also an essential component of TB control in any population.

If one group of infectious TB cases is excluded from treatment, TB morbidity, mortality and transmission, as well as the possible creation of drug-resistant TB, persist. These risks are not limited to this group only as transmission of infection to others continues through shared facilities, prisoner transfers and releases, and through staff and visitors.

## **6.3 Standardized Treatment under DOT and Compliance to Treatment**

Standardized treatment under DOT and compliance to the treatment are the essential tools for high efficiency of TB treatment and prevention of MDR-TB.

Although there are many advantages of standardized treatment of TB, the most important advantage is that this standardized treatment replaces the incorrectly prescribed individualized TB treatment. The usual problem of ‘individualized’ treatment is the confusion of definition, when under individualized treatment one, two or three

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<sup>28</sup> Section is cited from Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.31

anti-TB drugs are used for unclear periods of time. Many physicians and patients consider anti-TB drugs as potentially 'harmful' and prefer to find some "protective" approach in case management. The clinical approach of using one or two first line drugs and one or two second line drugs is considered to be especially dangerous. This 'individualized' treatment has doubtful efficiency and more over it leads to the creation of drug-resistant TB, with all its dangerous consequences for the entire population. A classical individualized treatment is used only if Drug Susceptibility Test (DST) is available and the TB patient is taking 4 or 5 drugs to which the patient is susceptible.

The methodology of DOT is very easy: the patient comes with a cup of water (or the nurse provides the patient with a cup of water) and he/she takes this and swallows all the tablets with some of the water in front of a treatment supervisor, usually a nurse. The remaining water is used by the patient to rinse his/her mouth or just to drink. Normally the patient is also asked to open the mouth in order to ensure that no tablets are held there.

Some patients might ask the staff to take the drugs with them and find many excuses not to take tablets directly observed. This is high risk behaviour, and the staff should concentrate their efforts on the education of such patients. If the patient is taking TB drugs not directly observed, then in most cases it is anticipated that the patient will take less drugs than prescribed, and in this case treatment success is doubtful, while the probability of developing MDR-TB is very high. It must be mentioned that a patient has the right to refuse treatment, but if he/she is following treatment, then it should be only directly observed.

Some patients might be motivated to acquire better living conditions, for example they might want to stay in the hospital, where conditions are much better, for longer periods. Thus, they might decide to default from treatment in order to become ill. In order to avoid this, health staff should try to educate the defaulters about the possible consequences of irregular treatment, and decision makers should be aware of the necessity to improve general conditions in prisons, that would take away the motivation of TB patients to want to spend longer periods in hospitals.

Although TB treatment is a short course treatment with standard regimens designed for 6 or 8 months, it is still difficult to keep some patients on treatment for the whole period. Most patients feel better after the first month of treatment and some of them do not see a reason to continue treatment. This is a critical moment for staff, when medical staff should turn from their usual duties to education of the patient. It is vital to ensure compliance to treatment up to the end. An interrupted or erratic treatment might result in failure, high relapse rate and acquisition of drug resistant TB.

In civilian TB programmes it is usually required to continue with DOT for at least the intensive phase (2-3) months, but in accordance with WHO guidelines, in prison settings it is essential to perform DOT not only during the intensive phase, but in the continuation phase as well. The reasons why it is more important to ensure DOT in prisons for the entire duration of treatment are that this reduces the chance of concealed defaulting, diversion of drugs, and it can also protect patients who may otherwise be coerced to surrender their drugs<sup>29</sup>.

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<sup>29</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.115

## 6.4 Effective HIV Control in Prisons

### 6.4.1 HIV Background

Unlike TB, HIV is not spread through the air by droplets. The transmission of HIV is through sexual intercourse (and other sexually transmitted infections especially those that cause genital ulcers increase the risk of HIV transmission), and blood borne transmission through injections with contaminated needles and syringes, contaminated blood transfusion, and the use of non-sterile skin-piercing instruments. About one third of children born to HIV-infected mothers are also HIV-infected, with infection occurring mainly around the time of birth.<sup>30</sup> There is a smaller risk of HIV transmission through breastfeeding. Taking into consideration the main ways of HIV transmission, the main target groups affected at the initial stage of HIV epidemics in a population/country are: intravenous drug users (IDUs), prisoners, commercial sex workers and men practicing sex with men. Very often the ways of transmission of HIV and the target groups are criticized by the general population, and behavioral aspects of HIV may lead to a very high risk of stigmatization of HIV. In an uneducated, unaware, hostile and stigmatized environment it is more difficult to have effective prevention of HIV. The reason why stigmatized societies are more exposed to the risk of HIV epidemics is because the general rule of HIV prevention “protect yourself and others” does not work here, and if an HIV patient is stigmatized then he has no reason to protect others. That is why the entire community and especially target groups should be aware and participate in HIV prevention without any discrimination, whether it be based on behavioral or personal aspects.

It should be mentioned, that HIV affects mostly target groups only in the first stage of epidemics, and in the next stage HIV affects the entire population on a massive scale, usually through unprotected sexual intercourse, affecting the most sexually active age group (15-50 years). As a result tragedies occur with huge armies of orphans, low life expectancy, decreased economical growth and poverty. According to estimates, unless comprehensive action is taken, Central Asian countries might expect to have, in the following 4-5 years, a fast growing HIV epidemic among IDUs, and afterwards, within 15-30 years, a massive epidemic of HIV in the entire population through sexual contact. It might repeat the scheme of HIV epidemics seen in other countries like Russia, Ukraine and Moldova<sup>31</sup>

Each country has to decide its own strategy of HIV prevention, and right now there is more optimism in countries where active preventive measures have been undertaken. The experience in some Eastern European countries show that the geometrical increase in HIV initially was mostly due to unsafe drug use and most of the affected patients were IDUs and their partners, but after 5-8 years HIV has changed its main transmission channel to unprotected sexual intercourse in the general population. The more comprehensive and less declarative the prevention of HIV, the more efficient it is. If HIV prevention faces serious organizational problems in target groups (like prisoners) then less time is available to society to prepare for the general epidemic.

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<sup>30</sup> TB/HIV: a clinical manual, WHO/HTM/TB/2004.329 p.29

<sup>31</sup> Ostanovit' Volnu, Rabochii doklad vsemirnogo banka N 54, May 2005, p.12

## 6.4.2 Impact of HIV in Prisons

TB and HIV are closely interlinked. TB and HIV fuel each other. TB is a leading cause of HIV-related morbidity and mortality. HIV is the most important factor fueling the TB epidemic in populations with a high HIV prevalence. The incidence of TB in incarcerated HIV-positive populations might be over 100 times higher than in HIV negative incarcerated populations. Where rates of HIV in civilian and detained populations have been compared, up to 75-fold increases in prevalence have been reported in the latter.<sup>32</sup>

HIV epidemics are a real threat even to successful TB control programmes (USA and Spain report HIV/TB among TB patients in penitentiaries to be 95% and 84% respectively<sup>33</sup>). At the initial stage of an HIV epidemic the population with TB appears to be less interconnected with the population of HIV patients. But after a while (a few years) the TB/HIV population grows constantly.

Reasons of high levels of HIV in prisons:

- A disproportionate number of inmates came from, and return to, backgrounds where the prevalence of HIV infection is high.
- Risk behaviours such as intravenous drug use and unsafe sexual practices (with or without consent) commonly occur in prison.
- Risk behaviours and HIV may not be officially acknowledged or they might be denied by authorities, hindering efforts at education regarding safer practices (injecting and sexual).
- Restriction of rehabilitation programmes for IDUs based on Substitution Programmes (substitution of illegal drugs with legal drugs like Methadone) and psychological support.
- Interventions to reduce risk of HIV infection (such as the provision of clean injecting equipment or condoms) may be restricted or considered unacceptable.
- There may be a high frequency of tattooing using unsterilized equipment.
- Other sexually transmitted diseases (e.g. syphilis) are common in prisons and encourage the transmission of HIV.<sup>34</sup>

To counteract the impact of HIV on TB, other interventions are required apart from effective TB case-finding and cure. These interventions include:

- Measures to decrease HIV transmission
  - Peer education of safe sexual behaviour and safe drug use.
  - Promotion of condoms.
  - Availability of needle exchange programmes.
  - Promotion of integrated programmes of IDU rehabilitation through substitution of illegal drugs with legal drugs (Methadone treatment) and psychosocial support.
  - Treatment of sexually transmitted diseases.
  - Prevention of mother-to-child HIV transmission.

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<sup>32</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.20

<sup>33</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.21

<sup>34</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.21

- HIV screening of blood for transfusion.
- Application of universal precautions by health workers.
- Antiretroviral therapy (ART or HAART) to improve or maintain immune function in people living with HIV infection.
- Care for people living with HIV infection (prevention and treatment of HIV-related diseases, palliative care and nutritional support).<sup>35</sup>

Very often health policies are rejected by prison administrations and the most usual obstacle is that administrations deny the problem of drug addiction, or insist that illicit drugs are not available in prison. At the same time only a very small amount of opiate mixed with about 10-15 chemical reagents might be used to have the same effect of a large amount of opiate by IDUs. So, substance abuse in prisons should be acknowledged. A disproportionate number of prisoners are substance abusers (alcohol or illicit drugs). They are in prison either for drug use, or because they have committed an offence either under the influence of drugs or alcohol or in order to be able to buy more drugs to serve their addiction. However, many use narcotics for the first time in prison and turn to substance abuse inside prison because of anger, frustration or boredom. Prison staff is also at risk of abusing alcohol or illicit drugs.

Drug addiction is a complex phenomenon, and needs many efforts to stop it. One of the most efficient ways is a combination of narcotic substitution (by a legal drug, like Methadone) and psychosocial support. Advantages of Methadone substitution programmes in prisons are:

1. Usually within one month of treatment patients are detoxified and are more cooperative and more open to education.
2. After a period of stabilization in many cases it is possible to gradually reduce the dosage of the drug.
3. If an addict is on Methadone treatment, that is available legally, then he/she has no need to find illegal ways to obtain illicit drugs. This then automatically becomes a tool to fight illicit trading of narcotics, resulting in a decriminalization process.

The weakness of Methadone substitution programme is that this is a perfect tool only for patients that have the desire to stop substance abuse and are ready to be on strict follow up and medical recording for their drug addiction. Many IDUs might prefer to be unsupervised and would rather continue substance abuse with illicit drugs. In order to have prophylaxis of HIV among this group, harm reduction programmes should be introduced through needle exchange.

### **6.5 Staff Management in Prison TB/HIV Control**

Prisons have a difficult working environment and sometimes working in prisons is not considered prestigious. Even if most posts are occupied, usually the turnover of prison staff is very high. This implies the need for an appropriate training system for staff on TB/HIV control. Staff trainings should be undertaken on a systematic basis, followed by retraining according to the need.

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<sup>35</sup> TB/HIV: a clinical manual, WHO/HTM/TB/2004.329 p.46

For TB case management it is recommended to train not only TB physicians, but other medical/nursing staff too. This will have the advantage of a larger implication of primary care in TB control.

Special consideration should be given to conflicts of interest.<sup>36</sup> Health is rarely a priority for prison administrations, which are more concerned with prison security and discipline. The health needs of individual prisoners or the prison population may come into direct conflict with security, judicial or legal requirements. An example would be the transfer of a prisoner with TB from a TB facility to a place where treatment cannot be assured.

In some situations, health staff may also be required to act as security staff. This creates many conflicts of interest between priorities for security and health. Such conflicts of interest damage the trust in the patient-carer relationship, impact negatively on patient confidentiality and often place prison health staff in a very difficult position.

In some countries health staff in prisons is part of the militarized organizational system of subordination. An example would be that a physician working in prison is considered primarily an officer, and secondarily a physician. This militarized organizational system has the power to put pressure on individuals to follow orders and limits the autonomy of health staff to deal primarily with health.

Conflicts of interest might decrease the professionalism of health staff, increase the rate of conflicts in prisons or decrease the motivation of staff, which is partly reflected in the high turnover rate.

Prison health staff may be poorly motivated because of lack of resources and consequent poor prognosis of patients, salaries that are low and/or late, lack of training and access to up to date medical literature and the hazards and stigma of prison work. Many prison health staff are isolated from their peers or forgotten by training programmes.

## **6.6 Efficient Drug Management**

Efficient drug management implies an uninterrupted supply of all essential anti-TB drugs with an internationally acceptable quality of anti-TB drugs and laboratory consumables.

Health services in prison are often badly under-funded. Access to health is therefore restricted because of lack of resources - accommodation, equipment, transport and staff - but also infrastructure and consumables such as diagnostic materials or medicines. Effective diagnosis and treatment are dependent on an uninterrupted supply of laboratory consumables and all first line anti-TB drugs. Without laboratory consumables health services fail in early diagnosis and treatment follow up. The only acceptable way to treat TB with standard treatment is to have available, on a constant basis, all first line drugs. If one or two first line drugs are missing, then the health staff is left in a dilemma: to treat with one, two or three drugs and to create drug resistance; or not to treat at all? (If we compare the second option with the first one, then it is better, from a public health perspective, to choose the second, which at least follows the requirement not to create drug-resistance).

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<sup>36</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.36

What is to be done if resources are not available for essential anti-TB drugs? The best choice is to supply all 5 first line drugs to high priority patients, new smear positive cases and other smear positive cases, as well as HIV/TB cases regardless of smear results. This approach will fit with the basic objectives of the TB control programme. But if resources are available then all TB cases should have access to standardized treatment in full range.

There are many models for organizing an uninterrupted supply of drugs. However, a good supply system foresees all first line drugs for an estimated number of patients for the entire duration of treatment, a certain percentage of drugs available in stock, quarterly distribution depending on the number of reported cases and the remaining amount of drugs from the previous distribution. It is very important to establish a reliable system of recording and reporting drug usage.

A critical aspect in drug management which sometimes might not be taken into consideration is the time required between follow up shipment calculation and receipt of drugs by patients. There are a few steps to calculate and organize: calculation of drugs, availability of funds, organization of procurement (via tender or direct procurement from an international non-profit agency), transfer of funds, transportation of drugs, customs procedures if imported and/or registration of drugs where required, quality control, organization of distribution to periphery's drug storage, distribution to TB facilities. Bearing this in mind shipments should proceed when a reasonable amount of drugs is still in storage to secure the period of drug supply.

Another important aspect is the quality of drugs and lab consumables. Quality control of drugs has a few levels of control. One of the most efficient is testing bioavailability, which is a very expensive test and requires a sample sized technique. Drugs with GMP certification have higher levels of credibility and it should be mentioned that there are international non-profit agencies accredited by World Health Organization, which provide high quality drugs (with laboratory analysis) for acceptable prices (examples are IDA and GDF). If the anti-TB drugs are of low quality, for example if bioavailability is only 50%, then patients will receive only half a dosage of the required drug, with the consequence of low treatment success and creation of drug-resistant TB.

### **6.7 Infection Control for Reduction of the Risk of Infection among Inmates, Visitors and Staff**

Prisons are associated with high levels of transmission of TB, so prisoners, staff and visitors are at increased risk of the disease. Staff protection from occupational hazards is a basic obligation of all employers.

The risk of transmission of infection depends on the concentration of infectious droplets in the air and the duration of exposure. That is why the most effective way to reduce transmission of TB is early diagnosis and effective treatment of all infectious TB cases. Poorly applied infection control measures or badly functioning equipment can do more harm than good because of the false sense of security they encourage.

Prevention of TB in institutions is based on three levels of infection control: administrative, environmental and personal respiratory protection. Administrative measures are the highest priority followed by environmental and personal respiratory

measures.<sup>37</sup> The description of these measures is adapted from “Tuberculosis Control in Prisons”, WHO/CDS/TB/2000.281.

### **6.7.1 Administrative Measures**

- Early diagnosis of potentially infectious TB cases – screening at entry, effective case finding through self referral, use of suspects’ registers, training and education programmes for staff and visitors, timely communication between laboratory and health personnel.
- Development of an infection control plan prioritizing the highest risk areas such as laboratories, sputum collection rooms, radiography and autopsy rooms, areas where prisoners with MDR-TB are held.
- Prompt initiation of effective and directly observed treatment, establishing systems to ensure completion of treatment if transferred during treatment, and an effective education programme.
- Prison health services should contain clear information about the principles of separation of TB patients. First of all smear positive cases should be separated from smear negative cases. If DST is available then drug-resistant cases (especially MDR-TB) should be separated from susceptible cases. If DST is not available or results are pending, then normally TB cases should be separated not only according to smear results, but smear positive patients should be separated additionally also according to case classification: new case, relapse, chronic cases. These types of separation reduce the risk of reinfection or suprainfection, especially with drug-resistant TB. HIV/TB patients are at a higher risk of reinfection.

### **6.7.2 Environmental Measures**

- Must be coupled with administrative measures above to be effective.
- Most simply, involves maximizing natural ventilation and controlling the direction of airflow by opening windows or external doors at opposite ends and using fans.
- Other more complex and costly methods include: mechanical ventilation (air extraction fans, exhaust ventilation systems), air filtration or ultraviolet germicidal radiation. These methods must be maintained in a good state of repair and installed with expert guidance and if used, should be prioritized for the highest risk areas (laboratories, sputum collection rooms, MDR-TB units).

### **6.7.3 Personal Respiratory Protection**

- Personal respiratory protection should only be seen as a complement to administrative and environmental measures and is not adequate when used alone.
- Surgical masks are not designed to protect the wearer. However, infectious TB patients may wear surgical masks to protect others during transport or meeting visitors for example. However, care should be taken not to stigmatize TB patients, and health education should accompany the distribution of masks.
- Respirators are a special type of mask that filter air inhaled and fit closely to face to prevent leakage. The specifications for protection against TB are that they

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<sup>37</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.137



must have 95% filter efficiency for particles of 0.3 micron in diameter. They should be fitted correctly. To test if respirators are fitted correctly one may stand in an area with nebulized sugar powder, and if a sweet taste is felt, it is an indication that the respirator is not fitted correctly.

- As widespread use of respirators is impractical and costly, their use should be limited to high risk areas (MDR-TB units, sputum collection, and laboratory).<sup>38</sup>

#### 6.7.4 Other Measures

In high TB prevalence settings tuberculin skin test and preventive therapy are categorically not recommended if effective control of active TB is not in place.<sup>39</sup> It is not feasible to try to detect, give and monitor preventive treatment to the prisoners with a positive skin test which may make up a significant proportion of the population (over 50% of new admissions to prison in one study). Using preventive treatment on cases where active disease cannot be reliably excluded may promote the development of drug resistance.

BCG vaccination acts by preventing the spread of TB bacilli in the body after initial infection rather than reducing the risk of infection. It has only been consistently demonstrated to reduce the risk of progression from infection to disseminated disease in children, while its protective role in adults is questionable.<sup>40</sup>

#### 6.8 Integration of Civilian and Prison Health Services

Usually health policies in most of countries are established and implemented by civilian health authorities. Many of these health policies are specially designed for most vulnerable groups. The efficiency of health services can best be assessed in prisons, because they are the “mirror” of society. Prisons are overrepresented by most of the vulnerable groups: orphans, homeless, mentally ill, substance abusers, the poor, former prisoners, ethnic minorities, etc. Many prisoners enter prison with certain diseases, with unhealthy habits, and in prison they might acquire additional diseases. On release their health might be worse. So if a society is already facing difficulties in control over communicable or somatical diseases, or mental health, in prisons all these difficulties represent a particular challenge.

Health is rarely considered a priority by the prison administration, which is mostly concerned with security, discipline and prison management. Resources might be also unavailable to perform most of the required health interventions. The amount of required health interventions is based on the principle of equivalence or equity of health care. Equivalence<sup>41</sup> of care means that prisoners have the right to the same standard of health care as the state provides for the general population. The principle of equity<sup>42</sup> of care considers that avoidable disparities in health status among individuals and groups are unacceptable and that provision of preventive and curative health care should be based on need. Therefore, there is a strong argument that, as prisons are often reservoirs of

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<sup>38</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.139

<sup>39</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.139

<sup>40</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.140

<sup>41</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.31

<sup>42</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.32

poor health and disease, comparatively more effort and resources should be directed towards raising the health status of prisoners to that of the community at large.

Prisoners may make up a significant proportion of the community with TB and HIV cases, sometimes over 10% of TB and HIV in a country are detained. This group is not entirely isolated from the society, there is a big turnover in prison populations, and many patients are released without diagnosis and completed treatment. Moreover, staff and visitors are also part of “outside” society. For these reasons, it is clearly in the interest of a civilian TB and HIV service to actively seek good TB and HIV control in prisons. As prisoners come from and return to sectors of society that may be very difficult for civilian health services to reach (e.g. the homeless or substance abusers), and given that TB cases originating in prison regularly enter the community and transmit their disease, civilian TB services cannot afford to ignore the prison problem. In the same way, prisons cannot ignore TB and HIV problems in the community.

Prison and civilian health services are administratively separate in many countries. Some historical disagreements or mistrust might blind civilian and prison health services to act in a coordinating manner.

Consideration of the above leads to the question of whether civilian and prison health services should be integrated or not. The Committee of Ministers of the Council of Europe recommends that: “Health policy in custody should be integrated into and be compatible with national health policy”.

What benefits might the integration of civilian and prison TB and HIV services bring?

Firstly, the experience of the civilian TB and HIV services in establishing TB and HIV control programmes in the community may be invaluable. Many systems and procedures could be adapted or used in prisons. Such systems would include the procurement and storage of drugs and laboratory materials, staff training, sharing of human resources, laboratory network for quality control, access to drug susceptibility testing, specialised equipment and specialised treatment (i.e. lung surgery), recording and reporting systems, and patient educational packages. Unnecessary expenditure could be reduced and the standardisation of and equivalence of care encouraged.

Secondly, in the interests of TB and HIV control in prison, as well as in society at large, it is imperative that prisoners released on treatment are given the possibility to complete it in the community. This is important for individuals to ensure their cure and for society, but also for the prison administration. These people may be re-arrested in the future and bring their uncured or even drug-resistant TB or drug-resistant HIV back with them to prison. Accurate rates of recidivism are not always known but some surveys indicated that 60% of prisoners had been incarcerated in the past, while 45% had three or more prior sentences. Likewise, given the subculture often associated with crime, it is conceivable that inadequately treated ex-prisoners may transmit their TB to future offenders.<sup>43</sup>

Thirdly, prison health services have extremely valuable knowledge of managing what can be a difficult and manipulative population and the potential structural and administrative pitfalls of establishing effective TB and HIV control in prisons.

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<sup>43</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.45

For a more effective and sustainable control of TB and HIV in any country it is necessary to establish National TB and National HIV Control Programmes, where both areas are represented: civilian and prison health services. Such involvement is likely to be mutually beneficial to both sectors. Having one authority with overall responsibility for TB and HIV control for all prisoners, former inmates and civilian society provides the best solution.

In some countries (e.g. Norway) civilian health authorities have been made completely responsible for prison health and this is reported to have contributed to improved health services and to strengthening of the respect of human rights of prisoner-patients.<sup>44</sup>

However, integration of services should be built carefully taking into account the following:

1. The need to alleviate concerns of detaining administrations about others operating in areas of their responsibility (clearly a high degree of trust and mutual co-operation is required);
2. The fact that prison health (including TB and HIV) may come last on the priority list of an already stretched civilian health service, so leading to less than adequate care in the prison context.<sup>45</sup>

The planning of an integrated service must be carried out in a coordinated and participatory manner, under the leadership of the most appropriate authority – e.g. Country Coordination Mechanism, or Health High Level Decision Making Board (governmental levels), or National TB and HIV Control Programmes (interdepartmental levels), if they are established. Normally, prisons should be represented during the decision making process regarding integration. Health policies and responsibilities across all parties must be identified and accepted. The most effective management should be established, taking into account strengths and weaknesses of each party. Legislation may need to be reviewed, the management system, technical policy, interdepartmental agreements, joint monitoring and evaluation procedures formalized in writing and endorsed. Responsibility for the payment of services provided by both sectors must also be addressed and the necessary budget planned. If serious financial gaps are identified, that are limiting integration of prison and civilian TB control programmes (or integration of prison and civilian HIV control programmes), then National TB and HIV Programmes should insist on separate budget lines to cover the needs of both prison and civil health services. For example in some countries government or local authorities could have a separate budget for the Ministry of Health for medical examinations like DST or HIV testing and specialised treatment for patients coming from vulnerable groups. So if prisoners are also officially recognized as a vulnerable group then they might benefit from these services. Even if separate budgets for integration are not available, then some steps that do not require financial commitment might be undertaken.

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<sup>44</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.45

<sup>45</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.45

An example of a framework for integrated tuberculosis control services is presented in the table below (adapted from “Tuberculosis Control in Prisons”, WHO/CDS/TB/2000.281. p.47).

**TABLE 1: FRAMEWORK FOR INTEGRATED TUBERCULOSIS CONTROL SERVICES**

<b>Area of responsibility</b>	<b>Prison</b>	<b>Civilian</b>
<b>Political commitment</b>	Shared and equal commitment to TB control and determination to create integrated services.	
<b>Technical policy</b>	Additional aspects for prisons – active case-finding and screening, on entry policies, preparation for release, additional MDR preventive policies (limitation of TB treatment category III or preventive treatment)	Responsible for National TB technical policy for case-finding, treatment, recording and reporting. To be used in every sector.
<b>Diagnostic facilities</b>	Provision of level 1 laboratories accessible to all prisons. Transport of specimens. If prisons do not have their own laboratories, an agreement with civilian laboratories should exist.	Provision of level 2 and 3 laboratories accessible to analysis of samples originating in prison system. Delivery of results.
<b>Treatment facilities</b>	Provision of basic treatment facilities accessible to all prisoners with infectious TB.	Provision of hospital services for the severely ill.
<b>Management of transfers</b>	Establishment of a rigorous system of notification for transfers into and out of prison and between prisons.	
<b>Recording and reporting</b>	Standardized (WHO-DOTS) recording and reporting system. Cohort analysis and quarterly reports to be submitted to civilian sector.	Collection of prison data. Reporting of prison data that is identifiable as such with national statistics.
<b>Staff</b>	Staff recruitment, employment conditions and job descriptions. Training in management of transfers. Provision of security rules. DOTS training, training in human rights, penal law and prison management.	Training in TB technical policy – case-finding, treatment, recording and reporting. Occupational health and safety standards.
	Identifying most optimal ways for the gradual transfer of prison health to civilian health services.	
<b>Supplies</b>	Ordering, storage, end-point distribution and monitoring. Direct observation of all TB treatment.	Procurement, transport, storage, distribution and monitoring of drugs, laboratory and stationary supplies (standard forms and registers). Assurance of quality.
<b>Education</b>	Prison specific educational materials for staff, inmates and visitors.	General educational materials for TB patients, their families, and for the entire community.
<b>Management and supervision</b>	Day to day management and supervision of the programme.	Overall responsibility for management and supervision.

<b>Prison living conditions</b>	Provision for all prisoners basic needs – including suitable accommodation, ventilation, nutrition, hygiene, general health care promotion, respect for human rights.	Governmental and/or non-governmental monitoring of compliance to voluntary codes and UN Minimum Standards.
<b>TB decisional levels and working groups</b>	Active involvement of representatives of the prison health service in national TB decisional levels and working groups.	
<b>Integration with other health services</b>	Integration with other health services: national HIV control programme, national drug addiction programme, etc.	

Sometimes civilian TB and HIV services are non-functional, while high rates of TB and HIV in prisons are real threats to health and life of inmates, staff, visitors and society at large. In this case if prison health services decide to implement a TB control programme based on DOTS strategy, then it still might have good results in achieving its objectives to decrease TB morbidity, mortality and prevention of drug resistance. The most serious consequence is the inability of patients to complete the treatment following release or amnesties. This problem is more evident during DOTS-plus when MDR-TB patients are treated for 24 months. It should be mentioned, that it is not ethically permissible to discriminate and to restrict access to diagnosis and treatment for any reason related to detention – whether it be related to the remaining time of incarceration, prison regime, gender, crime or any other reason. Also from an epidemiological point of view it is incorrect to exclude from treatment patients in need of treatment who are continuing to transmit infection, while in prisons there is a constant difficulty in predicting length of remaining detention/imprisonment (e.g. in the case of pre-trial prisoners, amnesties). Moreover, shortened treatment regimens have been demonstrated to increase the likelihood of relapse, but have not been demonstrated to create MDR-TB, unless followed by anarchic treatment.<sup>46</sup> So, if a prison TB service is to go ahead without the involvement of civilian services an effective mechanism to ensure that patients can complete treatment, if they are released, must be found that is both acceptable and feasible.<sup>47</sup>

## **6.9 Increasing TB/HIV Awareness/Common Unhealthy Behavioural Patterns and Ways to Change Them**

In both infections education is a crucial issue for patients, staff and the community.

Over 90% of TB cases expose symptoms of disease (cough over 3 weeks, or modification of cough for over 3 weeks with smokers or with patients with chronic pulmonary disease, weight loss, loss of appetite, fever and night sweating, sometimes thoracic pain). However, many TB cases are diagnosed late, even if diagnosis is accessible (many prisons report over one quarter of TB cases with massive destruction). This is a sign of very low level of TB awareness and/or low level of access to early case finding.

<sup>46</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.48

<sup>47</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.48

Treatment compliance is another challenge for health staff, a lot of effort being required to explain the necessity to follow the treatment regularly up to the completion of treatment.

The efficient prevention of HIV is also dependent on the increase in awareness among the general community and among target groups. Most effort should be concentrated not on “what is good and what is bad” but on “how is it safe, and how is it unsafe”. Educators in HIV prevention should be careful in making this distinction, because their role is not to blame some socially unacceptable actions (like intravenous drug use, or sex between men, or numerous sex partners), but their role is to encourage safer practices to avoid infections like HIV, Hepatitis C, or STI (practicing sex with condoms, or safer drug injecting techniques).

To ensure success in TB/HIV awareness it is necessary to follow a few principles:

- Continuity: awareness campaigns should be done continuously, especially in an environment with high turnover, like prisons.
- To concentrate large amounts of information in a few main messages. Positive messages are more efficient than negative ones, and are not frightening.
- To focus on the main issues that are vital for TB/HIV control and that are not understood by patients, staff or the community.
- Information should be explained in an attractive manner using non-stigmatizing and understandable language.
- Wherever possible, members of the target audience should participate in the design and production of materials.<sup>48</sup>

A very efficient way of education is peer education, when education is done by trained representatives of the same group, e.g. HIV and TB education for inmates is done by a few trained inmates. This increases the credibility of the information supplied to peers (since as a rule the level of trust to prison authorities is low among inmates, they would be more sensitized by information delivered by another inmate, who is in the same situation as them).

It is very important for TB and HIV control to identify the most common unhealthy behavioral patterns and to find ways to change them. Example: A person was tested for HIV a couple months ago and was found to be HIV negative. Therefore he/she is considered by other persons as “one hundred percent safe” for unprotected sex or unsafe drug injection. But any person after being infected with HIV has a period when he/she serologically might be negative and this might be during HIV testing, and moreover since the last test the person might already have been exposed to unsafe sex or unsafe drug use, resulting with infection. That is why it is safer to consider any person as potentially infected, and to apply the rule “to protect that person and oneself”.

So for better results in TB and HIV control, prison health services should foresee in their action plans interventions relating to awareness and behavioral patterns.

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<sup>48</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.130

## **6.10 Monitoring and Evaluation of TB/HIV Control Programmes**

Monitoring and evaluation in TB/HIV control are good tools in identifying if the adopted policies are implemented or not, the quality of implementation and the challenges during implementation. In an integrated health service joint monitoring has shown to be very efficient not only for quality control and information collection, but also as a good opportunity to correct some mistakes and to perform short high efficiency trainings.

TB/HIV programmes could use continuous monitoring to identify weaknesses and opportunities to further improve TB/HIV control.

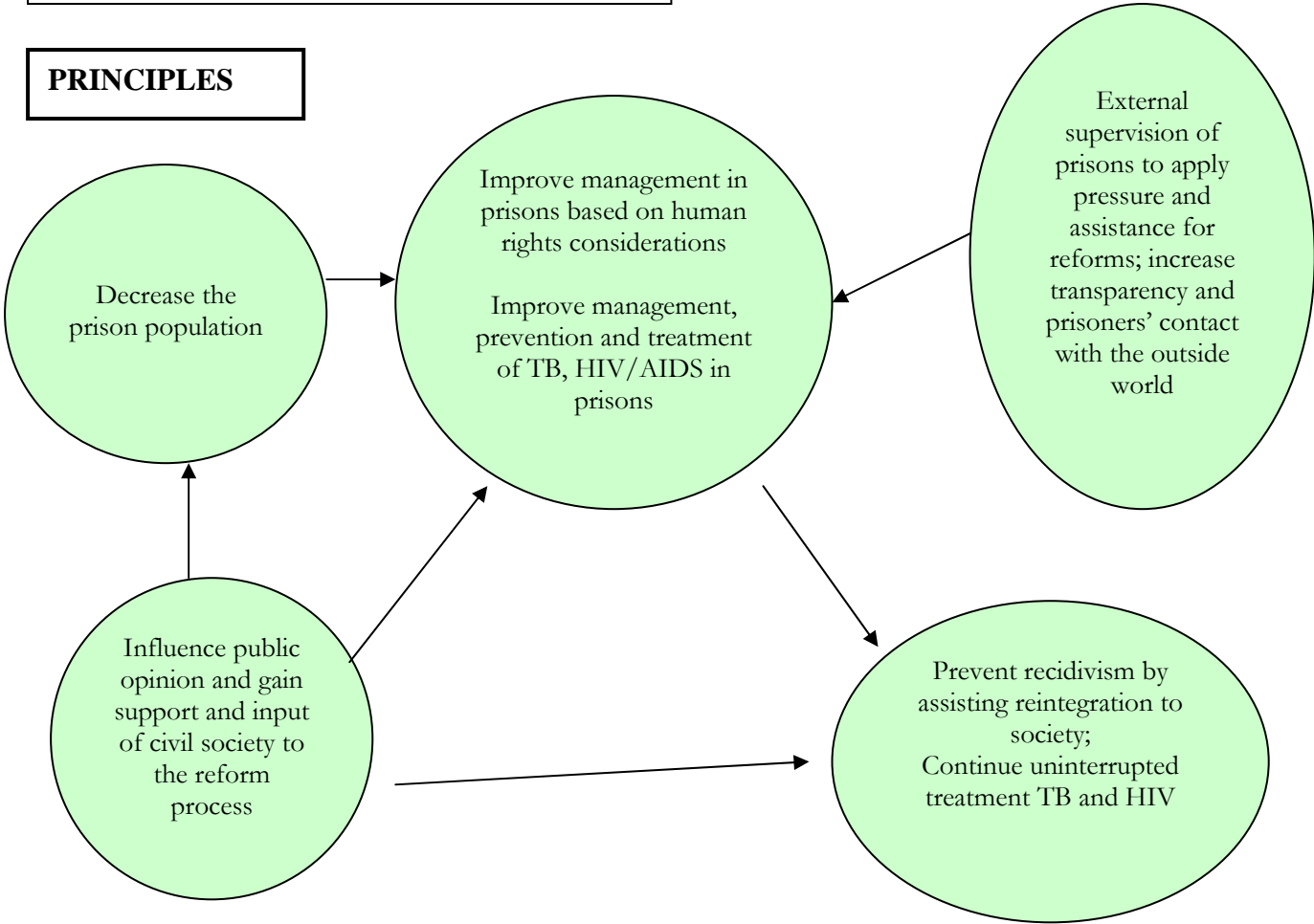
## **6.11 Reviewing Legislation to Avoid Double Standards and Discrimination**

Very often TB and HIV control programmes encounter problems when legislation is not reviewed to avoid double standards. It is therefore very important to update legislation to the needs of TB and HIV control programmes. A classical example would be adopting international strategies (e.g. DOTS for TB control) without any serious modification of the previous policies, resulting in confusion from: double method of case notification, double classification of cases, double case management, unclear drug supply mechanism, etc. In many countries National TB and HIV Control Programmes work in a virtual way, their decisions being mostly considered “recommendations” by health authorities, and moreover without clear financial commitment.

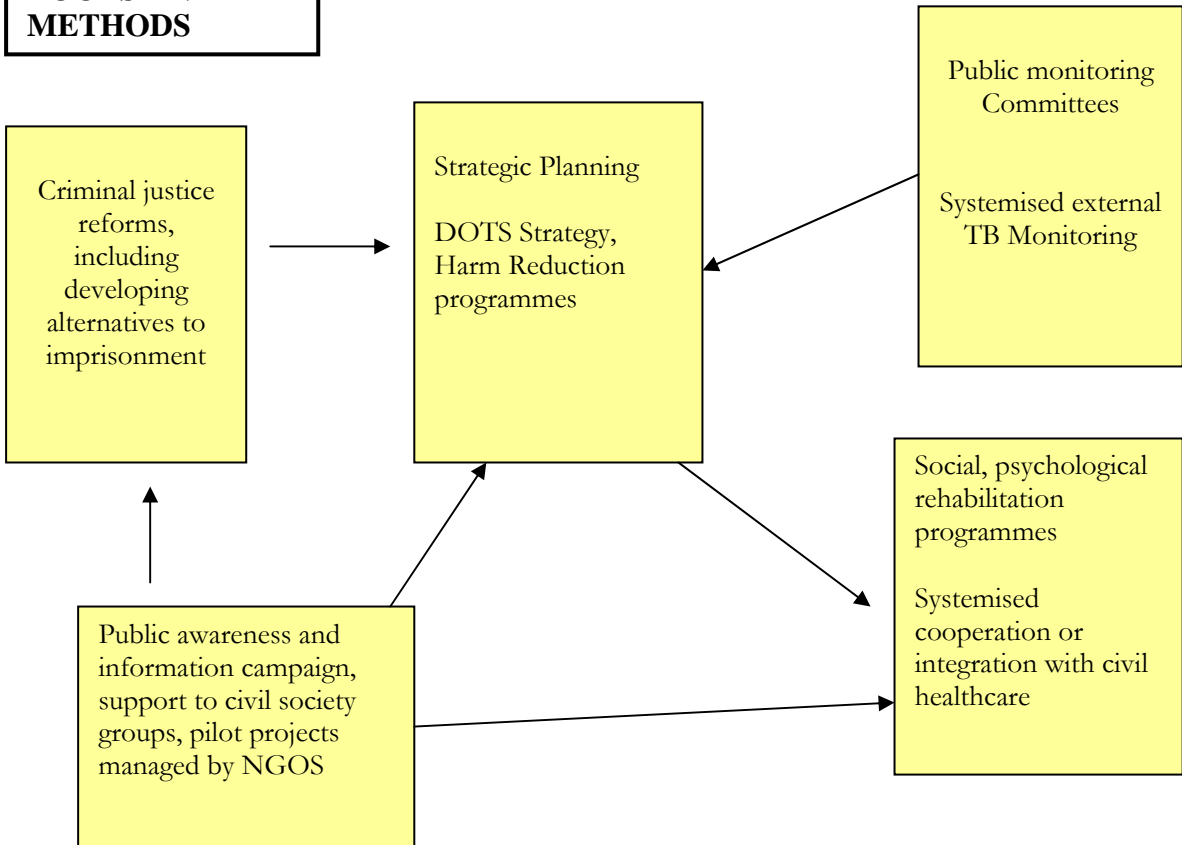
Another aspect of legislation review is the need to avoid discrimination of TB and HIV patients, especially in prisons. The more restrictive the legislation, the more area for discrimination and stigmatization is created, making TB and HIV a potential legislative threat to the patient or suspect. A more efficient way to influence these epidemics is through community mobilization and support, and not by “punishing” those who have an infectious disease. If legislation is not discriminating and the community is supporting these patients, they have an increased motivation to follow prevention rules and/or to take treatment regularly. In the opposite case, restrictive legislation shows lack of understanding and promotes unhealthy behaviour within these groups of patients. For example if HIV patients are refused access to some benefits of the community, it might happen that they will have to conceal their HIV status; or if TB patients are afraid of “enforced” treatment, then they will try to escape anyway, sometimes just to show their disapproval of existing “rules”.

**Chart 4: General Principles, tools and methods**

**PRINCIPLES**



**TOOLS AND METHODS**





## CHAPTER 3

### **KAZAKHSTAN: ACHIEVEMENTS**

#### **1. PRISON REFORM PROGRAMME**

It is impossible to say that all the achievements listed below are direct results of the PRI/KNCV programme, though many of them are a very clear outcome of activities undertaken within the joint programme. At the same time, the influence of the programme, which was implemented in close partnership with KUIS, Ministry of Justice of Kazakhstan, is clearly evident in many other positive developments. The immense influence of the PRI/KNCV project on changed penal policies was underlined by senior level prison staff and NGOs met in October 2005. This included the closer integration of human rights and health issues, both in legislation and in practice.

##### **1.1 Structural and Legislative Developments**

The prison system (excluding pre-trial detention facilities) was transferred from the Ministry of Interior to the Ministry of Justice in January 2002. The transfer of pre-trial detention facilities to the Ministry of Justice took place in January 2004. The transfer was one of the main recommendations of the Conference on Alternatives, organized by PRI/KNCV in Almaty in 1999. The transfer of the prison system to the Ministry of Justice was an important step towards the implementation of international standards, putting into practice the principle of separating the powers between those who are responsible for the investigation of crimes and those who are responsible for the upkeep of persons who are awaiting their trial or who have been sentenced to imprisonment. The transfer has had a very positive impact on the reform process in Kazakhstan. Most importantly, this step reduces the reasons for possible human rights abuses by prison authorities (in the investigation of crimes) and in practice changes the understanding relating to the aim of imprisonment.

Regional strategic plans from pilot oblasts (Kazakhstan II project) were used in preparing the Prison Committee's National Programme for the Development of the Penal System for 2004-2006. This programme has had an immensely beneficial effect on the prison system in Kazakhstan. It has also been noted that the new national programme which will cover the period 2007 to 2015, is based on strategic plans from oblasts. This is evident from its contents.

The national programme for 2004-2006, and the draft programme for 2007-2015, are characterized by a fundamental change in the approach to the penal system. This was the ultimate goal of the PRI/KNCV project, when it first started in 1998. The principle underlying the latest programmes is the need to reintegrate offenders into society and to keep out of prison those who do not represent a threat to the public. This contrasts with the previous punitive understanding of imprisonment. The draft programme highlights the need for a further conceptual change in the approach to imprisonment and non-custodial sentences.

The draft programme for 2007-2015 "Development of criminal executive policy in the Republic of Kazakhstan" reflects the conviction that prison reform cannot be undertaken in isolation from other sectors of the criminal justice system and puts forward the need of close cooperation between all relevant state agencies and non-

governmental organizations. The two main aims are stated as bringing conditions in prisons closer to the requirements of international standards, both in legislation and in practice, while improving the system of alternatives, to allow for their wider use. The complete abolition of the death penalty is also recommended.

The draft programme recognizes the need to improve the system responsible for the execution of non-custodial sanctions, both in legislation and in practice. It proposes the establishment of a probation system, with an increase in the budget allocated to criminal executive inspections (CEIs), and the staff quota. It recognizes the problems encountered in the introduction of new alternatives such as community service, both due to shortcomings in legislation and lack of clear implementation mechanisms. It highlights the increasing requirement to improve efforts to reintegrate offenders into society, starting from the first day of their imprisonment and including the period after their release. It proposes making major improvements in the education and vocational training possibilities offered to prisoners, as well as work opportunities. It aims to integrate the education in prisons with the civil education system. As in the previous programme, it underlines the principle that work should be of benefit to the prisoner, rather than aiming to make profit for the system. It provides for increased coordination between prison and civil health services. It acknowledges that better staff selection and training is required, as well as improved social and psychological support for prison staff.

KUIS has given PRI a chance to comment on the draft programme, which in itself is a clear reflection of the level of cooperation between prison authorities and civil society. PRI, acknowledging the positive steps outlined in the concept, has put forward its concerns and recommendations with regard to specific points.

Financing for the penitentiary system was increased significantly in recent years (especially as part of the national programme, 2004-2006), as a result of a higher level of attention to the human rights situation in prisons by the Ministry of Justice and KUIS. This was a direct or indirect result of the programme implemented by PRI/KNCV in partnership with KUIS. In 2001 the budget allocated for the upkeep of convicted prisoners was 5.7 billion tenge, which covered 51.1% of the needs, 6.4 billion tenge in 2002, covering 63.5% of the needs, 7.5 billion tenge in 2003, covering 73.9% of the needs, 10.4 billion tenge in 2004, covering 87.6 % of total needs.<sup>49</sup> (The total budget increased from 9,374 million tenge in 2003 to 14,892 million tenge in 2004). The share of budget allocated for the upkeep of one prisoner went up from 134.7 tenge (approx. USD 1) per day in 2003 to 174.4 tenge (approx USD 1.29) per day in 2004.<sup>50</sup> Interviews with prison staff in the two pilot oblasts visited in October 2005, confirmed that the increase in budget, coupled with the reduction in the prison population had led to increased access to better food, medication and other material needs in their prisons..

The joint order issued by the Ministries of Justice and Health on 25 May 2004 improved the coordination between prison and civil healthcare services. (Prior to this the medical personnel in prisons worked according to a Ministry of Interior order from 1992).

Prisoners benefited from a number of legislative changes and orders, addressing specific needs in prisons. For example, prisoners' right of contact with the outside world was

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<sup>49</sup> Pavlodar Monitoring Committee Report, April 2005, p. 9

<sup>50</sup> Informatsiia o deiatel'nosti ugolovno-ispolnitel'noi sistemy Ministerstva iustitsii Respubliki Kazakhshtan v 2004 godu, pp. 23, 24

improved with changes made to the Criminal Executive Code, which lifted limits on frequency of phone calls by prisoners. (Previously prisoners could only use the phone four times a year for 15 minutes each). A governmental order on the provision of food, free-of-charge, to pre-trial detainees, prisoners, and special categories of prisoners came into force in January 2004, improving the quality of nutrition in prisons.

A positive development with respect to staff training was the transfer in 2004 of the Kostanai Law Institute to KUIS. This reflects KUIS's intention, expressed in the national programme 2004-2006, and the current draft programme, to improve the qualification of staff. The focus of training in this institute will be, according to the draft programme, on legal specialists, pedagogues and psychologists for the penal system. Aids Foundation East-West (AFEW) is currently working on a basic programme for staff training "Health in the Penal System", in the resource centre established at this institute. It is expected to be adopted this year and included in the programme from September 2006. (Courses on law and human rights will also be taught separately). In future there are plans to expand the programme to cover staff already working in the prison system.

A stage-by-stage transfer of security functions exercised by the Ministry of Interior to the Ministry of Justice has been intended, since the transfer of the prison system. The transfer of controllers (guards) from the Ministry of Interior to the Ministry of Justice was undertaken in 2002. The draft programme includes the intention of transferring responsibility for all security functions, which would include in particular the perimeter security of prison colonies and SIZOs, from the Ministry of Interior to the Ministry of Justice. This would be a very positive step towards full demilitarisation.

In 2002 a psychologists' service was established in prisons. In 2005 the number of posts for psychologists in each prison establishment was increased to three. Their training is lacking, but courses to be developed in Kostanai Law Institute may address this need.

## **1.2 Strategic Planning Training and Practice**

20 national trainers were trained as trainers in strategic planning. 195 prison staff was trained by these trainers in a roll-out programme that covered regional departments and prison colonies in three pilot oblasts and regional departments of 10 oblasts. In Pavlodar 21 staff were trained in strategic planning, including regional department and prison facilities by international experts. Currently a number of the national trainers have high positions in KUIS and regional prison administrations.

Akmola and East Kazakhstan Oblast' high level staff said that they were still using strategic plans to improve conditions in their prisons, although the project has formally come to an end and this is not yet an official requirement by KUIS. They are doing this, they say, because the benefits are visible.

In Akmola Oblast' they have been using their 5-year strategic plans to complete their quarterly internal plans – the plans which are required for the existing official prison system planning. They find this to be easy and useful.

It must be noted, of course, that many plans can be implemented due to the increased budget for the prison system, thanks to the National Programme for the Development of the Penal System, 2004-2006. However, many other changes are not dependent on funds, but on a change in approach, creativity and motivation in individual colonies. It must also be remembered that the national programme itself was based on strategic plans from

pilot oblasts, so there is a concordance between the national plan and strategic plans, with the latter including more detail for each region and colony.

During interviews conducted in October 2005, all high level prison staff highlighted the fact that staff who had received training in strategic planning were clearly more advanced compared to other staff. They had increased interest in their work, a broader outlook and understanding, increased competence in prison management, from a human rights perspective.

A Strategic Planning Resource Centre and a Consultative Council on Strategic Planning was established by the central prison administration, by order dated 12 July 2005. This step had been recommended by PRI and an agreement had been signed between PRI and KUIS, prior to that date. According to this agreement, the Resource Centre will have the responsibility to:

- Introduce strategic planning, as an official planning method, into the prison system of Kazakhstan;
- Create a database on strategic plans from regions and provide informational support to regions;
- Assist with staff training in strategic planning, international standards for human rights, treatment of prisoners and management of prisons based on a human rights approach;
- Assist with the organisation of training seminars for prison staff, provide information and teaching materials, expert advice and technical assistance, for this purpose;
- Carry out scientific-analytical research and formulate recommendations for improving legislation and practice relating to the penitentiary system;
- Provide penitentiary system staff with the latest technology to access internet, e-mail and internal computer networks, in order to help them reach sources of international information relating to their profession;
- Assist with establishing cooperation with penitentiary services, educational and human rights organisations from CIS countries and others.

Responsibility for managing the Resource Centre is with KUIS, which has appointed a senior member staff (Head of Department responsible for alternatives to prison) to undertake this task, together with a member of the Organisational-Analytical Department and Head of Educational Department.

So a facility to work on the introduction of strategic planning into the penal system, to continue organising staff training, both in strategic planning and other areas, to carry out research and to manage information, is currently available to KUIS. One important aim is for this centre to develop KUIS strategic plans, i.e. the national reform plans for the penal system, based on strategic plans from oblasts.

The Resource Centre and the Consultative Council help ensure that responsibility for project leadership is passed on from PRI to KUIS, to be assisted by NGOs and other key stakeholders involved in penal reform in Kazakhstan. These are important steps towards sustainability.

However, there have been senior level changes in the prison administration, including the Chairman of KUIS on a number of occasions, since the PRI/KNCV project formally

came to an end in 2004, and most recently after the agreement was signed in relation to the resource centre activities. Thus, currently there is lack of clarity as to the future of training and the introduction of strategic planning as the official planning system of KUIS. During a meeting by the authors with senior members of KUIS in October 2005, it was stated that there was an intention to continue training and funds for this would be allocated in the budget. It was also stated that commitment continued to either integrate strategic plans with the current planning system or to use them in parallel.

### 1.3 Changes on the Ground

The management in prisons, based on a human rights approach improved significantly in the four pilot oblasts. An evaluation carried out in 2003 confirmed this.<sup>51</sup> The evaluation identified improvements in human rights in prison management, based on prisoner and staff questionnaires, prison inspections, meetings with officials, prison staff, NGOs, monitoring committees and former prisoners. The following are some of the results of anonymous prisoner questionnaires, which are cited in the evaluation report:

**Table 2: Dynamics of the Human Rights Situation in Prison Colonies in Pavlodar and East Kazakhstan (EK) Oblasts<sup>52</sup>**

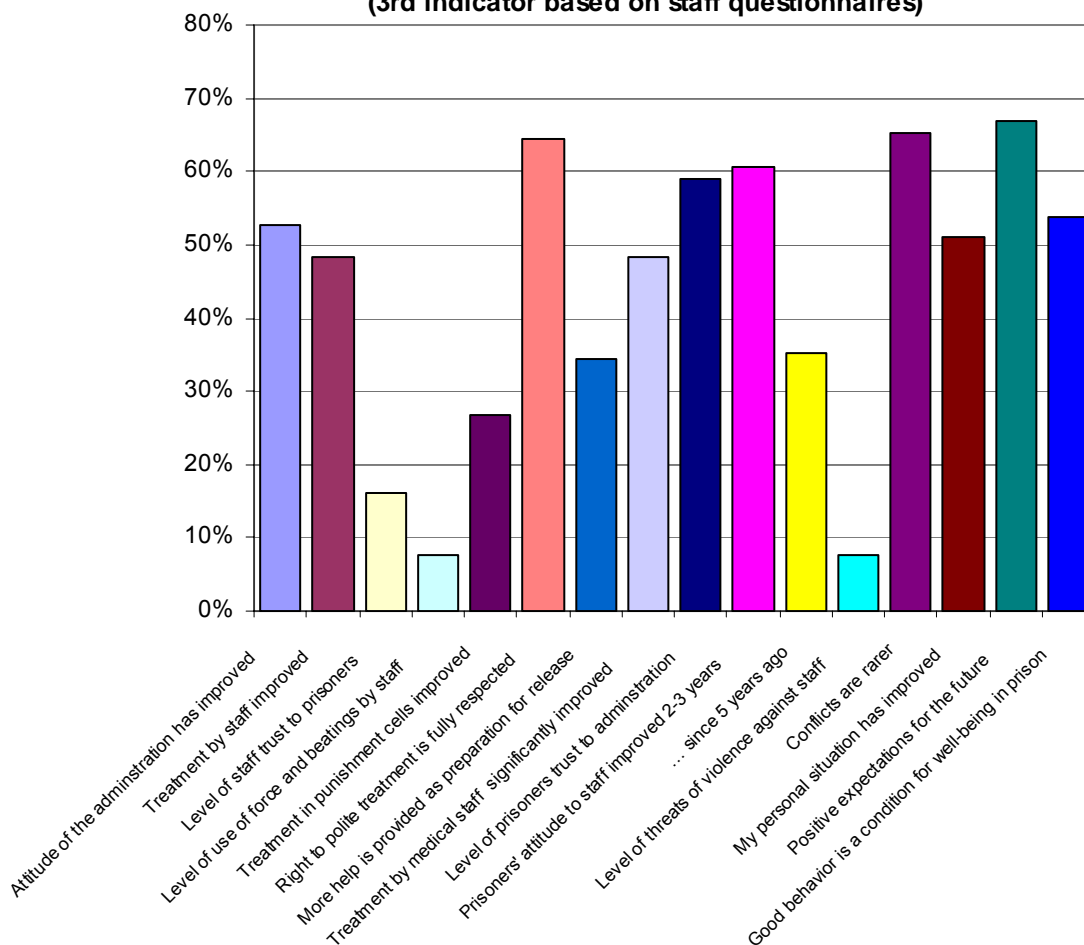
Indicators of human rights situation in prison	Percentage of positive answers by prisoners	
	Pavlodar	EK
Conflicts in prisons have become rarer	65.3%	61.5%
The level of violence has been reduced in the past 2-3 years	62.4%	64.6%
Prisoners fully enjoy the right to personal safety	65.6%	44.6%
Prisoners fully enjoy the right to respectful treatment	64.5%	41.5%
Treatment by staff improved	48.4%	36.9%
Food has improved	65.6%	47.7%
Living conditions have improved	53.8%	41.5%
Prisoners fully enjoy the right to humane living conditions	53.7%	32.3%
Medical care significantly improved compared to 5 years ago	48.4%	33.8%
Medical care is not OK	19%	35.4%
The main problem (in healthcare) is the attitude of medical staff	5%	13.8%

These figures showed a marked improvement in many areas, especially those relating to prisoner-staff relationships. They also demonstrated that more improvements had been achieved in Pavlodar Oblast, compared to East Kazakhstan. It was evident that in Pavlodar, where the project had started much earlier, more time had been available for changes in attitude to be reflected in staff behaviour and other elements of prison life, and for prisoners to acknowledge these improvements.

<sup>51</sup> Final Evaluation of the "Pavlodar Project" (1998-2000), Mid-term Evaluation of the "Kazakhstan II Project" (2000-2004), April 2003, Tomris Atabay, Valery Sergeev. (Henceforth "Evaluation Report, 2003")

<sup>52</sup> Based on information in Evaluation Report, 2003, p. 14, 15

**Pavlodar: Indicators of staff-prisoners relations**  
**Based on prisoner questionnaires**  
**(3rd indicator based on staff questionnaires)**



**Chart 5: Staff-prisoner relationship in Pavlodar Oblast, 2003<sup>53</sup>**

The change in staff attitude, which had been regarded as one of the most difficult tasks by many at the beginning of the project, was a particular success, since the nature of staff-prisoner relations is one of the most important indicators of a healthy prison and a positive environment.

Chart 6 above demonstrates the change in prisoner staff relationships in Pavlodar Oblast, which is reflected in more hope for the future.

The change in prison atmosphere and improvement of the relationship between prisoners and staff was also reflected in the number of prisoner offences. By 2003, three years after the end of the project in Pavlodar Oblast, the overall figures for prisoner offences per 1000 prisoners were as follows:

1998	1999	2000	2001	2002	2003
617	507	417	357	339	338

<sup>53</sup> Evaluation Report, 2003, p. 30

In 2001, the average number of prisoner offences in Kazakhstan, per 1000 prisoners, was 453. This figure increased to 517 in 2003. In contrast the trend was downwards in Pavlodar Region and the figures lower. What is particularly encouraging is that prisoner offences continued to decrease after the project had officially come to an end, indicating the sustainability of achievements.

In 2004 there was an overall reduction in prisoner offences in Kazakhstan and the trend is continuing in 2005.<sup>54</sup>

Regional figures from oblasts (East Kazakhstan and Akmola) and colonies visited in October 2005 confirm that this change in trend is evident in the two pilot oblasts. In Akmola Oblast' there had been a dramatic decrease in prisoner offences between 2004 and 2005, from 345 per 1000 in 2004, to 87 per 1000 in the first 10 months of 2005. In comparison the figure was 532 in 2003. In East Kazakhstan Oblast', there had been a reduction from 504 per 1000 in 2004 to 340 per 1000 in the first 10 months of 2005. In comparison the figure was 606 in 2003.

In Akmola Oblast' the use of punishment cells (DIZO, ShIZO, PKT: short and long term punishment cells) had reduced around 8-fold between 2004 and 2005. In East Kazakhstan Oblast', the reduction was around 1.3-fold.<sup>55</sup>

This trend demonstrates not only an improvement in prisoner-staff relations, but also the fact that improvement of human rights in prisons does not lead to lack of discipline, as feared by some. Taken together with the reduced use of punishment cells, especially in Akmola Oblast', it can be concluded that discipline is not achieved by the adoption of punitive measures, but by a change towards a more humane approach. Indeed, it is now acknowledged that prisons run safely and positively with the co-operation of prisoners. External security (prevention of escapes) and internal safety (prevention of disorder) are best ensured by building positive relationships between prisoners and staff. This is the essence of dynamic security.

Better living conditions and fairer treatment of prisoners appears to be reducing the influence of prison criminal leaders (authorities). This development was reflected in questionnaires, used as part of the evaluation in 2003.<sup>56</sup> At the time, Pavlodar Oblast', where the project had been running for a longer period, was ahead in this respect compared to East Kazakhstan Oblast'. There is no doubt room for improvement in this area, which depends also on the quality of staff training and improvement of the individual approach to prisoners' re-socialisation needs.

Basic prison conditions have improved in oblasts visited, including better sanitation and hygiene facilities, more space for each prisoner, single beds instead of bunk-beds (which improves access to natural light), better food and improved conditions in punishment cells. For example, the size of windows in most punishment cells was increased in pilot oblasts, and the possibility of opening from within introduced. This ensures access to proper ventilation. The improvement in the quality of food and hygiene is recognised to

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<sup>54</sup> Informatsiia o deiatel'nosti ugolovno-ispolnitel'noi sistemy Ministerstva iustitsii Respubliki Kazakhstan v 2004 godu, p. 7

<sup>55</sup> KUIS information.

<sup>56</sup> Evaluation report 2003, pp. 51-52

be important to reduce susceptibility to disease and is therefore one of the priorities of the prison system. These improvements are thanks to the reduction in the prison population (a direct result of the project), increase in budget for the prison system (indirect result of the project), and more attention by prison directors to ensure the implementation of international standards (direct result of the project).

The reduction in the size of the prison population also enabled prison administrations to apply more widely the principle of ensuring that prisoners serve their sentences in the regions of their residence. For example, the number of prisoners from other oblasts, serving their sentences in Pavlodar Oblast, was reduced from 1821 in 2003 to 795 in 2004.<sup>57</sup> There are still shortcomings in this area, however (partly due to the non-availability of all types of colonies in each oblast – especially juvenile and women's colonies).

An individualised approach to prisoners' rehabilitation is gradually being introduced, assisted by an increase in psychologists, and the decrease in the prison population. (There are currently 2-4 psychologists in the prison colonies of pilot oblasts). However, training for psychologists is lacking and urgently required. Some training has been undertaken by monitoring committees in Akmola and East Kazakhstan oblasts, but wide scale and regular training is needed. Despite shortcomings, the change in approach no doubt contributed to the reduction of disciplinary offences and the use of punishment cells, mentioned above.

One of the important tasks set out in strategic plans was to improve prisoners' contact with the outside world, since maintaining links with family, relatives and others is essential for prisoners' mental health and resocialisation after release. Over the project period, many obstacles for prisoners' contact with the outside world were removed or decreased, including exchange of letters, use of telephone and number of visits.

The right to correspondence is not restricted, however, it is censored. Only the censorship of appeals and complaints to higher level supervisory bodies is not permitted. Restrictions on telephone calls have also been lifted, as mentioned above, and payphones provided in prison establishments. An order issued by KUIS to remove glass partition between visitors and prisoners in short visiting rooms provided more humane circumstances for prisoners to have contact with their visitors. This order is not being implemented everywhere, but in most colonies visited in pilot oblasts over the last three years, the change had taken place.

The number of secondary schools in prisons increased from 30 in 2002 to 45 in 2005. The number of prisoners benefiting increased from 4247 to 6663, the recent figure covering almost all prisoners in need of secondary education<sup>58</sup>. (There is a need for one more school to be established). The number of vocational training schools increased from 20 to 32 during the same period. The numbers benefiting increased from 1982 in 2002 to 3500 in 2004. Pavlodar Oblast' administration was particularly active in this area, and succeeded in receiving support from the mayor to establish vocational training

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<sup>57</sup> Report of Pavlodar Monitoring Committee, April 2005, p. 8

<sup>58</sup> Informatsiia o deiatel'nosti ugovovno-ispolnitel'noi sistemy Ministerstva iustitsii Respubliki Kazakhstan v 2004 godu, p. 10; O deiatel'noisti podrazdelenii UIS po itogam 2001 goda, informatsionnyi biulleten' No. 1, p. 25.



schools in two of its prison colonies. Vocational training is recognised to be a weak area by KUIS itself and efforts for further progress are being made.<sup>59</sup>

Information on prisoners' rights and obligations, prevention from TB and HIV are generally placed clearly on the walls of each unit in colonies. Information booklets on legal rights, complaints procedures, produced by monitoring committees and NGOs are also widely available. Condoms are also more widely accessible, though not in all colonies visited.

Integrated TB and human rights training undertaken by PRI/KNCV has clearly led to a change in approach to TB management, to the relationship between medical services and others, while increasing the status of medical staff. In two of the pilot oblasts (East Kazakhstan and Karaganda) medical specialists have been appointed Deputy Heads of Region. This development has led to improvements in resolving health related problems in these oblasts.

Doctors advise prison governors in areas such as food, heating, access to natural light, ventilation, sanitation facilities and hygiene, as recommended by numerous international standards. In the TB colonies (Akmola and East Kazakhstan Oblasts) TB treatment is monitored not only by medical staff, but also by staff from other services trained as part of the PRI/KNCV programme. Thus, the understanding that a healthy prison is dependent on the cooperation of all services is reflected in practice.

As a result of better coordination between civil and prison health systems, opportunities for prison medical workers to receive higher qualifications have increased. (A total of 174 medical specialists were trained in Ministry of Health institutions in 2004).<sup>60</sup> Concerns remain, however, regarding the lack of adequate medical staff in the prison system. On the positive side, more assistance is available in prison health issues from civil medical specialists.

In colonies visited in 2005, the results of the project were visible. Reports from monitoring committees also confirmed improvements in others, which were not visited in October 2005.

In dormitories visited prisoners had their own beds and linen, in most bunk beds had been replaced by single beds. This allowed for more natural light from windows, which were not obstructed by bunk beds. With the help of prisoners, dormitories had been decorated, there were pictures on the walls and plants had been placed in some. Walls in one colony were painted in different colours, in consultation with the psychologist. More attention had been paid to the privacy in sanitation areas, particularly in one general regime colony.

Kitchen, laundry and sanitation areas were clean. The food looked nutritious and the weekly menu was varied and included adequate amounts of animal protein, dairy products, fruit and vegetables.

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<sup>59</sup> Informatsiia o deiatel'nosti ugovovno-ispolnitel'noi sistemy Ministerstva iustitsii Respubliki Kazakhstan v 2004 godu, p. 26

<sup>60</sup> Informatsiia o deiatel'nosti ugovovno-ispolnitel'noi sistemy Ministerstva iustitsii Respubliki Kazakhstan v 2004 godu, 16

In Akmola oblast, post-boxes had been placed in colonies for prisoners to use for communication with the Department of Prisoners Rights, KUIS, as well with the monitoring committee. Open days were being organised for relatives and prisoners to get together in both oblasts visited. Use of televisions was available to prisoners in communal rooms, where coffee and tea facilities were also provided.

Prisoners' right to practice their religion was being respected. There were chapels and small mosques, which were in use. The visit coincided with Ramadan, the month for Moslem fasting – prison administrations had changed the meal times for prisoners on fast.

### **A general Regime Colony, Akmola Oblast': Good Practice**

The prison governor of this colony had been trained in strategic planning. He was active in producing the strategic plan for this colony and now he was clearly active in transforming plans into reality. He has a total of six members of staff trained in strategic planning and the administration continues to use strategic plans to manage the prison.

The governor stated that even if there is no official order to use strategic planning, he would continue to use it. He was convinced that as a result of the improved human rights situation, through strategic planning, not only had the life of prisoners improved, but so had that of staff.

Prisoner offences had dropped dramatically to 69 and 53 per 1000 prisoners in 2004 and first 10 months of 2005 respectively. Punishment cells were used rarely (for 29 and 24 prisoners in 2004 and 2005 respectively). They were empty on the day of the authors' visit. Two punishment cells had been renovated to very good standards. They were clean and bright, had excellent sanitation facilities, and benches and a table for prisoners (which are not available in some punishment cells, even in pilot oblasts). There was still a need to ensure that windows could be opened from within, however. The governor said that all punishment cells would be renovated to these standards. This is a reflection of the principle that deprivation of liberty (including in punishment cells, which takes this to a further level) is a punishment in itself. Additional punitive measures, e.g. in the form of inhumane conditions, is not accepted by international instruments.

Dormitories visited were clean, with adequate natural light. Thermometers were in place ensuring that heating was monitored. The sanitation facilities visited were excellent and clean. A sports hall, sauna and small pool had been built for prisoners. Outside considerable effort had been made, with the help of prisoners, to plant grass and trees. "Social corners" for prisoners were provided with benches. These improved the psychological climate in the prison colony.

Sports events are organised between different prison colonies. Mixed teams of staff and prisoners play football. The prison administration encourages talented prisoners to participate in exhibitions and the organisation of cultural events. The governor maintains contact with the relatives of prisoners, and has a positive relationship with inmates. For example, he plays chess with them and uses the closed sports hall for training, together with prisoners. These kinds of initiatives, focusing on the people in the prison context and not only the physical conditions, are good ways of creating a mutual feeling of trust between prisoners and staff.

One of the main concerns in Kazakhstan prisons is the lack of useful activity and vocational training provided for prisoners. The governor of this colony had succeeded in receiving a tender to provide clothes for other colonies, which would provide work for all the prisoners. Currently some prisoners were producing furniture for the prison. There was also vocational training, with 120 prisoners being trained in cycles. Teachers came from the civil professional technical college.

The administration had a good working relationship with the monitoring committee and appreciated the constructive support provided by it.

This colony is a good example for demonstrating strategic planning in practice.

These are all very encouraging factors, as the main aim of strategic planning is, of course, to bring conditions in prisons closer to the requirement of Kazakhstan legislation and ultimately of international standards. Naturally, concerns remain and more needs to be done, especially in the area of “making best use of prisons” (e.g. providing more work, vocational training and a variety of educational opportunities to prisoners), as well as the improvement in individualised rehabilitation and introduction of programmes to prepare prisoners for release. Staff training, where progress has been made, has also been pointed out as a weak area by senior staff interviewed in October 2005. Therefore the transfer of Kostanai Law Institute to the jurisdiction of the Ministry of Justice is especially timely.

A weakness identified by evaluators in 2003 was that the momentum for reform in Pavlodar Oblast’ was gradually diminishing, despite the encouraging results. This was due to the lack of a clear plan by KUIS to introduce strategic planning as an official planning system, and the lack of an order from KUIS to continue strategic planning training in Pavlodar. Thus, it can unfortunately be concluded that such a development may be a question of time in the three pilot oblasts, despite current enthusiasm, unless active leadership to continue the training programme and introduction of strategic planning to the penal system is taken by KUIS. (See Appendix 3, for SWOT analysis on the strategic planning element of the project.)

#### **1.4 Public Monitoring of Places of Detention**

A law came into force on 16 September 2005, providing for the establishment of public monitoring committees in each oblast’, with responsibility to monitor the situation in prisons. This was a direct outcome of a project implemented by PRI, “Development of Independent Public Monitoring Mechanisms in the Prison Service of Kazakhstan”, financed by Foreign and Commonwealth Office, UK (FCO). Three monitoring committees (officially named “Public Oversight Commissions”) were established in Almaty, Zhambyl and South Kazakhstan oblasts, within the framework of this project.

On 29 December 2004 another law had been introduced, again as an outcome of the above mentioned project, which had given legal basis for public monitoring of pre-trial detention centres and prison colonies.

These legislative reforms also mark the culmination of successful activities carried out by public monitoring committees established in the four pilot oblasts, starting with Pavlodar

Oblast' in 1998, continuing with the other three pilot oblasts (East Kazakhstan, Karaganda, Akmola) under Kazakhstan II project. Thus, currently monitoring committees are working in a total of seven oblasts, covering half of Kazakhstan's 14 oblasts. They are all supported by PRI (with a grant from Cordaid), but a number of them have developed their capacities considerably and receive grants to fulfil monitoring and parallel activities also from other donors.

Establishing a clear legislative basis for public monitoring represents a large step forward in the humanisation of the penitentiary system, institutionalising systematic external scrutiny of prisons, involving the public in penal reform issues, increasing transparency of the prison system and developing a constructive relationship between prison authorities and civil society.

In March 2004 by order of the Minister of Justice of Kazakhstan, a Public Monitoring Council on the Penitentiary System of Kazakhstan was formed under the Ministry of Justice. The members of the council include the Vice Minister of Justice, representatives from the Ministry of Health, main human rights NGOs, including PRI, legal experts and academicians. It has the responsibility to:

- Provide consultative assistance to the Minister of Justice on issues relating to the penitentiary system;
- Formulate recommendations aiming to bring Kazakh legislation closer to international human rights standards and to assist in humanising the penitentiary system;
- Cooperate with the Ministry of Justice in implementation of activities relating to the reintegration of prisoners into society, in research, planning and the development programme for the penitentiary system;
- Undertake regular evaluation (monitoring) of the human rights situation in prisons.

Recommendations and suggestions by prison monitoring committees are to be sent for review to the Public Monitoring Council.

The contribution of public monitoring committees to penal reform in Kazakhstan has been immense and could provide a model for other countries in the region, and elsewhere. Reports prepared by monitoring committees give a very detailed and precise analysis of the situation in prisons visited, comparing practice with both international standards and Kazakh legislation. There is a constructive relationship between monitoring groups and prison administrations, with acknowledgment by the latter of the advantage of public monitoring. The trust developed between the administration and monitoring committees is so high that the latter are at times called to resolve conflicts in prisons (e.g. East Kazakhstan and Zhambyl oblasts).

Currently the four monitoring committees formed within Kazakhstan II project undertake monitoring both of the implementation of human rights standards, as well as prevention and treatment of TB/HIV in prisons. Monitoring of human rights is based on UN Standard Minimum Rules for the Treatment of Prisoners and Kazakhstan legislation, (both of which were taken as the basis for strategic planning), while monitoring of TB aspect follows the rules laid down for the successful implementation of DOTS strategy. Monitoring of HIV in prisons focuses on the level of information available to prisoners on HIV infection, prevention measures, as well as ethical issues

relating to the treatment of prisoners with HIV. The two elements of monitoring cannot be seen as two separate activities, however, as implementation of human rights standards, such as prisoners' right to sufficient fresh air, nutritious food, adequate sanitation facilities, access to sufficient information about TB and HIV, for example, are related to human rights as well as health. Thus, the monitoring activity is by its very nature an integrated activity.

Monitoring committees in pilot oblasts have helped improve coordination between prison and civil healthcare services significantly, with practical interventions aiming to improve uninterrupted treatment of prisoners after release. In addition, pilot oblast' prison monitoring committees include medical doctors from civil TB agencies, such as regional TB dispensaries, who are responsible for monitoring practices relating to TB management. They also provide practical on-site advice and assistance. In this way the project has helped establish a continuing link between the prison and civil health sector.

Monitoring committee members interviewed in October 2005 (Akmola and East Kazakhstan oblasts) underlined the importance of the principle they had adopted of not only monitoring, but also providing support to the prison administration by undertaking complementary activities. This increased trust and good relations between monitoring committees and prison administrations, while providing vital services to prisoners and staff.

Programmes of Monitoring Committees include the following parallel activities:

- Educational and training activities in the area of public health and human rights,
- Meetings with respective oblast authorities to exchange information and draw attention to the problems in the penal system,
- Providing inmates legal consultation during visits,
- Review of prisoners' written appeals and complaints,
- Publishing and distributing booklets on prisoners rights, health issues and preparation for release,
- Collection and analysis of tuberculosis statistics,
- Establishing a database on tuberculosis patients released from penal institutions and improving contact between prison and civil health authorities,
- Distribution of visual aids on human rights and tuberculosis control,
- Raising public awareness.

Examples from Akmola, East Kazakhstan and Pavlodar oblasts:

East Kazakhstan monitoring committee provided training for the oblast's prison psychologists, which was highly appreciated by the prison administration.

The legal expert of the Pavlodar monitoring committee receives and processes in the region of 350 letters of complaints from prisoners each month, mostly regarding sentences. Akmola monitoring committee provided legal assistance to 153 prisoners during their prison visits in 2003.

The Akmola Oblast' monitoring committee conducted 14 seminars of one day each for three months in the prison colonies, for 60 prisoners, and three members of staff from each colony. The seminars focused on prevention of TB and conflict resolution, where

an inter-active method of training was used. Prisoners were trained as “informational volunteers” with responsibility to pass on their knowledge to other prisoners. All 60 prisoners received certificates. A training of trainers was organised for a selected group of prisoners from each colony, who received trainers’ certificates. This peer group is now working within the framework of the educational work plan in colonies.

In both Akmola and East Kazakhstan Oblasts, thanks to the monitoring committees specialists from the civil health care sector have been able to visit penal institutions. The civil health care specialists provide consultation to the tuberculosis control programme coordinators working in prisons. Monitoring committee recommendations helped overcome challenges in tuberculosis prevention, some of them relating to the observance of human rights standards in prisons.

Pavlodar and Akmola monitoring committees took action to assist prisoners after release, and in particular to ensure that those suffering from TB continued uninterrupted treatment. In both cases round-tables were organised by all agencies that should be involved with former prisoners’ welfare and agreements of cooperation were reached between them, improving prospects for social and medical assistance, and thereby reducing chances of repeat offences or discontinuation of TB treatment.

East Kazakhstan monitoring committee conducted a comprehensive survey on HIV awareness in prison colonies of East Kazakhstan Oblast and national legislation relating to prisoners with HIV. Gaps were detected in the level of awareness among prisoners and staff on HIV infection and transmission. Articles in the Criminal Executive Code were also identified which amounted to a discrimination against HIV infected prisoners. The monitoring committee is taking steps to address these issues.

Thus, the monitoring committees constitute a dynamic and effective force and continued catalyst for reform in the penal system. They provide constructive criticism, as well as support to improve respect for human rights, including prisoners’ right to adequate healthcare.

In Pavlodar, the existence of a monitoring committee has helped counteract the slowing down of momentum in this oblast’, noted above.

Activities of monitoring committees correspond to one of KUIS priorities: “To ensure the effective development of the penal system, it is important to continue interaction with public associations, including human rights organisations and charitable foundations” (the National Programme for the Development of the Penal System for 2004-2006). KUIS support of monitoring committee activities is another demonstration of the prison administration’s intention to improve transparency of the prison system and develop cooperation with civil society to strengthen the sustainability of reforms.

## **2. ALTERNATIVES PROGRAMME**

### **2.1 Structural and Legislative Outcomes**

New legislation came into force on 8 January 2003, which increased the use of alternatives to imprisonment, reduced sentences for certain offences and relaxed the requirements for gaining the right to early conditional release, among other measures. The project played a direct role in the adoption of this law. (see Chapter 4, Section 2 for details). More work on

legislation is currently in progress, aiming to further rationalise sentencing to decrease the rate of imprisonment.

When the project started in 1998, the prison population of Kazakhstan totaled 86,000 (prison colonies) and 16,000 (pre-trial detention facilities). It occupied 3<sup>rd</sup> place in the world in terms of high prison population rate. By March 2005 these figures were 44,284 and 8,324 respectively and it was 25<sup>th</sup> in the world. This was achieved mainly as a result of legislative changes to the Criminal, Criminal Procedure and Criminal Executive Codes that came into force on 8 January 2003 (adopted on 21 December 2002), as well as through the changes in attitude towards humanization of the prison system. Over 50% of the Alternatives Working Group recommendations were included in the new codes.

### 2.1.1 Parole (Early Conditional Release)

The reduction in the prison population was achieved mainly due to the relaxation of rules regulating the right to early conditional release. The figure for prisoners released on parole more than doubled after the new law came into force (see figures for 2002 and 2003 in Table 3). The figure had dropped to 18,759 by 2004, explained by the fact that the large mass of prisoners who gained the right to early conditional release, with the changes in legislation was, by 2004, released. Henceforward a gradual decrease in the prison population or stabilization is expected. (Note that with the reduced prison population, the figure of 18,759 constitutes a relatively higher proportion of the total number of prisoners released, compared to figures in 2000 or 2001, when the prison population was much higher at 63,520 and 66,235 respectively). A sustainable reduction will depend on the rate of recidivism, and therefore is connected with availability of social and psychological support to released prisoners. The good news is that the general rate of recidivism (including all prisoners released) was decreased by 7.8% between 2002 and 2003, despite the increase in those being released from prison.<sup>61</sup>

**Table 3: Numbers of prisoners released in the past four years<sup>62</sup>**

<b>Basis for release</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>
Total	24544	32439	33468	36540
Term expiry	11115	10127	6276	5076
<b>Early Conditional Release</b>	<b>11814</b>	<b>14672</b>	<b>15360</b>	<b>31287</b>
Pardoned	34	27	71	48
Illness	250	255	457	325
Amnesty	1204	7137	10517	-
Term reduced	127	-	-	-

<sup>61</sup> Razvitie Ugolovnoi Politiki Respubliki Kazakhstan na Sovremennom Etape: Ot Kontseptsii k Praktike, I. I. Rogov, Gumanizatsii Ugolovnoi Politiki Respubliki Kazakhstan: Dostizhenie i perspektivy. Materialy Mezhdunarodnoi Nauchno-prakticheskoi Konferentsii, 29-30 aprelya 2004, p. 98.

<sup>62</sup> The Humanisation of Criminal and Penal Legislation of the Republic of Kazakhstan, V.I. Semushkin, M.R. Geta, p. 59. The figure for early conditional release in 2003 is given as 30732 in "Informatsia o deiatel'nosti sistemy ispolnenii nakazanii, Ministerstva Iustitsii, Respublik Kazakhstana, v 2004 godu", p. 9

It is also worth noting that there has been an increase in the number of prisoners transferred from prison colonies to semi-open colony settlements, since new legislation eased conditions for gaining this right. (From 686 in 2002, before the new law came into force, to 2963 in 2004).

### 2.1.2 Sentencing

Recent years has also seen a reduction in prison sentences. Whereas prison sentences amounted to 50,6% of all sentences handed out in 1999, by 2002, the share of prison sentences was down to 41,7%.<sup>63</sup> The following year, by September 2003 25,773 people received sentences, in comparison to 31,560 in the same period of the previous year. Of these 10,862 were sentenced to imprisonment in 2003, compared to 13,342 in the same period during 2002.<sup>64</sup> (That is around 42% of all sentences by September 2003).

This development was due, first of all, to the influence of the Working Group on Alternatives on sentencing policy (which included the Chair of the Criminal Committee of the Supreme Court) and later to the changes made in legislation.

In October 2001 a decision was taken by the Criminal Collegium of the Supreme Court to introduce a mechanism obliging judges to explain in their court decisions the reasons for imposing a prison sentence, rather than an alternative, if the law provided for both options for the offence committed. This requirement had an important impact on the reduction of prison sentences in late 2001 and 2002.

The change was reflected in figures, as follows:

In 2000, 51.3 % of sentences were imprisonment;  
 In 2001, 47% of sentences were imprisonment.  
 In 2002, 41.8% of sentences were imprisonment.<sup>65</sup>

### 2.1.3 Diversion from Prosecution

There has been an increase in diversion from prosecution, as a result of reconciliation between offender and victim.

**Table 4: Diversion from Prosecution 2002-2003<sup>66</sup>**

	2002	2003
Total cases of action withdrawn	14149	20834
Action withdrawn due to reconciliation	8474	19134

If the institution of reconciliation had not been available, then it is estimated that cases seen by courts would have risen to 56-58,000, of which around 40% would have been expected to receive prison sentences. The increase in the use of reconciliation was made

<sup>63</sup> The Humanisation of Criminal and Penal Legislation of the Republic of Kazakhstan, V.I. Semushkin, M. R Geta, p. 60

<sup>64</sup> Razvitie obshchestvennykh rabot kak vida ugolovnogo nakazaniia v Respublike Kazakhstan, Materialy "Kruglogo Stola", 12 Sentiabra 2003 goda, Almaty, p. 13

<sup>65</sup> Evaluation report 2003, p. 84

<sup>66</sup> The Humanisation of Criminal and Penal Legislation of the Republic of Kazakhstan, V.I. Semushkin, M.R. Geta, p. 60



possible by the amendments to the Criminal Procedure Code, which widened the scope of its use.

A weakness is that special programmes for reconciliation have not yet been developed, which may affect the sustainability of diversion from prosecution through mediation. Without special programmes, compensation for damage to the victim is unlikely to have the intended effect of healing victims, offenders and communities. International standards recommend the need for such a provision and of the appropriate legal backing for reconciliation.

Community Service came into force as a new type of non-custodial sentence in 2000. A growing tendency towards the use of community service sanctions is observed between 2000 and 2004. By 2005 however the number of community service sanctions was in decline. This is perceived to be related to a number of problems involving the implementation of this sentence.

**Table 5: Number of Offenders registered for community service at Criminal Executive Inspections<sup>67</sup>**

2000	2001	2002	2003	2004
313	881	1424	1976	2021

**Comparative figures for 2004 and 2005**

	January–September 2004	January – September 2005
Registered – total figure	1701	1388
Newly registered	1121	870

**Community service rules**

The rules for serving community service sanctions are set out in Article 31 of Kazakhstan’s Criminal Procedure Code. The offender is obliged to provide community service independent of his/her permanent job. The hours to be worked vary between 60 and 240, with no more than four hours of work per day. The period to be worked each week normally cannot be less than 12 hours. The offenders serve their sentence, undertaking the work assigned to them in their place of residence. They must let the CEI know if they change place of residence. If the offender repeatedly and clearly refuses to undertake the work assigned to him/her, then the sentence can be replaced by limitation of freedom or arrest.

**Community service mechanism**

At the beginning of each year CEIs send letters to local authorities requesting a list of available vacancies suitable for community service. Currently 600 work places have been identified in Kazakhstan where community service sentences can be served.

When a offender is registered at a CEI, the inspector sends a letter to local authorities or

<sup>67</sup> Figures from KUIS and “Razvitie obshchestvennykh rabot kak vida ugovnogo nakazaniia v RK”, Materialy kruglogo stola, 12 sentiabriaia 2003, Almaty, p. 19.

directly to the prospective employer, with information about the offender, including his place of residence, educational background, his permanent employment, if any, the article of the criminal code according to which the offender was sentenced, the length of sentence in hours, the rules of payment (by employer) according to article 32 of the Criminal Executive Code and the responsibilities of the administration of the employer organization (article 33 of the Criminal Executive Code). This letter forms the basis on which a workplace is identified for the offender. The offender does not receive a salary, but the pro-rata salary for the employment being undertaken is paid by the employer into the relevant state budget. Unfortunately, the responsibilities of local authorities and clear mechanisms for implementation have not been defined and workplaces have not been identified in all regions and sub-units of regions.

CEIs are obliged to regularly visit the workplace of offenders, check that they are working in accordance with the conditions of their sentence and keep a record of hours worked.

The reduction in the prison population and increased use of non-custodial sentences has not led to an increased rate of crime. On the contrary, the crime rate has steadily decreased, since 2002, and in 2004 was lower than in 2000. (See Table 6)

**Table 6: Dynamics of registered offences and prison population<sup>68</sup>**

	2000	2001	2002	2003	2004
Number of prisoners	58424	67937	70485	65151	48478
Offences logged	139431	150790	152168	135151	118485

Recidivism among those sentenced to non-custodial sentences is low, at around 1-2%. Recidivism among those released on parole, is however higher, according to one estimate 30% of all crimes committed being attributable to those on parole. This is a concern that needs addressing.

The legislative basis for alternatives and other measures aiming to reduce the prison population provide the basis for sustainability, - at least for a stabilization of the prison population figure, if not a gradual decrease over the coming years. This is a significant achievement, especially at a time when prison population figures are rising in many countries over the world.

However, challenges are being encountered in the implementation of non-custodial sentences, due to the lack of adequate investment in training and staffing, as well as the lack of clear guidelines setting out the responsibilities of all agencies involved in their implementation.

For example, although the workload and responsibilities of CEIs has increased significantly, staffing remains the same. Currently there are 209 CEIs<sup>69</sup> with a staff of 360

<sup>68</sup> The Humanisation of Criminal and Penal Legislation of the Republic of Kazakhstan, V.I. Semushkin, M.R.Geta p.58

inspectors. With 22,532 offenders registered at CEIs<sup>70</sup>, each inspector is responsible for an average of 62-63 offenders. This number varies from region to region, with well over 100 to one inspector in some. There had been plans to increase staffing to 1183, in the national programme for 2004-2006, but the necessary budget was not allocated and the issue was postponed.

There are also serious concerns relating to the work conditions of CEI staff. Formerly CEIs were under the Ministry of Interior, now since the transfer to the Ministry of Justice, a large majority has not yet been moved to new offices away from the Ministry of Interior. 172 of them remain with local Ministry of Interior bodies, mostly in very unsatisfactory conditions. For example, only 37 of CEIs have telephone connection<sup>71</sup>. Many cannot fulfill basic tasks like photocopying, do not have access to computers etc. This situation, coupled with the increase in their responsibilities, is creating additional stress for CEI staff. Some are leaving the system. (See also Chapter 6, 2.1).

## 2.2 Alternatives: Pilot Projects

Pilot projects constituted the logical next step, testing the results of new legislation in practice and identifying shortcomings hindering the wider use of alternative sentences. Out of five projects selected for support, three were directly relevant to non-custodial sanctions (two on criminal executive inspections, one on community service). Two related to women prisoners, with one dealing with women's legal rights, especially regarding early conditional release, the right of transfer to colony settlements and less strict regimes, all of which were modified under new legislation adopted in 2003.

The most significant outcome of the pilot projects were that they led to much increased involvement of civil society in problems and opportunities related to the development of alternatives to imprisonment. They thereby demonstrated the important role civil society can play in the humanization of the penitentiary system. They established a strong basis for cooperation between NGOs and authorities responsible for the effective implementation of alternative sentences, such as community service. The results of some of the projects are contributing to increasing the efficiency of alternatives and to institutionalizing the policy of sustained non-custodial sentencing.

### **Criminal Executive Inspections: A Step to the Future**

The project "Criminal Executive Inspections: A Step to the Future", implemented by Kazakhstan International Bureau for Human Rights and the Rule of Law, East Kazakhstan Branch<sup>72</sup>, was one of the most relevant and successful projects implemented within this programme.

<sup>69</sup> Informatsia o deiatel'nosti ugolovno-ispol'nitelnoi sistemy, Ministerstva Justitsii, Respubliki Kazakhstan v 2004 godu. Other sources give the figure for CEIs as 215.

<sup>70</sup> Figure at September 2005.

<sup>71</sup> Problemy i Perspektivy Razvitiya Sluzhby Ispolneniia Nakazanii bez izoliatsii ot obshchestva, Diusembin, I. I., Gumanizatsii Ugolovnoi Politiki Respubliki Kazakhstan: Dostizhenie i perspektivy: Materialy Mezhdunarodnoi Nauchno-prakticheskoi Konferentsii, 29-30 aprelia 2004, p. 39.

<sup>72</sup> Recently formed a new NGO, Kazakhstan International Foundation for Legal Cooperation, which is now responsible for the project activities.

Around 60 criminal executive inspectors from different oblasts, and including some inspectors from Kyrgyzstan and Tajikistan, received training. Head of KUIS department responsible for Alternative Sentences participated in all these trainings, thereby demonstrating high level cooperation and support. For some of the inspectors this was their first training ever, while others had received some training under a previous programme implemented by the same NGO, in cooperation with KUIS.

A resource centre for criminal executive inspectors was established in Oskemen, which is currently being used intensively by the inspectors working in the city. In the centre inspectors can find literature relating to their profession, they can use technical equipment and receive expertise and advice from Kazakhstan International Bureau for Human Rights and the Rule of Law.

The project developed a manual explaining the implications of legislation in practice and outlining possible methods of psycho-social work with offenders.<sup>73</sup> The latter is an area where CEI staff has no expertise, and have received no previous training, although in future they will increasingly be expected to contribute to the prevention of re-offending. The manual was officially accepted in the oblast as being a relevant basis for everyday practice. Draft versions of the manual were used in training seminars and were developed based on real, practical experience.<sup>74</sup>

Other booklets were prepared for the trainings, by experts taking part in the project, such as “A model Probation Service in Kazakhstan and other States of Central Asia” and “The Experience of Probation and its Implementation in the Republic of Kazakhstan”.<sup>75</sup>

In March 2005 a draft instruction “Community inspector of criminal executive inspections of Kazakhstan’s territorial penal system bodies” setting out clearly the rights and responsibilities of criminal executive inspectors was prepared by the project and submitted to the Chairperson of KUIS for consideration.

Over 160 students from the Law Faculty of East Kazakhstan State University were sent for practice at CEIs and are continuing to be sent, by order of the rector. Their contribution as social assistants helped reduce the burden of inspectors and enabled students to familiarize themselves with the execution of non-custodial sentences. Some of the students are continuing this work. Some wanted to receive employment in the system on a permanent basis, but due to the failure by central authorities to increase the staffing quota of CEIs, this potential was temporarily lost.

Three new obligatory courses were added to the programme for Jurisprudence, within the East Kazakhstan State University. These are “Alternative Sanctions in the Republic

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<sup>73</sup> Provozye osnovy deiatel'nosti ugovolno-ispolnitel'nykh inspektsii v Respublike Kazakhstan: Posobie dlia inspektorov ugovolno-ispolnitel'nykh inspektsii, K.Kh. Rakhimberdin, M. R. Geta, Ust-Kamenogorsk.

<sup>74</sup> See Evaluation of pilot projects on alternatives to imprisonment in Kazakhstan, Final Report, 2004, Rait Kuuse, Mary Murphy, p. 16 for more details. (Henceforth, “Final evaluation of pilot projects, Kuuse, Murphy”)

<sup>75</sup> Model' sluzhby probatsii v Kazakhstane i drugikh gosudarstvakh tsentral'noi azii”, M.R. Geta, K. Kh. Rakhimberdin, R. Kuuse; “Opyt' Probatsii i ego primeneniye v Respublike Kazakhstan”, M. R. Geta.

<sup>76</sup> Aktual'nost' i puti razvitiia sluzhby probatsii v Respublike Kazakhstan, Maksim Geta, ekspert proekta, Kuat Rakhimberdin, rukovoditel' proekta, Direktor, Kazakhstanskii Mezhdunarodnyi Fond Pravovogo Sotrudnichestvo.

of Kazakhstan and other Countries”, “Juvenile Justice” and “Restorative Justice”. 1000 students each year are expected to take these courses. This is a remarkable development, achieved thanks to the Director of Kazakhstan Bureau for Human Rights and the Rule of Law and Kazakhstan International Foundation for Legal Cooperation (who is also Head of Department for Criminal Law and Criminal Procedure, at the university). This step will raise knowledge about alternative sanctions among future legal professionals and contribute to institutionalizing the new thinking on sentencing.

Recommendations were formulated for the establishment of a probation system in Kazakhstan.<sup>76</sup> Some of them have been reflected in this document’s recommendations.

As a result of the project activities, East Kazakhstan Oblast’ currently has all the elements required to establish a model CEI system and it has the training potential to widen the training to cover all criminal executive inspectors.

Another pilot project, “Reform of the Criminal Executive Inspections”, implemented by International Human Rights Centre, Almaty, also formulated recommendations for the reform of the CEI system and developed a manual, which identified particularly the need to promote a psychological approach in the work of CEIs.

### **Developing Community Service**

A project that was very timely and relevant to the introduction of alternatives in Kazakhstan was the pilot project implemented by the Kazakhstan Criminological Association, “Developing Community Service”. Following systematic research and regular meetings with stakeholders, the project highlighted the problems hindering the wider use of community service. In a roundtable organized in September 2003, where participants included the presidential administration, Supreme Court, Parliament, KUIS, UIS, local government, scholars and NGOs, recommendations were developed for the improvement of community service implementation. They focused particularly on the need to remove employers’ obligation to pay for community work, to introduce the need for the agreement of offenders to undertake community service and to clarify the rights and responsibilities of CEIs and local authorities in ensuring the effective use of community service. Currently, a process of debate on improving legislation is ongoing, to which the project has made a substantial contribution.

In the fourth quarter of 2005 the Ministry of Justice will be putting a bill to parliament for consideration. This bill includes recommendations put forward by the Kazakhstan Criminological Association.

The pilot project, “Women in Prison: Legal Assistance to Women Prisoners”, implemented by Kazakhstan International Bureau for Human Rights and the Rule of Law, studied the human rights situation in a number of women’s prisons, provided legal assistance to 525 women applicants and held seminars with officials on preparation of cases for early conditional release. As a result of legal assistance provided, in 70 cases mitigation of sentence was achieved, including 42 women who were released conditionally and twelve who were moved to less strict regimes. The project also

developed recommendations on early conditional release and transfer to resettlement colonies, and produced a manual on the rights and responsibilities of women prisoners.<sup>77</sup>

Thus the alternatives programme is ongoing. A process has been started that practically cannot be reversed. This is a vital element of sustainability. Challenges remain, mainly in the implementation of alternatives, described in Chapter 6, but the important factor is that most of them are recognized and efforts are being made to address them.

### 3. TB/HIV MANAGEMENT PROGRAMME

The practice of PRI/KNCV in prisons is based on the WHO recommended approach of TB control in prisons: through establishing a prison DOTS TB control programme within a large penal reform framework.<sup>78</sup> Both medical and organizational aspects have been considered.

The main objectives of reduction of morbidity and mortality were achieved using the approach of DOTS implementation, coupled with penal reform. It has not been possible to analyse another main objective, prevention of MDR-TB, since DST testing was not available at the beginning of the project, therefore there is no data with which to compare. Another main objective of the PRI/KNCV project was to counteract transmission of HIV/AIDS and consecutive TB/HIV, a strategy recommended by WHO and STOP TB partnership.

**Table 7**

#### **Dynamics of TB in prisons\* of Kazakhstan**

<b>Years</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Total number of TB cases registered at the end of year	11,903	12,970	13,697	10,061	8,060	8,242	6,340	5,591
Number of new TB cases	5,555	5,061	5,591	3,434	3,038	3,011	2,137	1,388
Cases of death (TB)	1,302	1,218	345	175	174	134	103	74

\* TB data from colonies (SIZOs were transferred to Ministry of Justice at the end of 2004)

Usually the improved diagnosis and improved case-finding at the beginning of DOTS implementation has the result of an increase of TB notification rate and a gradual decrease of TB mortality, which in prisons of Kazakhstan was most visible in 1999 when an increased number of TB cases was registered at the end of the year, a higher number of new cases was registered during 1999, and a significant decrease in mortality was obtained. All these together show a good quality of implementation because expected outcomes were achieved in a short term. In fact it demonstrates a high level of

<sup>77</sup>Final evaluation of pilot projects, 2004, pp.12, 13.

<sup>78</sup> Tuberculosis Control in Prisons, WHO/CDS/TB/2000.281 p.32

commitment too, because many decision makers might be uncomfortable with increasing notification of TB cases, during DOTS implementation, and could try to stop DOTS implementation, as a result.

The dynamics of the TB epidemic from the year 2000 shows a significant and continuous improvement of TB indicators of morbidity and mortality. The achieved results most probably are related not only to DOTS implementation, but also to systemic penal reforms which were implemented along with DOTS strategy.

The decision to adopt a TB control programme based on DOTS was taken in Kazakhstan in 1998, prisons taking part in the nationwide implementation of the strategy. PRI/KNCV have supported the prison administration in DOTS implementation since 1998. The project introduced and strengthened WHO DOTS strategy framework, to assist with the development and/or adjustment of TB control policy in accordance with WHO recommendations.

### 3.1 DOTS Strategy

An achievement was that DOTS implementation inside prisons of Kazakhstan is in compliance with the WHO DOTS strategy framework. All five components were implemented: DOTS has political and financial commitment, smear microscopy is routinely available for case detection among symptomatic patients, standardized short course treatment is available for all TB cases, first line TB drugs are available usually without interruptions, a standardized recording and reporting system was implemented, and programme evaluation and monitoring has been done to some extent.

Political commitment was obtained to implement most proposed policies for TB/HIV control, including policies to decrease overcrowding, policies relating to case finding and standardized treatment, among others. Improved case management and infection control were achieved with the decision to treat all TB cases only in specialized TB colonies (at the end of 2004). KUIS has officially prioritized three main health challenges: TB, HIV and drug addiction.<sup>79</sup> In 2004, financial commitment for TB management corresponded to the planned expenses in National TB Control Programme 2004-2006 (the amount of funds allocated for prison TB services in 2004 being 201 millions tenge - about USD 1.5 million – excluding salaries).

A laboratory network has been established. Another achievement is that laboratory staff has access to training in the civilian sector, and as a result standard procedure of microscopy is being used. However weaknesses were identified too: high turnover of staff, some standard procedures are not followed as required (e.g. if saliva is brought to the laboratory instead of sputum, lab staff does not insist that sputum collection should be repeated). Another weakness is the quality of sputum collection in some prisons. It is not always directly observed<sup>80</sup> resulting in a high number of saliva being sent to the laboratory, followed by an under-diagnosis of TB cases.

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<sup>79</sup> Informatsia o deiatel'nosti ugolovno-ispolnitel'noi sistemy Ministerstva Iustitsii Respubliki Kazakhstan v 2004, p.16

<sup>80</sup> Proekt "Reformirovanie ugolovno-ispolnitel'noi sistemy. Alternativy tiuremnomu zakliucheniu. Lechenie Tuberkuloza v uchrezhdeniakh ugolovno-ispolnitel'noi sistemy Respubliki Kazakhstan.", T. Atabay, V. Sergeev, T. Demeulenaere, Almaty 2005, p.219

An achievement was that the project succeeded in establishing external monitoring and quality control of the prison smear microscopy laboratories by the civilian health service. But, at the same time quality control is limited only to the rereading of samples (all smear positive and 10 % of smear negative cases), and it is questionable whether the selection of samples is done blindly.

Standardized treatment is available to all TB patients. An achievement was that training of staff is undertaken regularly by the civilian TB service. Another achievement was that standard training modules were adapted and additionally prison medical/nursing staff is trained not only in DOTS case management, but also in human rights issues. An achievement is that the implementation of DOT, routinely followed in most TB facilities, resulted in a decreased mortality rate.<sup>81</sup>

First line anti-TB drugs are supplied usually without interruptions, and drug management has improved over the last years. However, the quality of drugs was questionable. An achievement was that drugs were supplied as part of a centralized system, but distribution to the periphery does not routinely take into consideration the number of patients and drug stocks. From time to time this results in overstock or stock-out of drugs in some periphery units.

A standard system of TB case recording and reporting has been implemented and an achievement is that the TB surveillance system is computerized. It must be mentioned that the prison health service is using a DOTS based computerized surveillance system, while unfortunately the civilian TB service has changed the computer based surveillance system to a non-DOTS one, resulting in challenges in the import-export of data. Moreover the information flow is one way from prisons to the civilian service.

An achievement was the establishment of public monitoring of prisons, including the monitoring of the TB control programme by the civilian TB service, which is represented on monitoring committees. A relative weakness was that it is not done systematically in all regions of Kazakhstan and monitoring criteria are not well established. The usual practice of monitoring is that civilian TB services perform separate monitoring visits without prison TB managers.

The prison health service, following a PRI/KNCV recommendation, has successfully piloted internal cross monitoring in four pilot regions (Pavlodar, Karaganda, Akmola and East Kazakhstan), where prison TB coordinators from one region monitored TB practices and quality of DOTS implementation in other regions. TB specialists from the civilian TB services participated to ensure correct technical monitoring. Participation of prison medical staff in internal monitoring has the advantage of making them aware of the problems in other regions as well as in their own, increasing experience, and making them more active and responsible. Specialists involved in the cross monitoring had an opportunity to discuss the results at a workshop and outline recommendations for future monitoring of the tuberculosis programme.

A threat to the prison TB control programme in Kazakhstan is the high rate of MDR-TB cases not only among relapses and failures, but also among new cases before treatment.

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<sup>81</sup> Proekt "Reformirovanie ugolovno-ispolnitel'noi sistemy. Alternativy tiuremnomu zakliucheniu. Lechenie Tuberkuloza v uchrezhdeniakh ugolovno-ispolnitel'noi sistemy Respubliki Kazakhstan.", Almaty 2005, p.209



(Preliminary results of a DST survey of primary MDR-TB show variations among regions and cohorts within a range of 20-44%). Treatment results are low in prisons, and this is partly due to MDR-TB.

### 3.2 Early Case Finding

Case finding has improved in Kazakhstan prisons, through ensuring accessibility to smear microscopy, performing awareness campaigns, staff training, and including health issues among priorities. Some colonies implemented the recommended standard scheme of TB diagnosis among suspects (with routine sputum examination, if result is negative then treatment for 10-14 days with broad spectrum antibiotics – Cephalosporins-followed by sputum collection. If the result is negative again then an X-ray examination is conducted and a clinical decision is taken as to whether the patient has TB). However, the number of passively diagnosed cases is low at about 12-25%, all the rest being found during massive x-ray screenings performed twice per year. The accuracy of X-ray in the diagnosis of TB might be only 69%, leaving large margin for over diagnosis of smear negative TB, because X-rays detect not only pulmonary TB but other lung pathologies as well (pneumonia, pulmonary mycosis, etc).

Progress in early case finding has been seen in some regions of Kazakhstan, e.g. in Pavlodar the proportion of late diagnosed cases in 1997 was 72% (TB cases with destruction) and by the year end of 2002 it had dropped gradually to 55%. This is an encouraging indicator, but it is much too early to predict the future of the TB epidemic when more than half of new cases are diagnosed late.

It is vital to maintain good laboratory support in early case finding. For example, in the same Pavlodar the proportion of patients identified microscopically has increased from 21% in 1998 to 72% in 2002.<sup>82</sup>

A suggested activity to increase passive case finding (through self-referral) would be to augment current DOTS policies with WHO recommended PAL strategy,<sup>83</sup> which means that four major syndromes should be focused on with all patients coming to medical units with respiratory problems. These are: TB, acute respiratory infections (in particular pneumonia), asthma and chronic obstructive pulmonary diseases. This approach might improve the diagnosis process in pulmonary diseases, because any physician would be able to make distinctions between the syndromes, i.e. cough in TB is for over two-three weeks, and in most acute respiratory infections (in particular pneumonia) cough disappears within ten days of treatment with broad spectrum antibiotics, etc. To make case finding more systematical ‘cough registers’ could be used in prisons. If appropriate, then an invaluable support might be received from volunteers – non-medical staff and inmates - attracted to educate prisoners and identify suspects, perform regular ventilation of dormitories and perform pre-test counseling.

### 3.3 Effective Treatment

Decrease in mortality is a good indicator of the effectiveness of treatment. But successful treatment outcomes are very low (within the range of 58.9% to 72%, the objective being

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<sup>82</sup> Proekt “Reformirovanie ugolovno-ispolnitel’noi sistemy. Alternativy tiuremnomu zakliucheniu. Lechenie Tuberkuloza v uchrezhdeniakh ugolovno-ispolnitel’noi sistemy Respubliki Kazakhstan.”, Almaty 2005, p.286

<sup>83</sup>see <http://www.who.int/tb/dots/pal/en/index.html>

treatment success rate of at least 85%). To readers who are not medical specialists it may seem like a contradiction to have a decrease in mortality together with low outcomes of successful treatment. But, in fact there is not a direct correlation between the two factors. An analysis of the low treatment success rate would need to take into account patients who have failed first treatment, but might be cured during the second time, defaulters, those who are transferred to other jurisdictions (Ministry of Health) due to end of sentence, humanitarian reasons, amnesties etc. Since there is little or no feedback from the civilian TB service in Kazakhstan regarding the final treatment outcomes of those patients who have been transferred to its care, of which there may be a considerable number, categorization of those outcomes becomes impossible. It should, however, be noted that the rate of successful treatment outcomes has not reached the objective of 85% in the civilian TB control programme in Kazakhstan (and many other countries) either. In fact, the analysis of the effectiveness of a TB control programme necessitates the analysis of all main TB indicators and existing trends over some years.

But to identify the main reasons of the low success rate, the high number of MDR-TB cases, quality of DOT and drugs should be considered (as explained above). Effective treatment requires also the prescription of correct drugs, in the correct dosages, for the appropriate duration of treatment. The prison health service is using standard regimens along with “individualized” treatment. Usually individualized treatment is mostly TB treatment category II for “treatment” of chronic cases, which previously followed a standard retreatment at least once (in fact it is more a placebo treatment for MDR-TB cases that are a considerable part of chronic cases). Special attention should be paid to the TB treatment category III, which is composed of only 3 anti-TB drugs. In most cohorts about 10% of patients are receiving category III, which is inappropriate to use in populations with high resistance levels. For example, in the preliminary DST data among new cases in East Kazakhstan prisons there were 44% MDR, 12% susceptible and 44% drug-resistant other than MDR. So the usefulness of TB treatment category III in this background is questionable.

### **3.4 Standardized Treatment under DOT and Ensuring Compliance to Treatment**

Treatment under direct observation is essential for effectiveness. It is considered that treatment in TB colonies of Kazakhstan is performed directly observed, which undoubtedly is a success. An open question was whether the treatment was directly observed in other colonies, (based on the fact that until 2004, TB treatment was available not only in TB colonies, but in all colonies). Supervision of treatment in many colonies was doubtful due to lack of medical staff, limited experience and organizational problems. However, the decision to concentrate TB treatment only in TB colonies was vital to ensure DOT. Unfortunately women and juveniles are still treated in their colonies, because TB colonies do not have a “room” system. It is therefore important to monitor DOT in juvenile and women’s colonies.

An achievement of the project was high compliance to the treatment within the penitentiary system. The number of patients with irregular treatment was limited over the years (in pilot regions under 4%). This fact is explained by two main reasons: increased TB awareness among patients and the result of prison reform.

How can prison reform decrease treatment irregularity? It is worth remembering that very often in prisons treatment interruption and default is used as a way to manipulate authorities to cooperate with incarcerated patients. In this context prison reform resulted

in improved prison management, promotion of adherence to international standards of human rights, improvement of prison conditions, decrease in conflict of interests and improved physician-patient relationships among others. All of these factors together resulted in a behavioral change among staff and inmates, less number of conflicts, less number of reasons to default from treatment, and a better environment to educate/raise the awareness of staff and inmates.

Increase of compliance to treatment of released TB patients was one of the objectives of PRI/KNCV in Kazakhstan. The compliance to treatment after release has improved in regions where social monitoring is done and NGOs are actively involved in developing policies to increase treatment compliance. For example, there has been an increase in successful transfer of patients to civilian care with the use of correct addresses of TB patients released from prison (i.e. rather than using the address of the former prisoner's official place of residence, the address of the actual place where he/she lives is used) of up to 75% by mid 2005 in some pilot regions. Previously the successful referral of released TB patients to civilian TB facilities varied between 50 to 58%. This is a good indicator for compliance but is not equivalent to treatment compliance, because patients might come for registration to health authorities but might follow treatment irregularly, or default. So, additional effort is required to increase treatment compliance after release. However increased use of correct address is an encouraging result of policy implementation which is based on the understanding that upon release the majority of inmates might face many challenges, and for them health might not be a priority. They might come from vulnerable groups (orphans, homeless, substance abusers, repeat offenders, etc) and might become more vulnerable upon release due to stigmatization and possible discrimination, resulting in difficulties in finding employment, difficulties in housing, loss of relationships with relatives and partners, psychosocial difficulties in adapting to the "new" world and established "new" rules, and even difficulties in obtaining identity cards. For some released persons these issues might be more than enough not only to default TB treatment but also to encourage them once again to break the law, resulting with another incarceration. To counteract this vicious circle a strategy should be developed to prepare inmates for release and to support them after release.

### **3.5 Staff Management**

The implementation of all reforms and new strategies depends on motivated and trained staff. An essential element of the PRI/KNCV project was staff training. Firstly, the prison staff at different levels was trained in Strategic Planning. The advantages of Strategic Planning are that it results in staff becoming more active and participative in all aspects of prison management, with the objective of bringing conditions in prisons closer to UN minimum standards. They create activity plans for the following five years, identify weaknesses of adopted plans and determine best solutions to achieve objectives. These include improved prison health, and activities for TB control contain a comprehensive plan to prevent and treat TB in prison settings. In pilot projects where Strategic Planning was implemented progress has been noted in respect for human rights, improved living conditions, improved access to health services (including to the civilian health service), and improved prevention of communicable diseases. This was achieved with the help of well trained staff, and increased staff motivation to change the prison environment, because it was the staff itself which had become knowledgeable about the requirements of UN minimum standards, aware of the existing situation in prisons, and developed action plans on how to achieve the proposed objectives. In addition the staff implements and assesses the implementation of its activities. In this context it is natural

that DOTS implementation was undertaken in an active and comprehensive way, with the help of better prison management, decreased violence, improved health awareness and increased integration with civilian health services. Staff interviewed in October 2005 clearly stated that almost all the improvements in prisons were a direct result of their training.

Another important activity performed by the PRI/KNCV project was DOTS training of prison TB staff in civilian training centers, this practice being sustainable over the last few years. It ensured a standard approach to DOTS implementation, and formed the basis for better integration. Additionally TB staff was trained in human rights in prisons, this practice being highly appreciated by the TB staff, because health promotion is one of the essential components of human rights. During 15 DOTS trainings 471 medical specialists were trained from the pilot regions, and during 9 Human Rights trainings 152 medical specialists were trained.

A problem of prison medical staff in many countries is their limited role in decision making. The promotion by PRI/KNCV of the policy of healthy living conditions in Kazakhstan prisons resulted also in an increased role of medical staff in prison management. Physicians in prisons are now acting as health consultants for the prison administration, and moreover the head of health units in prisons have been promoted to positions of deputy head of colonies. Recommendations made by physicians are being respected and taken into consideration by the administration, resulting in improved prison health. Undoubtedly, this is a major achievement for the improvement of prison health, resulting in an increased responsibility for health by both – administration and medical staff. Another important outcome of the reforms was a larger involvement of non-medical staff in health issues. For example, educational staff is present during directly observed therapy, and support medical staff in cases where patients are not complying or have irregular treatment. Medical staff highly appreciates educational staff for their effort in early TB case finding. The improved relationship between medical and non-medical prison services is also considered to be an achievement of reforms in prison health.

In two pilot regions (Karaganda and East Kazakhstan) heads of prison oblast health services were promoted to the position of Deputy Regional Directors. This resulted in a higher responsibility for the directors of health services, and augmented possibilities to improve health management in prisons of the region (including interventions in TB/HIV control).

Most of the health staff in prisons of Kazakhstan is part of the militarized organizational system, this fact being a potential source of conflict of interest. This problem is acknowledged by decision makers, and plans for removing medical staff from the militarized system are being discussed. The advantages of removing prison medical staff from the militarized system are that firstly a potential source of conflict of interest will end, and secondly this might result with new possibilities for the integration between the prison and civilian health systems. The disadvantage is possible loss for staff of the militarized system's benefits – an example being higher salaries or less years of service required before retirement. A possible solution would be a gradual reorganization of positions (a gradual decrease of “attested” positions to “civilian contracted” ones), and additionally to find sources of motivation compatible with the militarized benefits. It should be mentioned, that some activities have been done in this area by extending some of the attractive benefits for prison health staff to civilian health staff.

Another achievement in prisons of Kazakhstan is the decision that allows prison medical staff not to be requested to act as security staff during reinforcement.

### **3.6 Double Standards**

Many double standards in TB control were eliminated over the years, i.e. infection control rules versus security/regime rules, or extensive use of “individualized” TB treatment along with standard DOTS treatment.

However, weaknesses in TB control due to double standards are still present both in the civil and prison TB service. For example, there is an unclear policy of TB classification, which still considers cured patients as “active TB” for one year after completion of treatment, according to an old system of dispensary groups. Old dispensary groups were used in the former TB control strategies, with the initial purpose of finding relapses as soon as possible, this being epidemiologically more or less reasonable. But a lot of effort and finances were diverted to former patients, the final result being a low interest in TB suspects and effective treatment, with a very high interest in the former patients. Epidemiologically these circumstances are not considered very efficient.

Two main problems result from the practice of considering former patients as “active TB” for one year after treatment – first being reliability of data (prevalence internationally being calculated on TB cases that are on treatment or default, but not on data of former patients), and secondly it diverts the efforts of the TB control programme from effective case-finding and effective treatment to the group of former patients. For example, TB patients and former TB patients are detained in TB colonies of Kazakhstan, usually in one colony but in different buildings. In many TB colonies it is not possible to entirely separate all smear positive patients from smear negative,<sup>84</sup> and if possible, then many of those smear positive patients are not separated according to DST results (if available) or according to classification: new cases, relapses and failures, resulting in low infection control with an increased risk of re-infection with MDR. This particular problem in those colonies might be at least partly solved if the bed capacity of former TB patients would be used. KNCV consultants have proposed improving infection control in TB colonies, by transferring former patients to their colonies, and most TB colonies started recently to transfer former TB patients with minor radiological forms of TB after completion of treatment, to their colonies.

### **3.7 Integration of TB Services**

Integration of civil and prison TB services in Kazakhstan is under way, having both achievements and weaknesses. Political commitment for shared TB control has increased over the years. The prison health service has participated in writing the National TB Control Programme. However the structure of NTP contains vague information about participation/place of Prison TB Control Programme in the national context, this being partly resolved by the signing of an agreement between Ministry of Health and Ministry of Justice concerning TB control. National TB Control Programme 2004-2006 also contains confusing data relating to TB in prisons, such as “the epidemiological situation

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<sup>84</sup> Proekt “Reformirovanie ugolovno-ispolnitel’noi sistemy. Alternativy tiuremnomu zakliucheniu. Lechenie Tuberkuloza v uchrezhdeniakh ugolovno-ispolnitel’noi sistemy Respubliki Kazakhstan.”, Almaty 2005, p.210

in the country is aggravated by an annual increase of the number of TB cases in penitentiary institutions. Active TB morbidity rate among this category of people is more than 30 times higher and mortality 9 times in comparison with the civilian population of the Republic”, although TB trends from 1999 has changed radically in prisons.

Prisons are working according to the national technical policy for case-finding and treatment. Additionally prisons are using technical policies for active case finding (x-ray screenings) and on entry policies (isolation for two weeks of all new prisoners that come to colonies and investigation of suspects).

Prisons in Kazakhstan have access to level 1 laboratories (smear microscopy laboratories). Additionally, one oblast', Karaganda, has its own culture/DST laboratory (supported by Project “HOPE”), while others do not. It is therefore an achievement for integration that an agreement was signed between the Ministry of Health and KUIS to ensure accessibility to regional reference laboratories for culture/DST testing.

A very important aspect of effective cooperation is the necessity to have integration at different levels; TB services should cooperate not only at central level but at local level as well. In some regions of Kazakhstan this was achieved. For example in East Kazakhstan, the regional TB dispensary has opened a special room for incarcerated patients, where severe cases from prisons can have access to the same health service as the general population, including lung surgery. The civilian TB-DOTS manager is in charge of monitoring TB in the entire region, including prisons, and is motivated to ensure good TB control in prisons. A factor that influences the motivation of civilian TB managers to include prisons in the regional TB control programme is the consideration that most inmates are being detained in the region where they come from, and will return into the society in the same region. This achievement is a result of penal reform. Previously only a small number of inmates were imprisoned in the region of their residence. Following this organizational reform, most TB issues can be solved more easily between civilian and prison TB services at oblast' level. Regional civilian TB services are active in public monitoring of prisons; as a result they are more aware about difficulties in prison TB management and more helpful. Civilian TB service at oblast' level is highly motivated to maintain good cooperation with the prison TB service, stating “we need each other”, because of the impact of prison TB on the general community through released patients, staff and visitors on the one hand, but also due to difficulties in reaching suspects from some vulnerable groups in the general community on the other hand (i.e. substance abusers, or former inmates).

Management of transfers from prisons to civilian TB services is working better at regional level, with an acceptable quality (about 75% in pilot regions). Very helpful support was provided by monitoring committees and NGOs, which suggested abandoning the practice of trying to find patients after release according to their official place of residence, and adopting the practice instead of contacting them at their actual place of residence, to which patients will return. In addition monitoring committees and NGOs are supporting many released patients with legal issues, social support, informational support relating to TB and human rights, providing trainings for prison psychologists and acting as a link between prison and civilian services.

Increase of successful patient transfer to civilian services is an achievement, but it should be taken into consideration that some TB patients go to other oblasts, after release and at the moment the management of transfers in the civilian system is not working properly

among oblasts. This is due to impediments in drug distribution (based on the residence principle), and due to gaps in the TB surveillance system. Often TB patients (including released patients) from other regions do not have access to medical facilities of the region where they decide to stay, or they are not reported because TB managers report only the TB cases from their region. This results in difficulties with follow up treatment compliance and reporting treatment outcomes, or even with drug supply.

The integration of TB services is done at many levels and in many areas: in staff training, supplies management, management and supervision and staff management, diagnosis, and quality control.

In summary the integration of prison and civilian TB services has resulted in an improved TB control inside and outside prisons. Monitoring committees and NGOs have acted as catalysts of this process.

### 3.8 Infection Control

Epidemic rates of TB in prisons, as well as the high level of MDR-TB hinder the improvement of infection control in prisons. A very important aspect of infection control is recognizing the importance of implementing primarily administrative measures of infection control. In Kazakhstan prison administrative measures of TB control were prioritized as recommended, and early case-finding of infectious TB cases and DOT became routinely promoted. High risk infection areas are prioritized: ventilated rooms for sputum collection have been established, most safety principles are being respected in smear microscopy laboratories. The principle of separation of smear positive TB cases from smear negative TB negative cases is respected in pilot TB colonies, and this is an important achievement, because previously separation of inmates in a colony followed instructions of separation according to security/regime issues in opposition to infection control rules.

Environmental measures became more respected in prisons, proper ventilation of buildings and dormitories are being promoted.

Staff in many high risk areas (laboratories, sputum collection rooms) has respirators that are used in a reasonably complementary way to administrative and environmental measures.

Another important aspect in TB prevention is the need to decrease overcrowding. And in this area an important success was achieved with the reduction of the rate of incarceration, as a result of penal reform, which in practice increased the space available to each prisoner. The survey conducted by AFEW among inmates in 2003-2004 contained questions about the number of inmates detained in a room:

**Table 8: Overcrowding in prisons**

Overcrowding (70% responders), persons in a dormitory	2003	2004
1 – 20	14,2	13,9
21 – 60	15,6	41,3
61 – 100	38	37,7
101 – 200	32,2	7,6

As seen in Table 8, substantial decrease in dormitory overcrowding has been achieved, through shifting from the groups of 101 – 200 to 21 – 60.

### 3.9 HIV Control

Kazakhstan's penal system provides a good example of the implementation of a comprehensive TB control strategy in a wider penal reform context. Over the years both the prison population and TB among those who remain in prison has decreased significantly. TB mortality has decreased over ten times. These results are encouraging.

However, in a wider context, the following need to be considered:

Firstly, TB rates have decreased and case notification per 100.000 (calculated by annual turnover) in 2004 reached 1573, compared to case notification in 1997 when it was 5591. But in Kazakhstan prisons there is still a TB epidemic, and is ten times higher than in civil society. Thus it is too early to say that the TB epidemic has ended.

Secondly, the epidemic of HIV has been increasing over the last years with a geometrical progress, and already affects TB control. If this situation continues HIV will overtake the current TB epidemic and could fuel an increase in the TB epidemic. The proportion of TB/HIV co-infected patients will grow, and moreover a large number of HIV/TB patients might be smear negative, rendering diagnosis of TB more difficult.

In 2002 in Kazakhstan prisons there were 200 cases of HIV, while at the beginning of 2005 the number of HIV cases has tripled, rising to 600, these being official data. It might be expected that the real number of infected prisoners is higher. So, the prevalence of HIV has increased to 1.1% of the prison population by the beginning of 2005, and a further increase of HIV among inmates is only a question of time.

Drug addiction has seriously affected Central Asian countries and Eastern Europe. In Kazakhstan the number of registered drug users at the end of 2003 reached 50.000 persons, 4419 of them being in detention at the end of 2003.<sup>85</sup> Estimations of UNODC show that about 25% of drug users from Kazakhstan are registered. If that is so, then the real number of drug users in the country at the end of 2003 might be 200.000 persons,<sup>86</sup> and the real number of drug users in prisons might be higher by a few times too. The impact of drug addiction on current HIV trends are a cause for concern, over 80% of HIV cases being considered to be drug users in Kazakhstan.

TB/HIV co-infection was identified in 60 cases at the beginning of 2005 (10% of the prevalent HIV cases), and this number may increase in the following years too.

As a response to the HIV epidemic the prison health service has coordinated its efforts on HIV control by starting cooperation with the National HIV Control and National Drug Addiction Programmes. A very valuable external partner has been AFEW which has conducted intensive educational work in HIV awareness among inmates and prison staff.

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<sup>85</sup> Informatsia o deiatel'nosti ugolovno-ispolnitel'noi sistemy Ministerstva Iustitsii Respubliki Kazakhstan v 2004, p.16

<sup>86</sup> Ostanovit' Volnu, Rabochii doklad vsemirnogo banka N 54, May 2005, p.53



In prisons of Kazakhstan in the year 2004 alone 17 HIV conferences have been organised, 469 trainings conducted, 1897 volunteers trained, with 1502 of them being inmates.<sup>87</sup> This is an impressive amount of educational work.

Very valuable data was obtained during surveys undertaken in 2003 and 2004 by AFEW. The surveys were conducted in a randomized, voluntary, and confidential way, among inmates and staff in four colonies (1262 inmates in 2003, and 1228 in 2004). The survey aimed to gather the information required for preparation for future steps in HIV prophylaxis. The surveys were composed of questionnaires containing questions about HIV and TB knowledge, perceptions, attitudes and habits.

**Table 9: Description of the group taking part in AFEW survey**

Males		93%
Age	23-30	77%
	15-22	12.5%
	>30	10.5%
Currently married		29%
Have children		51%
Recidivism		65%
Sentenced for drug related offences (88.2% - responders)		14.3%

**Table 10: Access to prevention means**

	2003	2004
Accessibility of chlorine disinfection solution (85.6% - responders)	80.7%	88.6%
Accessibility of condoms (75.5% - responders)	45.3%	52.4%

It was established that accessibility to health care and preventive materials had improved. Voluntary testing for HIV had increased from 41.3% to 44.9%. Pre-test and post-test counseling had also increased. A good achievement was also an increase of interest in the information on HIV among inmates, this being connected to the increased access to information via representatives of AFEW.

**Table 11: Knowledge of HIV transmission**

HIV is transmitted through:	2003	2004
Sex intercourse of HIV infected woman with male (86.1% - responders)	94.4%	95.5%
HIV infected woman to the child (83.2% - responders)	92.1%	89.4%
Use of a needle/syringe that was used by HIV positive person	61.9%	63.6%
Tattoo with unsterile needle	61.7%	63.9%
Use of razor that was previously used by a HIV positive person	58%	59.6%

**Table 12: Knowledge about HIV prevention methods**

Methods of HIV prevention:	2003	2004
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<sup>87</sup> Informatsia o deiatel'nosti ugolovno-ispolnitel'noi sistemy Ministerstva Iustitsii Respubliki Kazakhstan v 2004, p.17

Use of condom during intercourse <b>prevents</b> HIV transmission (80.8% - responders)	82.7%	86.4%
Washing the needle/syringe with boiled water <b>does not prevent</b> HIV transmission (74.6% - responders)	71.6%	63.7%
Boiling of all needles and of instruments <b>decrease</b> the risk of HIV transmission (77.3% - responders)	70.6%	77%

The above tables show an increase in knowledge about HIV transmission. But the reduced number of responders and the reduced percentage of correct answers are in the area of safe drug use.

**Table 13: Sex practice of prisoners**

The number of sex partners during the last 6 months (42.9% - responders)	2003	2004
One	52.6%	64.6%
Two	17.6%	15.6%
Three or four	10.0%	5.9%
Five or more	19.8%	14.0%
Condom use during the last intercourse (89.9% - responders)	24.6%	37.9%

<b>Sex practice in colonies</b>	<b>2003</b>	<b>2004</b>
Sexual intercourse (92.9% - responders)	15.4%	16.4%
Use of condom (89.4% - responders)	9.7%	14.3%
Sex-service for money, things, drugs or protection (89.8% - responders)	3.2%	3.8%
Money, things, drugs or protection in exchange for sex (90% - responders)	13.7%	10.9%

Use of condoms (89.3%)	2003	2004
Never	41.6%	32.6%
Rarely	15.8%	14.9%
Sometimes	16.3%	18.0%
Often	13.7%	10.9%
Always	15.9%	22.8%

The above tables show that unsafe sexual practices exist in the prison environment; however there are trends towards more stable sex partners and safer sex habits. It is very important to correlate this data with accessibility data. In 2004 52.4% of inmates responded that condoms were available (75.5% responders answered the question regarding condom accessibility). So on the one hand we have improved access to condoms, but not enough, and on the other hand an increased number of inmates are practicing sex with condoms, but again the percentage is still very low (only 22.8% always use condoms, and 32.6% never use condoms, all the rest being in somewhere between).

**Table 14: Use of injecting drugs**

Use of injecting illicit drugs (95.5% - responders)	2003	2004
At least once	33.1%	29.3%
First time in prison	16.2%	24.1%
First time in this colony	36.1%	19.8%

Use of used syringes last time	43.3%	22.8%
Unsterilized syringes last time	9.5% (15/158)	49% (123/251)

Injecting drugs and unsafe behaviors exist in prisons. There are two main trends: decrease (almost twice) of use of others' syringes, which is an achievement of effective education. At the same time there is a trend of using unsterilized syringes of others (this might be due to increased education too, when people know more about sterilization methods, but do not use them). Nevertheless the small number of responders to the last question should also be taken into account. Tattoo practices have the same trends in prisons, and use of tattooing has decreased, but the use of tattooing with unsafe equipment has increased.

Very promising results were obtained in the area of improved attitude to People Living with HIV/AIDS (PLWHA). Two thirds of responders accepted the idea of PLWHA living in the same dormitory as them (compared to 2003 when only half would accept). Over 80% are not afraid to shake hands with a PLWHA. The percentage of persons that have the feeling, that they may protect themselves from HIV infection has increased from 76.7% to 83.1%.

The same survey conducted among prison staff reveal that the level of HIV awareness has not changed radically during 2003-2004 (sharing needles might transmit HIV – 86% of responders, condom use may not transmit HIV – 89%). Risk behaviour didn't change radically either (half of responders did not use condoms during their last intercourse with the occasional partner). Attitude to PLWHA has improved among staff (96.7% of responders answer that PLWHA need understanding and support). This fact allows for support from staff if new policies targeting HIV prevention and treatment are to be implemented.

Highly active antiretroviral treatment (HAART) to maintain and to improve immune status of HIV/AIDS patients is not implemented in prisons. There are plans to integrate HAART with civilian AIDS centers (the first step being already taken by ensuring continuity of HAART to imprisoned patients who began treatment before incarceration in the civilian sector). ARV treatment is a life long treatment, and it should also be performed under DOT with no interruptions and with uninterrupted supply of ARV drugs in order to avoid creation of drug-resistant HIV.

### **3.10 Palliative Treatment**

Palliative treatment of HIV/AIDS is problematic in Kazakhstan prisons, mostly due to legal aspects, because palliative treatment implies also morphine-like painkillers that are not allowed yet for use in prison settings. Life quality of persons in need of palliative care (not only HIV, but also TB, cancer, etc.) could improve if palliative care is performed. Basic needs of dying persons should be met, including pain control.

### **3.11 Legislation on TB/HIV Control**

An achievement is that DOTS strategy was officially institutionalized in National TB Control Programme since 1998. The National TB Control Programme for 2004-2006 is based on DOTS too, but additionally contains polices that are not considered cost-

efficient (prolonged hospitalization, rehabilitation of former TB patients with sanatorium “treatment”, etc.).

Interdepartmental agreements were signed to optimize integration between Ministry of Health, Ministry of Justice and Ministry of Interior.

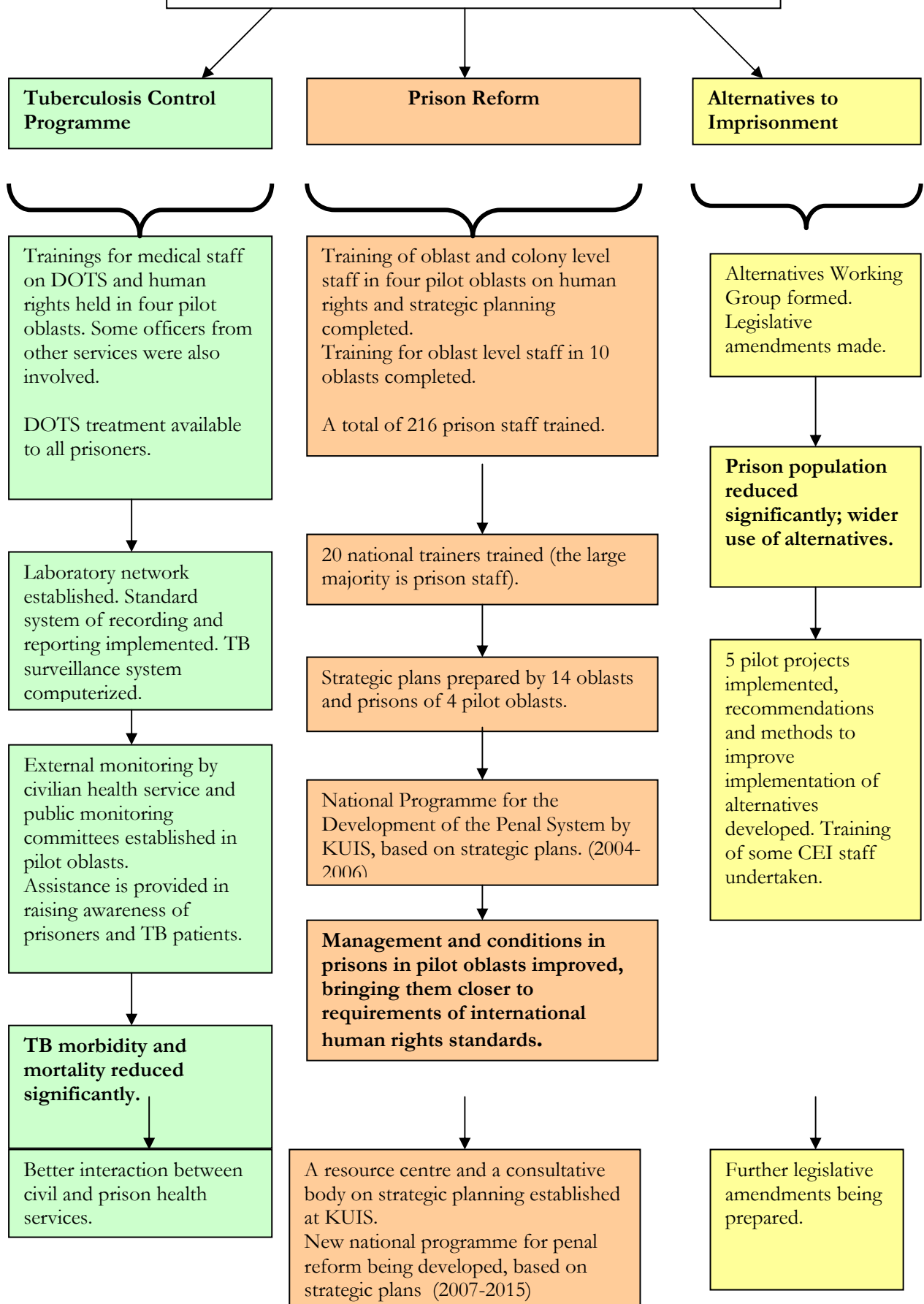
A very important success was achieved in HIV testing policies. From the year 2002 HIV testing is not mandatory any more, and is conducted entirely on a voluntary basis. Pre-test and post-test counseling is used more often.

People with HIV are not detained separately any more also due to a review of legislation. This represents a good contribution to the decrease in the stigmatization of HIV infected persons, and creates a better environment for HIV awareness and prevention.

Articles, which were discriminating against prisoners with HIV, were removed from penal legislation.

In the civil sector legislation relating to drug addiction treatment was revised (but incompletely), allowing Substitution Methadone Therapy for the treatment of intravenous opiate users.

**PRISON REFORM, ALTERNATIVES TO IMPRISONMENT AND FIGHT AGAINST TB IN KAZAKHSTAN**





Legislation adopted on public monitoring of prisons.  
Four Monitoring Committees established in pilot oblasts and new ones set up in three more oblasts. A total of seven monitoring committees functioning, covering half of Kazakhstan's oblasts.  
Public Monitoring Council formed under the Ministry of Justice

Public awareness raised, with a wide scale, massive campaign, including roundtables, conferences, press competitions, interviews, television programmes, and films.

Public support for penal reforms improved. Active contribution of civil society to penal reform increased.

**Chart 6: Kazakhstan: main activities undertaken and results**

## **CHAPTER 4**

### **KAZAKHSTAN: PROCESS**

#### **1. PRISON REFORM PROGRAMME**

##### **1.1 Pavlodar Project (1998-2000)**

###### **1.1.1 Training: Strategic Planning / Human Rights**

Training was conducted by international experts over a period of three years, which involved two visits each year, with each visit covering two weeks. Three-person planning teams were set up in the Regional Department and each of the six prisons (one pre-trial detention prison and five prison colonies). Experts worked with the strategic planning teams intensively during their visits, while reviewing changes on the ground.

###### **1.1.2 Study Visit to Poland, 1999**

A two-week study visit took place in 1999. Eight members of the Pavlodar Prison Administration and a key representative from the Central Prison Administration participated.

The objectives of the study visit were that:

- The visitors should see the changes in the Polish Prison Service which had followed the transition from a communist to a democratic society, and take back learning points which could be adapted to or implemented in Kazakhstan.
- The visitors should understand the limited financial investment which had supported these changes and that low cost or cost-neutral changes were also important.

Prisons visited were selected on the basis of their relevance to specific themes in the UN Training Manual, in order to demonstrate theory in practice.

###### **1.1.3 Prison Refurbishment**

Refurbishment was carried out in prison facilities, based on strategic plans with budget submitted by each prison colony and approved by PRI/KNCV. The refurbishment was monitored by the Pavlodar monitoring committee. This activity linked strategic plans with physical improvements in prisons and the role of the monitoring committee in a visible manner. The aim was to demonstrate how the system could work in future, when strategic plans would be submitted to KUIS and funds received on the basis of their approval. Another important aim was to motivate prison staff, while helping provide some vital needs of the prison establishments, which were in appalling condition when first visited in 1997.

## **1.2 Kazakhstan II Project (2000-2004)**

### **1.2.1 Training: Strategic Planning/Human Rights**

The project started with an introduction in Pavlodar for the heads of the three new pilot oblasts and staff from the Pavlodar Law College, the institution responsible for staff training in Kazakhstan. Then strategic planning teams were set up in colonies and headquarters in pilot oblasts and KUIS.

This was followed by three trainings in strategic planning in each of the three oblasts, for regional strategic planning teams, and for the KUIS strategic planning team. Trainings were conducted by international experts.

### **1.2.2 Study Visit to Poland, 2001**

The twelve participants included high level staff from the Prison Committee, heads of region from project oblasts, other senior staff members from the three oblasts, two local experts from Pavlodar, and senior representatives from the Department for Pre-trial Detention facilities. Three of them later participated as trainers in the roll-out training programme.

### **1.2.3 Training of Trainers and Advanced Training of Trainers**

A total of 20 trainers were trained in 2002 and 2003 by PRI trainers and new training modules developed. The new trainers were prison staff from pilot oblasts and teachers from Pavlodar Law College. At the time it was hoped that strategic planning would be introduced into the curriculum of Pavlodar Law College and trainers from this college were selected especially to prepare for this development. Unfortunately, this step has not yet been taken.

### **1.2.4 Dissemination of Training at National Level (Roll-Out Programme)**

The trainers formed five groups, each group responsible for 1-2 training cycles. Each cycle consisted of Foundation Training, Strategic Planning Training, Review Training.

Colony-level training programme: 3 pilot oblasts

Oblast-level training programme: 10 new oblasts

Colony level training was conducted in the three pilot oblasts (Akmola, Karaganda and East Kazakhstan), regional training having already been completed in the first phase. 12-14 colonies were included in each of the regions, trainings being conducted in two cycles, for 6-7 colonies each.

Two teams were responsible for the oblast' level training, which included "new bi-lingual oblasts", where training was conducted in Russian and Kazakh.

After the training was completed, regional departments prepared and sent their strategic plans to KUIS, following comments by trainers.

In parallel to training in human rights and strategic planning, training was undertaken by KNCV on TB management in prisons, for medical staff in the pilot oblasts, together with training in human rights for a selection of medical staff. (See Section 3).



### 1.3 Public Monitoring

Independent public monitoring of programme implementation was introduced in 1998 in Pavlodar Oblast<sup>7</sup>. Starting as a small informal group the Pavlodar Monitoring Committee was legally registered as an NGO in 2001. Once established as an NGO it became more self-sustaining, receiving grants from a number of donors, and expanded its activities.

The Pavlodar Monitoring Committee was the first of its kind in Kazakhstan, which worked on a regular basis in particular prison colonies, reporting to prison authorities and international organisations. It was taken as a model for the establishment of three monitoring committees within the Kazakhstan II project during 2001 to 2004, in East Kazakhstan, Akmola and Karaganda oblasts. The monitoring committees in East Kazakhstan and Karaganda oblasts were formed by members of the NGO, Kazakhstan International Bureau for Human Rights and the Rule of Law, while the committee in Akmola was formed in 2003, by an initiative group involved in penal reform issues.

Within the framework of another project implemented by PRI and funded by FCO, three new monitoring committees were established in Almaty, Zhambyl and South Kazakhstan oblasts in 2004.

The members of monitoring committees include legal specialists, psychologists and specialists from civil TB agencies.

Training for monitoring committees was provided by PRI on a number of occasions. The monitoring committees keep in regular contact and meet on a six monthly basis. These meetings allow participants to exchange information, skills and expertise on monitoring and working methods. Monitoring Committees also co-operate with NGOs and IGOs working in the field of human rights.

Monitoring committees visit prisons within their oblast on a quarterly basis, though priority prisons, such as TB colonies and problematic strict regime colonies are visited more often. They prepare reports and recommendations following each visit, which are sent to the Regional Prison Administration and governors of colonies. In two oblasts visited (Akmola and East Kazakhstan), Regional Directors gather together the governors to discuss issues raised and recommendations made by the monitoring committees, trying to find solutions to problems. Monitoring Committees confirm that administrations take action to fulfil many of their recommendations.

The practice adopted by the Akmola Oblast<sup>7</sup> prison administration is noteworthy, as it prepares its responses to recommendations in writing, which are submitted directly to the monitoring committee.

#### **Example: Monitoring in Akmola Oblast<sup>7</sup>**

The Akmola monitoring committee prepares a report and a letter with recommendations after each prison visit and submits these to the Regional Director, with copies to the relevant governors. The Regional Director then calls a meeting with governors, where the recommendations are discussed and plans of action agreed.

Subsequently the governors write directly to the monitoring committee on action taken to fulfil recommendations. The monitoring committee then checks these on their next visit.

They also have verbal discussions with the Regional Director and governors.

Monitoring committee activities were funded by Cordaid, as part of the PRI/KNCV project. They have now become more self-sustainable and will continue activities, with grants received from various donors.

#### 1.4 Conclusions

- During the pilot project in Pavlodar Oblast', all elements of the programme were introduced and tested for the first time. International experts returned to Pavlodar on a regular basis to train and to review changes on the ground. Refurbishment was carried out, on the basis of strategic plans. A monitoring committee was set up, which started with monitoring TB treatment, then went on to monitoring the implementation of standards set out in the UN manual, as well as refurbishment activities. Piloting a comprehensive set of activities proved to be successful.
- The first training in Kazakhstan II, which was aimed at senior level staff in KUIS and pilot oblasts were conducted by international experts. They had been involved in the strategic planning training in Pavlodar Oblast' and conducted review visits to Pavlodar during the implementation of Kazakhstan II project. This provided continuity between the first and second phases.
- Study visits, organised within the context of the comprehensive project on penal reform and health in prisons, and linked directly to the training in strategic planning, were acknowledged to be effective in convincing participants that aspirations could be transformed into reality and motivating them.
- Training of Trainers (ToT), conducted by national trainers, who had been trained during a separate PRI training programme funded by EU, was a turning point in the project. In practical terms, the ToT handed over responsibility for the project to the national team and fuelled motivation.
- The introduction of roll-out training, conducted by Kazakh trainers was a particularly successful element of the project.
  - This process helped develop a joint sense of ownership for the project between PRI and the Kazakhstan prison administration;
  - Training of staff by their own colleagues, was very effective, since the trainers could relate well to the problems and difficulties encountered by trainee staff; they knew methods of persuasion and motivation, as they themselves worked in the same system and had gone through a similar process.
- An inter-active method of training was used, including role plays and group work. This was very effective. The quality of trainers and training activities were evaluated highly both by staff being trained and by independent evaluators in 2003.
- The three trainers who had been to Poland on the study visit were able to explain vividly how international human rights standards had been put into practice in Poland, with little funding. This was regarded as very useful by trainees;
- The organisation of roll-out training, involving repeat trainings in different regions, conducted by five different groups, covering a large number of staff, was a massive

enterprise. Without active support and leadership from KUIS (which was responsible for trainee staff selection, orders to regions on the organisation of trainings and so on) this programme could not have been undertaken. Leadership and support was vital.

- KUIS demonstrated its leadership also by forming a strategic planning team and taking part in all trainings, demonstrating a thorough understanding of strategic planning principles.
- Staff selected was mainly from regime and educational services, heads of unit and some psychologists. The inclusion of regime personnel in the training was a wise decision, influencing the approach to prison regime. As one trainer noted in 2003: “At first the Heads of Regime were very much against the whole process, but then some of them became so convinced of the need for human rights in prisons that they actually became leaders of reform. Some even changed their positions to educational work in prisons. The mentality is changing among staff responsible for regime”.<sup>88</sup>
- Facilitating contact and cooperation between regime and educational workers was an achievement, leading to understanding between two services that traditionally operate quite separately and in different ways in CIS countries.
- A weakness was that insufficient medical staff took part in the strategic planning training. Their participation would have further strengthened contact between medical and other services, and further promoted the understanding that all services are responsible for health in prisons, while medical workers’ responsibilities should not be limited to treating the sick alone.
- Another weakness was the lack of support from many governors and some heads of region to the strategic planning process. So, the training of governors and heads of region would be essential in future, to gain their understanding and support.
- A relative weakness was that monitoring committees did not directly monitor the implementation of strategic plans (an activity which was undertaken in Pavlodar both by international experts and to some extent by the monitoring committee). In fact, at this stage, this should normally have been the responsibility of KUIS, together with monitoring committees. An aspiration was for the evaluation criteria of the regular prison inspections undertaken by KUIS to be changed in accordance with the new approach introduced by the project. This has not happened.

## **2. ALTERNATIVES PROGRAMME**

### **2.1 Alternatives Conference**

In designing the Pavlodar project, it was recognised that sustainability of reform in the long-term was fundamentally linked to addressing the acute problem of overcrowding in Kazakhstan’s prisons. Thus, the project had to start the debate on alternatives to imprisonment and encourage the process of legislative reform and the introduction of mechanisms to ensure the wider use of non-custodial sanctions. An international conference on alternatives to imprisonment was held in Almaty in the second year of the project, in October 1999. It was attended by a wide cross-section of stakeholders from all parts of the criminal justice system in Kazakhstan and other countries in the region. A resolution was adopted by the conference and recommendations formulated to ensure the

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<sup>88</sup> Evaluation report 2003, p. 72.

introduction and implementation of a range of alternative measures to imprisonment in Kazakhstan.

Key Conference Recommendations:

- To ensure the implementation of the recommendations of international documents with respect to non-custodial sentences.
- To speed up the introduction of alternative means of punishment provided for in the new criminal legislation, including the timely allocation of funding for their implementation.
- To transfer the prison system from the Ministry of Interior to the Ministry of Justice, including pre-trial detention centres, with the transfer of the latter being considered as a priority.
- In collaboration with the mass media, to raise public awareness about the negative effects of widespread use of imprisonment as a form of punishment and educate public opinion to adopt a positive attitude to the use of alternative measures.
- To consider the possibility of setting up a research unit for the study of penal issues within the Research Centre of the Interior Ministry Academy of the Republic of Kazakhstan, in order to increase the capacity for gathering, analysing and processing statistics and other information relating to the penal system.
- To acknowledge the expediency of more widespread use of NGO networks and the mass media in order to obtain co-operation with the prison system, including by setting up a centre for public communication attached to the Committee of the Penal System.
- To acknowledge the benefits of setting up a commission, consisting of representatives of all relevant governmental departments and non-governmental organisations, responsible for ensuring the implementation of the above recommendations.

The Alternatives Programme in Kazakhstan II was based to a large extent on the recommendations of the conference.

## **2.2 Working Group on Alternatives**

PRI facilitated the setting up of a Working Group on Alternatives, consisting of representatives of all relevant governmental departments and non-governmental organisations, as recommended by the conference. PRI also arranged for some Working Group members to go on study visits to countries, such as Sweden, France and Germany, where various forms of alternatives were being used successfully. The Working Group met regularly to formulate recommendations on amendments to criminal legislation. It had a significant influence on the content of the new law that came into force on 8 January 2003, which increased the use of alternatives to imprisonment, rationalised sentencing policy and relaxed the requirements for gaining the right to early conditional release, among other measures.

## 2.3 Key Legislative Changes

### Criminal Code

- Deprivation of liberty was excluded from sanctions for 13 offences of low and medium gravity;
- Alternatives were added as a possible sentence to 13 other articles.
- Maximum sentences were reduced for 12 offences. At the same time seven types of offences of the grave category were transferred into the medium grave category and two types of offences of medium gravity were moved to the category of minor gravity. These included the most frequent offences (e.g. theft and fraud). These changes not only reduce lengths of sentences, but also enabled prisoners sentenced under these articles to receive the right to early conditional release earlier.
- The term that needs to be served before receiving eligibility for early conditional release was reduced from  $\frac{1}{2}$  to  $\frac{1}{3}$  in the case of crimes of low and medium severity, from  $\frac{2}{3}$  to  $\frac{1}{2}$  for severe crimes and from  $\frac{3}{4}$  to  $\frac{2}{3}$  for especially severe crimes. (Article 70)
- Reconciliation: Proceedings must stop immediately for crimes of low severity and for first time offences of medium severity, which have not resulted in death or severe harm to health, in the case of reconciliation between victim and offender and redress of harm inflicted. Previously this was only a possibility. Proceedings may be stopped in relation to offences of medium severity if the offender has reconciled with the victim and compensated for the damage caused. Criteria used in this case are the circumstances of the crime and the offender's level of danger to the public. Previously mediation could be used only in the cases of first time offenders and did not have an unconditional nature. (Article 67)
- Limitation of freedom: A very important change was made to the nature of this sentence, which in fact transformed it into a new form of punishment. Under the new law the sentence does not have to be served in a specialized institution, but at home under supervision of a special agency, for a term from 1 to 5 years. The courts impose responsibilities, such as restrictions on changing the place of permanent residency, on changing the place of employment and education without notification; on visiting certain places; on leaving home except for work or study. In addition the court can also impose an obligation to undergo treatment for alcoholism, drug addiction, STD etc or to support the family. (Article 45)
- Extension of "limits of self defense": The Criminal Code decriminalised self-defence by all possible means if there had been an assault on the life or health of a person with the use or attempt to use arms. In addition if a person's property is assaulted and he/she uses arms against the assaulter and causes damage, he is not to be held responsible. (Article 32)

- The consideration of mitigating circumstances has been introduced which can reduce the maximum sentence to up to  $\frac{1}{2}$  for offences of low and medium gravity, up to  $\frac{2}{3}$  for grave offences and up to  $\frac{3}{4}$  in the case of especially grave offences. Previously the rule of  $\frac{3}{4}$  reduction applied to all offences. (Article 53)
- More flexibility has been introduced in respect of sentences imposed on a combination of crimes and in respect of repeat offences (a reduction of the lower limits of sentences and absorption of the less strict penalty by the stricter penalty). (Articles 58 and 59)
- Prison sentences imposed on juveniles for murder and murder combined with other crimes are now limited with 12 years. Juveniles between 14-16 years of age cannot be subjected to imprisonment for offences of medium gravity and those who are between 14 and 18 cannot be subjected to imprisonment for offences of low gravity. Previously imprisonment was only excluded for 14-16 year old juveniles for offences of low gravity. Limitation of freedom of between 1-2 years was added as a possible sentence. (Article 79)
- The term that needs to be served, following which the unserved part of a sentence can be replaced with a more lenient sentence was reduced from  $\frac{1}{2}$  to  $\frac{1}{3}$  of the prison term, for crimes of low and medium gravity. Such a possibility was also introduced for grave offences and offences committed while on early conditional release, where consideration to replace the prison sentence with a lighter sentence being given after  $\frac{1}{2}$  of the prison term has been served. (Article 71)
- Women's sentences can be suspended, if they have a child of up to 14 years, except for those who have been sentenced to 5 years and over, for grave or especially grave offences. (Previously the upper limit for the child's age was 8 years). (Article 72)
- An article was introduced providing criminal liability for torture perpetrated by officials and above all by those who are conducting investigation and interrogation. (Article 347-1)

#### Criminal Procedure Code

- The number of crimes for which pre-trial detention can be used was reduced.
- More possibilities were introduced for reduced and fast court proceedings for crimes of small and medium severity, under certain circumstances. (Article 363)
- A suspect can now use the phone immediately on detention in order to inform relatives/lawyers about his/her detention. (Article 68)

#### Criminal Executive Code

- A prisoner's regime can be changed from general and strict to colony-settlements after  $\frac{1}{4}$  of term served on light regime conditions in the case of offences of low

and medium severity and 1/3 in the case of severe offences. Previously the time that needed to be served was 1/3 for all offences. (Article 73)

- Disciplinary punishments can be lifted after 6 months, instead of 1 year, as previously. (Article 113)
- A prisoner becomes eligible to privileged regime conditions after spending 2/3 of his/her prison term in light regime conditions, for no less than 3 months. Previously 3/4 of the prison term had to be completed and no less than 6 months spent in light regime conditions. (Article 118)

## 2.4 Piloting Alternatives

In order to ‘demonstrate the opportunities for using alternative measures to imprisonment in Kazakhstan and raise public confidence in them.’ five pilot projects, implemented by different NGOs, were funded under Penal Reform International’s “Kazakhstan II” project.

The Working Group on alternatives played the leading role in selecting the following projects for support:

- Women in Prisons: Legal assistance to women prisoners, implemented by Kazakhstan International Bureau for Human Rights and the Rule of Law, Almaty.
- Criminal-Executive Inspections: A Step to the Future, implemented by Kazakhstan International Bureau for Human Rights and the Rule of Law, Eastern-Kazakhstan Branch Office, Oskemen.
- Developing Community Service, implemented by Kazakhstan Criminological Association.
- Women in Prisons: Rehabilitation, implemented by Public Foundation “Shyrak”, Almaty,
- Reform of the Criminal-Executive Inspections, implemented by International Human Rights Centre, Almaty.

The projects were selected according to the following criteria<sup>89</sup>:

- Correspondence between the aims of the project and the aims of the PRI project on alternatives
- Relevance of the project to the real situation in Kazakhstan and to the needs of the project’s target groups
- Appropriate project methodology
- Realistic budget
- Realistic activity plan
- Evidence of partnership with other organisations and official bodies
- Likelihood of the project producing a concrete, replicable outcome

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<sup>89</sup> Final evaluation of pilot projects on Alternatives to Imprisonment in Kazakhstan, 2004, R. Kuuse, M. Murphy, p.11

PRI provided advice and technical assistance to NGOs implementing pilot projects and facilitated coordination between the NGOs, as necessary. A mid-term and final evaluation of the projects was carried out by international consultants.<sup>90</sup>

## **2.5 Public Awareness Raising**

Recognising the crucial importance of public support for the success of the penal reform programme, PRI carried out a massive public awareness campaign throughout the project lifetime (and continues to do so) to increase public knowledge about the harmful effects of imprisonment and benefits of alternatives.

The following are some of the public awareness activities carried out:

- The invitation of press to all training seminars conducted within the project framework;
- Training seminars conducted for journalists and NGOs in East Kazakhstan and Karaganda Oblasts;
- A competition for journalists between April 2002 and February 2003, which resulted in a press conference and the distribution of awards in the juvenile colony in Almaty;
- Publication of articles by the members of the Working Group on Alternatives in the press;
- Special training for PRI trainers on communication with the press during the advanced training of trainers in April 2003;
- The training of press secretaries of prison service regional offices;
- Provision of funding for a TV serial in Karaganda oblast over ten months, which consisted of a 20 minute programme each week on the prison system;
- Social clips on TV focusing on alternatives over one month;
- A series of TV programmes on a republican private TV channel on different topics in the context of penal reform;
- Interviews with press representatives on a regular basis.

## **2.6 Conclusions**

- The organisation of a conference on alternatives, with genuine intention to take action based on its recommendations, was a successful strategy. It ensured involvement of all key stakeholders in Kazakhstan in the alternatives programme from the very beginning;
- The programme included a comprehensive set of activities, taking the project from legislation to practice. A key guiding role was played by the Working Group on Alternatives, which proved to be a vital force in the success of all elements of the programme;
- Legislative changes were successful in rationalising sentencing policy and terms of early conditional release in a way that had an immediate impact on the prison population;
- Pilot projects tested implementation and provided valuable outcomes and recommendations for improvement. They also strengthened cooperation

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<sup>90</sup> Final evaluation of pilot projects on Alternatives to Imprisonment in Kazakhstan, 2004, R. Kuuse, M. Murphy; Pilot Projects on Alternatives: Interim Evaluation, 2003, Mary Murphy.



between civil society and criminal justice authorities, which contributes to sustainability;

- The raising of public awareness, a constant activity that requires energy and persistence, and where immediate results are not always measurable, was seen as a priority at all stages of the project. The outcome is increased support to penal reform in Kazakhstan, which helps authorities to introduce new interventions, with less risk of public reaction.

### **3. TB/HIV MANAGEMENT PROGRAMME**

- DOTS training was made available for medical and laboratory staff, sustainability being provided by involvement of the civilian TB service.
- 471 prison medical specialists were trained in DOTS and 152 were trained in human rights and international standards, in the four pilot oblasts. 24 regime officers also participated in trainings on human rights.
- A collaborative activity performed with Project HOPE in DOTS trainings.
- Improved diagnosis through smear microscopy promotion and accessibility to DST testing through supply with consumables for culture/DST testing.
- Improved reporting and recording through established TB surveillance system according to standard DOTS requirements.
- Assisted integration of prison health service and civilian health service. Sustainability being achievable through signed agreements between Ministry of Justice and Ministry of Health (access to DST, National TB Programme responsible for TB control both in civilian and prison areas).
- Joint TB/HIV monitoring by public monitoring committees in pilot oblasts.
- Collaborative HIV - TB activities developed.

### **4. INTEGRATION OF PRISON REFORM AND HEALTH INTERVENTIONS**

The management of the project was shared between PRI and KNCV, both at headquarters and field levels. At headquarters level, integration began with the development of a joint project design, with activities in the same selected pilot oblasts. The periodic meetings of the steering committee at headquarters level, including not only PRI and KNCV, but also donors, ensured management decisions to be taken in consultation and in line with the integrated project strategy. At the field level, the project benefited immensely from the establishment of a programme office (later becoming PRI sub-regional office for Central Asia) in Kazakhstan. PRI and KNCV coordinators in Kazakhstan had main responsibility for the implementation of the project, shared project reports, took implementation decisions at the field level and organised joint or complementary activities.

Some elements of the project content brought together the two parts of the project naturally. For example, the alternatives programme, which achieved a very significant reduction of the prison population of Kazakhstan, had an extremely positive impact on the health element of the project. A smaller prison population meant that resources, including health resources, were distributed among a smaller number of people, that

there was more space, fresh air, ventilation, natural light, better food, improved sanitation and hygiene facilities, medication and more time and attention from medical staff available to inmates. This situation, on its own, contributed to the improved immune system and health of prisoners and gave those infected with TB, HIV and other diseases better chances of recovery. (These achievements were complemented by the increased budget allocated to the prison system, as explained in Chapter 3, 1.1).

Strategic Planning also brought the two elements of the project together naturally in many respects, since it included planning in areas of prison management, which had an impact on the health of prisoners. These include all those issues mentioned above, relating to space, fresh air, ventilation, natural light etc. Other specific human rights concerns, such as the need for better conditions in punishment cells, also contributed to achieving a healthier environment in prisons (e.g. by ensuring that prisoners were able to open windows of punishment cells from within, by improving sanitation facilities etc). Strategic planning also improved the management of the prison health service directly, since strategic planning teams had to collaborate with all services in their prison establishments in order to formulate their plans.

However, the mid-term evaluation and later project development mission noted a weakness with the integration of the two elements of the project at the strategic planning level. The first of these was the lack of medical staff on strategic planning teams, the second was the lack of medical staff among trainers conducting strategic planning training.<sup>91</sup> The first concern could not be addressed sufficiently at that stage, since strategic planning teams had already been formed and received full training. However, the concern would be addressed in the next stage of the project. In order to address the second concern mentioned, and to compensate for the first, PRI Director and KNCV Coordinator arranged for existing trainers (one of whom was a former prison doctor) to receive training on TB prevention and specifically on the links between health and human rights in prisons. Trainers also received a training pack relating to TB/HIV management in prisons. Thus, in the roll-out training programme the trainers imparted this knowledge to staff on strategic planning teams.

In future it would still be essential to include medical staff on strategic planning teams, since the input of medical workers into decisions relating to nutrition, lighting, sanitation facilities, heating etc are of great importance. Secondly, the understanding that medical staff are not only responsible for the treatment of the sick, but that they should also contribute to creating a healthier prison environment needs to be instilled in all staff. This would contribute to increasing the status and respect enjoyed by medical staff in prisons.

Integration between the two elements of the project was strengthened by the training of medical personnel on human rights issues, alongside DOTS. In the later stages non-medical staff was also included in trainings on human rights, in the context of prison health.

Monitoring of prisons by public monitoring committees had a crucial role to play in integrating the health and human rights elements of the project, as well as strengthening the links between prison and civil health services. As mentioned above, monitoring

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<sup>91</sup> Evaluation Report, 2003, pp. 15, 80; Project Development Mission Report, 2004, T. Atabay, V. Sergeev, pp. 14-16

committees were responsible for monitoring prison conditions and treatment of prisoners, as well as issues and activities relating to TB and HIV management in prisons. Prison authorities took their reports seriously and acted upon their recommendations. In addition, monitoring committees included representatives from civil health agencies, such as oblast TB dispensaries, which helped improve the link between prison and civil health services. Monitoring committees were also involved in assisting with the continued treatment of former prisoners with TB and HIV, improving their referral to civil health services.

Most importantly, the results of the project itself, as well as lobbying by PRI and KNCV representatives in Kazakhstan, influenced policy makers and senior level prison and health staff, as a result of which the above mentioned order was issued and agreement signed between the Ministry of Justice and Ministry of Health on closer cooperation, the status of medical staff was officially raised in some pilot oblasts and opportunities for prison medical staff to receive training in the civil health sector were increased significantly. More assistance is now being provided by civil health specialist to prison health services.

## CHAPTER 5

### MOLDOVA

As mentioned in Chapter 1, in Moldova PRI and KNCV are working in partnership with the Institute for Penal Reform (IRP) and Caritas Luxembourg (CL). IRP has been responsible for implementing the alternatives and prison reform element of the project (working with PRI Bucharest Office). CL has responsibility for the TB and HIV components, working with KNCV TB coordinator in Moldova.

The information on prison reform and alternatives programmes in Moldova is based on an evaluation carried out by two independent consultants in June 2004<sup>92</sup> and information provided by IRP<sup>93</sup>. Information on the TB/HIV programme is given by a medical expert, CL, actively involved in TB/HIV management strategy development and implementation in Moldova (one of the authors of this review).

A mission to Moldova was not carried out specifically for the preparation of this review, therefore analysis of activities is limited. Nevertheless, it is felt that the available information is relevant and useful in the context of PRI and KNCV's approach to prison reform and health in prisons, as it provides an example of a different level of integration and joint project management. In addition, there are lessons to be learnt from the way in which different activities of the project were prepared and implemented.

#### **1. PRISON REFORM PROGRAMME**

The aims of the prison reform element of the project in Moldova focus mainly on the development of preparation for release programmes in prisons and resocialisation after release. An important goal is ensuring uninterrupted treatment of prisoners with TB and HIV.

##### **1.1 Prison Reform Programme: Achievements**

The project introduced for the first time preparation for release programmes, new working techniques in group-work sessions and training of psychologists and social workers in Moldovan prisons. Due to the structure of the trainings, especially the roll-out trainings, programmes introduced to the prison staff can be adapted to specific local needs.<sup>94</sup>

Two rehabilitation centres were set up in Chisinau and Ungheni in June and November 2005. They are managed by two NGOs. Forty prisoners have benefited from assistance

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<sup>92</sup> Strengthening Civil Society, Health and Human Rights in Prisons, Evaluation Report, June-August 2005, Rait Kuuse; Strengthening Civil Society, Health and Human Rights in Prisons, Project Evaluation Report, June 2005, Diana-Olivia Călinescu. (Henceforth referred to by names of author only)

<sup>93</sup> Community Service as an Alternative to Detention in Moldova, Sorin Hanganu, Head of Community Service Department, IRP; Problems and Solutions in Mediation Implementation in the Republic of Moldova, Diana Popa, Head of Mediation Department, IRP; Implementation of Probation in the Republic of Moldova, Realities and Perspectives, Victor Zaharia, Head of Probation and Institutional Reform Department, IRP, November 2005, separate responses by e-mail to specific questions from V. Zaharia, and IRP website: [www.irp.md](http://www.irp.md).

<sup>94</sup> Evaluation report, Diana-Olivia Călinescu, p. 9

provided by the Chisinau rehabilitation centre, which conducted regular visits to three penal institutions (Rusca, Pruncul, Cricova) since its establishment. The rehabilitation centre in Ungheni, set up in November 2005, has concluded an agreement with the territorial office of the Department of Enforcement, and is providing assistance to prisoners released on parole. The activities of rehabilitation centres are linked to the preparation for release programmes, mentioned above. They are also connected to the activities of the working group set up to strengthen coordination between all agencies involved in preparation for release and continued care of TB patients, which has now been expanded to cover other prisoners as well. (See 3.3).

The preparation for release programme for prison psychologists and social workers, working group on preparation for release and rehabilitation centres, bring together the health and human rights elements of the project. These activities, starting in prison, and continuing into civil society represent a good example of a comprehensive approach to the resocialisation of prisoners, including TB patients and others.

## **1.2 Prison Reform Programme: Process**

During the first year of the project, a conference on preparation for release was organized in order to expose relevant prison staff to international experience in the area.

During the second year, specialized training was delivered to social workers and psychologists of each prison. They were trained on specific programmes to be used with inmates.

Over 50 educators and psychologists from prisons and pre-trial detention facilities in Moldova were involved in training activities starting with 2004. Three seminars were held in 2004 and 2005.

The goal of the first seminar was to familiarize the participants with the main programmes in Romania and the Netherlands relating to prisoners' preparation for release. Within the second seminar participants were divided into three working groups with different themes that studied the programmes presented by the experts from Romania and the Netherlands.

- The first programme presented by experts from Romania and the Netherlands (from Prison Fellowship Romania and Goldstein Programme, the Netherlands) was Goldstein Programme – “therapy of structured learning”. This programme aims to develop communication abilities within groups of people, including the category of detainees.
- The second programme presented by a social assistant from the Romanian Group for Protection of Human Rights, was the “resocialisation programme”, which aims to promote reintegration into society, as well as teaching certain behaviour and specific social abilities for problem solving, which prisoners could use after release from penitentiary institutions.
- The third programme presented by experts from Prison Fellowship, Romania, was the Development of the Moral Reasoning Programme, which is addressed especially to psychologists from penitentiaries to help with their work with pre-release prisoners. The goal of the programme is to evaluate the level of prisoners' reasoning, and through specific exercises raise their sense of responsibility for their own behaviour.

The third training seminar, entitled “Organizing and carrying out psycho-correctional activities in penitentiary institutions” was organised in September 2005, in collaboration with the Department of Penitentiary Institutions. The target-group of this training was the psychologists from penitentiary institutions. The trainers were representatives of the Department of Penitentiary Institutions, who put into practice skills obtained in a Training of Trainers seminar, organized by PRI in 2000 in Romania.

Seven roll-out trainings are planned.

## **2. ALTERNATIVES PROGRAMME**

The alternatives programme brings together a number of interconnected activities. The community service programme and introduction of mediation are part of the joint PRI/KNCV project. PRI has made some contribution to the introduction of a probation system, but activities in this area are part of a different project, mainly funded by Soros Foundation Moldova, UNICEF and the British Embassy. All programme elements are being implemented according to a united strategy, care being taken to ensure that activities are complementary.

The initial achievement of the alternatives programme was that IRP provided assistance in amending criminal legislation (Criminal, Criminal Procedure and Criminal Executive Codes), in particular in widening the use of alternatives to detention. (Adopted in 2002, 2003 and 2005 respectively).

According to data provided by the Department of Penitentiary Institutions, the prison population (convicted prisoners) gradually decreased over the past two years, from 7525 at the beginning of 2003 to 6542 at the end of 2005. One cause for the reduction of the prison population was the larger number of detainees being conditionally released (on parole). In 2003, the figure was 682, in 2004 – 1031, and in the first 9 months of 2005 – 790. This was due to the more favourable legislative framework.

The reduction was also a result of a large amnesty, carried out in 2004-2005.<sup>95</sup>

### **2.1 Community Service: Achievements**

Community service was piloted successfully in six pilot districts of Chisinau municipality. Local committees for community service were created to ensure that mechanisms for implementation worked, public awareness activities carried out to gain the support of the community, execution of sentences were supported and monitored by local coordinators.

Although it is too early to conclude that community service is having a significant impact on the size of the prison population, data provided by the Supreme Court of Justice, Moldova shows a constant increase in community service sanctions and decrease in prison sentences over the past two years<sup>96</sup>. (See Table 15)

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<sup>95</sup> Information from V. Zaharia, IRP.

<sup>96</sup> Information from V. Zaharia, S. Hanganu, IRP.

**Table 15: Dynamics of sentencing in Moldova, 2003-2005**

	<b>2003</b>	<b>2004</b>	<b>2005 (9 months)</b>
Sentenced to prison	3551	3019	2001
Conditional suspension of sentence enforcement	7738	6303	4614
Community service	4	155	1051
Fine	5027	2046	1467

Thus, evidence suggests that community service is gradually gaining the trust of judges, prosecutors and the public, as an effective sanction.

There are two points where the implementation of community service differs from that in Kazakhstan. These also constitute achievements.

The agreement of the offender is sought by the judge before sentence is passed. (In line with Council of Europe, Committee of Ministers Recommendation R (92)16 Rule 35)

The existing mechanism in Moldova does not provide for the payment by the Local Public Administration for the work performed by the offender. Thus local authorities are motivated to engage offenders in community works. (In Kazakhstan organizations employing offenders must pay their salaries to the state budget).

There are, however, difficulties in Moldova that are similar to those in Kazakhstan. Despite good indicators, there is still a lack of confidence among judges in the implementation capacity of criminal-executive inspections. As in Kazakhstan, the lack of finances aimed at developing the implementation of community service, lack of training by the state and lack of adequate staff, among others, contribute to this. (The head of the regional enforcement department is, for example, dealing with 100 cases). Trainings and roundtables organized in cooperation with IRP contributed to changes positively, but more needs to be done.<sup>97</sup>

## **2.2 Community Service: Process**

### **2.2.1 Legislative Framework**

Community service was introduced in the new Criminal Code, which came into force on 12 June 2003. The Code stipulates that this sanction can be applied to juveniles between 16 and 18 and to adults for committing minor and less serious offences (for which sentences would have been up to 5 years' imprisonment).

Taking into consideration the complex nature of the punishment, legislation allowed for the gradual application of the sentence by piloting.

On 31 December 2003, the Regulations on Community Service Sanction Enforcement Modality were adopted. The Regulations had been drafted by the Working Group on Alternatives, established by IRP in collaboration with the Ministry of Justice. These Regulations define in detail the community service enforcement mechanism, the rights

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<sup>97</sup> Evaluation report, Rait Kuuse, p. 11

and duties of offenders, bailiffs, and local public authorities. Annex 2 of the Regulations contains a list of jobs that can be given to offenders sentenced to community service.

The Criminal Executive Code, in force since 2005, contains regulations on the enforcement of court decisions on community service. Together with the above-mentioned regulations, these two documents represent the legal framework for community service sanction enforcement.

On 4 July 2005, the decision of the Plenum of the Supreme Court of Justice “On the application of certain provisions of national and international legislation on the application of community service by courts and the enforcement of these sentences” was adopted. The decision of the Plenum includes guidelines for judges on sentence application and makes reference to certain points, such as the agreement of the offender to the application of the sanction, determination of the length of sentence in case of a number of offences, commitment of the offender and certain issues of sentence enforcement, among others.

### **2.2.2 Public Awareness Activities**

An extensive public awareness raising campaign was carried out, in order to inform experts and the general public. Within the informative and training seminars organized for judges, prosecutors, bailiffs, lawyers and others, the community service concept, its functioning mechanisms and its benefits were outlined.

Various information materials were published and disseminated (e.g. “Guide for Experts who Work with Juveniles in the Criminal Justice System”, “What is good to know if you are in conflict with the law?” and “What is good to know if you have been sentenced to community service?”). Brochures, Juvenile Justice Informative Bulletins and articles were published on the webpage of IRP.

### **2.2.3 Piloting Community Service**

The activities on sentence implementation included piloting, initially in Centru sector of Chisinau municipality, Ungheni and Nisporeni, and later in Făleşti, Edineț and Cahul.

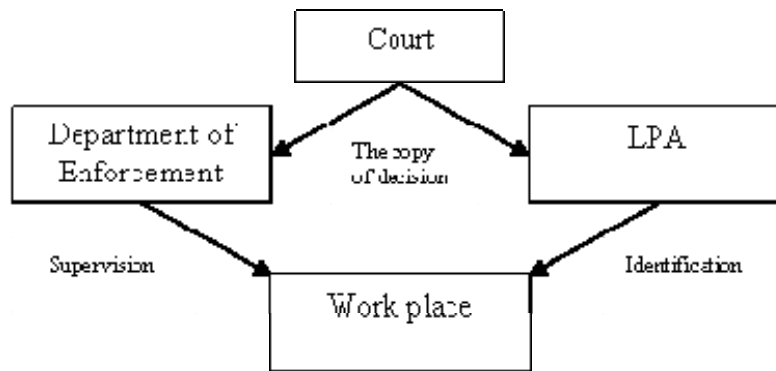
IRP organised a number of preparatory activities prior to piloting and piloting extension. Some information about the roundtable recommendations relating to Centru sector of Chisinau municipality and Nisporeni, put forward prior to initial piloting, is given below.

#### District Centru of Chisinau municipality

The round table conference “Application and enforcement of community service in district Centru of Chisinau municipality” was held in January 2004, aiming to establish a plan of actions at sector level regarding the enforcement of community work and a network between institutions that were to be directly involved in enforcement. Members of law enforcement bodies and directors of institutions that were to offer places for community work were invited.

Based on the presentations and discussions a draft scheme that represented the relationship between the institutions directly involved in applying community service sanctions was prepared.





LPA: Local Public Authority

**Chart 7: Relationship between institutions involved in the implementation of community service<sup>98</sup>**

At the end of the round table conference, the need to create a local committee was discussed. The committee would have responsibility to rapidly solve problems that might arise during the period of implementation.

In conclusion, participants got acquainted with the problems that might interfere with implementation, drafted strategic solutions and, what was very important, they had the possibility to establish contacts for subsequent successful collaboration.

Nisporeni

The round table conference on enforcement of community service was organised in Nisporeni in collaboration with the Court of Nisporeni in February 2004. After discussion of the specific problems of Nisporeni district, the following recommendations were made:

- To create a local committee that would facilitate the functioning of the mechanism relating to the implementation of community service. This initiative came together with certain proposals, for example, the identification of the members of the committee, the organisational form, the number of meetings etc.;
- To organise a meeting with all the mayors of villages from Nisporeni district, in order to inform them about the essence, purpose and mechanism of enforcing community service. This recommendation took into consideration the fact that the offenders sentenced to community service would be from a locality of Nisporeni district and were to carry out the sentences at their place of residence;
- To involve the social assistance service, taking into consideration the importance of the social usefulness aspect of the sentence, as well as underlining the responsibility at national level to identify the places where community service can be carried out;
- To take into consideration, during the enforcement of punishment, holidays and week-ends;
- To pay special attention to the offender’s health;

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<sup>98</sup> IRP website.

- To present the list of work places in advance to the Service of Enforcement of Judicial Decisions;
- For the first stage, to apply community service only to adults;
- To avoid the enforcement of sentences by a few offenders at the same time, in the same place.

A similar round-table was organised also in Ungheni, prior to piloting.

#### Mid-term evaluation

During the first phase of piloting a mid-term evaluation was carried out analyzing the implementation of over 20 community sentences. Recommendations were made, to be taken into consideration when applying community service at national level. They were as follows:

- The offender's personality must be taken into account when adopting the sentence, as well as his family situation, home and his attitude towards the punishment.
- For efficient enforcement, an information campaign is necessary, through the mass-media, both for the staff of institutions directly involved in the mechanism of applying community service and the entire community.
- Work with offenders should not be limited to supervision. Discussions must be carried out in order to explain to them the essence of the punishment, their rights and obligations.
- Seminars should be organised for the representatives of the local public administration, in order to train them in working methods with offenders, and to let them know the rights and obligations of the convicted.

#### **2.2.4 Extension of Piloting**

A number of activities were carried out in preparation, taking into account the experience gained in the initial piloting. In this context round table conferences were carried out in Cahul, Făleşti and Edinet.

The purpose of the round table conferences was to establish a network between the institutions that would be directly involved in applying community service sentences. Collaborators of law bodies and directors of the institutions that would directly provide places for community service were invited to the round tables.

The participants were informed about the specifics of community service. Problems that had interfered in the pilot sectors at the first stage were also discussed, in order to avoid them in the next stage.

In Făleşti, the round table conference took place in July 2004, where members of the local committee were identified. A local coordinator was also selected. He was to be responsible for facilitating the work of the local committee and for organizing coordination between IRP and the local committee.

The members of the local committee included a judge, Head of the Enforcement Office, Deputy Prosecutor from the Prosecutor's Office, Legal Counselor, Senior Specialist from the Guardianship Body (all from Făleşti).

The round table conference in Cahul took place in September 2004. The same topics were discussed and the local committee was selected. The members included the president of the Court of Appeal, the prosecutor of Cahul District, Head of the Enforcement Service, a Lawyer from the District Council (all from Cahul district).

The prospects of applying community service in Edinet district was discussed at the round table conference that took place in Edinet on the in October 2004 and members of the local committee selected.

Following the results acquired during piloting, the following priorities were set for 2005: the extension of implementation, informing the legal community in the country on community service, organizing for this purpose round tables in the majority of regions of Moldova, and continuously monitoring the implementation of community service.

### **2.3 Probation System: Achievements**

The project aims to assist the gradual introduction of a probation service in Moldova. At the first stage activities focused on the piloting of a pre-sentence probation service for juveniles. The intention is to expand the project to cover the whole of Moldova, with supporting legislation.

Social assistants and psychologists were trained in three pilot districts in preparation of pre-sentence reports, implementation of pre-sentence probation and community service.

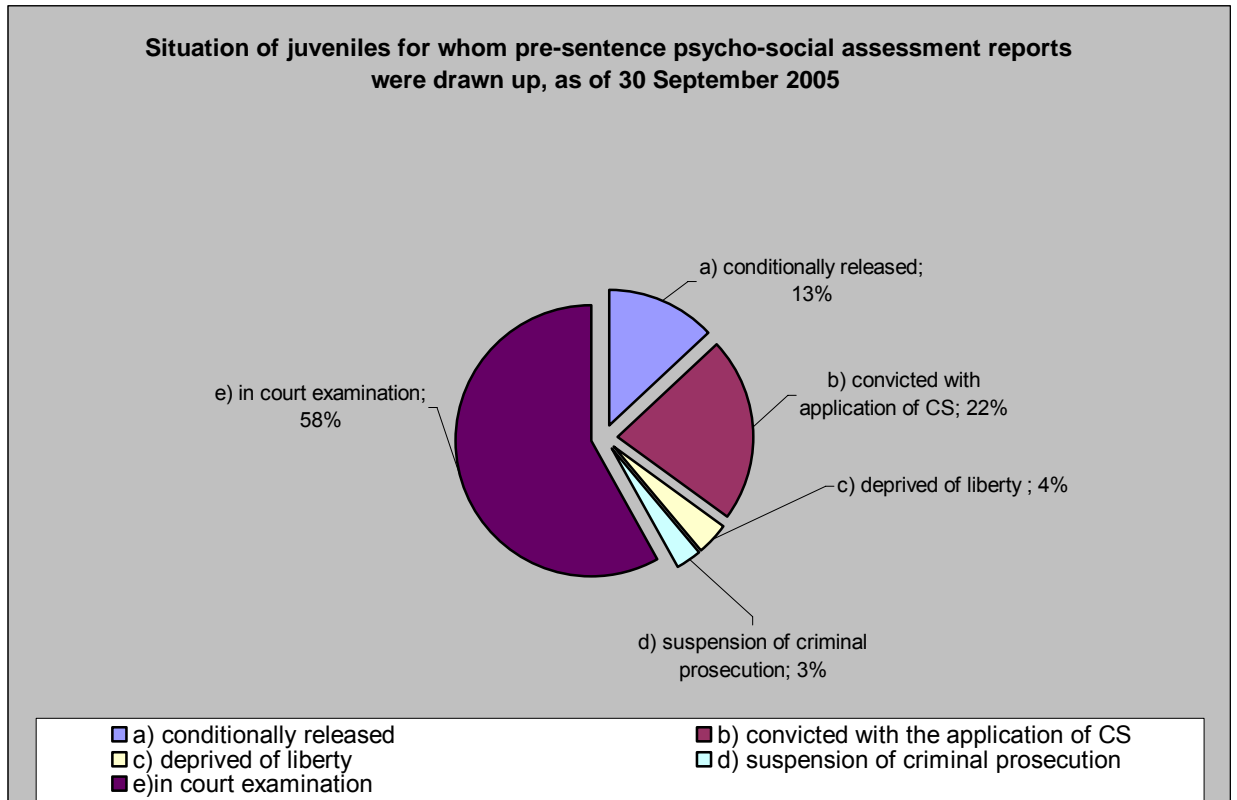
The mechanisms for requesting and drawing up pre-sentence reports were established. Interaction mechanisms between the court, probation counselor and the persons who are to provide data about the offender were put in place.

Cooperation agreements were concluded with the Court of Centru Sector and the Municipal Board for the Protection of the Rights of the Child on the implementation of community service and pre-sentence probation.

Standard acts were developed to regulate the process of drawing up psychosocial assessment reports.

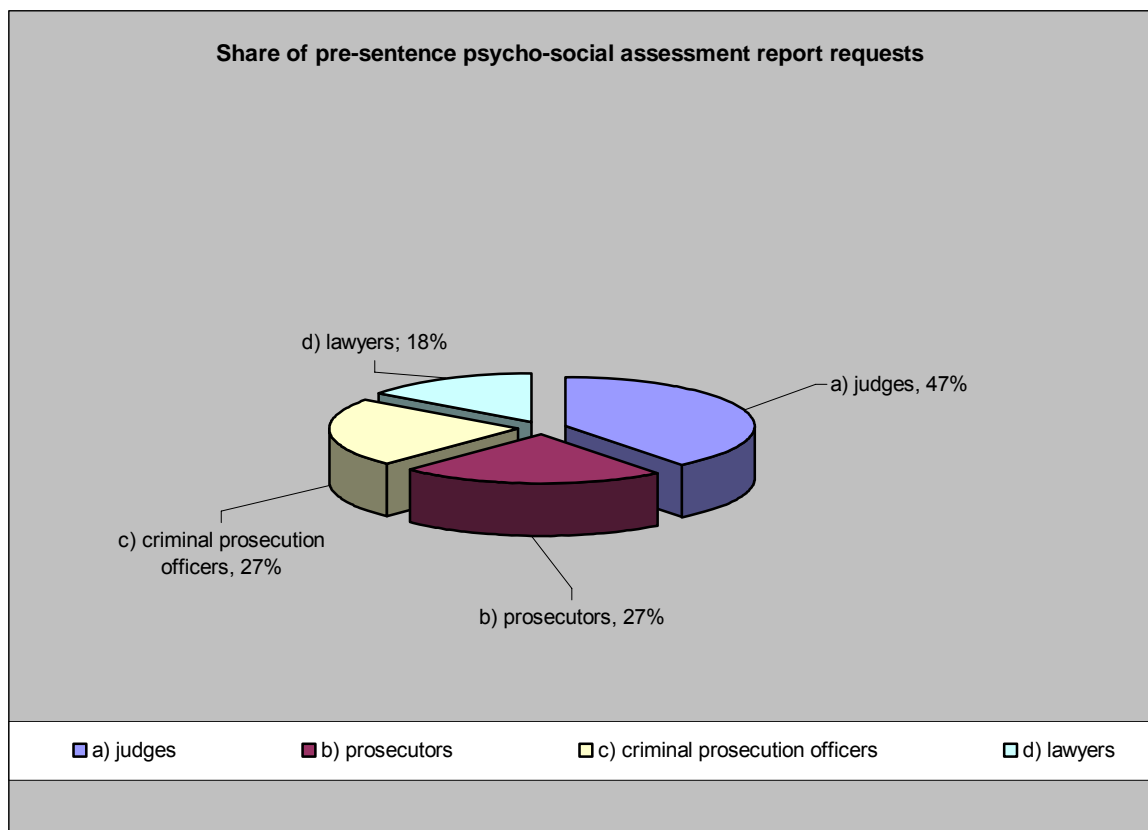
Within the period of piloting (1 January, 2004 – 31 October, 2005), the following number of pre-sentence reports were received and drawn up, according to each sector:

- Chisinau Municipality – 96;
- Ungheni Rayon – 33;
- Cahul Rayon – 11;



**Chart 8: Situation of juveniles for whom pre-sentence psycho-social assessment reports were drawn up, as of 30 September 2005.<sup>99</sup> (CS: Community Service)**

<sup>99</sup> Implementation of Probation in the Republic of Moldova, Realities and Perspectives, Victor Zaharia, Head of Probation and Institutional Reform Department, IRP, November 2005



**Chart 9: Share of pre-sentence psycho-social assessment report requests by requester<sup>100</sup>**

Opinion of judges, prosecutors and lawyers on pre-sentence psychosocial assessment reports

Results of a survey carried out by IRP, aiming to assess judges', prosecutors', and lawyers' views of pre-sentence psychological reports, included the following:

1. 79% of those questioned had familiarised themselves with the pre-sentencing report for the juvenile criminal case they participated in.
2. 97% felt that they were useful.
3. 15% felt that the goal of pre-sentencing reports was to help decide whether to apply preventive detention; 85% felt that the goal was to individualise sentencing.
4. In the case of minor offences, 35% felt there was a need for pre-sentence reports, for less serious offences, 54% felt there was a need, in the case of serious and extremely serious offences this share was 73%.

A number of problems have been identified by IRP, including the lack of initiative for requesting pre-sentence psychological assessment reports, impossibility of the probation officer to make field trips, especially to rural areas, in order to collect information, due to lack of transportation means, lack of cooperation between the applicant and the probation counselor during the process of drawing up pre-sentence assessment reports, lack of requests to have the probation counselor present in court sessions and in examining cases, in which psychological assessment reports have been requested and

<sup>100</sup> Implementation of Probation in the Republic of Moldova, Realities and Perspectives, Victor Zaharia, Head of Probation and Institutional Reform Department, IRP, November 2005

drawn up. There are other challenges, some of them relating to the technicalities. IRP has identified possible solutions and is making efforts to overcome these difficulties.

As with community service, the gradual, piloting approach, enables gaps to be removed in stages, before expansion.

## **2.4 Probation System: Process**

Activities on the establishment of a probation system in Moldova started in June 2003, when a group of international experts carried out a Needs Assessment Mission (NAM).

The assessment mission came to the following conclusions:

- There is a positive context, in which probation can be implemented.
- Probation must be developed and implemented for adults and juveniles separately. A probation system is necessary for adults. A re-socialization and reintegration system should be created for juveniles. Taking into consideration the structures and resources available today, both systems must be developed gradually.
- The partnership between governmental and non-governmental structures should serve as the basis for probation implementation.

In order to ensure efficiency of the probation system it was necessary to change the legal framework, as follows: to pass a Law on Probation or to introduce special provisions on probation in the Criminal Procedure Code and, in order to put all these provisions into practice, to adopt regulations on probation that would cover all the issues that might arise within the process of implementing probation nationwide.

In order to fulfil the NAM recommendations, a Working Group on Probation was formed in 2003. Its purpose was to develop a legal framework on probation, being a counselling and reference group at the same time. In April 2004, the draft law on probation was completed. The Law on Probation had the structure and content of an ordinary law, thus being an act that introduced the notion of probation to Moldova and was the basis of subordinate acts adopted afterwards.

Practical activities for the implementation of probation services started by piloting pre-sentence probation (drawing up psycho-social personality assessment reports) in the cases of juveniles, starting on 1 January 2004.

The purpose of the project activities was to:

- prepare the conditions to carry-out pre-sentence probation activities relating to juveniles;
- create a pilot service of pre-sentence probation relating to juveniles within IRP
- define the mechanism of the process for requesting, drawing up and presenting probation reports;
- extend the activities of this service to other piloted sectors;
- assess the implementation of pre-sentence probation activities;
- identify conditions that are necessary for the implementation of pre-sentence probation activities at the national level.

In order to initiate pre-sentence probation activities, piloting preparation activities were carried out, directed towards:

- Identification of the piloting sector;
- Selection of social assistants for the position of probation counsellors and for their participation in project workshops;
- Creation of a working group that would assist the piloting process of the pre-sentence probation service for juveniles;
- Conceptual development of the questionnaire for juvenile psycho-social assessments;
- Determination of a mechanism for requesting and drawing up pre-sentence probation reports;
- Establishment of the interaction mechanism between the court, probation counsellor, and the persons, from whom the data about the juvenile are to be collected;
- Development of standard acts that regulate the process of drawing up psycho-social assessment reports.

At first, piloting was initiated in Chisinau, then in Ungheni and Cahul (from 1 January 2005).

The first training for the selected social assistants was carried out in November 2003 under the title: “Pre-sentence inquiry (probation report) in cases involving juvenile delinquents”. The second training for specialists in psychology and social assistance took place in January 2005, under the title: “Implementation of pre-sentence probation and unpaid community service for juveniles in the criminal justice system”.

Piloting activities are continuing and will be extended to another three sectors in 2006.

## **2.5 Mediation**

The possibility of reconciliation between victim and offender through mediation was introduced in the Criminal Procedure Code, adopted in March 2003, for minor and less serious offences. Thus, the elaboration of a special law, which would regulate in detail the functioning mechanism of the mediation process, then became necessary.

With the help of international experts, the members of the Working Group on Alternatives gathered information about international practice in mediation and restorative justice. The existing situation in Moldova was also analyzed, concluding with the elaboration of a draft-law regarding victim-offender mediation.

One important achievement in the field of mediation in Moldova was the introduction of a Code of Ethics for mediators.

In addition, a mediation piloting centre in Chisinau was set up and 24 mediators trained.

There are challenges in expanding the use of mediation in Moldova. These include the lack of a well structured legal framework, lack of trust among the judicial community in mediation, lack of well established mechanisms and lack of adequate support from the public. So it is not yet being used widely. IRP has identified ways of resolving these

issues. They include introducing articles into penal legislation which will regulate mediation practice and give the mediator judicial status in the penal procedure; signing collaboration agreements between the Mediation Centre and legislative bodies to organise information activities, establishing collaboration with the institutions which are responsible for the training and retraining of prosecutor's office, police and court staff, raising public awareness via the mass media, among others. The crucial factor for success was identified as the need to involve many different stakeholders from central and local state bodies, as well as civil society in the process.

### 3. TB/HIV CONTROL IN PRISONS

The decision to establish effective strategies to counteract the two main health emergencies - TB and HIV/AIDS - in the prison system and to increase civil society access to penitentiaries was taken after the transfer of the prison administration to the jurisdiction of the Ministry of Justice in 1997. At the time, poor living conditions, lack of funds, improper health polices and high incarceration rates were fueling TB and HIV, with transmission to the general public. Partnerships were established between the prison administration and international foundations (Caritas Luxembourg Foundation and Soros Foundation). A local NGO was also involved in HIV control (Medical Reforms in Prisons).

#### 3.1 TB/HIV Control: Achievements

The policy of TB control was readapted and DOTS strategy was implemented in a pilot project that started at the end of 2000 with the support of Caritas Luxembourg Foundation. It was not possible at the beginning to integrate prison and civilian TB services, due to the fact that the Ministry of Health was not committed to implementing DOTS strategy. However, outdated TB polices in the civilian TB service failed, and the experience of the prison health service of establishing a TB control programme based on DOTS led to the adoption of a National TB Control programme based on DOTS, one year later in 2001. The National TB programme 2001-2005 established the two main partners in TB control – Ministry of Health and Ministry of Justice. Some technical polices that are used in prisons were specified in the NTP (active case finding, on entry polices, preparation for release, etc.). In the year 2003 joint efforts of the prison health service and the civilian TB service resulted in 100% DOTS coverage of the country, including all prison TB facilities.

**Table 16: Dynamics of TB cases in penitentiaries of Moldova**

	2000	2001	2002	2003	2004
Total number of TB cases registered at the end of the year	1030	1115	765	435	412
Number of new TB cases	251	497	351	278	293



Cases of death from TB	51	47	52	32	24
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The Penitentiary System of Moldova has a population of 10.000 (at 2005), and an annual turnover reaching 25.000 prisoners. The TB prevalence (total number of patients at the end of year) has decreased by 63% between 2001 and 2004.

A good indicator is the increased number of TB patients in 2001, because it corresponds to the expectation of having an increased number of TB patients due to improved diagnosis, increased access to treatment and increased credibility of the health service. Another good indicator of DOTS strategy is the gradual decrease that follows the peak. The gradual decrease from 2001 to 2004 consists of 41%.

TB mortality has decreased by half by the fourth year of DOTS implementation. This indicator should be analyzed along with another indicator – the release of TB patients on humanitarian grounds, which also decreased over the years. In 2003, 28 TB patients were released on humanitarian grounds and in 2004 the figure was 19 (32% less). Since most patients released on humanitarian grounds were severely ill with low life expectancy, the general indicator of mortality and humanitarian release shows a substantial decrease in case fatalities from TB in Moldavian penitentiaries.

Another achievement of the prison TB service was to succeed in equalizing the number of released TB patients with the number of TB patients entering prison (with a ratio of 51% to 49%) over the period of five years. So, effective TB control in prisons resulted in the fact that prisons begun to lose the role of “TB pump” into the society, and are actually taking over the role of “TB filter” for the society.

Progress in early case finding has been registered as well: if in 2000 about 37% of new cases were with late diagnosis, then from the year 2001 the proportion of late diagnosis decreased to below 30% (in 2004 being 29%).

According to DST survey results DOTS in Moldavian prisons has resulted in preventing a further MDR burden during the first three years of DOTS implementation, followed by a low decrease in MDR among TB cases during the fourth year of implementation. This is what was expected: standardized treatment with no interruption that is directly observed prevents MDR-TB. According to a DST survey in 2004 Primary MDR was 10.9% among inmates (compared to 15.8% in 2003), and combined resistance (primary and secondary) has shown a stabilization of MDR at 49% in 2003, compared to 50% in the year 2000, and a decrease to 40% in 2004.

HIV control started in prisons in 2000 with the piloting of harm reduction projects through peer education and followed by needle exchange projects (based on distribution through volunteers among inmates). Condom distribution, education of prison staff, voluntary testing, pre-test and post-test counseling were conducted as components of the HIV control strategy. Integration of the prison HIV service with the civilian HIV service proceeded without impediments. The National HIV Control Programme 2001 – 2005 has a comprehensive structure. Prisoners were considered as one of the main vulnerable groups and supported to the same extent as other vulnerable groups. The success of this programme was noted by prison administrations elsewhere. For example, at the end of 2003 a delegation from the Ministry of Justice of Lithuania visited the prison needle

exchange project in Moldova and, despite initial skepticism, decided to adopt Harm Reduction Strategy through needle exchange in Lithuanian prisons.

Implementation of Methadone Substitution Therapy started in 2004 in civilian drug addiction dispensaries. One year later, in 2005, after fulfilling the pre-requisites, the prison HIV control programme was augmented with Methadone Substitution Therapy as well. The experience in Canadian prisons was taken into account.

Is Harm Reduction working in prisons of Moldova? Data from Sentinel Surveillance show a decrease of HIV among men from 3.2% in 2001 to 2% in 2003. Lessons learnt: effective HIV programmes need to be comprehensive.

In 2004 access to HIV/AIDS antiretroviral treatment was ensured to all inmates with HIV/AIDS. HAART implementation was also integrated with the civilian HIV Control Programme.

As was expected TB/HIV co-infection begun to affect the TB control programme in Moldova, initially in prisons, but then in the civilian sector as well. TB/HIV co-infection was reported in a small number of cases until 2001, but a geometrical progression then followed. By the end of 2003 4.3% of TB cases were HIV co-infected. A relative stabilization in the co-infection was noted during 2004, with 6 % of TB cases being co-infected with HIV. In the same period of 2003-2004 mortality of HIV/TB co-infected patients increased. In 2004, 25% of TB deaths were patients with TB/HIV co-infection.

Co-treatment of TB and HIV co-infected patients in Moldova currently takes place only in penitentiaries due to a successful integration of the prison TB and HIV services, this being a model to follow for the civilian TB and HIV services.

## **Outcomes**

- reduced morbidity and mortality from TB in penitentiaries
- effective HIV prevention
- increased treatment compliance after release
- access to antiretroviral treatment
- a pilot DOTS-plus project for treatment of MDR-TB (about 30% of cases will be enrolled from prisons), approved by Green Light Committee

Achievements in prison and civilian TB/HIV control in Moldova are attributed to dedication and coordinated efforts of all stakeholders: Prison Administration, Prison Health Service, National TB Programme, National HIV Programme, Caritas Luxembourg Foundation, Soros Foundation, GFTAM, USAID, MSH, PRI/KNCV, WHO, AIHA, GDF, Medical Reforms in Prisons and Innovative Reforms in Penitentiaries.

## **3.2 Other Polices and Organizational Aspects in TB/HIV Control in Prisons of Moldova**

The main prison treatment capacity is the Prison Hospital of Moldova, which has a “room” based system, and where TB treatment is available to all TB patients, including juveniles, women and pre-trial prisoners, because there are enough rooms to separate them, and moreover respiratory separation of cases is easier to perform – not only smear

positive being separated from smear negative cases, but also MDR-TB patients being separated from susceptible cases, minimizing the risk of re-infection. The rooms in the Prison Hospital are designed taking into consideration the need for 4 square meters per inmate. In smaller rooms 2-4 patients might be accommodated, in larger rooms, 5-10 patients. This system allows for better infection control, (infection control being an important pre-requisite for the implementation of DOTS-plus pilot projects for treatment of MDR-TB patients). Moreover in the same hospital it has been possible to have under treatment TB/HIV patients on co-treatment (DOTS and HAART), with minimal risk of re-infection.

The prison health service in Moldova has a reasonable level of autonomy and integration with the civilian service. TB/HIV policies are based primarily on international strategies, but are also coordinated with policies applied by the Ministry of Health. Some health policies are applied by the prison health service with the vital interest of the prison community according to international recommendations, even if they are not officially adopted by Ministry of Health. An example would be MDR-TB policies:

- TB treatment category III was restricted to patients who had begun the treatment on TB treatment category III in the civil sector, but were imprisoned during treatment.
- Promotion of fixed dose combined drugs (combined Isoniazid and Rifampicin from the year 2000, and 4-FDC drugs from 2005).
- Early identification of MDR-TB cases and separation of patients according to DST results. All new cases and relapses have access to DST before the beginning of standard treatment, so the results are available within 1-2 months. Previous policies provided for DST testing only for failures, not taking into account the fact that many patients might be infected with MDR-TB before the treatment.

### **3.3 Preparation for Release**

The best direct link between human rights and TB management was achieved in the establishment of a working group for the preparation for release of TB patients

Before the PRI/KNCV project started legislation and competent state structures that should prepare inmates for release and support them after release (including the newly established prison service of social workers) were already in place. However, a certain organizational mechanism was not established. The project succeeded in identifying gaps and improving collaboration between state structures of different jurisdictions (Ministry of Health, Ministry of Social Protection, Ministry of Interior, and different sub-units of the Department of Penitentiary Institutions). Moreover valuable NGO partners were identified to help eliminate many of the gaps.

A working group was created which identified major obstacles in successful preparation for release and support after release. A mechanism of actions and responsibilities was established and implemented. The mechanism was based on a comprehensive approach: including medical aspects, information flow to civilian structures and feedback, different aspects of social support, incentive strategy, involvement of local authorities and community mobilization.

As a result of the working group activities, the successful referral of released patients to civilian TB facilities increased from 50% to 75% (as was predicted), and more

importantly, treatment compliance increased from less than 50% before the project, to preliminary data of 75% (i.e. patients came regularly with no interruptions to DOT treatment up to completion). 40% of released patients that did not continue treatment were those who re-offended and were re-incarcerated in a period of less than 6 months after release. In the group of released patients that continued treatment after release only 6.6% were incarcerated in the period of 6 months after release. The initial target group of the working group was TB patients released from prison. Later the established mechanism was considered efficient by authorities from different jurisdictions, and the same mechanism has begun to be used to some extent with all released inmates.

### **3.4 TB Monitoring**

DOTS training and monitoring was another activity promoted by PRI/KNCV in Moldova. An efficient TB monitoring team was created by KNCV/Caritas Luxembourg, based on joint monitoring. In this context PRI/KNCV experience in Moldova might be useful and applied to some extent in Kazakhstan. The Prison TB Monitoring Committee is composed of a trainer from the civilian TB service, prison TB manager, TB/HIV consultants and communication consultants from NGOs. The joint monitoring has the advantage of performing, in addition to standardized monitoring visits, very effective short “on-the-spot” trainings and effective “on-the-spot” education for staff and inmates. In this way, all participants learn from each others’ experience. The presence of the prison TB manager ensures unrestricted access to prisons. The role of the communication consultant in the team is that he leads assessments (through questionnaires, focus groups, interviews) of the educational needs and efficiency of the already promoted educational policies in the areas of TB/HIV awareness, like knowledge or behavioral habits.

## **4. INTEGRATION OF PRISON REFORM AND HEALTH INTERVENTIONS**

The integration of the prison reform and health elements of the programme in Moldova has not been as strong as in Kazakhstan. For example, a joint training programme in prisons or joint monitoring has not been implemented. Strategic planning, which helps bring together human rights and health reform activities in prisons, was not introduced.

Successful results have been achieved somewhat separately, in the areas of alternatives to prison and TB/HIV management in the prison system. However, the implementation of an alternatives programme, aiming to reduce the size of the prison population, alongside a health programme in prisons, represents a *de facto* integration of health and prison reform interventions. The rationale is that the reduction of the prison population will have a positive impact on the success of the TB/HIV programme in the long term, notwithstanding whether the management of the two elements of the project are united.

The integration of the prison reform element of the programme and TB/HIV element is being strengthened with focused and closely connected activities aiming to improve the preparation for release of prisoners and their resettlement after release, which includes ensuring the continued treatment of patients with TB or HIV. In this respect, the Moldova project provides a good example for Kazakhstan and other countries.

Practical reasons for looser integration in Moldova, include the fact that the project is not being managed by a joint PRI/KNCV programme office as in Kazakhstan. In addition, TB/HIV management and alternatives programmes had already started, with funding from different donors, before the PRI/KNCV programme was introduced. The PRI/KNCV programme aimed to widen the scope of activities in both areas and ensure collaboration between the two elements and the two NGOs (CL and IRP) implementing them. This was achieved to a considerable extent.

At the management level collaboration is achieved through two bodies: a steering committee at headquarters level, including participants from PRI, KNCV and project donors (ICCO, Cordaid), and a field steering committee, which brings together PRI, KNCV, CL and IRP representatives, as well as other NGOs directly involved in implementing the different elements of the project. Regional Director, PRI Bucharest and KNCV Technical Consultant are responsible for monitoring and supporting project activities and are members of the field steering committee. This system ensures that all partners are kept informed about the progress of the programme as a whole, activities are developed and implemented in line with the joint strategy and adjustments are made as necessary.

The PRI/KNCV programme in Moldova can therefore be considered as an example of looser integration, which may be more realistic to achieve in countries where developing a joint programme, managed from one programme office, is not possible for various reasons.

## CHAPTER 6

### KAZAKHSTAN: SUSTAINABILITY

#### 1. POSITIVE FACTORS

- The prison reform programme, implemented in partnership with KUIS, Ministry of Justice, with important contributions from prison monitoring committees and NGOs, has created a firm basis for the sustainability of reforms. KUIS demonstrated its commitment to reform both by its partnership with PRI/KNCV during implementation, and with the national programme for penal reform (2004-2006), which was developed on the basis of project strategic plans. Many tasks included in that programme were backed up with finances, which increased the success of the PRI/KNCV project. The new draft national programme for 2007-2015 was also based on strategic plans from regions, and as explained above, demonstrates the continued commitment of KUIS to the reform process. The results of strategic planning in the prisons of four pilot oblasts are evident, with significantly increased respect for the human rights of prisoners, improved prison conditions, better prison atmosphere and a more positive relationship between prisoners and staff.
- The TB management programme, where, in addition to the Ministry of Justice, main partners were the Ministry of Health, National TB Centre and Oblast TB Dispensaries, led to the implementation of DOTS strategy in the prison system of Kazakhstan with DOTS being accessible to all prisoners. Total number of TB cases were reduced by more than half between 1998 and 2004, and deaths from TB from 1,218 in 1998 to 74 in 2004. Cooperation between prison and civil health services was improved significantly, especially in pilot oblasts, with valuable assistance from monitoring committees.
- The Alternatives Programme, where, in addition to the Ministry of Justice, important partners included representatives from the parliament, from the Prime Minister's office, the Supreme Court, Prosecutor's Office, National TB Centre, the police investigation branch and representatives from NGOs, played a fundamental role in legislative reforms, which led to a reduction of the prison population from over 65,000 convicted prisoners at the beginning of 2003 to just under 45,000 in 2005 (and reduced from 86,000 in 1998). The amendments were aimed at ensuring sustainability in the levels of incarceration. New amendments are planned to further rationalize criminal justice policy. In the meantime pilot projects are assisting with improving implementation.
- The project has expanded and developed in sophistication over the years, having established a momentum that is now practically irreversible. In fact, at times it is difficult to differentiate between those achievements which are direct outcomes of the project, and those which are indirect results. This is a positive indicator, demonstrating that reforms are wide-scale and dynamic, fuelled by the PRI/KNCV programme. This result was exactly what the project aimed at, from the very beginning. When the Pavlodar Project started, "the outcome of the project was intended to be a prison system, which had embarked willingly on a process of change, which would lead it eventually to achievement of international human rights standards".

As a result of the project, the Kazakhstan penal system currently is in possession of the following assets:

- A fundamental change in the approach to penal policy and the prison system's place within the criminal justice system;
- An understanding at all levels (Ministry of Justice, KUIS and pilot oblasts) that health and human rights issues are interconnected and that reforms must adopt an integrated approach to resolve problems in both areas;
- A prison population reduced almost by half, since the project started in 1998;
- Legislation in place for a sustained reduction and stabilization of the prison population, including with the use of alternatives to prison. Further legislative reforms in progress;
- Pilot projects on non-custodial sentences assisting with addressing challenges in implementation;
- 20 national trainers, and over 200 staff trained in strategic planning and human rights;
- Strategic planning training modules;
- A strategic planning model, which can be changed/ adapted as necessary in future.
- A strategic planning resource centre to work on introducing strategic planning into the penal system, to organize trainings, research and data collection established and a strategic planning consultative council formed;
- Training modules developed for criminal executive inspectors and prison psychologists (within pilot project supported by PRI);
- DOTS strategy being implemented all in prisons as part of the National TB Programme. DOTS accessible to all prisoners;
- TB mortality and morbidity in prisons reduced significantly;
- DOTS training modules developed; 471 medical staff in pilot oblasts trained in DOTS and 152 trained also in human rights;
- Improved recording and reporting systems on TB cases in pilot oblast prisons;
- Monitoring of TB programme being undertaken, with participation from civil TB specialists; cross monitoring between pilot oblasts introduced;
- HIV/AIDS awareness among prisoners and staff increased, some prevention means introduced to prisons;
- HIV prisoners not isolated, HIV testing conducted on a voluntary basis and stigmatization of prisoners with HIV decreased;
- Status of medical staff improved in prisons, cooperation between medical services and others developed;
- Cooperation between prison and civil health services increased significantly, especially in pilot oblasts;
- Public Monitoring Council established, to consult KUIS, Ministry of Justice on penal reform issues on a regular basis;
- Legislation that allows for the public monitoring of places of detention in place; seven trained monitoring committees functioning, four of them with years of experience;
- Increased cooperation between NGOs and the prison service;
- Increased public awareness about the harmful effects of imprisonment, and therefore increased support for reform initiatives.

All these project outcomes, which relate to changes in approach, reforms to legislation, increased skills, knowledge and motivation of staff, development of modules and trainers for continued training in future, establishment of permanent bodies, such as monitoring committees and the strategic planning resource centre, as well as public support, are forward looking. They institutionalize the process of reform.

Many challenges remain however. This is not surprising for such a comprehensive and interdisciplinary project, which introduces many new concepts, laws and programmes to Kazakhstan, and in view of external factors, such as the frequent senior staff changes in the Ministry of Justice, which has slowed down continuity from time to time.

## **2. MAIN CONCERNS AND RECOMMENDATIONS**

### **2.1 PRISON REFORM AND ALTERNATIVES PROGRAMMES**

- Sustainability of the prison reform programme depends on the level of institutionalization, at national level, of reform mechanisms. In this case the main mechanism is the use of strategic planning, based on human rights principles. Strategic planning has not yet been introduced into the system as the official planning method, on the basis of which oblast prison administrations receive their funding.

Two ways of introducing strategic planning into the national system was discussed with KUIS representatives and other senior level prison staff in Kazakhstan.

Integration of current planning system with strategic planning: This would be the preferable solution. If a decision is taken to integrate the two planning systems, it would be recommended that PRI, together with the Consultative Council on Strategic Planning, provides expertise during the process.

Parallel use of plans: Although this may be a good interim solution, which has been suggested by some KUIS staff and is the method being used in some pilot oblasts, it also has a number of drawbacks. Strategic planning includes many elements, which cannot be reflected adequately in the current official planning system. Thus when using strategic plans to complete internal plans, it is important to continue to refer to strategic plans in the individual management of prison establishments. Also, in order for strategic plans not to lose their dynamic quality, adjustments made to them during implementation need to then be reflected in the following official plan. Of course, the other important shortcoming is that an obligation to complete two plans would be time consuming and put additional pressure on staff.

- The project has demonstrated what a key role trained and motivated staff can play in prison reform. The particular advantage of strategic planning is that the process of planning itself is an activity that constantly trains and re-trains prison staff in implementing human rights standards and improving health in prisons, while improving management, at the same time. If strategic planning is to be introduced officially then staff training at the strategic planning resource centre should begin without delay, under the leadership of KUIS. Introducing strategic planning into the curriculum of Pavlodar Law College and Kostanai Law Institute



is also recommended. In the latter, there is an opportunity to coordinate the programme with the basic course on health in prisons, currently being prepared by AFEW. This would be an effective way of strengthening the link between health and human rights during training.

- If strategic planning is to be introduced to the penal system, then KUIS should ensure that a monitoring mechanism, to check the implementation of strategic plans, is developed. This is an essential element of strategic planning (see Chart 2). Monitoring by KUIS should be undertaken in parallel to the activities of the public monitoring committees, which do not monitor the implementation of strategic plans specifically and in any case do not have the authority to take management decisions on behalf of the penal system. In order to do this, it would be desirable to integrate the current regular prison inspections by KUIS, with the monitoring of strategic plan implementation. This necessitates the evaluation criteria of the current inspection visits to be changed, which should be done anyway, to reflect the new understanding about the role of imprisonment in the criminal justice system and new expectations from the penal system.
- A weakness is the lack of effective programmes preparing prisoners for release and post-release rehabilitation/socio-psychological assistance programmes, which gives rise to the risk that those being released from prison may easily fall back into criminal behaviour patterns. If this problem is not addressed, the decrease in the prison population may not be very sustainable. Therefore, priority should now be given to assisting former prisoners not to resort once again to crime, due to problems with housing, jobs, broken relationships, lack of social support, psychological difficulties and so on. This assistance is also crucial to ensure that TB patients continue uninterrupted DOTS treatment after release. Therefore an assistance mechanism combining social/psychological/health issues should be considered.

There are two areas of focus: (1) Developing effective programmes to prepare prisoners for release. (2) Developing reintegration/rehabilitation programmes for released prisoners.

KUIS, Ministry of Justice, Ministry of Health, prison social workers and psychologists, civil health and social services, employment agencies, NGOs, monitoring committees need to be involved.

The comprehensive approach adopted in Moldova, where prison psychologists and social workers were trained in preparation for release, a working group established to ensure coordination between services involved in pre-release preparation and aftercare of prisoners (including continuum care of TB patients), followed by support by post-release rehabilitation centres could be considered.

- Social and psychological support should also be available to the increasing number of offenders, who are expected to be sentenced to non-custodial sanctions over the coming years. It is impossible for CEIs, on their own, to provide the support needed, even with appropriate training. Thus the programmes developed should take into account the needs of those sentenced to alternative sentences as well, including the special needs of different categories, such as juveniles, women etc.

Specific concerns relating to CEIs and organisational aspects of the implementation of alternative sanctions can be summarised as follows:

- The staffing levels of CEIs are extremely inadequate, especially when taken into account together with their increased responsibilities.
  - CEIs are not receiving official, regular training to help them cope with new responsibilities relating to the overseeing of sentences such as limitation of freedom and community service. (Some training has been provided by the Kazakhstan International Bureau for Human Rights and the Rule of Law, in cooperation with KUIS, within the framework of the project, “A Step to the Future”, supported by PRI, as mentioned under Chapter 3, Section 2.2).
  - No additional funding has been allocated to CEIs to improve their work conditions, to enable them to travel the large distances often involved in visiting offenders under their care and to carry out simple office related tasks. Work conditions are extremely unsatisfactory in many cases and getting even worse in some. CEI staff is leaving the system.
  - The successful implementation of community service sentences relies on close coordination between criminal executive inspections, which are responsible for overseeing the execution of sentences, and local authorities, which are responsible for identifying work-places for offenders. This coordination is not working satisfactorily in many oblasts.
  - Criminal executive inspectors also have to establish and maintain close links with agencies of the Ministry of Interior, judges, prosecutors, social services, financial services, employers and educational institutions. The mechanisms of this coordination and responsibilities of each agency are not clearly set out in law or regulations. This situation puts immense pressure on CEIs, increasing their workload as they try to fulfill their obligations with little support.
  - There are plans to add the task of supervising those released on parole to the responsibilities of CEIs. This is a logical step, but will increase CEI workload very substantially and will make the need for additional staffing and resources all the more urgent.
  - Many courts are not cooperating well with CEIs in resolving technical issues, which leads to additional difficulties – some of which can be resolved with discussion. For example, in East Kazakhstan Oblast’, the Kazakhstan International Bureau for Human Rights and the Rule of Law, managed to get CEIs and judges together to come to a satisfactory understanding about many technical issues.
- Taking into account all the above, it is clear that increasing CEI staffing, investing in the training of inspectors, to help them cope with their new

responsibilities, and improving their working conditions is vital for the successful execution of non-custodial sentences. The sustainability and credibility of the use of alternatives in Kazakhstan depends on swift action in this area.

- It is also necessary to train judges and increase their confidence in the implementation of alternatives (the latter being dependent on ensuring that mechanisms of implementation really work).
- A new law and corresponding regulations need to be adopted on non-custodial sentences, with very clear definition of the responsibilities of each agency involved in the implementation of alternative sentences. This could become the basis for a probation service in future.
- However, if a probation system is going to be introduced a gradual, step-by-step process is strongly recommended, perhaps following the Moldova example (but not necessarily starting with the same priorities) In Kazakhstan, which is much larger than Moldova and has much more complex administrative structures, the problem of introducing a probation service without testing it in pilot areas, may lead to many difficulties.
- The achievements of the project implemented by Kazakhstan International Bureau for Human Rights and the Rule of Law, East Kazakhstan branch, “A Step to the Future”, should be built upon. A model CEI system, perhaps to be developed into “a model pilot probation system” (corresponding to the suggestion above), could be established in this oblast’. The resource centre could continue functioning as a training and meeting centre for inspectors. A group of CEIs trained within the project framework could take the training wider to cover selected pilot regions of Kazakhstan. Recommendations and training literature developed by the project could be tested in East Kazakhstan and improved, based on practical experience. It would be essential to obtain commitment from the Ministry of Justice, KUIS, to support and actively take part in activities, in order to ensure continuity.
- As regards community service, specifically, perhaps it has been too ambitious to introduce this sentence nationwide, rather than trying it out in pilot oblasts first. In addition to concerns relating to organizational and staffing aspects mentioned above, there are also legislative difficulties, leading to shortcomings in implementation.
- The fact that employers are obliged to pay the earnings of the offender into the state budget as well as being responsible for overseeing the offenders’ activities renders the employment of offenders unattractive for prospective employers. In the meantime, this situation transforms this type of sentence into any employment, competing on the market, perceived to be taking away employment from others. As a result, the number of workplaces available for offenders is very inadequate. However, if payment had not been required, then a considerable amount of socially useful work might be available, with non-commercial organizations, civil society groups and local authorities. The additional

benefit would be that the work would have restorative value, which is the main principle underlying the use of this sentence.

- An individual approach towards offenders does not exist. First of all their consent is not sought prior to sentencing. Secondly, their state of health and physical possibility to fulfill their obligations are not taken into account, which leads to problems in implementation. For example, one inspector interviewed in October 2005, said that of the three offenders sentenced to community service under his responsibility, one had alcohol problems and did not go to work on a regular basis, another had drug related problems and refused to work. Another inspector said that of the two offenders under her responsibility, one refused to work and she had difficulties finding work for the other.
- Recommendations have been made by the Kazakhstan Criminological Association, and participants of the roundtable in 2003, following thorough research of the problems and opportunities relating to the wider use of this sanction. The arguments and recommendations are convincing and based on reality. It is suggested that they be taken into account when improving current legislation.

They include:

- Removing employers' obligation to pay for the work of offenders, which has been identified as the main obstacle to the wider use of community service;
- Receiving offenders' consent to community service sentences prior to sentencing. This is not only required by international standards, but is also essential for the effective implementation of the sentence;
- Adopting an individual approach in each case, taking into account the health and circumstances of the offender, before passing a community service sentence.
- Some activities relating to improving the implementation of community service could perhaps be undertaken more easily if they are introduced gradually, starting in pilot oblasts. Again, the step-by-step approach adopted in Moldova, with substantial effort made in advance to prepare for the implementation of community service, then piloting it and extending the piloting, taking into account lessons learnt in the first phase, might be useful for Kazakhstan.
- Restorative justice: There is a need to supplement existing legislation with the requirement to organize a programme of reconciliation, setting out clearly the mechanisms of this programme and the responsibilities of agencies involved. Training for mediators must also be carried out.
- There are good opportunities to develop links between the projects in Moldova and Kazakhstan, which are following the same strategy of integrating health and

human rights issues. There are a number of areas where experience in one country may be useful to the other.

For example:

- There is a need for wider staff training in Moldova, to cover all services. IRP has undertaken staff training in the past, with support from Netherlands Helsinki Committee, but there is more that could be done. Moldova being a small country, with no regional prison administration levels, it might provide a good opportunity to introduce the strategic management model. If the Moldova prison administration would be interested and committed, strategic planning training could be introduced, starting with training of trainers by trainers from Kazakhstan.
- The comprehensive preparation for release programme introduced in Moldova, as a possible example for Kazakhstan, has already been mentioned.
- Again, as mentioned, Kazakhstan might also benefit from the experience in Moldova of piloting community service and probation.
- A general consideration is the extremely important role some NGOs have been fulfilling during the reform process, sometimes taking over functions, which should really belong to state structures. This development is to be welcomed on the one hand and KUIS, Ministry of Justice, praised for its collaboration with NGOs. But it also leads to some concern as to whether the state (Ministry of Justice mainly, but also Ministry of Health and of course the Ministry of Finance) will assume some of these responsibilities themselves in the coming years, backing up responsibility with resources. If not, in the long term sustainability will be at risk, since NGOs neither have the capacity nor ultimately the authority to undertake certain programmes in all Kazakhstan. However, their crucial role in supporting reforms should certainly continue.

## **2.2 TB/HIV MANAGEMENT PROGRAMME**

- A major concern is the current impact of MDR-TB on the effectiveness of the TB control programme. To minimize this threat there is a need first of all to identify all organizational and medical weaknesses of current DOTS TB control programme, followed by effective interventions, and then to fulfill all pre-requisites for implementation of DOTS-plus project for MDR-TB patients.
- The second major concern is that all achieved results in TB control might be threatened by a HIV epidemic. Efforts undertaken for HIV management are limited to education and partly to condom accessibility. Prisons do not participate in other HIV preventive measures – e.g. harm reduction through needle exchange programmes and Methadone Therapy, which are already available in the civil sector.
- Further effort is required to improve early case finding through ensuring directly observed sputum collection, education of staff and inmates, implementing TB peer group volunteering among inmates for education and change of unhealthy

habits, implementation of additional active screenings based on questionnaires regarding symptoms and body mass index followed by smear microscopy for suspects with high scores (experience exists in Georgia and Moldova).

- One of the main concerns for the Prison TB control programme is infection control.
  - Infection control has weaknesses in the practice of separation of TB cases depending on classification: new, relapse, failure, chronic, and so on.
  - Environmental measures of infection control are not clearly specified (how many hours a window in a room should be open or how often ventilation of corridors should be performed). The staff in many places prefers to use ultraviolet lamps instead of natural ventilation. Inmates are not aware of the frequency necessary for adequate room ventilation. In many dormitories where 50-60 inmates stay, windows are opened only for ten minutes or less per day.
  - Personal measures are overestimated by staff, which intensively uses surgical masks for “TB protection”. Respirators are available in high risk areas but the staff does not test whether they fit correctly.
- A concern regarding the prison TB control programme in Kazakhstan is that commitment is lacking in opening TB hospitals or changing the status of existing TB colonies to TB hospitals. TB hospitals would allow for the detention of patients in smaller numbers (2-10 patients) in smaller dormitories according to their medical and epidemiological conditions (according to principles of separation of TB cases). Another advantage of TB hospitals with a “room system” is that it creates the possibility of treating women and juveniles in the hospital. At the moment all patients have access to treatment in TB colonies with the exception of women and juveniles, who are still treated in the medical facilities of colonies in which they are detained, where treatment quality and infection control is supervised to a lesser degree.

Opening prison TB hospitals with a “room system” will also create the opportunity to analyze the appropriateness of the implementation of a DOTS-plus pilot project for MDR-TB patients (which in some cohorts in Kazakhstan are 44% of new cases), and moreover might improve treatment results of TB/HIV patients, which are particularly exposed to re-infection.

- TB drugs distribution to the periphery is not routinely taken into consideration. As a result drug stocks for the right number of patients are not always available, resulting from time to time in some periphery units in overstock or deficiency of drugs (the same being seen in the civil sector as well).
- A constant threat to DOTS quality is the high turnover of prison TB staff, and constant need of trainings. Retraining is available, but there is no clear strategy for retraining. Normally retrainings should be performed at set times (i.e. annually), or upon the decision of the DOTS monitoring committee, when certain mistakes may indicate the need for retraining. A good practice is when trainers are included in DOTS monitoring committees, thus being in a position to analyze effectiveness of previous trainings, make short trainings on the spot

and decide whether a retraining is necessary. If this is done systematically then the professionalism of staff will be increased. Otherwise misunderstood information will result in repetitive mistakes that will impact not only on reliability of data but the entire TB control programme (e.g. in one TB colony visited patients in the 5<sup>th</sup> month of treatment were smear positive and were not reported as treatment failure).

- An opportunity to improve quality control of laboratories would be to instruct laboratory monitoring teams to replace the actual rereading system with rereading of “blind” sample sized selected samples, (the method of LQAS – Lot Quality Assurance System) and additionally to monitor how prison staff follows the technique of smear preparation. A recommendation would be for civilian monitoring teams to bring their own staining solution during monitoring visits (to ensure that the quality of staining solutions are compared as well), and to prepare two samples from the same material using prison and civilian staining solutions.
- An opportunity for the project will be to insist on improving drug management by introducing procurement of good quality drugs, either from international non-profit agencies approved by WHO (IDA or GDF), or through tenders where a pre-requisite should be GMP certification of the drugs.
- The lack of informational feedback from civilian to prison service is creating difficulties in following treatment results of released patients to civilian facilities. Civilian health authorities find an unreasonable excuse about legislative impediments of sharing health information of released patients with other jurisdictions, whether it be the Ministry of Justice or Ministry of Interior. This excuse should be analyzed by PRI/KNCV experts and by law competent institutions.
- The experience achieved in TB integration might be used for other health areas as well, i.e. HIV, Hepatitis C, somatic diseases, mental health. Not a single prison health service is able to provide all health services to the same extent as a civilian health system (organizational and financial aspects being serious impediments) resulting in decreased access to health services by prisoners. The more health authorities and society are involved in prison health issues, the better health access will be for prisoners. In order to acquire new sustainable achievements in the area of prison health, there is a need for a gradual transfer of the responsibility for prison health to civil health authorities, in a broad reform process (demilitarization of prison health staff, national programmes targeting vulnerable groups where prisoners would be officially considered a vulnerable group, legislative and financial reforms allowing the process to become irreversible, continuation of penal reform).
- To improve preparation for release there is a need to create the service of social workers in prisons, who will deal with all social aspects of detained persons, including preparation for release from the first day of detention, and coordinate with prison health services in this respect.

- To increase access to condoms. Peer distribution and availability in all dormitories and visitors' rooms is recommended. To establish access to condoms not only in colonies but in SIZOs as well.
- Not to delay implementation of a Harm Reduction Strategy through needle exchange programmes. To ensure access to syringes and needles through peer voluntary distribution. The advantage will be not only prevention of HIV, but also effective prevention of other diseases: Hepatitis B, Hepatitis C, Hepatitis D, etc.
- To prepare two comprehensive programmes of drug addiction treatment through implementation of Methadone Substitution Programmes and psychosocial rehabilitation for drug addicts.
- Before initiating the implementation of HAART on an extensive scale in prisons, the HIV control programme should ensure effective prevention of HIV (continuation of peer education, resulting in less risk behaviour, implementation of needle exchange programmes, and Methadone Substitution Therapy), and afterwards to concentrate efforts on HAART expansion. If HIV is not prevented effectively then HAART will have a very limited impact on HIV and consequently on the TB epidemic.
- Before the initiation of HAART prison health services should foresee if prisons have the capacity to implement co-treatment of TB/HIV. This is necessary because it enables better case management of co-infected cases (dealing with immune reconstruction syndrome and pathological reactions), ensures a better protection of HIV/TB patients, and helps avoid re-infection/suprainfection with TB, as HIV patients are more susceptible to TB.
- To establish an effective mechanism of palliative treatment to persons in need, including PLWHA. To revise drug policy and to adjust legal aspects in order to ensure access to pain control and other needs of palliative care.
- To replicate the experience of East Kazakhstan and Karaganda in increasing the status of heads of prison health services to that of deputy director of Oblast' Prison Administration.
- To increase the number of medical staff trained in human rights and strategic planning.



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## USEFUL INTERNET RESOURCES

**All instruments of the Council of Europe concerning penal issues, including all recommendations of the Council of Europe, Committee of Ministers, referred to in this document:**

[www.coe.int/T/E/Legal\\_affairs/Legal\\_co-operation/Prisons\\_and\\_alternatives/Legal\\_instruments/List\\_instruments.asp](http://www.coe.int/T/E/Legal_affairs/Legal_co-operation/Prisons_and_alternatives/Legal_instruments/List_instruments.asp)

**CPT Standards: "Substantive" Sections of the CPT's General Reports:**

[www.cpt.coe.int/en/docsstandards.htm](http://www.cpt.coe.int/en/docsstandards.htm)

**United Nations Standard Minimum Rules for the Treatment of Prisoners:**

[www.unhchr.ch/html/menu.3/b/h\\_comp34.htm](http://www.unhchr.ch/html/menu.3/b/h_comp34.htm)

**United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules):**

[www.unhchr.ch/html/menu.3/b/h\\_comp46.htm](http://www.unhchr.ch/html/menu.3/b/h_comp46.htm)

**WHO documents on TB and HIV control:**

<http://www.who.int/tb/hiv/en>

<http://www.who.int/tb/publications/en/>

<http://www.who.int/docstore/gtb/publications/prisonsNTP/index.html>

<http://www.who.int/tb/dots/pal/en/index.html>

## Appendix 1: The Model of Strategic Planning Tables used for Prison Management in Kazakhstan

<u>Standard</u>	<u>Evaluation/Review</u>		<u>Plan</u>								<u>Action</u>	<u>Monitoring and Reaction</u>				
1	2		3		4		5				6			7	8	
<u>International Standards</u>	<u>Current Practices</u> , according to Kazakhstan's legislation		<u>Gaps</u>		<u>Vision</u>		<u>Action Plans</u>				<u>Constraining and Contributing Factors</u>			<u>Monitoring and Evaluation</u> (based on Table 5)	<u>Verification, Revision and Response</u>	
	2.1	2.2	3.1	3.2	4.1	4.2	5.1	5.2	5.3 – 5.4.	5.5	6.1	6.2	6.3	<b>Implementation</b>		
The current practices, according to Kazakhstan's legislation	The current practices (actual situation)	Gap between the current national legislation and UN standards	Gap between the current practices and national legislation	What we want to achieve in five years	Priority setting (based on Table 3)	Action plan (according to Table 3)	Responsible person	Terms, by years (1-5 years)	Needed resources	Constraining factors (who, what, how)	Contributing factors (who, what, how)	Actions				
	a) Positive practices  b) Gap between the current practices and national legislation											a) Elimination of constraining factors  b) Mobilisation or strengthening of contributing factors				

## APPENDIX 2

# MANUAL ON HUMAN RIGHTS TRAINING FOR PRISON STAFF

- Section 1 Introduction**  
Ch. 1 Human Rights and Prisons  
Ch. 2 Sources, Systems and Standards for Human Rights in Law Enforcement
- Section 2 Maintaining Human Dignity**  
Ch. 3 Torture and Ill-Treatment are Always Prohibited  
Ch. 4 Admission and Release  
Ch. 5 Accommodation  
Ch. 6 Hygiene  
Ch. 7 Clothing and Bedding  
Ch. 8 Food  
Ch. 9 Exercise
- Section 3 Health Rights of Prisoners**  
Ch. 10 The Right of Prisoners to Have Access to Health Care  
Ch. 11 Healthy Conditions in Custody  
Ch. 12 Responsibilities and duties of Health Care Personnel  
Ch. 13 Screening for all new prisoners  
Ch. 14 Specialist care
- Section 4 Making Prisons Safe Places**  
Ch. 15 Security  
Ch. 16 Good Order and Control  
Ch. 17 Discipline and Punishment
- Section 5 Making the Best Use of Prisons**  
Ch. 18 Work  
Ch. 19 Education and Cultural Activities  
  
Ch. 20 Religion  
Ch. 21 Preparation for Release
- Section 6 Prisoners' Contact with the Outside World**  
Ch. 22 Letters  
Ch. 23 Visits  
Ch. 24 Telephones  
Ch. 25 Home Leaves and Temporary Conditional Release  
Ch. 26 Books, Newspapers and the Media
- Section 7 Complaints and Inspection procedures**

- Ch. 27 The General Right to Make Complaints
- Ch. 28 Arrangements for Inspections

**Section 8 Special Categories of Prisoner**

- Ch. 29 Women in Prison
- Ch. 30 Juveniles in Detention
- Ch. 31 Non-Discrimination
- Ch. 32 Prisoners Under Sentence of Death

**Section 9 All Persons Under Detention Without Sentence**

- Ch.33 The Legal Status of Persons Under Detention Without Sentence
- Ch.34 Access to Lawyers and the Outside World
- Ch.35 The Treatment of Pre-Trial Prisoners
- Ch.36 Release on Bail
- Ch.37 Civil Prisoners and Persons Arrested or Detained Without Charge

**Section 10 Non-Custodial measures**

**Section 11 The Administration of Prisons and Prison Staff**

**APPENDIX 3: ANALYSIS OF STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT)  
FOR IMPLEMENTING STRATEGIC PLANNING IN THE REPUBLIC OF KAZAKHSTAN**

Project title	STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
<b>Strategic Planning (SP)</b>	<p>Political will to reform the penal system.</p> <p>Legislative amendments made to humanize the penal system and increase transparency.</p> <p>Stable political and economical situation in the country</p> <p>SPs used by KUIS for the National Programme for Development of the Penal System (2004-2006), and for the draft programme for 2007-2015.</p> <p>Very positive results of the integrated approach to “Human Rights and Health” evident.</p>	<p>The process of training and introduction of SP into the penal system was interrupted due to staff changes at KUIS.</p> <p>The majority of prison staff members in Kazakhstan have not been trained in SP.</p> <p>Too few medical workers were trained in SP.</p> <p>No official system established to monitor implementation of SP.</p>	<p>Adherence of KUIS to the reform process.</p> <p>Establishment of Resource Centre on SP at KUIS and the formation of a Consultative Council on SP.</p> <p>The existence of a SP module, adapted to local needs.</p> <p>The involvement in SP training of all levels of the prison system, from colonies to the central prison administration. Working experience on SP in all regions.</p> <p>Team of SP trainers available to expand training. (20). National experts on SP available.</p> <p>Trained staff in all oblasts. (216)</p> <p>Existence of two staff training facilities: Pavlodar and Kostanai Law Colleges.</p> <p>Strong network of NGOs and international organizations supporting the reform process.</p> <p>Legislation in place for public monitoring of places of detention. Existence of monitoring committees in 7 oblasts.</p> <p>Possibility of using prison inspections by KUIS to monitor implementation of SP.</p>	<p>Possible change of priorities at Ministry of Justice following senior staff changes.</p> <p>Difficulty in integration SP to the internal planning system of Ministry of Justice.</p> <p>Finances for SP training and monitoring may not be specifically foreseen in the new budget of prison system.</p> <p>Absence of necessary resources (human and technical resources) in regions for working on SP.</p>



