Human Rights in Prisons and Other Closed Institutions

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Mid-term Assessment Report on the Georgian Prison Healthcare Reform Strategy and Implementation Plan for the Period of January 2013 to June 2014 (18 Months)

prepared by

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Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CoE	Council of Europe
CCH	Central Correctional Hospital (former Central Prison Hospital, CPH)
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DOTS	Directly observed TB treatment short course
DRG	Diagnosis-related Groups
GIP	NGO "Global Initiative on Psychiatry"
GoG	Government of Georgia
GP	General Practitioner=family doctor
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immune Deficiency Virus
ICPS	International Centre for Prison Studies
ICRC	International Committee of the Red Cross
JD	Job Description
MCLA	Ministry of Corrections and Legal Assistance of Georgia
MoLHSA	Ministry of Health and Social Affairs of Georgia
NGO	Non-governmental organizations
OT	Operation Theatre
PHC	Primary Healthcare Centres
PEHR	Personal electronic health record
PPTC	Penitentiary and Probation Training Centre
TB	Tuberculosis
ToR	Terms of Reference
ToT	Training of Trainers
VCT	Voluntary counselling and testing
WHO	World Health Organization

Introduction

The Mid-term Assessment Report on the Georgian Prison Healthcare Reform Strategy and Implementation Plan for the Period of January 2013 and June 2014 (18 months) (hereinafter, the Report) was prepared by Dr. Jörg Pont and Mr. Giorgi Baliashvili, medical advisors, Council of Europe (CoE) Consultants in the framework of the EU/CoE Joint Programme "Human Rights in Prisons and Other Closed Institutions".

The Report gives a general overview on the situation of prison healthcare in Georgia as of December 2013, evaluates the progress made in this field against the objectives set in the Prison Healthcare Reform Strategy and its Implementation (Action Plan) for the Period of 2013-2014 ½ – 18 Months (hereinafter, the Strategy) of the Ministry of Corrections and Legal Assistance of Georgia (MCLA); and in comparison to the situation before 2013 and in light of the CoE recommendations and of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) standards. It also contains recommendations for possible further steps and actions to be made towards the successful implementation of the prison healthcare reform. The recommendations are summarised at the end of each chapter.

The Report is largely based on observations and information gathered during an initial assessment visit carried out by the Consultants between 13 and 16 December 2013 in Georgia. The assessment visit was followed by some additional meetings with the representatives of the MCLA and the Ministry of Labour, Health and Social Affairs (MoLHSA) during 17 December 2013 and 27 January 2014. The detailed list of on-site visits and meetings and the position of the persons met can be found in Annex 1. Supplementary information was gathered also from available national and international documents listed in Annex 2.

The Assessment Team of the two CoE Consultants was assisted by Mr Givi Mikanadze, Senior Project Officer of the Directorate General of Human Rights and Rule of Law of the Council of Europe and was supported by an interpreter.

The Authors and the EU/CoE Joint Programme Team thanks all those persons, authorities and agencies mentioned in the Report who helped the Assessment Team in fulfilling its mission and understanding the present status as well as the envisaged future development of healthcare in the penitentiary institutions as far as this was possible within the available time limits.

Executive Summary

As a result of this mid-term assessment, the Assessment Team became aware of significant and, given the short time since the start of the Strategy, most remarkable improvements of prison healthcare, particularly in comparison with 2012 and the years before. The reform process largely follows the Action Plan and the assessment results allow the assumption that the majority of the set goals will be achieved by the end of the Strategy period provided the efforts are maintained at the same level.

This impressive progress was made possible owing to a significant reduction in the number of prisoners and a huge increase of prison healthcare budget resulting in a more than four-fold increase of per capita spending for prisoner healthcare. In addition, the following reforms of governing structures and infrastructure of prison healthcare have been implemented:

The Medical Department of the MCLA has been completely reorganized and restructured in a task-oriented way, according to the modern associative management model.

Primary healthcare units have been rolled out to all penitentiary institutions, staffed and supplies ensured. The effective and patient-oriented functioning of PHC network is comprehensively assisted by activities of the International Committee of the Red Cross (ICRC), according to the Trilateral Agreement, signed between the MCLA, the MoLHSA and the ICRC.

In regard of secondary healthcare - the penitentiary N19 TB Treatment and Rehabilitation Centre has been functioning from the current year.

The TB facility planning, re-construction and equipping was conducted according to modern standards (including installation of a high-tech negative gradient pressure ventilation system).

The newly renovated Central Correctional Hospital is due to open from March 2014.

Besides, cooperation with civilian hospitals has been intensified contributing to a five-fold increase in the number of referrals to secondary healthcare facilities. In addition, a transparent electronic waiting list for the mentioned non-urgent referrals has been successfully implemented, ensuring objective and medical expediency-based implementation of the whole process.

The infectious diseases database and standardized medical data management using international codes (ICD-10 and ICPC-2) were introduced and further improvement of electronic data processing is ongoing.

Food standard has been improved; food quality, caloric content and variety of products have been upgraded. Process of food provision, sanitary conditions and equipment functioning in the kitchen/food blocks and dining rooms mostly meet the corresponding legal requirements.

Essential part of quality control and assurance system is already functioning in the penitentiary system - it includes but is not limited to use of guidelines, protocols and best practices; introduction of personal electronic health record (PEHR); planning, monitoring and analysis of diagnostic/treatment services' provision process; organizing market research and price rating for different services and their provider facilities; improvement of pharmaceutical management through elaboration and adoption of basic standard.

In regard of human resources, salaries for healthcare professionals have been remarkably increased in order to be competitive with civilian healthcare services, new healthcare staff has been employed and part of the previous healthcare staff has been replaced. The numerical relation of healthcare staff to prisoners has been adapted to those of most Western European countries. Training and re-training of healthcare staff has been started.

Constant collaboration has been carried out between the MCLA and MoLHSA in order to execute the state policy, heading the processes in penitentiary and civilian health systems towards maximal and reasonably quick unification and standardization of the main processes and legislative documents.

The successful ongoing activities are carried out as obvious examples of such collaboration, e.g.: PHC system development in prison healthcare; implementation of "vertical" programmes (TB, HIV/AIDS); joint task force for HCV program; unification of medical data processing; Joint Commission for compassionate release; mental reform task force etc.

All of the above measures contributed to a definite improvement of healthcare practice in Georgian prisons approximating respective Council of Europe and CPT standards, a significant improvement of primary and secondary healthcare services with remarkably increased numbers of referrals to specialized care for somatic and mental disorder, alongside with a reduction of the mortality rate in prisoners. In addition, vertical projects focusing on prison specific healthcare problems such as mental healthcare, drug dependency, infectious diseases and violence have been introduced and/or strengthened and are increasingly pursued.

The recommendations point to those challenges that, according to the Assessment Team's opinion, should be focused in the remaining period of the present strategy and/or in the next strategy round such as:

- Make the reduction of the prisoner number sustainable by exhausting alternative measures to imprisonment as far as possible;
- Develop Medical Services Standards for the penitentiary system and elaborate a combined set of qualitative and quantitative indicators for quality assurance including a DRG-based costing method;
- Elaborate together with the MoLHSA a legislative compliance database moving towards full compliance of penitentiary with civilian healthcare services and proceed in acquiring licensing permissions for penitentiary in-patient facilities;
- Ensure compliance with legal requirements for particular PHC facilities, which are carrying out the high-risk medical activities;
- Elaborate and implement with the MoLHSA a joint plan for penitentiary and civilian healthcare integration;
- Identify specific training needs and elaborate practice-orientated and competency-based training programme for the employees of the Medical Department;
- Contribute to the increase of the Medical Department's policy-making activities' through the above-mentioned training programme;
- Transfer the responsibility for outsource contracts on management and control of sanitary and hygienic conditions from the Department of Prisons to the Medical Department of the MCLA;
- Permanently upgrade the equipment in PHC-s, where possible – improve the planning of the space;
- Develop the procurement and maintenance strategy for medical equipment in penitentiary health facilities;
- Proceed in implementation and rolling-out of systematic medical data collection and management;
- Draw action plans for development of the Central TB Treatment and Rehabilitation Centre and the CCH, including the breakdown of activities and resources allocation;
- Provide guidelines for referrals to secondary healthcare facilities and see for appropriate security management of prisoners transferred to civilian hospitals;
- Scale up training and re-training of healthcare professionals, develop and implement evaluation tools for efficiency and sustainability of training, prioritize training topics according to results of need assessments and pay particular attention to mental healthcare, suicide prevention, drug dependency, infectious diseases, harm reduction, aftercare, prevention of violence and medical ethics;
- Single out the training component in the future strategy document as a separate Strategic Goal – including and covering all spheres and groups of beneficiaries, connected with the Prison Healthcare Reform implementation;
- Provide clear job descriptions to healthcare professionals working in prison and to staff of the Medical Department;

- Develop a comprehensive action plan for establishing quality assurance system and its sustainable institutionalization – with clearly defining the role of Medical Department in the given process;
- Improve monitoring and analysis of the prison healthcare budget indicators through breakdown of expenses, constant execution of financial flow analysis and planning;
- Anchor standards of medical ethics in prison, such as professional independence and confidentiality in penitentiary laws;
- Consider medical confidentiality at application for medical consultation and perform medical consultations only in well-grounded exceptions outside of the privacy of the consultation room;
- Proceed in adapting harm reduction measures to international recommendations;
- Conduct a comprehensive study/assessment for analysis and identification of the preferable model of unification and integration for penitentiary and civilian healthcare systems – based on experience of developed states with patient-oriented and effective penitentiary healthcare systems;
- Establish Project Coordination Unit (PCU) for effective and comprehensive management (planning, implementation and monitoring, also evaluation) of Unification Plan and, generally, the entire process of Prison Healthcare Reform new strategy.

I. Key features of the Georgian penitentiary system in 2013 and its healthcare indicators in comparison to 2012

	2012	2013
Number of prisoners	20.493	10.338
Sentenced		8.994
Pre-trial		1.334
Prisoner Population Rate (10^{-5})	473	227
Official Capacity	25.354	25.354
Occupancy level	>99%	42%
Total number of staff		5.103
Healthcare Budget	7 Million GEL	12 Million GEL
Healthcare spending/prisoner	180 USD	760 USD
Pharmaceutical spending/prisoner	23 GEL	128 GEL
Salary GP/per month	650 GEL	1.200 GEL
Salary Nurse/per month	350 GEL	750 GEL
Relation doctor:prisoner	1:245	1:92
Relation nurse:prisoner	1:162	1:61
Referrals to Secondary Healthcare	<1200	>5000
Mortality Rate (10^{-4})	55	19

The key features are dominated by the dramatic decrease of the number of prisoners, the prisoner population rate and the occupancy level of prisons in comparison to 2012 and previous years which can be contributed to the Amnesty Act from 12 January 2013. In addition, an impressive increase in the prison healthcare budget in comparison with the amounts from 2012 and from previous years, combined with the quoted massive reduction in the number of prisoners allowed for considerable increases in healthcare

spending per prisoner, medicament expenditures, salaries for healthcare staff and the number of referrals to facilities providing secondary healthcare for prisoners.

Recommendation:

- ***The reduction of the number of prisoners/prison population rate achieved by the Amnesty Act should be made sustainable by appropriate use of alternative non-custodial measures of sentencing, early conditional release, re-considering the laws and the sentencing practice for the consumption of illicit drugs by drug dependent persons and the removal of cumulative sentences from the Criminal Code.***

II. Current healthcare structures in the penitentiary system

In Georgia, prison healthcare is under the responsibility of the MCLA. Previous plans of transferring prison healthcare to the MoLHSA have been regularly postponed on the part of the MoLHSA, see Chapter VIII.

The Medical Department of MCLA was re-organised in 2013, in accordance with the Decree No.59 of the Minister of Corrections and Legal Assistance of Georgia from 15 March 2013 on the Approval of the Statute of the Medical Department of the MCLA. A new organisational structure was created with four Divisions:

a) Division of Primary Healthcare and Outpatient Services;

b) Division of Specialized Medical Services;

c) Division of Medical Practice Regulation;

d) Division of Healthcare Economy and Logistics.

When presenting the newly structured Medical Department, the Deputy Minister emphasized that as a result of the re-organisation "Medical services have become independent in decision making – medical decisions are taken by medical professionals. Autonomy of the doctor is secured." Indeed, interviews with prison doctors during the assessment visit conveyed the impression that these physicians now could act in professional independence without interference of non-medical superiors. However, professional independence of healthcare staff in prison is not addressed in Decree No.59 and should be legally anchored.

Currently, the number of healthcare personnel is 439 (175 doctors, including 100 GPs and 75 doctors by specialties and 264 nurses) for 10.328 inmates. Besides them, there are 141 social workers and 15 psychologists. The quantitative relation of inmates/medical staff has improved remarkably in comparison to previous years. Moreover, after December 2012, up to 40% of medical staff was replaced by newly employed or re-employed medical staff. However, this fact has also created a need of training of newly employed staff on peculiarities of healthcare in prison.

The Penitentiary and Probation Training Centre (PPTC) recently has been engaged in training courses on healthcare issues for non-medical and medical staff of prisons. Training topics included identification and documentation of the signs of ill-treatment, detection and treatment of mental disorder, handling hunger strikers, health prevention and promotion, and information on HIV/AIDS. The PPTC is aware of the need of increasing the number and frequency of training courses as well as of needs assessment and respective prioritization of training topics. Besides, evaluation tools on sustainability of training efficiency have to be developed.

In the visited prisons and, according to the Deputy Minister of MCLA also in other prisons, primary healthcare centres (PHC) have been established in accordance with the Trilateral Agreement between MoLHSA, MCLA and ICRC, signed on 6 June 2013 and valid until May 2014. The PHCs are equipped and appropriately staffed.

The Prison Healthcare Reform Strategy and its Action Plan states that some 250.000-300.000 GEL is needed for upgrading the medical equipment in PHCs. This has already been accomplished to some extent; however, the equipment of several medical units is still in need of improvement. In most of the prisons visited, former cells have been converted into examination rooms and thus they have a narrow space, below the recommended standard of 12 m^2 per examination room, specified by the Order of the Minister of MoLHSA N01-25/n (19 June 2013). Although, it must to be noted that the provisions of the given Order are applicable only to those PHC facilities which implement the Universal Health Coverage state program and therefore they can be considered only as recommended standards for other, similar units in penitentiary healthcare system The Assessment Team was not informed about any deficiencies in regard of medicament supplies. The fact that the volume of medications bought by prisoners from private pharmacy enterprises selling medications in prison remarkably went down during 2013, was considered by the Deputy Minister of MCLA as a confirmation for the sufficiency of the list of essential medicaments.

All of the PHC visited used uniform medical record forms; the same as used in the community for primary health care, which were, as far as we could judge, filled in and kept properly. Moreover, ICD-10 codification of diagnoses and ICPC–2 codification of interventions are increasingly used. This hopefully will improve in future ensuring the continuity of medical information exchange between establishments, assessment and monitoring of diagnostic and treatment services, use of data for the planning and development of medical facilities and staff optimization, monitoring and evaluation of the activities of consulting physicians, managing the demand and supply of medication, gathering and processing of epidemiological data, and monitoring and evaluation of health indicators and enable to better determine priorities and allocate resources as envisaged in the Strategy paper.

In regard to secondary healthcare, the Central Correctional Hospital (CCH) N18 (former Central Prison Hospital (CPH)) is still in the state of renovation and rebuilding and will not be re-opened before the end of March 2014. It is expected that due to the rebuilding of the establishment, combined with the recent reduction of prisoner numbers, the increase of compassionate release procedures, and the increased willingness for transfers of inmates to civilian hospitals for secondary and tertiary healthcare, the former precarious condition of the CPH characterized by severe overcrowding and substandard equipment and material conditions, will not come back anymore. It is

worth to note that the new establishment N18 will have a special ward for disabled prisoners.

The newly renovated penitentiary TB Treatment and Rehabilitation Centre in Ksani presently serves 200 patients, but has an overall capacity of 698 patients.[1] There are on-going considerations on how to use the currently empty wards – see Chapter IIIa.

The increase of the number of referrals to secondary healthcare care institutions including psychiatric facilities in 2013 (>9000), particularly to facilities in the civilian community (5750 transfers), in comparison with previous years (<1200) is indeed remarkable. The visit to the West Georgian prisons Kutaisi N2 and Geguti N14 and the regional National Medical Centre for West Georgia in Kutaisi gave the impression of a well-functioning medical co-operation between the penitentiary institutions and the civilian clinic. However, the security management during treatment in this hospital definitely needs to be improved: skackling prisoner patients to hospital beds, a practice that was reported to the Assessment Team by the healthcare staff of the the hospital, is contrary to international standards[2] and has been regarded by the European Court of Human Rights (ECtHR) as violation of Article 3,[3] i.e. inhuman treatment.

Recommendations:

- ***Clearly define the degree of cooperation and/or integration of prison healthcare with public health structures as repeatedly recommended by the Council of Europe, the CPT and the WHO;***
- ***Anchor safeguards for professional medical independence and other international standards of medical ethics including medical confidentiality and patient autonomy in the Code of Imprisonment;***
- ***Use the newly gained space by the reduced occupancy levels in prisons for the increase of space of primary healthcare centres (at least to the minimum recommended (not obligatory – see above) national standard of 12 m² per examination room and also for improvement of material conditions and infirmaries in prisons;***
- ***Intensify ICD-10 codification of diagnoses* and ICPC–2 codification of interventions *in hard-copy medical records and support the development and roll-out of electronic medical records;***
- ***Taken decision on the future use of the non-used bed capacity in the penitentiary TB Centre in Ksani;***
- ***Improve security management of prisoner patients in the Kutaisi civilian hospital and avoid shackling them to their beds.***

III. Key contributors to the implementation of reforms in the penitentiary system

IIIa) Service provider units - stationary health facilities

[1] Order of the Minister of Corrections of Georgia N 184 (27.12.2010)
[2] Rule 36, extract from the CPT General Report CPT/Inf (93)12
[3] *Mouisel v. France* 67263/01 and *Tarariyeva v. Russia* 4353/03

The health service providers inside the penitentiary system include the PHC facilities network and 2 large bed-capacity stationary medical facilities: N19 TB Treatment and Rehabilitation Centre in Ksani and the Central Correctional Hospital (CCH) N18, being in the state of renovation – see Chapter II.

Effective functioning of both, PHC facilities network and in-patient facilities, significantly influences the system performance and thus – the success of Health Reforms Strategy as a whole.

The functioning of PHC network is comprehensively assisted by ICRC activities (according to the earlier mentioned Trilateral Agreement), which contributes to adequacy, quality of provided services and their compliance with the local legal requirements.

Taking into account the priority role of in-patient facilities for the penitentiary health system and challenges in the processes of their management, the Assessment Team considered it necessary to produce a brief examination of the mentioned two hospitals.

Ksani N19 TB Treatment and Rehabilitation Centre

A short description of primary problems directly related to non-compliance with regulative requirements, which has a direct effect on quality and efficiency of the provided medical services, comprises the following list:

The floor in the rooms, where diagnostic examinations and/or minor surgeries are performed, lacked the obligatory anti-static linoleum cover.

The ventilation system's outer ends, coming out in the treatment room wall, were not isolated in due manner using so-called iron "diffuser"-s, in several rooms.

The medical gases centralized supply system, which is of priority importance for any stationary facility, was not in place. The Team was informed that it was projected in the initial building plans (2008y) of the facility.

Another crucial problem identified was unproper maintenance of high efficiency particulate absorption (HEPA) filters, which are the main part in the laminar airflow system. The HEPA filters ensure the absolutely clean air supply to Operation Theatres (OTs) and manipulation rooms and largely contribute to prevention/decrease of the possibility of nosocomial infection outbreak. The filters are reportedly not replaced regularly but just cleaned/or washed in water, which is absolutely unacceptable.

The facility re-construction included a high-tech negative gradient pressure ventilation system that contrasts to the concrete floor everywhere in the building which is not very favourable for disinfection procedures.

The hospital has not yet started functioning of the new laundry which was scheduled for the end of January 2014. According to recent information, operating of the laundry is postponed until the end of February 2014.

Another problem causing difficulties in the work of the staff is that the intranet system is not established, producing delays for doctors who are not able to get needed medical information from the data-base in their PCs in the staffroom and have to receive it from the Statistic Department located on the ground floor. The MCLA declares that the intranet system will begin to work in the nearest future – the PCs are in place, only network has to be installed after adoption of the security protocol.

According to the observations during the limited time of the visit, it can be stated that the process of food provision and sanitary conditions in the kitchen/food block and dining room mostly meet the legal requirements. The relevant kitchen equipment works normally, there is enough space, caloric content and food quality control is performed in compliance with the corresponding regulatory document (see below, Sub-Chapter Vd. - Joint Order of MCLA and MoLHSA Ministers N87-83/N (20-25.05.2011)).

The main challenge of the Hospital seems to be its low occupancy rate. Only around 200 beds from 698 available are occupied.

Several officials of the MCLA shared ideas during the assessment visit on how to utilise the currently empty wards. These included the transformation into a multi-profile facility, a unit for psychiatric in-patient treatment, a unit for treating Hepatitis C in-patients and an out-patient policlinic for patients in need of specialist doctors.

The issue of bed distribution will likely to be on the agenda in discussions between international organisations, the donor community and the MCLA in the near future. An important fact which should be remarked is that at the time when the hospital was designed, the total number of imprisoned persons was substantially bigger than nowadays. Therefore, the facility was designed to become an acute-treatment site, while currently it rather seems to comply with long-term care unit functions.

Lack of competent management activity can be also considered as a main problem. Members of the top management of the facility have the necessary medical qualifications but they do not have the managerial background or skills. This fact raises concerns about the efficient functioning of the facility on shorter and longer terms and on the sustainability of the quality of services provided.

As the Assessment Team was informed, from January 2014 the Medical Department is planning to start to implement a special plan for the TB Centre. The plan aims at the improvement and enhanced monitoring of both medical and managerial issues and processes of the TB Centre on a permanent basis, with the technical assistance from the Department. The priorities of the plan are as follows:

- Receiving of a civilian license for the facility, scheduled for February 2014;
- Elaboration of job descriptions (JD) for the entire staff (currently only done for certain positions);
- Establishing a staff performance system;
- Putting in place/increasing the number of indicators for TB diagnostics and treatment evaluation;
- Checking and monitoring of patients' medical records;
- Analysing and improvement of pharmaceutical management;

- Monitoring and ensuring the permanent strict separation of sensitive (-) and sensitive (+) patients, also of MDR/XDR (-) and MDR/XDR (+) inmates; particular attention has to be paid towards the new cases;
- Permanent monitoring of sanitary/epidemiology standards, epid-surveillance process, inmates' food provision process;
- Developing effective managerial potential for the Centre.

The above mentioned priorities are undoubtedly very important. Their implementation can largely contribute to the smooth functioning of the TB Centre and to the provision of cost-effective and evidence-based medical services.

Recommendations:

- ***Draw up an action plan for the development of the Ksani TB Centre which addresses the above-mentioned problems of non-compliance with national legal provisions, international standards and practices; inefficient practice for bed fund distribution;***
- ***Ensure the proper functioning of important services such as laundry and IT database and intranet;***
- ***Preferably to conduct the installation of centralized supply system of medical gases – considering technical regulations/limitations and expenditures analysis;***
- ***Ensure the proper maintenance of the HEPA filters;***
- ***Provide the anti-static linoleum for the diagnostic examinations and minor surgery rooms;***
- ***Ensure the proper isolation of the ventilation system outer ends in the rooms, where the special "diffusers" have to be installed;***
- ***Strengthen the managerial skills and competences of the managerial staff;***
- ***Implement the specific plan, launched by the MCLA for technical assistance and monitoring of facility's functioning. The adaptation of activities and relevant resources' allocation must be conducted permanently and based on needs and valid evidence.***

<u>Central Correctional Hospital N18</u>

The Assessment Team was provided with enough information about the Hospital which is planned to operate from March 2014. With a total bed fund of 160, it will be located in a 5-storied building and will have modern diagnostic, treatment and care capacities. The information provided includes the structure, bed capacity and the list of staff members (see Annex 5).

Based on the above-mentioned information, several priority problems/issues can be highlighted in brief at the moment:

- Insufficient staffing level is experienced due to severe lack of required qualified staff - concerning the doctors with sub-specialty "Emergency Medicine";

- The above-mentioned absence of relevant personnel make it impossible to meet licensing requirements and get relatively "high-level" permission for the provision of services implied in case of functioning of the Emergency Department (as regulated by the Decree of the Government of Georgia N385 (17.12.2010) on the "Approval of regulations for the procedure and conditions for issuing a license to practice medicine and permit for stationary facilities");
- The establishment of a fully-fledged Emergency Department is not possible; currently an Emergency Room is in place. The Internal Medicine Department for long-term care instead of the Intensive Care Unit (ICU), is planned to start functioning soon. This fact will limit the provision of the internal urgent services and partially increase the number of cases and expenditures, connected with referrals to civilian sector;
- Absence of the medical services' standard for penitentiary system, which are not yet developed;
- Lack of development plan and necessity to identify available resources in order to address the priority needs of the facility and requirements of its management.

Recommendations:

- ***Elaborate a development plan for the CCH;***
- ***Develop an Annual Work plan including the breakdown of activities and resources' allocation;***
- ***Draft guidance for daily operational management;***
- ***Elaborate medical services standard for the penitentiary system, based on universal DRG-based costing method;***
- ***Put in place a guidance regulating criterion and internal procedures for referrals to the civilian sector;***
- ***Develop a training plan for the staff.***

IIIb) Policy and managerial unit – Medical Department of MCLA

Implementation of the Prison Healthcare Reform is directed and supervised by the MCLA and its Medical Department, in particular and done in close cooperation with the MoLHSA, and with the assistance of international organizations such as the CoE, EU, ICRC, OSGF and USAID as well as NGOs.

Medical Department is in charge of planning, monitoring and analysing all medical and health-related activities in relation to the penitentiary health system, including reform process. Besides that, it is also under the Department's competence to propose and prepare necessary organisational or legal changes concerning the system. They are staffed with specialists and related advisers (see Annex 3).

Taking into account the priority role of the Medical Department in reform implementation, it was considered necessary to identify the problems and needs in more details, by particular divisions.

The Assessment Team defined the following problematic issues on priority needs, hindering daily smooth functioning of the Medical Department:

Regarding the Division of Medical Practice Regulation:

- Monitoring of functioning and maintenance of the medical equipment is problematic because it is done mostly by various private persons/companies which are outsourced by the Medical Department; as a result, monitoring of validity for diagnostic/treatment procedures and quality of provided services lacks unified approach and thus becomes substantially complicated;
- Partial lack of proper tools for data analysis - the Division has a lot of statistic information which preferably has to be structurized and unified for receiving valid evidence datum;
- Lack of on-site training activities (though trainings are conducted on a regular basis, included the ones, directly targeted to the whole Department's staff – see Sub-chapter VIIa). Training priorities were identified as follows: processing of medical documentation; evidence-based policy.

Regarding the Division of PHC and Outpatient Services Division:

- Partial non-compliance of the particular PHC units, carrying out the high-risk medical activities, with legislative requirements (Decree N359 of the Government of Georgia on "Approval of technical regulations of high-risk medical activities", Article 3; Article 13: "Technical regulations – requirements" (22.11.2010))

Re: The above-mentioned non-compliance with the obligatory technical regulations refers to particular PHC units (located in the penitentiary facilities NN 2, 7, 8 and 15), executing high-risk medical activities – namely, related to infectious diseases (including TB, Hepatitis, HIV/AIDS);

- Low reliability of the procured basic medical equipment (stethoscopes, blood pressure monitors) which causes the comparatively frequent breakages limiting the accessibility of health services;
- Lack of job descriptions for PHC staff;
- Need to improve the unified data management system (especially - system simplification, data analysis and reporting) for the PHC;
- Certain difficulties in staffing and ensuring optimal staff performance – due to legal differences between international and local legislative requirements concerning the list of provided medical services, which have to be executed under the particular specialties/sub-specialties implied by corresponding state certificates; also the lack of corresponding skills which hampers the efficient work of PHC staff.

Regarding the Division of Healthcare Economy and Logistics:

- Problems with procurement (drugs, consumables, ME): acting legislation forces to make selection by lowest price – otherwise the biddings are essentially delayed or even cancelled; such approach substantially limits de-facto choice of quality procured products and decreases the outcomes of provided treatment and/or other services;
- Need to increase both the inner and outside expertise capacity on procurement planning;
- Lack of DRG-based costing method for medical services which should be legally put in force both in civilian and penitentiary healthcare;

- Low capacity to perform cost-effectiveness analysis for essentially increased outsourced services in the civilian sector;
- Lack of internet connection with inside-system pharmacies.

Regarding the Division of Specialized Medical Services:

- Difference between the specialties (according to local state certificates) and related services provided, also practical skills of GP-s (see above) – e.g. minor surgical operations in Georgia are de-facto mostly made by surgeons (though have to be done by GP, according to the state curriculum requirements), in EU countries – by GP;
- Lack of individual job descriptions for Division staff, both for specialists and advisers. At the moment, general job descriptions are elaborated only according to the spheres of work (e.g. legal adviser, policy adviser).

Some particular issues, besides the already mentioned ones, were additionally discussed with the Head of Medical Department, namely:

- Problem that lies in the situation when some inmates regularly keep pressing for diagnostic/therapeutic/expertise expenditures that go beyond their right on appropriate medical care as guaranteed in Article 45 of the Law on Patients' Rights. In this regard we were informed that in order to counteract without weakening Article 45 concerning prisoner patients' rights, the MCLA has initiated elaboration of the prison medical service standard - "Bill of Rights" for the prisoners, which will be comprehensive and clearly define burden of medical services available in the penitentiary system. Following the Georgian legislation, the healthcare standard in the penitentiary will be equal to the one available in the civilian sector, although certain services will be expanded and added considering international best practice, valid medical evidence and needs of prisoners;

- Ensure the operation of the entire system on a high-level of quality – e.g introducing personnel performance appraisal system, setting measurable performance indicators, institutionalizing national guidelines and protocols, establishing Quality Unit (see the Order N01-63/n of the Minister of MoLHSA, Chapter Va), ensuring legislatively proper facility staffing etc.;

- Consider development options for Ksani N19 TB Centre and plan the running of the Central Correctional Hospital which is being still under renovation.

Recommendations:

- ***Identifying specific training needs and elaborate practice-orientated and competency-based training programme for the employees of the Medical Department;***
- ***Contribute to the increase of the Medical Department's policy-making activities' through the above-mentioned training programme;***
- ***Work out detailed and individual Job Descriptions both for the Medical Department staff and also for the personnel of the penitentiary health facilities;***

- ***Develop Medical Services Standard for the penitentiary healthcare defining the package of services available inside the system - but without compromising the rights provided in the Article 45 of the Law on Patients' Rights;***
- ***Conclude the currently ongoing process of getting licences/permits for the stationary penitentiary facilities;***
- ***Ensure compliance with legal requirements for particular PHC facilities, which are carrying out the high-risk medical activities;***
- ***Develop procedures in order to improve data management in PHC facilities through identifying and addressing particular shortcomings or needs in corresponding statistical forms and more efficient and unified processes of data analysis and reporting;***
- ***Increase the practical skills of the PHC staff in order to ensure provision of all services implied in specialties/sub-specialties requirements.***

IV. Current Healthcare practice

The PHCs of the prisons visited and the interviews with prisoner patients and healthcare staff conveyed, for the most part, that the practice of primary healthcare has remarkably changed to the positive in the last 12 months in regard to attitude, commitment and medical independence of healthcare staff, to patient/doctor relationship and to trust by prisoners towards the healthcare staff as well as to quality and availability of medical care. An example of good policy in practicing primary healthcare is also distribution of toiletry sets to newly admitted inmates.

However, the representatives of the Public Defender's Office (PDO) gave the information that 90% of prisoners' complaints in 2013 referred to inadequate healthcare provisions. The issues most often complained by the prisoners to the staff of the PDO were insufficient provision of psychotropic drugs, inaccurate diagnoses made and also delays of medical care, primarily of secondary healthcare services when being lined-up on the electronic waiting list for non-urgent secondary healthcare interventions.

In regard to complaints, the Assessment Team was pleased to find complaint boxes in all the prisons they visited, however, as a rule, they were fixed in an area which was under video camera surveillance.

Next, we will approach current healthcare practices by reporting details about the healthcare practice according to the seven CPT principles on healthcare and medical ethics in prison[4]:

In regard to free access to a doctor, the Assessment Team has been informed by representatives of the Medical Department of the MCLA that in closed-type and pre-trial establishments as a rule the inmate has to inform (in a written form or orally) a prison guard that she/he wishes a medical consultation and the guard informs the doctor who

[4] Free access to a doctor, Equivalence of care, Patient's consent and confidentiality, Preventive health care, Humanitarian assistance, Professional competence and Professional independence

visits, examines and consults the inmate in the inmate's cell. This procedure comes in conflict with the principle of medical confidentiality by disclosing patients' complaints to the guard and by the presence of other inmates and security staff during examination and consultation in the cell.[5] With the exception of emergencies, any medical examination and consultation should be conducted in the privacy and confidentiality of the medical consultation room.[6] As an example of good policy, this is well managed in prison N8, where the nurse and/or the PHC physician makes a daily round on the ward to see who is in need of a medical consultation and orders the patient to be brought to the PHC consultation room.

Access to non-urgent secondary healthcare services is presently well regulated by the electronic waiting list. However, it should be kept in mind and explained to inmates and all healthcare staff that any patient on the waiting list who's treatment becomes urgent, according to the opinion of the doctor, will have immediate treatment and that the waiting list is a guarantee to allow for urgent interventions.

Healthcare in prison will come closer to equivalent to general healthcare as soon as material conditions and medical equipment in PHC are fully upgraded. However, as healthcare standards in the civilian healthcare are not yet clearly defined, equivalence of care in penitentiary system is difficult to assess.

Medical confidentiality seems to be well pursued with the exception of the above described application and examination practice in some closed-type establishments. However, the Article 24.2 of the Code of Imprisonment conflicts with medical confidentiality[7] by requiring that a report from the medical examination on admission shall be drawn up to be kept in the personal (=non-medical) file of the prisoner.

The principle of preventive healthcare points both to the importance of health promotion and protection in regard to general living and environmental conditions, nutrition, sanitation, physical and mental exercise as well as to targeted preventive measures against prison specific pathologies such as infectious diseases, mental health, drug dependency and violence addressed in the respective chapter below.

Humanitarian assistance refers mainly to vulnerable prisoner populations such as women, pregnant women, mothers with children and sexual/ethnic/language minorities. In Rustavi N5 women establishment, vulnerable prisoners are well identified and cared for. Deliveries are performed only in civilian hospitals. Significant increase of the number of compassionate release of prisoners grounded on the newly developed list of diseases and criteria for the joint commission was also an important step towards humanitarian assistance to severely and terminally ill prisoners.

In regard to medical professional independence, we were informed by the healthcare staff that currently there is no intervention whatsoever from non-medical superiors, and that they had never been asked to certify inmates fit for solitary confinement or any other punishment, or to participate in body searches or to apply forced feeding in hunger strikers. However, as mentioned above, medical professional independence and

[5] Paragraph 51, extract from the CPT General Report CPT/Inf (93)12
[6] *Ibid.*, Paragraph 35
[7] *Ibid.*, ParagraphS 50-51

the other principles of medical ethics in prison should also be reflected in the penitentiary legal framework.

Initial and continuous training is required as is pursued and on-going within the goals 1, 2, 4, and 11 of the Action plan (see below Chapter IX) in order to achieve and maintain professional competence of penitentiary healthcare staff. Training endeavours by the PPTC, supported by national NGOs and the universities as well as by international organizations, need to be strengthened. Drafting of clear job descriptions, outlining the required skills and competencies of medical staff need to be accomplished.

Legal determinants: Georgian Code of Imprisonment partially complies with international standards on penitentiary healthcare and medical ethics (e.g. see above Article 24.2 of the Code of Imprisonment). In order to secure international standards of penitentiary healthcare and principles of medical ethics in prison, anchoring them legally in penitentiary law remains desirable.

Recommendations:

- ***Complaint boxes should be installed outside the vision of surveillance video cameras;***
- ***Medical confidentiality and privacy should be observed at application for and during medical examination/consultation and medical examinations/consultations should be conducted in the PHC consultation room rather than in cells;***
- ***Adequate explanation on the purpose and functioning of the electronic waiting list for secondary healthcare services should be given to prisoners concerned;***
- ***Article 24.2 of the Code of Imprisonment in regard to medical confidentiality should be reconsidered and principles of medical ethics should be set in the Code of Imprisonment;***
- ***Degree of cooperation or integration of penitentiary healthcare with public healthcare and civilian healthcare structures should be reconsidered and defined.***

V. Regulatory framework – existing legislation overview; legal gaps/problems

One of the priority factors in the smooth implementation of reforms is to make the penitentiary system facilities, both PHC and stationary, basically comply with corresponding legislative regulations. Several key documents, given below, provide obligatory requirements for facilities in terms of quality assurance, health planning, spacing limits, sanitary and hygienic standards, infrastructure and equipping demands, staffing standards, medical documentation management rules etc.

Va) Legislation, regulating the quality assurance in health facilities

Order N01-63/n of the Minister of MoLHSA on "Ensuring functioning of internal system for improving quality of medical services and safety of patients in stationary health facilities" (12.09.2012) regulates the establishment of an internal unit for quality assurance in stationary facilities and to ensure patient-orientated, quality and cost-effective service provision.

The Quality Unit is to monitor priority areas such as: existence of permissions; proper functioning of physical infrastructure and medical equipment; staff qualification; sanitary, hygienic and epidemiology-surveillance regime; institutionalization of national guidelines and protocols; control of nosocomial infections; management of medical documentation, including statistics and management of referral care.

Present condition: The Order has not yet been implemented. The MCLA plans to conduct the relevant activities, both in PHC and stationary activities in February-March 2014 (for this purpose it is planned to recruite a separate Policy Adviser to the Medical Department from January 2014).

Once the unit is established and relevant monitoring is in place, the Order can largely facilitate to comprehensive management of stationary facilities and staff performance.

Vb) Legislation, regulating the requirements for PHC facilities

Order N01-25/n of the Minister of MoLHSA on "Classification of medical interventions and minimal requests for PHC facilities" (19.06.2013) identifies primary required conditions. It has to be noted that the requirements included in the given Order, are applicable and mandatory only to PHC facilities implementing the Universal Health Coverage state program. However, they are high-standard requirements which can be recommended also for PHC units in penitentiary healthcare system as voluntary guidelines. Out of the requirements, covered by the Order N01-25/n, the following ones are rarely met in the facilities visited:

- minimal space of 12m^2 for waiting room/reception (according to the given Order – Annex 1, Chapter 2);
- minimal requirements for ensuring access for disabled persons – e.g. ramps entrance to PHC facility;
- Minor incompliance of the equipment in PHC units, included in the "Cold Chain Cycle", with Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP) standards (particularly, lack of pharmaceutical refrigerators; ice lined refrigerators/freezers); lack of "Cold Chain Cycle" management system.

In general, it has to be underlined that the legislative basis regulating the Primary Health Care is still not fully in place as a comprehensive organic law hindering the smooth and efficient functioning of the system as well as planning and the evaluation of the system's performance.

The organic law will put together all primary issues in PHC system and clearly identify the development strategy.

The Assessment Team was informed by the MoLHSA (see Chapter VIII) that the organic law on "Primary Health Care" is under elaboration.

Vc) Legislation, regulating the requirements for stationary facilities and high-risk medical activities

This section provides a short explanation of the relevant legislation, underlining the particular requirements which are rarely met in the stationary healthcare facilities/PHC units of prisons.

Decree N359 of the Government of Georgia on "Approval of technical regulations of high-risk medical activities" (22.11.2010) covers the particular high-risk activities carried out in the penitentiary system and related to infectious diseases, including TB, Hepatitis and HIV/AIDS. At present, the following required conditions are rarely met in the visited facilities:

- Proper waste disposal, limited monitoring of disinfection process from the medical staff side (the mentioned activities have to be legally regulated according to the Order N300/n of the Minister of MoLHSA (16.08.2001) – this problem refers to PHC facilities;
- Lack of proper maintenance for the equipment for OTs, designed in order to guarantee 95% of airflow to be absolutely clean (which in fact means to be equipped with the laminar airflow system with HEPA-filters) – in particular, the filters are not changed according to corresponding technical requirements; this problem is present at Ksani N19 TB Treatment and Rehabilitation Centre (see Chapter IIIa);
- Equipping the examination/manipulation room(s) with ventilation system to ensure reduced pressure; this problem applies to the particular PHC units (located in the penitentiary facilities NN 2, 8 – visited by the Assessment Team; and also reportedly – to units in the facilities NN 7 and 15), executing high-risk medical activities – see Chapter IIIb.

At present, the following required conditions under Decree N385 of the Government of Georgia on "Approval of regulations for the procedure and conditions for issuing a license to practice medicine and permit for stationary facilities" (17.12.2010) are rarely met in the facilities visited:

- Planning standards and requirements which are defined by the Decree N385 of the Government of Georgia (e.g. minimal space per patient is requested to be $8m^2$, Annex 2.1 of the Decree) were not documentary assessed, as far as the technical documentation/drawings were not accessible and estimation of space could be done only visually;
- Management of nosocomial infections as part of quality assurance process (the related document is above Order of MoLHSA Minister N01-63/n (12.09.2012));

- Management of ventilation and sewerage systems – the systems must be separated in case of infectious and/or contagious patients (that request have created certain difficulties while projecting and conducting civil works in renovated Central Correction Hospital);
- Centralized system of medical gases – as an obligatory system (requirement is met in above under-renovation CCH, but the system is absent in Ksani N19 TB Facility).

Vd) Legislation, regulating the sanitary and hygienic standards

- Order N300/n of the Minister of MoLHSA on "Approval of sanitary rules for waste disposal, storage in treatment-prophylactic facilities" (16.08.2001), though mostly out-dated, still has de-jure and de-facto power (because of the lack of similar up-to-date documents). It has included several practically needed issues and regulations such as: division of waste by classes according to its hazardousness level; waste decontamination rules; rules for waste collection; rules for temporary storage of waste; rules for medical equipment and consumables disinfection; waste disposal requirements to general, infectious and TB facilities etc.

- Joint Order N87-83/N of the Ministers of MCLA and MoLHSA on "Feeding norms and sanitary-hygienic standards for pre-trial and sentenced inmates" (20-25.05.2011) mostly covers all relevant requirements and norms directly connected with the food preparation, food quality, number of fed inmates, calorie content and variety of products, human rights of different inmates' categories. Important issues such as prevention of infections in food block, staffing of the block, list of obligatorily needed equipment are covered very briefly and not sufficiently for comprehensive regulation.

Other important sanitary and hygienic processes in medical facilities (both PHC and stationary) are addressed through the out-sourced contracts, concluded between the MCLA Department of Prisons and service providers. Though the health staff and management consider that standards referring disinfection, disinfestations, cleaning the rooms, waste disposal etc. are met, it seems difficult to check the reality without analysing the content of the contracts.

The main common problem, identified during the site visits, is that most facilities don't comply fully with number of legislative requirements as was mentioned above. Therefore, the quality of care and patient safety are correspondingly affected. It has to be underlined that due to time shortage only the most common/frequent and easily seen issues of incompliance with regulative requirements have been identified and are mentioned in the Report.

The main objective of the MoLHSA policy is aimed to give the MCLA reasonable time (while not specified) and intensive support for gradually upgrading the penitentiary healthcare facilities, eligible for legal regulation and corresponding control/monitoring - in order to meet legislative requirements. Such approach is considered by the MoLHSA as a certain indirect assistance to the implementation of the reforms. However, it has to be mentioned and taken into account that the given policy concerning the non-

compliance to obligatory requirements, is currently not "packed" in any official document/agreement.

Recommendations:

- ***In cooperation with MoLHSA work out a "Legislative Compliance Database" with a further break-down by particular eligible facilities and corresponding problems (the database has to be used for developing an action plan with the main objective of moving gradually towards maximal compliance with corresponding health legislation/regulations);***
- ***In cooperation with MoLHSA elaborate a resource allocation plan;***
- ***Jointly with MoLHSA identify the time period, dedicated for the eligible facilities in order to meet legal requirements in full;***
- ***Medical Department of the MCLA and - not the Department of Prisons - should assume the responsibility to establish outsource contract(s) on management of sanitary and hygienic conditions in prisons and monitor its fulfilment by the service provider/s;***
- ***Elaborate the "Cold Cycle" management system using the requirements of ISO standards; the process of management has to be preferably conducted by the Division of Medical Practice Regulation, Medical Department of the MCLA;***
- ***Contribute, within the legally regulated format, to the prompt elaboration of the organic law on "Primary Health Care".***

VI. Prison specific health problems – clinical issues

Mental Health: Mental healthcare has been regarded by the Deputy Minister of MCLA still as one of the weak points in the present stage of prison reform and has been specifically addressed in goal 4 of the Action Plan. In the Strategy Paper it is stated that data on disease prevalence for the period of 2011-2012 can enable the MCLA to determine priorities and allocate resources correctly. This is definitely not the case for mental disease: Given that international statistics show a prison prevalence of mental disorders of about 70%, the presented percentage of <3% of mental disorders in Georgian prisons in the year 2013 must be understood as an indicator of insufficient identification of mental disorders rather than of the true prevalence. Likewise, when asking for the prevalence of mental disease in the visited prisons we were given the number of patients under neuroleptic or anti-depressive pharmacological treatment and many patients with personality disorders remain unnoticed or unidentified or not ICD-10 codified. Strengthening training on these issues, availability of at least one psychiatrist in each penitentiary institution and increased cooperation of the medical staff with psychologists and social workers as planned and started within the goal 4 of the Action Plan as well as intensified cooperation with the NGO "Global Initiative for Psychiatry" (GIP) will hopefully improve the identification and care of inmates with mental disorders. In addition, patients with acute psychosis should be treated not in prison but in psychiatric institution, also if they are not eligible for forced treatment in the Kutiri Psychiatric Hospital in Khoni municipality. In this regard, the GIP initiative for a penitentiary psychiatric hospital unit in one of penitentiary facilities should be further pursued.

Identification of mental disorders at admission and during detention by healthcare and by non-medical staff is an important part of suicide prevention. In addition, the suicide prevention program and guideline as presently being developed with the support of EU/CoE Joint Programme "Human Rights in Prisons and Other Closed Institutions" will be an important step forward. As an example of good policy the referral of all suicidal inmates to psychiatric in-patient treatment as pursued by the healthcare team in Rustavi women's prison should be mentioned.

The Assessment Team has been informed by the Medical Department that that self-harming prisoners can be made liable for the costs they cause by their self-harm. According to the opinion of the majority of experts for mental disorders in prisoners, the approach to self-harming inmates should rather be therapeutic than punitive.

Drug dependency: Dependency on psychoactive drugs, in part a relic of uncontrolled provision of psychoactive drugs to prisoners in the past, imposes still big problems to healthcare management of inmates and is a main reason for complaints, self-injuries and suicide attempts. The problem has been well identified by the Medical Department of the MCLA and strategies to improve the situation have been developed. When addressing prison physicians with this problem during the assessment visit, the Assessment Team got impression that the prescription of psycho-active drugs is now handled with much greater caution. For a few inmates a specialized, in-patient treatment in the URANT clinic has been made possible while out-patient treatment by URANT narcologists visiting regularly several prisons are ongoing.

In regard to opiate dependent inmates, methadone detoxification programs for a period of up to 6 months are available in two pre-trial prisons (Kutaisi N2 and Tbilisi N8) with the support of the Global fund. However, the maximum used dose of methadone at the beginning of the detox (35 mg) is rather low and most probably the reason of the reported craving for additional psychotropic drugs. A detox program for women in Rustavi N5 is planned but not yet implemented. Up to now, no methadone maintenance programs are envisaged by the authorities. Aftercare of drug dependent prisoners in the especially vulnerable phase immediately after their release should be intensified by careful pre-release preparation and cooperation with outside agencies caring for drug dependent patients.

The parenteral infections HIV/AIDS and particularly hepatitis C (HCV) are a major concern of the Prison Reform Strategy and are addressed in the strategy goals 7 and 8. Intensified screening by VCT (HIV > 6000, HCV only recently started > 400) are undertaken with the support by NGO Tanadgoma ("Support"), percentage of overall inmates tested positive was not yet given. Preventive and harm reduction measures such as educational events, low-threshold condom availability need to be intensified and rolled out, the introduction of harm reduction strategies with proven efficacy in the community and also in several prison systems such as needle/syringe exchange programmes to the penitentiary system definitely should be taken into due consideration. Hepatitis B (HBV) vaccination for 5000 prisoners is planned for 2014. Antiretroviral treatment for inmates with advanced HIV disease is provided on advice and under supervision of the Republican Clinic for Infectious Diseases. The initiation of the currents HCV/HBV program covering 12000 Hepatitis C tests and 500 treatment courses a year as well as 5000 Hepatitis B vaccinations was made possible within the

framework of a programme supported by the Open Society Georgia Foundation and induced a 60% discount of Hepatitis C treatment drugs for the whole country.

Improvement of prevention, testing and treatment of tuberculosis is the content of the strategy goal N6. According to the Medical Department of the MCLA, the number of new cases in prison in 2013 has decreased to 117 (in comparison to 2011 - 800). The renovated Ksani N19 TB Treatment and Rehabilitation Centre allows for better living conditions and food for TB patients, appropriate separation measures according to their contagiousness and resistance pattern, and operates in coordination with the National TB Program of Georgia. The laboratory equipment does not reach beyond sputum microscopy and definitely needs updating of the safety equipment (particularly, the "exhaust hood"). For mycobacterial culture and sensitivity testing specimens are forwarded to the National TB Centre. Gene-Xpert technology is available there but is used only if regarded as necessary by the pthisiologists. In the Ksani N19 TB Treatment and Rehabilitation Centre currently there are 200 patients treated for tuberculosis, 48 undergo DOTS plus for MDR TB, 4 patients are treated for extensively drug resistant (XDR) TB and 4 patients for treatment of both TB and HIV diseases. All over Georgia there are currently 224 prisoners undergoing DOTS treatment and 50 DOTS plus.

Declared hunger strikes have been and still are frequent events in Georgian prisons. In the Kutaisi N2 prison one physician is dedicated only to the care of hunger strikers. According to what healthcare professionals reported during the assessment visit, most often they are not total fasting hunger strikes but allow for intake of fluid nutrition, vitamins and electrolyte infusions. In the prisons visited, in 2013 none of the hunger strikers underwent forced feeding, none had a fatal outcome. Guidelines for management of hunger strikers have been developed,[8] training on management of hunger strikers according to these guidelines have been started by the PPTC.

In all of the prisons visited, we were shown injury reports that are regularly kept and compiled. Newly admitted inmates are screened for signs of violence to be documented and reported to the authorities. Training on violence prevention and documentation has been started and needs to be intensified.

Recommendations:

- ***Strengthen identification and care of inmates with mental disorders including personality disorders by training, pertinent availability of psychiatrists and interdisciplinary cooperation;***
- ***Establish a psychiatric in-patient hospital inside the penitentiary system;***
- ***Intensify inter-professional training on suicide prevention in accordance with the new suicide prevention protocol and guidelines in preparation;***
- ***Proceed in the treatment and prevention strategies for dependency of psycho-active drugs;***
- ***Establish methadone detoxification at Rustavi women's N5 prison and consider methadone maintenance programs for opiate addicted prisoners;***
- ***Engage in aftercare strategies for drug dependent inmates after their release by cooperation with outside agencies and NGOs;***

[8] Order of a Minister of Corrections of Georgia N169 (04.07.2013)

- ***Intensify screening by VCT on HIV and HCV, roll out and intensify already existing harm reduction strategies and duly consider introduction of proven additional harm reduction measures to prisons as recommended by WHO and UNODC/UNAIDS;***
- ***Intensify training on violence prevention, documentation and reporting.***

VII. Prison specific health problems – non-clinical/managerial issues

VIIa) Quality

Quality, as a complex and interdisciplinary process, is incorporated in every sphere of penitentiary healthcare from institutional capacity-building to service planning and provision, also in the field of patients' satisfaction. Therefore it has direct or indirect impact on all thirteen Strategic Goals of the Reform implementation. Thus, the quality issue in general has to be addressed towards different processes and approaches presented below:

- Quality of implemented processes, which are part of particular Strategic Goals in Prison Healthcare Reform

Indicators of accomplishment of the Action Plan of the Reforms are final result-stating indicators. Though giving a clear understanding whether the particular activities were executed or not, they give less or no opportunity to evaluate quality of activities included and implemented under the plan. Certain sets or a combination of input, process, output and outcome indicators, which would be countable, process-specific and valid – would be much more effective and helpful.

Recommendation:

- ***Elaborate a combined set of quality and quantity-measuring indicators in order to evaluate Strategic Goals in a comprehensive and evidence-based way.***

- Quality of health services provided to inmates both in hospitals and PHC units situated in penitentiary facilities

The quality control and assurance system in a modern, comprehensive understanding of this process is not yet in place in full in the prison healthcare system. While the particular parts of the system are already functioning (it includes management of medical records, diagnostic/treatment process control, use of guidelines, relevant trainings (though not enough in quantity), PEHR, patient satisfaction survey (conducted in 2013 with the OSGF assistance), electronic management of referrals), others such as information flow control, financial flow assessment, rational drug usage analysis, procurement process effective management, cost-effectiveness analysis – have to be elaborated and/or inculcated.

Absence of a DRG-based costing system is a crucial problem caused by legislative gaps and also partial functional overlapping between the Medical Department's corresponding Division and Economic Department of the MCLA. This fact limits the Ministry to better analyse, plan and implement penitentiary health expenditures. In particular, it is rather complicated to conduct cost-effectiveness analysis of medical services provided by outside-system facilities. Taking into account the essential increase of health expenditures allocated for referral services in the civilian sector, the given problem can become a serious obstacle both for system performance assessment and budget "targeted" planning. It has to be underlined that from the beginning of November 2013, the Medical Department has organized the market research and price rating covering different services and corresponding provider facilities during the entire year 2013. Results of the research are planned to be used for procurement of services. The first draft of this research has to be completed for the mid-January 2014. It can be stated that this document will essentially contribute to the evidence-based approach concerning the cost-effectiveness and quality of healthcare services.

As the team was informed, the similar research and price rating, covering the year 2012, has been also carried out.

In regard to the healthcare budget, it must be mentioned that the Assessment Team was provided with basic numbers and breakdown of expenses by items. Detailed data by facilities and quarters/months, which would make the budget-related information clearly reflecting the dynamics of financial processes and thus valid for preliminary analysis, was not available.

It must be underlined that in the future, quality control/assessment/evaluation processes have to be measured by relevant, informative and transparent indicators – ready to provide valuable and valid information for future services provision and utilization planning.

Recommendations:

- ***Develop a comprehensive action plan for establishing quality assurance system and its sustainable institutionalization – with clearly defining the role of Medical Department in the given process;***
- ***Work out/tailor DRG-based costing method for health services;***
- ***Establish cost-effectiveness analysis for outsourced medical services;***
- ***Improve monitoring and analysis of the prison healthcare budget indicators through breakdown of expenses, constant execution of financial flow analysis and planning.***

➢ Quality of trainings conducted in the penitentiary system – both for medical and non-medical staff

First, it must be mentioned that in general, the training process related to Prison Health Reforms, is conducted according to the Action Plan but seems evidently not enough to address the existing needs. The variety of topics and coverage of trainees – both medical

and non-medical staff, are relevant to the objectives of the overall process. At the same time, every visit to prison PHC facilities and TB Centre as well as discussions with the MCLA staff revealed the willingness for additional, more practical-orientated trainings. At the moment it seems quite complicated to evaluate the objective necessity of the mentioned requests and concerns. The most adequate response would be the elaboration of training needs database after thoroughly analysing the argumentation for particular needs.

At the moment the ongoing structured program is PHC staff training, supported by ICRC; the other activities to be mentioned are HIV, HCV and TB trainings supported by OSGF, Tanadgoma and ICRC. EU/CoE Joint Programme "Human Rights in Prisons and Other Closed Institutions" has allocated significant resources for trainings and intends to support development of a comprehensive training program. Most recent example of the activities under the mentioned programme was the training for the MCLA staff, conducted in the period of December 14-19, 2013. The topics covered priority managerial, medical and ethical issues.

In regard to quality-oriented approach towards trainings, it must be mentioned that until now no follow-up indicators for evaluating training activities are put in place.

In general, according to the situational analysis, it has to be underlined that the trainings should be more intensive and fruitful if the MCLA would be more active and consistent in training needs assessment, corresponding requests both to PPTC and donors and a permanent, interactive collaboration process.

As to PPTC, taking into account its capacity and resources, it could be a reliable base for professional development, training and certification of the medical staff – though for fulfilling these goals a substantial effort will be needed from the top management. On the moment of the Team visit it was located in temporary site - poorly planned and having limited space. According to the PPTC information, they have conducted limited number of trainings for medical staff, 8 in total, during the period of 2011-2013.

The Assessment Team was informed that the PPTC would be re-dislocated to a renovated facility by mid-January 2014.

Recommendations:

- ***Carry out training needs assessment and develop comprehensive program for both medical and managerial medical staff training;***
- ***Establish a mechanism/format for better coordinating the management of training activities within the frames of the reform - it can be a small working group, staffed by motivated representatives of involved stakeholders;***
- ***Make a particular stress on assessment of practice-oriented and realistic training needs;***
- ***Evaluate and inculcate training follow-up indicators;***
- ***Pay particular attention to essential increase of Medical Department's activity and overall role in the training activities;***

- ***Single out the training component in the future strategy document as a separate Strategic Goal – including and covering all spheres and groups of beneficiaries, connected with the Prison Healthcare Reform implementation;***
- ***Single out the training activities for the medical staff of the MCLA as a separate Strategic Goal (including and covering all spheres of Reforms) in the future strategy document.***

VIIb) List of common problems, identified in the penitentiary facilities visited

Regarding the sanitary and hygienic standards, planning standards:

- Majority of sanitary and hygienic activities defined by relevant legislation (see Chapter V) are out-sourced. Though declared both by staff and the management of prisons that they are conducted in time and due way, at the moment it is not possible to evaluate the work done by contractors, because the contract copies were not provided;
- Most of the rooms where the PHC services are provided are situated in former cells, that certainly limits quality of care provision; the reality is understandable as majority of the 10 PHC units of the system are "products" of re-planning activities and not planned specially for medical purposes;
- The surface of the walls was mostly not even (some kind of "shaggy" surface), that is not acceptable because it increases the possibility of infection;
- The floor cover (mostly so-called laminate/or linoleum) passes minimal standards/requirements in the examination rooms; at the same time the mentioned standards are not met in the majority of rooms in which diagnostic examinations (especially Ultrasound) and/or minor invasions are performed – and where the anti-static linoleum is required;
- The ventilation system, though present in every medical unit/facility, raises questions about its design/or performance of installation: In several facilities, the outer end of the system coming out in the treatment room wall wasn't isolated in due manner, had no "diffuser", leaving the ventilation outside hole just made inside bricks/blocks – without any isolation. Such situation essentially increases the possibility of nosocomial infection and needs to be clarified. Related technical drawings of the ventilation system were not provided for assessment needs.

Recommendations:

- ***List, analyze and gradually solve the problems, causing non-compliance with the legislative requirements – regarding sanitary and hygienic conditions, health planning standards;***
- ***For this purpose – use the action plan within the framework of the "Legislative Compliance Database" (see recommendations - Chapter V);***
- ***Elaborate the corresponding resource allocation plan;***
- ***Use comprehensive approach in order to effectively prevent nosocomial infections; carry out relevant infrastructural activities.***

Regarding the Medical equipment (ME):

- The relatively frequent breakdowns of simple devices in PHC facilities; the reason is low quality of procured products;
- Particular PHC units conducting high-risk activities (see Chapter IIIb), as well as Ksani N19 TB Centre, lack certain equipment for fully complying with the definition "Cold Chain Cycle Equipment" as given in the international regulatory requirements – in particular, pharmaceutical refrigerators, ice lined refrigerators/or freezers (if needed);
- In the Ksani N19 TB Centre so-called "exhaust hood" in the lab is about 20 years old and out-dated;
- Some small pieces of equipment are donated by different donors and became obsolete (e.g. gynaecologic examination table in Women N5 Facility);
- The equipment is not yet unified according to some inner standards/requirements, suppliers, performance functions; that makes the ME maintenance, repair and planned procurement processes much more difficult;
- The maintenance of equipment: at present is partially not preventive but breakdown-type, which makes it more complex and costly, besides it limits the accessibility of care provided to patients during at least limited period of time. The good example was Ksani N19 TB Centre where company "Humana", manufacturer of lab equipment and supplier of consumables, does preventive maintenance and needed calibration procedures once every 3 months.

Recommendations:

- ***Develop the medical equipment procurement and maintenance strategy; it must include the establishment comprehensive and full inventory of ME by all facilities of prison healthcare system (briefly describing its origin, specifications, condition, maintenance issues, repair and spare parts/consumables needs) – giving priority to preventive maintenance activities over the breakdown ones;***
- ***Constantly conduct monitoring of the new ME – analysing the staff demand and medical service utilization datum; based on the given service utilization information, identify evidence-based need/request for other equipment and/or technology(ies).***

VIII. MCLA – MoLHSA collaboration, Government policy

As it was declared during the meeting in MoLHSA Health Department, the main objective of the Ministry in regard to Prison Healthcare Reform is to closely and permanently collaborate with MCLA and assist in reform implementation.

It was also underlined, that the given attitude is based on considering the priority role of Prison Healthcare Reform, also in frame of constant collaboration between top and mid-level officials of the Ministries and generally, reflecting the state policy, heading the processes towards the gradual (while not specified in time) unification of penitentiary and civil healthcare systems.

Though it has to be mentioned that the joint plan of penitentiary and civilian healthcare integration is currently not in place.

The collaboration activities are based both on high-level personal relations and inter-institutional cooperation under different programs and formats.

The successful examples of such collaboration are PHC system development in prison healthcare (under the trilateral agreement between the Ministries and ICRC), unification of medical data (electronic medical records, statistical datum), implementation of certain state medical, so-called "vertical" programmes (TB, HIV/AIDS, Hepatitis C), being implemented in prison health system.

The MoLHSA is also activating its work towards elaboration of the organic law on Primary Health Care, which can largely contribute to increasing accessibility and effectiveness of penitentiary healthcare. At present, the legislative work is mostly executed in format of the "Council on PHC", established by the Ministry and staffed with qualified experts. The process is on stage of approving core framework for the PHC Law.

The assessment has revealed that the MCLA expresses readiness for discussing problems concerning the inside-system facilities which are legally eligible but de-facto yet don't comply with current legislative requirements due to legal gaps.

On the other hand, the MoLHSA policy is aimed to give the MCLA reasonable support and time for gradually upgrading the above-mentioned facilities in order to meet legislative requirements. Such mutual approach can be considered as constructive and realistic.

Recommendations:

- ***Carry out the coordination and harmonization of different reform strategies and approaches from MCLA and MoLHSA - for reaching the primary objective, i.e. implying the unification of priority legislative base and processes under MCLA Healthcare System and MoLHSA;***
- ***Elaborate and implement the joint plan of penitentiary and civilian healthcare integration.***

<u>Changes in the Government Strategy, corresponding correction/amendments in state activities</u>

The short- and long-term strategy of cooperation and future integration of prison health with the MoLHSA, according to the previous-period (2010-2012) governmental plans and statements, was included partially in basic policy documents, such as:

- The Joint Order N24-N28/n of the Ministers of MCLA and MoLHSA on "Ratification of the Action Plan for the Healthcare Reform of the Penitentiary System" (05.02.2010);

- The penitentiary healthcare strategy, endorsed by the Ministers of MCLA and MoLHSA on November 25, 2011;
- Action plan, amended by the Joint order N44-N01-16/n of the Ministers of MCLA and MoLHSA (23.03.2012).

Unfortunately, up today there was no progress achieved towards the integration. Both ministries used to postpone the plan having not progressed in reaching this declared goal. Today the ministries treat the issue of possible integration more realistically, the general approach has been partially changed: MCLA, with support of MOHLSA has to bring entire system's capacity to the certain level and only afterwards initiate the discussion on integration.

Both the Head of Health Department, Ms. Marina Darakhvelidze and Deputy Minister, Ms. Mariam Jashi – have expressed the main short-term strategy objective. It implies not merging prison and civilian health systems, but maximal and reasonably quick unification and standardization of main processes and legislative documents in the following fields: regulation of licensing and/or accreditation of the health facilities and pharmacies; certification and/or training of the personnel; managing/monitoring vertical state programs on health; elaborating program and system-evaluating indicators; costing health services etc.

Such an approach is stated as an intermediary stage of the unification process, the possibility of the final merger isn't discussed right now – though there is a chance that the political message can change in near future towards identifying the integration as a clear goal.

The MCLA – in particular, Deputy Minister Mr. Archil Talakvadze – has proposed and outlined several models for transition and merger. As a transitional institutional option, the MCLA has a suggestion to transform penitentiary healthcare system into an independent agency, responsible either before MoLHSA or before both Ministries.

Finally, it has to be stated unambiguously that Georgia, according to recommendations from CoE, CPT, WHO and EU has undertaken obligations to protect the health of inmates and, in general, humanize the prison health system. One of mostly recommendable "paths" in the mentioned direction is gradual merger of prison healthcare with civilian sector, implemented according the relevant strategy and action plan.

The merger process is extremely important because in case of its successful accomplishment, the performance of the prison healthcare staff and the quality of the provided services will be assessed and monitored by the qualified medical authority(es) - and not by the Ministry, which at the same time is responsible for management of the prisons and non-medical staff working in these facilities. Such reality will have direct and profound effect on the essential increase of the professional independence of health staff resulting in better protecting of inmates' rights, improving doctor/patient relationship and thus ameliorating the efficiency and outcome of healthcare services.

Recommendations:

- ***Develop a concept and plan for the MCLA – fully covering the gradual process of unification with civilian healthcare;***
- ***Conduct a comprehensive study/assessment for analysis and identification of the preferable model of unification and integration for penitentiary and civilian healthcare systems – based on experience of developed states with patient-oriented and effective penitentiary healthcare systems;***
- ***Establish Project Coordination Unit (PCU) for effective and comprehensive management (planning, implementation and monitoring, also evaluation) of Unification Plan and, generally, the entire process of Prison Healthcare Reform new strategy.***

IX. Prison Healthcare Reform, Strategy, and Its Implementation

Part of the goals has been accomplished by 2013 and most of them are ongoing in accordance with the Action Plan. However the reconstruction of CCH N18 will not be accomplished before the end of February 2014. Present status of the particular strategic goals is provided as follows:

Goal 1. Improvement of the Management of Penitentiary Healthcare System

1.1. Develop and apply optimal organizational and management structure for prison medical service. ***Accomplished, to be continued;*** According to Decree N59 of the Minister of the MCLA on "Approval of the Statute of the Medical Department of the Ministry of Corrections and Legal Assistance of Georgia" (15.03.2013), the Medical Department has been re-organized by creating a new structure with four Divisions. However, the capacity building of the Department needs to be continued to establish the fundamentals of the evidence-based policy development.

1.2. Implement proper standard for medical information management. ***Introduction accomplished, full implementation needs further efforts;*** as there is still a lack of standards in the national healthcare system, hampering the analysis of needs and defining components and resources, to be implemented. However, in the prisons visited, at least the same forms of medical records as used in the community are in use and diagnoses are increasingly ICD-10 coded. An electronic medical record for the two prison hospitals reportedly is in development.

1.3. Development of human resources. ***Not yet accomplished/ongoing*** (at the time of the assessment visit there was a training programme for healthcare managers for the Medical Department running), no HR management plan yet presented, JD-s are not yet elaborated.

1.4. Develop and implement efficient health financing model. ***Accomplished,*** However, there are no established service units and pricing, which impedes the effective use of resources and planning, as well as quality improvement and the monitoring of system parameters.

Goal 2. Development of Primary Healthcare (PHC) and Outpatient Services at Detention and Custodial Establishments

2.1. Roll-out of the PHC Model to all Establishments. ***Roll-out accomplished***, Trilateral Agreement signed and is under implementation. In all prisons visited, PHC were established and reportedly they are already established in all prisons. In the prisons visited, there was sufficient medical staff continuously available and the infrastructure and equipment was in accordance to their needs. However, we found no indicators that greater integration with the civilian healthcare sector, a goal expected in 2.1., has been achieved. The basic list of medicines has been developed and adopted. A monitoring and evaluation report on PHC for 2013 has either not yet been developed or were not shown to the consultants.

Selection and re-training of Medical Staff at Establishments. ***Partly accomplished,*** Job competitions for medical staff have been conducted and medical personnel recruited, eased by considerable increase of salaries for medical staff in addition to incentive payments for good performance. Training of medical staff into family physicians and general practice nurses is envisaged with the support of the EU/CoE JP "Human Rights in Prisons and Other Closed Institutions", the ICRC and the Global Fund, but has not been yet accomplished.

Goal 3. Development of the Capacities of Specialized Medical Institutions and Partnership with Civilian Healthcare

3.1. Capacity building of CCH N18 for Accused and Convicted Persons. ***Not yet accomplished***, the restructured and refurbished CCH N18 will not be opened before the end of February 2014. Presently the medical staff of CCH N18 is supporting the medical units of Tbilisi Prison N8.

3.2. The new TB Treatment and Rehabilitation Centre N19 has been opened and is largely functional. ***Accomplished.*** However, only 200 beds of the full capacity of 698 are in use and parts of the laboratory equipment needs to be upgraded.

3.3. Evaluation and Optimization of Existing Cooperation with Civilian Hospitals. ***Accomplished,*** As to Western Georgia, the National Medical Centre for Western Georgia has been contracted for specialized medical care and operates in cooperation with regional penitentiary institutions seemingly in mutual satisfactory cooperation. No cost-effectiveness analysis has been yet presented.

Goal 4. Providing services to the mentally ill and promoting mental health

4.1. Develop and apply regular screening mechanism for ensuring early identification of inmates suffering from mental disorders. ***Ongoing***, Training of psychiatrists and PHC staff is still ongoing in order to introduce regular screening of mental disorders. Development of referral criteria/schemes to specialized psychiatric institutions/departments are not yet developed, apart from those who need coercive treatment and are referred to the Forensic Bureau.

4.2. Ensure timely access to the doctor-psychiatrists working/invited in the system. ***Ongoing***, Number of reviewed cases and referrals for 2013 not yet assessed. Currently there are 13 psychiatrists full-time employed and 3 psychiatrists contracted for the committee.

4.3. Ensure cooperation between psychologists, psychiatrists, family doctors and social workers to promote better mental health in the penitentiary. ***Ongoing***, Guidelines for

cooperation between medical professionals, psychologists and social workers as well as between medical and non-medical staff regarding mental health promotion not yet developed, training on mental health promotion is ongoing.

Goal 5. Treatment and Rehabilitation of Drug Addicts

5.1. Methadone Program and Psychosocial Rehabilitation Programmes. ***Partly accomplished***, Methadone supported detoxification programmes only in 2 prisons (Kutaisi N2 and Tbilisi N8). At Rustavi N5 women's penitentiary establishment methadone detoxification program is not yet established and detoxification services are provided via Tbilisi N8. Training and re-training on the methadone detoxification program as well as on pre-release preparation of the prisoners dependent on psychoactive substances needs to be further enhanced. 5.2. Develop ToR for specialized centre in the penitentiary responsible for full treatment and rehabilitation of drug addicts. ***Ongoing***, ToR for specialized Centre in the penitentiary system, responsible for full rehabilitation of drug addicts, is in preparation.

5.3. Conduct needs assessment for harm reduction services in the penitentiary facilities and develop plan for implementation of harm reduction services in the penitentiary institutions. ***Not yet accomplished***, Needs assessment for harm reduction services for drug dependent inmates in the penitentiary system has not been accomplished and discussion on the extent of harm reduction measures in prison is still ongoing.

5.4. Ensure access to the treatment and rehabilitation for psychotropic drug addicts; Prevention of misuse of legal psychotropic drugs in the penitentiary institutions. ***Partly accomplished, Ongoing***, Access to treatment and rehabilitation for psychotropic drug addicts has been started in cooperation with NGOs and the narcological clinic Urant and prevention of misuse of and reduction of prescribed psychotropic substances presently is pursued by the medical staff, but needs to be further enhanced.

Goal 6. Early Detection and Management of Tuberculosis in Establishment

6.1. Control the TB infection in the penitentiary institutions and ensure access to treatment. ***Ongoing***, Improvement of early detection of contagious TB disease and rapid access to treatment is to be expected by the roll-out of PHC to all prisons and the newly opened TB N19 Treatment and Rehabilitation Centre in Ksani. However, resulting decreases in numbers of new cases in prison and TB induced mortality in prison, for epidemiological reasons, should not be expected to show up immediately.

6.2. Opening of the new hospital for TB infected inmates. ***Accomplished***, Opening of the new TB Centre in Ksani with 200 functional beds (and a presently not used additional capacity of approximately 500 beds).

6.3. Monitoring and prevention of the risk factors for spread of TB infection. ***Mainly accomplished***, Documentation and monitoring of TB infections conducted in accordance and close cooperation with the national TB program.

Goal 7. Improvement of the Epidemiology of HIV/AIDS

7.1. Provision of HIV/AIDS Testing and Consultation and HIV/AIDS Treatment and Prevention. ***Ongoing***, More than 6000 inmates have been screened for HIV by VCT supported by NGOs, total Number of HIV positive inmates were not provided. Education

of staff members on parenteral infection is ongoing; discussion on introduction of additional harm reduction measures in prison is ongoing.

Goal 8. Management and Improvement of the Epidemiology of Hepatitis Infections

8.1. Collection, Processing of Epidemiological Data on Hepatitis C, and the Development of a Treatment Program. ***Ongoing***, Special program on HCV infection and disease has been developed with support of Open Society Georgia Foundation: screening of HCV has been started among more than 400 prisoners, up to 500 inmates can be treated per year, and HBV vaccination of 5000 inmates is planned for 2014.

Goal 9. Protection of Patients' Rights, Regulation of Medical Activities and Implementation of Standards of Medical Care, Patients' Safety and Security

9.1. Effective follow-up of health related complaints and improving regulatory framework so that penitentiary healthcare standards become equal to civilian healthcare standards. ***Partly accomplished, ongoing;*** As far as healthcare standards in the civilian healthcare are not yet defined, equivalence of care of penitentiary healthcare is difficult to assess. Results of comprehensive analysis of complaints on healthcare in prison from 2013 are not yet known. Training of staff on international standards of inmates' rights to health is ongoing.

9.2. Introduce tools to ensure quality control of medical service. ***Not yet accomplished***, Medical guidelines and protocols approved by the MoLHSA as well as tools for quality control of medical services in prison are not yet developed. Order N01-63/n of Minister of the MoLHSA on "Ensuring functioning of internal system for improving quality of medical services and safety of patients in stationary health facilities" (12.09.2012) is not yet institutionalized.

Goal 10. Improvement of the Mechanism for Compassionate Release of Prisoners in Connection with Health Condition

10.1. Make compassionate release mechanism effective. ***Accomplished,*** Statute of the Joint Standing Commission between MoLHSA and MCLA reformed, a new list of criteria adopted, 103 inmates released in 2013 on grounds of compassionate release.

Goal 11. Crisis Management and Medical Staff

11.1. Hunger Strikes, Self-Harm and Suicidal Attempts. ***Accomplished and ongoing,*** Guidelines for medical staff on hunger strike adopted and in use, a draft of guidelines on suicide prevention supported by EU/CoE JP "Human Rights in Prisons and Other Closed Institutions" is in preparation and training on these issues is planned.

Goal 12. Health Promotion, Healthy Environment, and Disease Prevention in the Prison System

12.1. Ensuring control over the basic environmental parameters (air, water, sanitation, food safety, waste management, recreation). The establishment of a controlling body and team designated for monitoring visits for control of environmental parameters (air, water, sanitation, food safety, waste management, recreation). ***Not yet accomplished***, Training on health promotion has been planned for all medical staff and social workers

of prisons within the framework of the EU/CoE JP "Human Rights in Prisons and Other Closed Institutions" from February to September 2014.

Goal 13. Provision of Adequate Healthcare in Establishments for Women and Juveniles

13.1. Eradicate inequalities in terms of access to healthcare between male and female inmates; eradicate discrimination of females while accessing the healthcare. ***Largely accomplished, ongoing.*** Methadone detoxification centre in the women's prison in Rustavi is not yet implemented.

13.2. Ensure adequate access to medical services for juveniles. ***Accomplished.***

Concluding Remark

In the framework of the mid-term assessment of the Georgian Prison Healthcare Reform Strategy and Action Plan of 2013 to 2014 ½ – 18 Months, the Assessment Team recognised and was pleased by significant improvements achieved in the prison healthcare system in 2013. A considerable number of the goals of the ambitious Action Plan to be reached by the end of 2013 have been accomplished; others are still pending as indicated in the Report. The Assessment Team express its hope that the recommendations attached to the above chapters of the Report will serve in achieving planned goals of the Strategy, as well as assist in developing a new Strategy and Action Plan for the next period.

Annex 1: Mid-term assessment of the Georgian Prison Healthcare Reform Strategy and Action Plan 2013-2014 ½ on 13–16 December 2013

AGENDA

13 DECEMBER

10.00 – 12.00	Meeting at the MCLA (Deputy Minister Talakvadze and staff of the Medical Department)
12.30 – 13.30	Meeting at the PPTC (Director Khasia, Mikanadze, Merkviladze)
14.00 – 15.00	Meeting at the MoH (Head of Healthcare Department Darakvelidze and her team)
15.30 – 17.00	Meeting with the NGOs at the CoE Office (NGOs: GIP, GCRT, Empathy, Tanadgoma, Youth for Justice, OSGF)
17.30 – 18.30	Meeting at the Office of Public Defender (Deputy Public Defender, NPM and other staff working on prison healthcare issues)

14 DECEMBER

08.00 – 11.00	Travelling to Kutaisi
11.00 – 12.00	Visiting Kutaisi #2 Remand Prison and Closed type establishment (Medical Unit)
12.30 – 13.30	Visiting Kutaisi Clinical Hospital (where the prisoners are transferred for medical treatment)
14.00 – 15.00	Lunch
15.30 – 16.30	Visiting Geguti #14 Semi-open type Prison Institution (Medical Unit)
16.30 – 19.30	Travelling back to Tbilisi

15 DECEMBER

10.00 – 12.00	Visiting Tbilisi #8 Remand Prison and Closed type establishment (Medical Unit)
12.30 – 13.30	Visiting Juvenile Correction Establishment #11 in Tbilisi
14.00 – 15.00	Lunch
15.30 – 17.30	Visiting #19 TB Treatment and Rehabilitation Centre in Ksani

16 DECEMBER

10.00 – 12.30	Visiting Women #5 Penitentiary Establishment in Rustavi (Medical Unit)
13.00 – 15.30	Visiting Narcological Clinic "Urant"
16.00 – 17.30	Meeting at the Forensic Bureau
19.00 - 21.00	Debriefing Meeting at the MCLA (Deputy Minister Talakvadze and staff of the Medical Department)

The Additional Meetings

The following additional meetings were held in the period on December 17–18, 2013:

1) Division of Medical Practice Regulation – Medical Department, MCLA;
2) Division of Healthcare Economy and Logistics – Medical Department, MCLA;
3) Head of Medical Department, MCLA;
4) Staff of Healthcare Department, MoLHSA;
5) NGO "Empathy" – meeting with the Director.

Another series of meetings took place on December 23 – 24, 2013:

1) Deputy Minister of MoLHSA – Ms. Mariam Jashi;
2) Division of PHC and Outpatient Services – Medical Department, MCLA;
3) Division of Specialized Medical Services – Medical Department, MCLA;
4) Head of Medical Department, MCLA;
5) Deputy Minister of MCLA – Mr. Archil Talakvadze.

Finally, 2 additional meetings were held on January 27, 2014:

1) Head of Medical Department, MCLA;
2) Deputy Minister of MCLA – Mr. Archil Talakvadze.

Annex 2: List of Documents

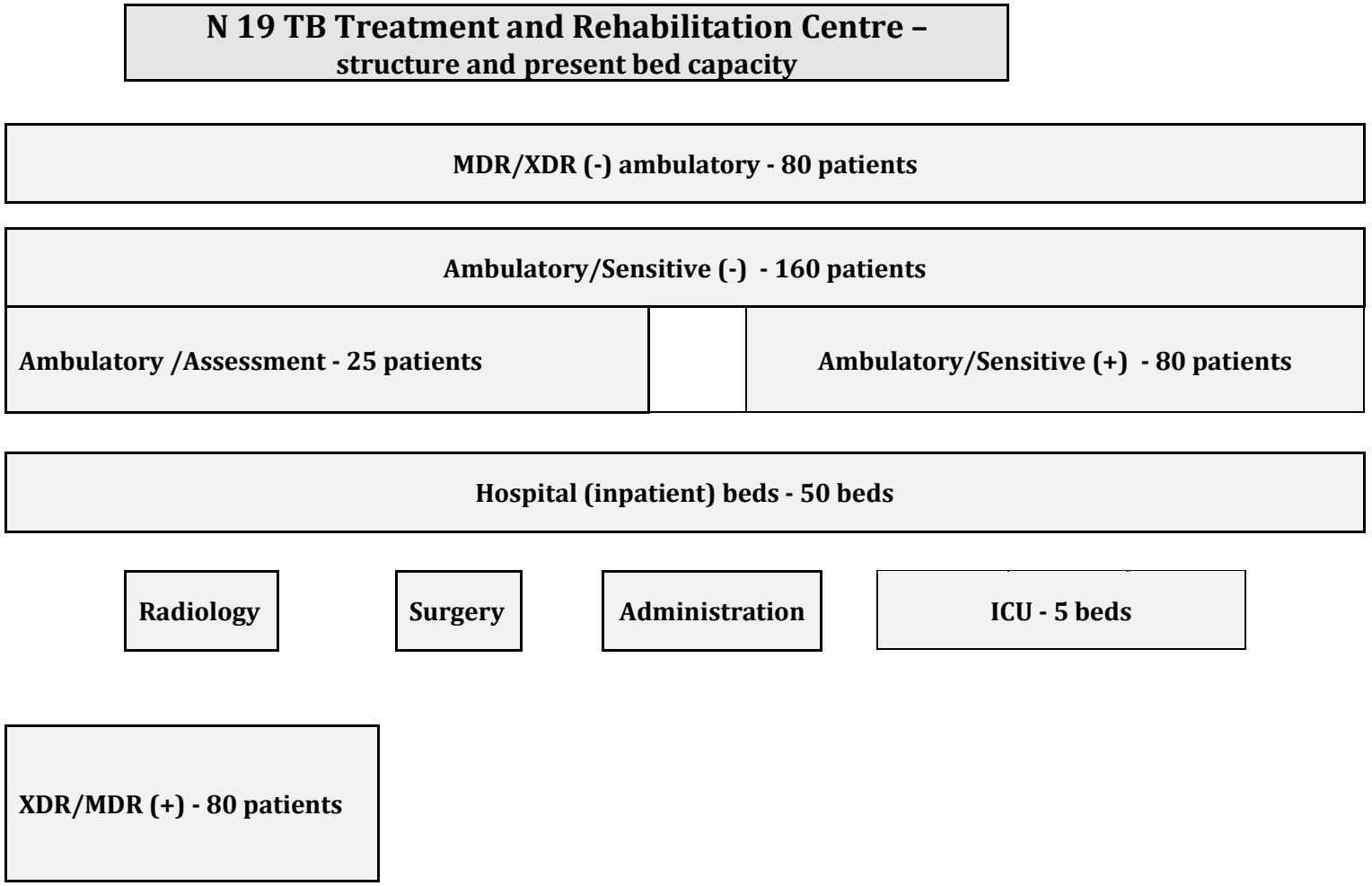
1. Prison Healthcare Reform, Strategy, and its Implementation for the Period of 2013-2014 ½ – 18 Months. Ministry of Corrections and Legal Assistance of Georgia, 2013 Tbilisi, Georgia;
2. Action Plan for the Penitentiary Healthcare Reform;
3. Laws of Georgia, Imprisonment Code;
4. The Law of Georgia on the Rights of Patients; 30 May 2011 Order No 97 of the Minister of Corrections, Probation and Legal Assistance of Georgia On the Approval of Regulations of Pre-Trial Detention Establishments, Custodial Establishments, Mixed Type Establishments for Accused/Convicted Persons, Medical Establishments for Pre-Trial and Convicted Prisoners, and Tuberculosis Treatment and Rehabilitation Centre"; Annex No 4: Regulation of the Medical Establishment for Pre-trial and Convicted Prisoners;
5. 10 March 2011 Order No 38 of the Minister of Corrections, Probation and Legal Assistance of Georgia on the "Approval of the Regulation on Transfer of Ill Accused/Convicted Persons from Pre-Trial Detention/ Custodial Establishments to the General Hospital, TB Treatment and Rehabilitation Centre and Medical Establishment for Pre-Trial and Convicted Inmates under the Penitentiary Department";
6. 18 December, 2012 Order N 181/N 01-72/m of the Ministry of Corrections and Legal Assistance of Georgia and the Ministry of Labor, Health and Social Affairs of Georgia on the "Establishment of the Joint Permanent Commission of the Ministry of Corrections and Legal Assistance of Georgia and the Ministry of Labor, Health and Social Affairs of Georgia in accordance with subparagraph "c", part 1, Article 37 of the Code of Imprisonment and part 1, Article 61 of the General Administrative Code of Georgia";
7. 15 February, 2013 Order N 01-6 m of the Minister of Labor, Health and Social Affairs of Georgia on the "Approval of the list of grave and incurable diseases, which serve the grounds for the release from serving the sentence in compliance with part 2, Article 37 of the Code on Imprisonment and part 1, Article 61 of the General Administrative Code of Georgia";
8. 15 March 2013 Decree N59 of the Minister of Corrections and Legal Assistance of Georgia on the "Approval of the Statute of the Medical Department of the Ministry of Corrections and Legal Assistance of Georgia";
9. 12 September 2012 Order N 01-63/n of the Minister of MoLHSA on "Ensuring functioning of internal system for the quality of medical services and patients' safety improvement in stationary health facilities";
10. 07 November 2013 Order N 01-230/o of the Minister of MoLHSA "On establishing working group for evaluation 2013 state programs and introducing amendments in the given programs for the year of 2014";
11. 19 June 2013 Order N 01-25/n of the Minister of MoLHSA on the "Classification of medical interventions and minimal requests for PHC facilities";
12. 22 November 2010 Decree N 359 of the Government of Georgia on "Approval of technical regulations of high-risk medical activities";
13. 17 December 2010 Decree N 385 of the Government of Georgia on "Approval of regulations for the procedure and conditions for issuing a license to practice medicine and permit for stationary facilities";
14. 28 December 2012 Decree N479 of the Government of Georgia on "Introducing changes to the Decree N385 of the Government of Georgia on "Approval of regulations for the procedure and conditions for issuing a license to practice medicine and permit for stationary facilities";
15. 16 August 2001 Order N 300/n of Minister of MoLHSA on the "Approval of sanitary rules for waste disposal, storage in treatment-prophylactic facilities";

16. 20-25 May 2011 Joint Order N 87-83/N of the Ministers of MCLA and MoLHSA on "Feeding norms and sanitary-hygienic standards for pre-trial and sentenced inmates";
17. 15 August 2011Order №01-41/n of the Minister of Health, Labor and Social Affairs of Georgia on "Approval of Rules of Maintaining of Outpatient Medical Documentation";
18. 19 March 2009 Order N 108/n of the Minister of Health, Labor and Social Affairs of Georgia on "Approval of Rules of Maintaining Inpatient Medical Documentation";
19. 17 July 2002 Order №198 /n of the Minister of Health, Labor and Social Affairs on "Rules of Storing of Medical Records in Healthcare Facilities";
20. 9 August 2007 Order №338/n of the Minister of Health, Labor and Social Affairs on "Approval of the Form on Health Status of a Patient and Rules of Filling in of the Form";
21. Ministry of Corrections and Legal Assistance of Georgia: Prison Health Care Reform in Georgia –Keeping the Promise 1 January – 3 December 2013, MCLA Conference Short Information;
22. Annual Report of the Public Defender: The Situation of Human Rights and Freedom in Georgia, 2012;
23. Memorandum of Understanding between the Ministry of Corrections and Legal Assistance of Georgia and the Ministry of Labor, Health and Social Affairs of Georgia and the International Committee of the Red Cross on Roll-out the Primary Health Care Model in the Penitentiary System of Georgia 2013 ("Trilateral Agreement");
24. CPT/Inf (2013)18 www.cpt.coe.int
25. CPT/Inf (2013)19 www.cpt.coe.int
26. International Centre of Prison Studies, Country Report Georgia www.prisonstudies.org

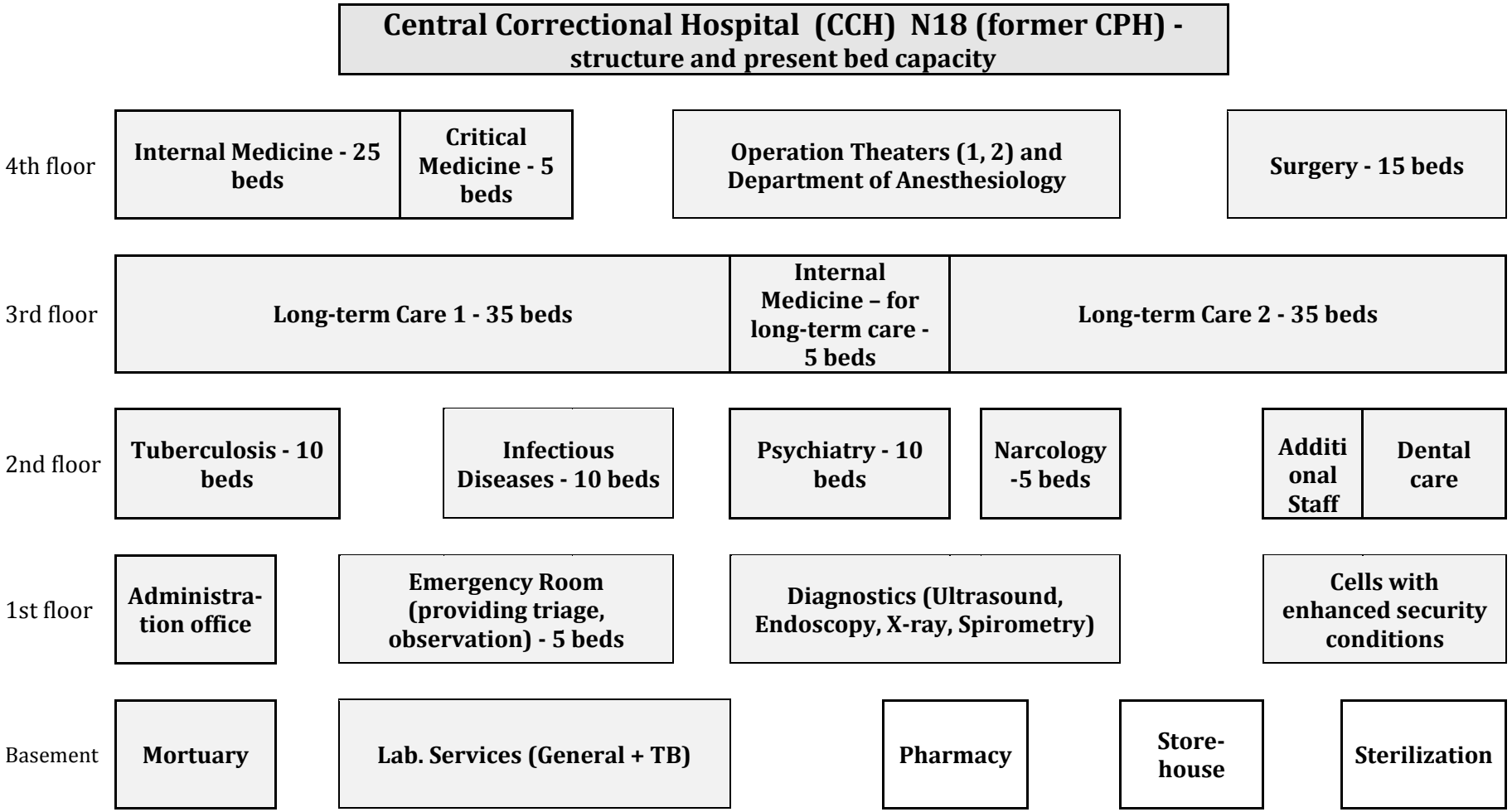
Annex 3: MCLA Medical Department – structure and staff

		MCLA – Medical Department Ms. Natia Landia – Head of Department Mr. Nikoloz Megrelishvili – Deputy Head of Department					
Division of PHC and Outpatient Services		**Division of Specialized Medical Services**		**Division of Medical Practice Regulation**		**Division of Health Economy and Logistics**	
Ms. Khatuna Tsitsava	Head	Mr. Mikheil Ivanishvili	Head	Mr. Giorgi Nioradze	Head	Mr. Giorgi Fruidze	Head
Mr. Otar Abuladze	Adviser	Ms. Marine Nikoleishvili	Adviser	Mr. Badri Balavadze	Adviser	Ms. Nona Oniani	Adviser
Mr. Konstantine Turashvili	Adviser	Mr. David Ergemlidze	Adviser	Ms. Ketevan Chakhnashvili	Adviser	Mr. Levan Zozirashvili	Chief Specialist
Ms. Tekle Razmadze	Adviser	Ms. Tinatin Sikhmashvili	Chief Specialist	Mr. Giorgi Chidrashvili	Adviser	Mr. Iva Kumaritashvili	Adviser
Ms. Lela Ichkhitidze	Chief Specialist	Ms. Tatia Okruashvili	Chief Specialist	Ms. Ketevan Usuphashvili	Chief Specialist		
Ms. Lela Korashvili	Chief Specialist	Ms. Maka Kilasonia	Chief Specialist	Ms. Eliso Bichashvili	Adviser/Pharmacy		
Ms.Nona Mchedlidze	Chief Specialist			Ms. Keti Bakhutashvili	Adviser		

Annex 4: N 19 TB Treatment and Rehabilitation Centre – structure and present bed capacity



Annex 5: Central Correctional Hospital – structure, present bed capacity and staff



Central Correctional Hospital (CCH) N18/former Prison Central Hospital – future list of staff members	Number of Staff
Administration	Subtotal: 5
Chief Doctor	1
Deputy Chief Doctor (clinical field)	1
Deputy Chief Doctor (administrative field)	1
Statistician	1
Matron	1
Department of Long-term Care	Subtotal: 16
Head doctor of department	1
Internist	2
Chief nurse	1
Nurse	8
Nursing assistant	4
Department of Psychiatry	Subtotal: 13
Head doctor of department	1
Psychiatrist	4
Nurse	4
Hospital attendant	4
Department of Tuberculosis	Subtotal: 5
Phthisiatrician	1
Nurse	4
Department of Internal Medicine services - for Long-term Care patients	Subtotal: 15
Head doctor of department	1
Internist	4
Nurse on duty	8
Nursing assistant	2
Department of Stomatology/Dental Care	Subtotal: 2
Stomatologist	1
Nurse	1
Emergency Room (providing triage, observation)	Subtotal: 13
Head doctor of department	1
Doctor on duty	4
Nurse	8
Department of Diagnostics	Subtotal: 9
Doctor - Radiologist	1
Doctor - Radiologist	1
Doctor – Ultrasound specialist	1
Doctor – Endoscopist	1
Assistant radiologist	4
Nurse	1
Laboratory	Subtotal: 11
Head of laboratory	1
Laboratory assistant (with nurse degree)	6
Laboratory assistant	4

Pharmacy	Subtotal: 4
Pharmacist	2
Assistant pharmacist	2
Department of Infectious Diseases	Subtotal: 6
Infectiologist	2
Nurse	4
Department of Internal Medicine	Subtotal: 18
Head doctor of department	1
Doctor on duty	4
Chief nurse	1
Nurse	8
Nursing assistant	4
Department of Critical Medicine – for therapeutic patients	Subtotal: 5
Head doctor of department (Critical Medicine)	1
Nurse	4
Department of Surgery	Subtotal: 25
Head doctor of department	1
General surgeon	5
Surgeon - proctologist	1
Surgeon - urologist	1
Surgeon - traumatologist	1
Scrub nurse – A and B blocks	4
Nurse	8
Nursing assistant	4
Operation Theaters and Department of Anesthesiology	Subtotal: 9
Head doctor of department	1
Anesthesiologist	4
Anesthesiology nurse	4
Department of Narcology	Subtotal: 5
Narcologist	1
Nurse	4
Sterilization Block/Department	Subtotal: 4
Nurse	4
Additional Staff/Specialists	Subtotal: 9
Doctor - Cardiologist	1
Doctor - Neurologist	1
Doctor - Epidemiologist	1
Doctor - Endocrinologist	1
Doctor - ENT	1
Doctor – Dermato-venereologist	1
Doctor – (particular specialty to be identified according to needs)	2
Psychologist	1
Total number of staff	**174**