Ծրագրային համագործակցության կառուցակարգ
Հայաստանի, Ադրբեջանի, Վրաստանի, Մոլդովայի Հանրապետության, Ուկրաինայի և Բելառուսի համար

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REPORT ON THE ASSESSMENT MISSION ON HEALTH CARE IN PRISONS IN THE REPUBLIC OF ARMENIA JUNE/JULY 2015

Within the framework of the Project
"Strengthening health care and human rights protection in prisons in Armenia"
funded by the European Union and the Council of Europe
and implemented by the Council of Europe

Vladimir Ortakov, Jörg Pont, international consultants
Roza Babayan, Naira Gharakhanyan, Davit Khachaturyan, national consultants

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Executive Summary

This report is on the assessment mission on penitentiary health care in the Republic of Armenia carried out from 29 June to 3 July 2015 within the Project "Strengthening health care and human rights protection in prisons in Armenia". The mission focused on assessment of and possible improvements in the current legal/organisational framework of prison health care, material conditions in primary health care units, prison infirmaries and prison hospital, practice of medical ethics and protection of human rights in health care of prisoners, and training needs for staff involved in health protection of prisoners. The assessment team is very grateful for the outstanding support of all authorities, persons and institutions involved in the assessment visit.

The analysis of the legal and organisational framework led the assessment team to strongly suggest that, in order to establish professional independence of prisoners' medical care from the penitentiary administration, governance of penitentiary health should be taken away from the penitentiary department and, whether administratively allocated to the Ministry of Justice or Ministry of Health, health care of prisoners should be brought to the same regulatory and professional level as healthcare in the community. This includes supervision of sanitary-hygienic conditions, licensing and qualification of penitentiary health care units, supply and maintenance of equipment and medications, training requirements of health care professionals, medical documentation and health care complaint mechanisms by competent expert agencies from the Ministry of Health. In addition, current weaknesses in protection of medical confidentiality and independent documentation of injuries should be strengthened by legal amendments as proposed in detail in the report and in Annex 3.

The assessment of material and sanitary-hygienic conditions, equipment, medication and staffing of prison health care units and the prison hospital showed that a number of them do not comply with European standards. Minimal requirements of primary health care units in prison should be defined in line with those in the community and supervised by independent expert agencies from the Ministry of Health. Specialised medical services at the secondary health care level, particularly major surgical interventions, should be provided in secured wards of civilian hospitals in order to achieve equal quality of specialised care for prisoners as for patients in the community as practiced now already for female prisoners. The prison hospital should be closed.

Provision of penitentiary health care at the primary health care level needs improvement of staffing with physicians qualified as general practitioners or family doctors by providing incentives for recruitment, supervision of qualification and continuous medical education. Physicians in military rank shouldn't wear uniforms while caring for patients and military physicians should gradually be replaced by civilians in order to signal and/or advocate professional medical independence. Introduction of ICD coding in medical documentation and keeping reliable nosological statistics is necessary not only for sound planning and budgeting of health care supplies and needs but supplements also epidemiological survey of the whole community with essential data. In addition, regular injury statistics should be recorded.

The present state of mental health care in the penitentiary system is a matter of great concern: all prisons must have regular access to a psychiatrist's service, the number of psychiatrists in the penitentiary system needs to be increased and clinical psychologists independent from the penitentiary department should be included in the caring team in order to identify and prevent mental health problems including suicide intention. Inter-professional suicide prevention programs should be set up in every prison. Mentally disturbed prisoners requiring inpatient psychiatric treatment should be promptly transferred to appropriate hospital facilities which are adequately equipped and possess appropriately trained staff.

The assessment team strongly proposes to implement modern, evidence based treatment approaches to substance dependent patients, reconsider the appropriateness of the laws on compulsory treatment of substance dependency and expand the initiated harm reduction measures in regard to injecting drug use and blood-borne viral infections.

The recent success in control of TB achieved in collaboration with national public health agencies and international support should serve as an example of fruitful trans-mural cooperation of health services and should be expanded to all the other areas of health care including participation of prisoners in national health programmes. However, improvement of material and living conditions of imprisoned TB patients and provision of a rapid TBDST testing system to the central penitentiary TB laboratory for early TB detection and control in the penitentiary system are strongly recommended.

In regard to medical ethics and human rights, the issue most often stressed during the assessment was current lack of professional medical independence. In addition, concerns about patients' free access to health care, such as mental care health or specialised medical services, equivalence of health care quality, consent to treatment such as compulsory treatment of substance dependency, medical confidentiality during examinations and in medical documentation, and proper complaint procedures were raised and need to be addressed by adequate measures as described in detail in the report.

There was a unanimous complaint about virtually complete lack of training of health care professionals and need to develop curricula/syllabus on health care, prevention and health promotion training as well as evaluation tools for penitentiary health care staff and non-medical staff in cooperation with NIH, Medical University and International Organisations. Penitentiary health care staff should be included in the same qualification control and CME requirements as in the civil sector.

Following the express wish of many stakeholders the assessment team met during its visit, an alternative model of health care governance that would accommodate most of the above quoted challenges has been outlined by the assessment team in Part V of the report. Its cornerstones are: 1) penitentiary health care service is taken away from the responsibility of the Penitentiary Department and subordinated to a government body under direct scrutiny of the parliament such as the Ministry of Justice. 2) Intensive cooperation, guided by an inter-ministerial MoJ/MoH working commission enables joint usage of resources, regulatory provisions, professional supervision, licensing, medical data documentation, documentation based budgeting, professional development and training of primary health care services at an equivalent level in the community and in the penitentiary system. 3) In the long run, full integration of penitentiary health with public health care can be considered.

Abbreviations

CoE	Council of Europe
CME	Continuing Medical Education
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
ECHR	European Convention on Protection of Fundamental Rights and Freedoms
ECtHR	European Court of Human Rights
DST	Drug Sensitivity Testing
GDP	Gross Domestic Product
GP	General Practitioner
HCP	Health Care Professionals
HPIU	Health Implementation Unit of the Ministry of Health
HRDO	Human Rights Defenders Office
ICD-10	International Classification of Diseases, 10th Revision
ICU	Intensive Care Unit
MDR-TB	Multi-Drug Resistant Tuberculosis
MMR	Mass Miniature Radiography
MMT	Methadone Maintenance Treatment
MoH	Ministry of Health
MoJ	Ministry of Justice
MSUoPD	Medical Services Unit of the PD
NIH	National Institute of Health
NPM	National Preventive Mechanism
NSEP	Needle Syringe Exchange Program
PDO	Public Defender's Office
PH	Prison Hospital
PHC	Primary Health Care
PD	Penitentiary Department of the MoJ
RoA	Republic of Armenia
SHC	Secondary Health care
TB	Tuberculosis
UN	United Nations
UNODC	United Nations Office for Drugs and Crime
WHO	World Health Organisation
WMA	World Medical Association

Introduction

This assessment report is the result of the assessment mission within the 6-month work plan for the period 1 June – 30 November 2015 of the Project "Strengthening health care and human rights protection in prisons in Armenia". The assessment visit took place from 29 June to 3 July 2015 and included meetings with representatives of the project partners, Ministry of Justice (MoJ), Penitentiary Department (PD), Medical Services Unit of the Penitentiary Department (MSUoPD), Human Rights Defender's Office (HRDO), World Health Organisation's Office (WHO) in Yerevan, several NGOs and visits to six prisons, the prison hospital and the civilian Psychiatric Hospital and Forensic Department in Nubarashen (Annex 1: Agenda of the assessment visit).

The assessment team wishes to express its gratitude to all authorities, persons and institutions involved in the assessment visit for their hospitality, their understanding for the time consuming meetings and visits, and their will to support the assessment work of the team!

In accordance with its Terms of Reference, the assessment team laid particular emphasis on the four pillars, i.e. 1) the legal/institutional framework of health care in penitentiary institutions; 2) improvement of material conditions in primary health care units, prison infirmaries and prison hospitals; 3) medical ethics and protection of human rights in health care of prisoners; and 4) training needs for health care professionals as well as for non-medical staff in regard to health protection.

The assessment team is aware that, in spite of all the support of the involved authorities, persons and institutions, it virtually is impossible to achieve in the short time available a complete picture of the current prison health care situation in the country. However, the team truly hopes that the recommendations and proposals, all of them made on the basis of the assessed or observed facts, will serve the country in strengthening health care and human rights protection in prisons.

Methodology

The assessment team consisted of two international medical consultants (V.O., J.P.), one national public health consultant (N.G.), and two national legal consultants (R.B., D.K.) who jointly collaborated in preparing the assessment, conducting the visit and preparing the report.

The assessment methodology includes: 1) direct observations of the penitentiary institutions with their health units and surrounding amenities (Annex 1: Agenda of the assessment visit); 2) interviews with key stakeholders (state officials, service providers, organisations working with the penitentiary institutions and prisoners); 3) desk review of the materials available (reports, research/study assessment results, official information, lists, local legal and policy documents); 4) literature review related to penitentiary health system in Europe and Armenia (Annex 2).

It should be mentioned that during the whole visit of penitentiary facilities and their medical units, the head of the MSUoPD (Mr Ara Hovhannisyan) was nearly all the time present and several times he provided answers to the questions the assessment team directed to the health care staff of the facilities. This might have been helpful for gathering some additional data and opinions from the head of the MSUoPD but might have been also an obstacle for the subordinate medical staff to speak out openly.

Recommendations and proposals ground on assessment findings and on national law, on European and internationally consented documents (covenants, conventions, recommendations, declarations, rules) as listed in Annex 2. In addition, proposals for alternative health care management models have been made upon the explicit wish of the MoJ, PD and MSUoPD as expressed by their representatives during the assessment visit.

The sequence of listed recommendations and proposals (both in the executive summary and body of the text as well as in the summary of recommendations and proposals) should not be understood as a sequence according to their importance. The assessment team regards all of the recommendations as important and many of them are interrelated with each other, i.e. one without the other might have little or no effect.

Key features of the Armenian penitentiary system and its health care provision

The penitentiary system in Armenia is managed by the Penitentiary Department (DP) which has comes under the Ministry of Justice since 2001. However, the Head of Penitentiary Department is appointed directly by the President of Armenia. Management of health care for detainees and prisoners is under the responsibility of the Medical Services Unit of the Penitentiary Department (MSUoPD).

The prison health care network in Armenia is organised in 11 prisons and one prison hospital. The health care facilities in the frame of the penitentiary institutions are not licensed as it is the case for all health institutions in the country.

There is a separate budget for the penitentiary health care services. In cases when prisoners are transferred to civilian hospitals, the expenses for the treatment are covered by the Ministry of Health.

Every member of the penitentiary staff, including the ones employed in the prison health care system, undergoes training at the Law Institute of the Ministry of Justice. However, this training cannot be considered as professional medical training. The Ministry of Health is not officially involved in the development of this training.

The current four key problems of penitentiary health care in the Republic of Armenia as identified by the Deputy Minister of Justice at his meeting with the assessment team are: need in amendments of the respective legislation, lack of professional independence of prison healthcare workers from the prison administration and the Penitentiary Department, lack of medical equipment and adequate material conditions in the penitentiary health care units and lack of training of medical and non-medical staff on health care issues.

Key numerical denominators

Number of inmates (as of 01.01.2014)	3899
detainees	1092
prisoners	2807
Prisoner population rate (per 100000 inhabitants)	130
Official capacity	4576
Occupancy rate	85%
Number of penitentiary institutions including one Prison Hospital	12
Number of health care staff posts	166
Current vacancies of health care staff	24
Salary for prison doctors	180000 to 250000 AMD
Health care costs total 2014	43,000,000 AMD
Health care cost state budget 2014	28,879,700 AMD
Health care spending/prisoner 2014	7,400
Primary health care consultations 2014	71673
Number of referrals to prison hospital 2014	408
Number of referrals to civil hospitals 2014	708
Number of prisoners died 2014	38
Suicides 2014	4

Establishments visited by the assessment team

Kentron Prison

The prison is situated in the central part of Yerevan. It has been under the jurisdiction of the Ministry of Justice since 2003. The prison is aimed for sentenced prisoners, as well as for remand prisoners that cannot be held with other prisoners for security reasons. The capacity of Kentron prison is for 60 prisoners, and the current occupancy is 42. Only 5 prisoners are sentenced, and 3 out of these 5 are with life-sentence. The prison only accommodates male adult prison inmates.

The medical unit of the prison consists of one medical room for consultations, examinations and occasional application of infusions. This room also serves for dental care interventions. There are no separate rooms for inpatient stay.

The full-time health care team consists of one doctor who is a general practitioner and one feldsher, both of them in military rank.

Nubarashen Prison

The prison currently accommodates 974 inmates, out of this number 200 are sentenced and 770 on remand. The official capacity is for 600 prisoners, but under the circumstances they have to hold more than this number, meaning that the prison is overcrowded (the cells were designed for 8 prisoners each, but more prisoners are placed in the cells than the envisaged number). Out of the total number of prisoners 92 were serving their life sentence. There is a plan for removal of 40 of the prisoners with life sentence to the new prison in Armavir next year. Nubarashen Prison only accommodates male adult prison inmates.

The medical unit of the prison consists of two divided parts – a) the part with few rooms for medical consultations and distribution of medication and b) the inpatient unit.

The medical inpatient unit is located in an old two-floor building. The capacity of the medical unit is 45 beds. At the time of our visit there were 35 prisoners on treatment at the unit. Additionally, there are 10 beds at the TB unit, which is separated from the other part of the medical unit with metal bars.

Also, a separate part in the same building represents a surgical unit where the surgeon performs interventions without anaesthesia, namely, minor surgical interventions. There are no separate beds for the surgical unit.

Regarding the medical staff, the full-time health care team consists of 7 doctors (head doctor: neurologist, gastroenterologist, surgeon, dentist, phthisiatrician, psychiatrist and general practitioner), 5 feldshers, plus a laboratory assistant, an x-ray technician, a surgical nurse and a nurse for the TB department. All members of the medical staff are in military rank, except for the surgeon and the psychiatrist.

Abovyan Prison

The prison currently accommodates 172 female inmates and 8 male juveniles at the age of 14 to 21. Three of the juveniles are sentenced, and 5 of them are on remand. 39 of the women in the prison were on remand and 138 were sentenced prisoners. There were 27 sentenced prisoners in an open regime. They have two mothers with children in the prison, and one of them is in an open regime. There weren't any women with a life-sentence (there is no life-sentence for women in Armenia).

The Health Care Service of the prison is scattered in three different buildings: The medical part for the sentenced prisoners and the one for the prisoners on remand are divided one from another. The part for the sentenced prisoners consists of one room for medical consultations and examinations, an adjacent room for the nurse, and a small storage room with a fridge for insulin. There are also 5 beds located in 2 rooms for inpatient treatment.

There are 5-6 prisoners in the prison under the surveillance of a psychiatrist.

In another building, now not in use for detention purposes, there are 2 rooms used for the purposes of medical care. One of these rooms is the dentistry room. The other room is for gynecological examinations.

In a third building, there is a medical consultation room for prisoners on remand. The juveniles are seen in this part. The doctor carries out minor surgical interventions in here. Also, prisoners could sometimes receive medical infusions in this room. The full-time health care team in Abovyan Prison consists of 3 doctors (2 gynecologists and a dentist, one of the gynecologists, the head doctor, also being a specialist in general medicine) and 4 feldshers (all women). Except for the dentist, one female gynecologist and one of the feldshers, all the other members of the medical staff are in military rank.

Armavir Prison

The prison was officially opened in November 2014, and the planned prison capacity is 1200. At present, only two of the prison buildings are commissioned, and each of them has a capacity of 200 prisoners. However, the current occupancy of the prison is 120. Out of this number 5 prisoners are on remand, and the rest of them are sentenced prisoners (although the prison was designed only for sentenced prisoners, at present it accommodates prisoners on remand as well). Part of the sentenced prisoners is in a closed regime. There are no prisoners with life-sentence at present, although there are plans to accommodate them in future as well. By the end of the year two new buildings are planned to be commissioned.

The medical unit is not yet in function. It is a huge empty structure that includes 2 big operation theatres planned for major surgery, lots of empty rooms planned for diagnostic procedures and examinations and also intensive care block. The inpatient care block of the medical unit includes 18 rooms, and it was planned for 120 beds (according to the Soviet Union standards for 1 hospital bed per 10 prisoners).

The managers of the prison do not know when the unit will start functioning. Only the dentistry room is equipped and in function.

Regarding the medical staff, the present health care team consists of 2 doctors, .e. the head doctor, who is a general practitioner with specialisation in toxicology and the stomatologist (while two other doctors currently are still assigned to other prisons) and 4 feldshers.

Vanadzor Prison

The total number of prisoners accommodated at Vanadzor Prison at present is 198. Out of this number 31 prisoners are on remand (17 under investigation and 14 in the process of trial), and 147 are sentenced prisoners (65 in a semi-closed and 82 in a closed regime). There are no prisoners with a life-sentence in Vanadzor Prison. The prison only accommodates male adult prison inmates.

The medical unit of the prison consists of one medical room for consultations, examinations and occasional application of infusions and one dentistry room. There are also 3 separate rooms for inpatient stay at the medical unit containing 2 beds each.

The full-time health care team in Vanadzor Prison consists of 5 feldshers. The director of the prison, who had taken up this post only two weeks before the assessment visit, stated that for four years no doctor could be recruited, but he succeeded to hire a doctor, and she will start with her work in one week. 4 feldshers out of the total 5 work on 24/7 shifts, and the head feldsher on day shift coordinates the work in the medical unit, carrying out all the medical tasks. She also takes care of the medical files.

Sevan Prison

The current occupancy in the prison is 530 prisoners. As for the prison capacity, it was designed for 950 prisoners. Only sentenced prisoners are accommodated in Sevan Prison. The prison serves mainly for the ones who serve their first sentence.

The Medical Unit consists of two doctors' consultation rooms, a room for dental care, one empty, not equipped operation theatre planned for minor surgery, and the rooms for inpatient stay. There are 8 rooms in the medical unit, with a capacity of 12 beds.

The full-time health care team in Sevan Prison consists of 1 doctor and 4 feldshers.

Yerevan Prison Hospital

The Prison Hospital in Yerevan is the only such establishment in the Armenian prison system. The hospital receives only male sentenced prisoners. Women and juvenile prisoners are treated in civil hospitals. The capacity of the hospital is 415 beds, and it accommodated 132 patients at the time of the assessment visit.

The hospital beds are distributed in six wards: therapeutic (internal diseases), surgery, psychiatry, tuberculosis (consisted of two parts, one for MDR patients and one for "regular" TB patients), narcology and infectious diseases. There are also other departments such as: Dental ward, X-ray department, Laboratory and Functional Diagnosis department.

The total number of the medical staff posts is 78; there are 13 vacancies so that currently the number of medical staff is 63, out of them 18 doctors.

Psychiatric Hospital in Nubarashen

The Psychiatric Hospital functions under the Ministry of Health. The capacity of the hospital is 350 beds. It currently accommodates 281 patients. All patients in the hospital are adults, men and women. Patients on compulsory narcological treatment are not treated in this hospital.

The hospital is divided into 9 departments (wards) with the following bed fund:

	Department	Nr. of beds
1	Psychiatric ward of women	40
2	Psychiatric ward for men	40
3	Forensic ward for conscripts	40
4	Psychiatric ward for men	40
5	Psychiatric ward for men	40
6	Inpatient forensic psychiatry ward	10
7	Special type of compulsory treatment psychiatric ward	60
8	Psychiatric ward for men	40
9	Psychiatric ward of women	40
	Total	350

The biggest part of the hospital serves the purposes for treatment of "civil" patients. Only a part of the hospital is of importance for the purposes of the penitentiary system, and it includes the following structures:

A.) The inpatient forensic psychiatric ward, with the capacity of 10 beds, serving the purposes of forensic psychiatric expertise. There were 3 persons for forensic psychiatric expertise at the time of the visit;

B.) The special type compulsory treatment ward, with 60 beds, for patients who had committed heavy crimes and had been compulsory treated on the basis of criminal irresponsibility. It currently accommodates 58 patients, and among them there are 2 women at this ward, placed in the separated part for women;

These two wards are completely separated from the rest of the hospital with a high concrete wall.

C.) The patients declared criminally irresponsible who could also be treated in the ordinary "civil" wards in the hospital. Altogether, including the two above mentioned forensic wards, there were 120 to 130 patients for compulsory forensic treatment in the hospital.

PART I: Legal and institutional framework of healthcare in the penitentiary

The International Covenant on Economic, Social and Cultural Rights Article 12 and Universal Declaration of Human Rights (UDHR) Article 25 are stating that everyone is entitled to have the "highest attainable standard of physical and mental health" and everyone has the right to a standard of living adequate for the health and well-being.

In common with all other human beings, prisoners have also all these basic human rights entitlements: Art. 2 of the revised European Prison Rules (Recommendation Rec (2006)2 of the Committee of Ministers to member states of the European Prison Rules) declare that "Persons deprived of their liberty retain all rights that are not lawfully taken away by the decision sentencing them or remanding them in custody."

Prison Health as a part of public health cannot be considered as an entity separate from the society and public health sector (WHO Moscow Declaration 2003). Gaps and bottlenecks in prison health services are definitely transferred into civil society. The vast majority of prisoners is going back to their communities and may create an additional burden to the public health sector. Therefore, prisoners' health imperatively is as important as the health of every citizen in the country.

Legislative framework

Below, legal regulations on health care, on penitentiary health care and particularly those that need to be amended in order to comply fully with European standards such as professional medical independence, confidentiality, quality control of health care and sanitary-hygienic requirements, recruitment of medical staff and prevention of ill-treatment are quoted:

General legal regulations on health:

In accordance with Article 38 of the RA Constitution, "Everyone shall have the right to benefit from medical aid and service under the conditions prescribed by law. Everyone shall have the right to free benefit from basic medical aid and services. The list and the procedure of the services shall be prescribed by law. However, up to now the list of basic medical services and the procedure of services provision have not been adopted.

Legal regulations in regard to penitentiary health care:

Article 12 of the RA Law on Medical Care and Services stipulates that "imprisoned, detained and arrested individuals have a **right to receive medical aid** in accordance with the legislation of the Republic of Armenia." Healthcare rights of arrestees, detainees and individuals confined to a correctional institution are regulated by healthcare laws and regulations as well as within the framework of rights of detainees. Prisoners' rights to healthcare are provided by the above-mentioned Law of the Republic of Armenia "on Medical Care and Services", RA Law on "Treatment of Arrestees and Detainees"/adopted on February 6, 2002, RA Law on "Prophylaxis of the disease caused by human immunodeficiency virus" /adopted on February 3, 1997/, RA Government resolution N 825-N of 26.05.2006 on the organisation and implementation of medical, sanitary and medical-preventive assistance to detainees, their right to seek medical assistance at health care facilities as well as the procedures of the engagement of healthcare personnel in correctional institutions", RA Government resolution N 318-N of 04.03.2004 on "Free medical assistance and services guaranteed by the State", RA Government resolution N 351-N of 02.04.2009 on "the procedure of treatment of the arrestees and detainees by the RA Government affiliated RA police" etc.

The analysis of the health rights in the RA law on Treatment of Arrestees and Detainees has identified certain problems related to the acting system imperfection (the system has created insufficient conditions for the protection of health rights of detainees; a right defined by the RA constitution), these problems are also related to the gaps in the basic right protection, caused by the obstacles derived from the incomplete legislation.

According to Point 7 of the 1st part of Article 4 of the 'RA Law on Correctional Service', part 4 of Article 6 of the same

law in line with RA N 1256-N decision made on 24 August, 2006 the **legislation of the penitentiary department** of the Ministry of Justice of RA, and in line with N 825 Decision made on May 26, adopted by the RA Government in 2006, the human, material and financial resources of the medical unit are under the penal system supervision. The treatment and evaluation of the treatment quality as a rule are also under the supervision of the correctional-penal system.

One peculiarity of the realisation of inmates' right to healthcare in correctional institutions is that health care is managed by the correctional administration and not by a health service. Among other peculiarities are the exposure of the healthcare system to the requirements of the prison regime and operational services, and lack of possibility to choose medical institution, physician and medications.

The majority of the physicians and all the heads of healthcare units are members of the military correctional institution personnel. Along with professional duties they are expected to follow the instructions of the prison authorities. Objective medical indications regarding inadequate health condition are not sufficient for the physician to make a decision for treating the prisoner. The decision has to be confirmed by the prison administration.

The legislative regulation of the penitentiary institutions allows the medical personnel to fulfill other responsibilities along with treating the prisoners. Physicians in correctional institutions are appointed by prison authorities who undermine the **physician's professional independence** and give rise to the necessity to choose between work benefit on the one hand and protecting the patient's rights on the other.

Article 5 of the RA Law on "Medical aid and population services", Article 145 of the Criminal Code of the Republic of Armenia and paragraph 7 of the RA Government Decision N 825-N define liability for revealing **confidential information about individual's disease** or medical examination results by healthcare personnel without professional necessity. The information considered medically confidential can be provided only upon requirement of the court (judge), prosecutor, preliminary investigation, as well as other competent authorities in accordance with the procedure defined by law. Yet it should be noted that the Law of the Republic of Armenia does not regulate that the state bodies and public officials should also refrain from divulging the medical confidentiality info even in case when there is no regulation (because of the failure of the state itself) on preservation of that info.

Article 43 of the RA Law on **Licensing** provides that the practice of "medical aid and services" is subject to licensing. Moreover, the license is issued through "complex" procedure in accordance with RA government resolution 276-N on medical aid and types of services and RA government resolution 1936-N in case of presence of mandatory requirements and conditions. The above-mentioned requirements refer to both medical equipment and competent professionals. The issuing body is the Ministry of Health of the Republic of Armenia. State duty for issuing license as well as annual tax for further activities is charged according to RA Law on "State duty". It should also be noted that the requirement to receive proper and safe medical aid and services is stipulated by Article 19 of the RA Law on "Medical aid and population services", i.e. "Entities providing medical aid and services shall: b. provide the quality and quantity of extended medical aid and services in accordance with set standards. This is a major issue for the implementation of activities carried out by correctional institutions. Moreover, the activities of the hospital are omitted from the above-mentioned legislative regulations.

It should also be mentioned that Article 46 of RA Law on "Licensing" stipulates that: "It is prohibited to perform activities subject to licensing under this Law without license. Performance of an activity subject to licensing under this Law without license shall bear responsibility and compensation shall be charged in the amount of licensing fee as state duty as defined by law".

According to Article 18 of RA Law on "Medical aid and population services": "Medical activities can be realised by individuals who have respective higher education and specialisation in the Republic of Armenia, possess license for carrying out certain medical activities as stated in the Law of the Republic of Armenia". It should be noted that the above-mentioned provision of the law has not been amended, but in 2002 after the RA Law on "Licensing" entered into force, individual licensing of doctors was suspended /according to the RA Law on "Licensing" the type of the medical aid and service is subject to licensing/.

In order for medical personnel to carry out professional activities the RA government resolution of July 19, 1994 N 330 provides: "Doctors and pharmaceutical experts who have obtained the right to carry out private medical and/or phar-

maceutical activities in the territory of the Republic of Armenia and in accordance with the Law of the Republic of Armenia shall attend practical training in their field of specialisation for 2-6 months not later than 5 years after receiving professional qualification or after the last practical training. After completing the training program professionals receive respective certificates about the attended training. In case of missing certificate or the expiry of the prior certificate the physician or pharmaceutical expert can be deprived of the right to carry out private activities. The procedure, conditions and duration of the professional training and additional programs are determined by the Ministry of Healthcare of the Republic of Armenia. It should be noted that the requirement to have professional training for the past 5 years is defined by the licensing procedure.

According to Article 21 of the RA Law on Treatment of Detainees and Arrestees, "Medical-sanitary and medical-preventive aid to arrestees and detainees shall be provided in accordance with the legislation of the Republic of Armenia and internal regulations. The administration of places of arrest and detention shall ensure that **sanitary-hygienic and anti-epidemic requirements** aiming at maintaining health of arrestees and detainees are met." Sanitary-hygienic norms are set out in a number of orders of the Minister of Health of the Republic of Armenia, namely the hygienic requirements for drinking water, air and noise. The authorised body for surveillance of the above-mentioned norms is the state healthcare inspection of the RA Ministry of Health. Yet, the latter is not authorised to investigate the correctional institutions. In subordinate institutions sanitary-hygienic control must be realised by the department. Yet, this function is not duly fulfilled. According to Article 5 of RA Law on "Medical aid and population services": "Every individual seeking or receiving medical aid and services has a right to b. receive medical aid and services in accordance with hygienic requirements."

Existing **regulations limiting the recruitment of health care staff** such as the requirement that a person, including the health personnel can join the service only before turning 30, because of the military nature of penitentiary service, and that doctors are not permitted to work medically outside the penitentiary facility should be repelled, given the high number of vacancies of health care workers. In contrary, efforts should be undertaken to attract medical personnel for the health care services in the penitentiary system and to transform the military health care staff into professionally independent civilian medical staff.

Art. 26 of the Law on Medical Assistance should be supplemented by "After every instance of using force by state agents a thorough medical examination should be performed". This requirement should also be enshrined in the Penitentiary Code and the Law on Treatment of Arrestees and Detainees.

Art. 21, paragraph 5 of the Law on Arrestees and Detainees as well as the Criminal Procedure Code should be amended in such a way that an independent expert's documentation on body (and/or psychological) injuries must have the same evidentiary value as the investigator's appointed expert's findings, in line with the CPT and the CoE "Effective investigation of ill-treatment" Guidelines on European Standards 2014, as well as the well-established jurisprudence of the ECtHR. The CPT emphasises that there should be no "barriers" between forensic doctors and persons alleging ill-treatment, whether or not the services of such doctors have been formally requested by investigative, prosecutorial or other officials. (See, for example, the CPT's Report on the visit to Albania carried out from 23 May to 3 June 2005, CPT/Inf (2006) 24, Para 49).

The standard case law of the ECtHR on Article 3 of the ECHR clearly imposes a procedural obligation on the states to secure professional independence of forensic doctors:

> "59. … The Court further reiterates that proper medical examinations are an essential safeguard against ill-treatment. The forensic doctor must enjoy formal and de facto independence, have been provided with specialised training and been allocated a mandate which is broad in scope (see Akkoç v. Turkey, nos. 22947/93 and 22948/93, § 55 and § 118, ECHR 2000X). When the doctor writes a report after the medical examination of a person who alleges having been ill-treated, it is extremely important that the doctor states the degree of consistency with the allegations of ill-treatment…"[1]

1 Barabanshchikov v. Russia, Judgment of 8 January, 2009, par 59.

In the same judgment (Para 48) the ECtHR unequivocally stated that:

> "...it is struck by the fact that the expert examination on 9 August 2001 was ordered by the same police investigator, Ms Z., who had questioned the applicant after his arrest and could have witnessed the alleged beatings. That police investigator also formulated questions to the medical expert. The Court entertains doubts whether this fact could have influenced the expert's findings".

Hence, the ECtHR clearly calls the member-states to allow the alleged victims of torture to autonomously seek for forensic evidence and to pose own questions to the experts.

Art. 79 Paragraph 4 and Art 68.1(8) of the Penitentiary Code are discriminating and should be amended.

As far as overcrowding and the problem of release of convicts with diseases incompatible for imprisonment still persist in Armenian prisons[2], the specific legislative provisions should be made to ensure the transparent and objective adjudication of the motions for early conditional release, as well as to enable the convicts to directly apply to the court with the said motion, especially when such a release is objectively necessitated by the convict's medical condition and his/her inability to serve the sentence.[3] Of course, this does not preclude applications by the administration of penitentiary institutions in cases where the convict or his legal representatives do not apply duely.[4]

Concrete proposals for amendments of the respective laws as elaborated by the legal experts of the assessment team are summarised in Annex 3.

Recommendations:

Strive for legal amendments that ensure

- ★ Bringing medical services of correctional institutions under direct subordination of the Ministry of Justice and possibly in the long run under the Ministry of Health;
- ★ Within the time period of preparing the necessary basis for these transfers, consider establishment of an internal complaints mechanism outside the penitentiary, to ensure the impartiality of a body which adjudicates the complaints against the penitentiary employees.
- ★ the professional medical independence of health care professionals in the penitentiary system; In case the prison administration decides against a doctor's decision/recommendation, this must be grounded and, according to European prison Rule 45.2, forwarded to the superior administration in the MoJ; to gradually transform the military health care staff into professionally independent civilian medical staff;
- ★ a comprehensive regulation on keeping patient related medical information confidential;
- ★ assigning sanitary-hygienic supervision to the state inspection of the MoH;
- ★ assigning supervision/licensing of health care units in prisons to the state inspection of the MoH;
- ★ abolishing of regulations that inhibit the recruitment of health care personnel in prison and provide for solutions that attract medical personnel to the health care services in the penitentiary system;
- ★ obligatory thorough medical examination after every instance of using force by state agents;
- ★ that an independent expert's documentation on body (and/or psychological) injuries must have the same evidentiary value as the investigator's appointed expert's findings;

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2 According to statistics by the Ombudsman, as many as 85 prisoners died in Armenia from 2012 to 2014, o of which 14 convicts had diseases incompatible with serving imprisonment;(source: http://www.forrights.am/?ln=1&id_=19&page_id=79)

3 Para 2 of Article 429 of the CPC does give the convict such a right: „The convict is entitled to appeal to the court which made the decision for the postponement of the implementation of the court decision, for exemption from the punishment due to illness, disability or expiration of the postponement, for parole and for replacement of the unserved part of the punishment with a softer punishment, for the change of conditions in the correction institution, and other appeals envisaged in this Code. In contrast to that, Para 7 of Article 113 of the Penitentiary Code (which is enforced in all cases) clearly prohibits that: „The motion on releasing from the remaining part of the sentence due to mental or other serious disease shall be filed with the court by the head of institution executing the sentence". There is also inconsistency between Para 2 of Article 429 and Para 1 of Article 432 of the CPC, with the latter containing the provision endorsed in the Penitentiary Code. Thus, Para 1 of Article 432 of the CPC should be amended or removed.

4 For example, on November 9, 2015, one of life prisoners who had served 24 years in prison and suffered of psychiatric disorder, died, having no relatives who would represent him; (source: http://www.forrights.am/?ln=1&id_=19&page_id=79)

- ★ introduction of independent medical experts whose conclusions will be considered in court when reaching a verdict about precautionary measures for citizens with serious diseases;
- ★ clarify the inconsistency between the Criminal Procedure Code and the Penitentiary Code in regard to early conditional release on grounds of the convict's medical condition by giving the convict the right to directly apply to the court and seek his/her release .

Organisational Framework

A) Organisation of the public health care system and recent health reforms in Armenia

The health care system in Armenia has three organisational levels: national, regional and community levels. The regulation and planning of the Armenian health care system is mainly executed on the national level. The country lacks a unified systematic quality assurance mechanism. Institutions providing health care services belong to either public or private sectors[5]. The national level includes Parliament and the Ministry of Health, the Ministry of Finance, the Ministry of Education and Science, the Ministry of Labor and Social Affairs and others which are responsible for developing national policies. The Ministry of Justice proves all normative 0tem, though the universities and medical schools both for nurses and doctors are supervised by the Ministry of Education.

The Republic of Armenia Ministry of Health (MoH) as an executive state health body elaborates and implements the policies and main strategic directions in the healthcare sector such as maternal, child and adolescent health, fighting against TB, HIV/AIDS prevention, non-communicable diseases, forensic medicine, promoting healthy lifestyle and implementing other preventive programmes such as Immunisation, Reproductive Health, etc. The MOH has also a function of control and supervision of the sanitary-epidemiological situation, infection control; collecting statistical data, licensing, quality assurance, etc. Within the structure of MOH there are standalone units/agencies, such as **National Healthcare Agency**, providing actual disbursement of funds for the work related state-guaranteed free medical care and services under the contracts with health practitioners and via state budget, ensuring efficient and effective use of financial resources.

Newly established **State Health Inspectorate** affiliated to MOH implements Ministry of Health entrusted supervisory functions. Acting on behalf of the Republic of Armenia, the Inspectorate sets up quality standards, imposes sanctions for breach of healthcare services, work safety and labour legislation standards and provisions[6].

Along with that there is another entity within the MOH, i.e. **The National Institute of Health**, ensuring the development and implementation of the national clinical guidelines and standards, collecting the information and statistical data from medical services, establishing state health registry of human resources and implementing major nationwide health system evaluations.

MOH Health Implementation Unit (HPIU) supports the Ministry of Health of RoA, and is in charge of overall coordination, planning, management, supervision, including procurement and fiduciary aspects of project implementation. The Health Financing and Primary Health Care Development Project implementation was initiated in September 1997 when a loan agreement between the Republic of Armenia and the World Bank was signed. Later the projects were elaborated and enlarged into Strengthening Primary Health Care, Strengthening Health Financing System, State Health Care Optimisation and Health System Modernisation, which contained not only reforming elements in health financing, standardisation of the health care services, strengthening the stewardship, but also upgrading and renovating, building new clinics, equipment and furniture provision, training of medical personnel. All these interventions led to establishment of upgraded PHC level and secondary level medical facilities in all marzes/districts of Armenia, including some tertiary care clinics in Yerevan. HPIU "Disease Control and Prevention" loan program, funded by the World Bank, was launched in 2013. The project development objective is to improve: a) maternal and child health services and early detection, prevention and management of the selected non-communicable diseases at primary health care level, as well as b) the quality and efficiency of the selected hospitals in Armenia. In the frames of the programme it is planned to implement non-communicable diseases (hypertension, diabetes mellitus and cervical cancer) screening activities of target population which aims at their early detection and prevention.

5 Hakobyan T, Nazaretyan M, Makarova T, Aristakesyan M, Margaryants H, Nolte E. Health Systems in Transition: Armenia Health system review. Padstow: European Observatory on Health Systems and Policies 2006. 1817-6119 Vol.8 No.6.

6 Available at http://www.moh.am on June 3, 2015

Health Care Financing and Reforms

The health system in Armenia has undergone tremendous challenges since country's independence in 1991. The health care budget reduction started since mid-1990s and continued till 2000-2002 (0,80% - 1,10% of GDP) and started to grow till 1.7% of GDP in 2014. Although state health funding continuously grows, it is still far from being satisfactory. It consists of 39% of the total health expenditures, where the biggest portion (52%) comes from out-off-pocket money[7].

State-reimbursed prices significantly differ from the real costs and are not sufficient to cover actual costs of health services and to pay more or less good salaries to health practitioners, which is the lead reason for shadow turnover and limited access to care. Co-payment system has been established since 2012, where part of the health care costs has been covered by service users. The latter also definitely created financial difficulties for population. Despite a high level of geographical (physical) access to healthcare and an ample number of people eligible for and the broad scope of healthcare services contained in the Basic Benefit Package (BBP) of state guaranteed free-of-charge healthcare services, 39% of ill people did not seek medical care due to financial constraints[8].

In the last 10 years in order to overcome this situation, the Government of Armenia (GoA) has begun to initiate large-scale health sector reforms, reorienting health services towards more cost-effective primary health care systems and prioritising maternal and child health, prevention of non-communicable diseases, TB control and HIV/AIDS prevention, health system strengthening, etc. The decentralisation, including devolution and privatisation, has been moving the responsibilities of health services provision from the central national government to the regional governments, shifting financial responsibilities from the governmental to facility level, as well as privatisation of health care facilities including dental and pharmaceutical. One of the most important reforms was the introduction of the family medicine, increase in Primary Health Care (PHC) funding (relative to tertiary care) to 35% of the overall health care budget in 2006, which later has grown till 38% in 2014. This has promoted free public PHC services under Armenia's Basic Benefits Package. Another progressive step was done through introduction of the open enrolment (OE) system, giving the patients a right to choose a PHC provider at their own discretion. This has materialised the provisions of the RA Law on Provision of medical care and services to the Population of Armenia on the freedom of health provider choice. Great achievements of the National TB Control Programme have been stated via external evaluators - reducing the default rate of new sputum smear-positive pulmonary TB patients from 14% to 8% in four years and programmatic management of drug resistance. Projects financed by grants from the Global Fund to Fight AIDS, TB and Malaria (GFATM) and USAID are continued to be implemented, and a close collaboration with national and international partners, CSOs and Médecins Sans Frontières, has been established to address MDR-TB and support the National Program on HIV/AIDS Prevention. A continuum of TB treatment and antiretroviral treatment, ensuring it for (ex-) prisoners, CSOs continuous work, focusing on injecting drug users (IDU) and strengthening the collaborative mechanism between the civilian and penitentiary services[9].

The last important reform that has been regulated by law is **Licensing of medical facilities**. The latter passed several changes and has started to be reinforced since January 2013. Certain requirements related to the types of medical services, physical condition of the facilities, equipment, human resources, sanitary-epidemiological standards, statistical recording and other key characteristics and norms of the medical facilities are considered while the clinic gets the license. For example, in case of eligibility of surgical department, an Intensive Care Unit is a compulsory requirement.

It is worthy to mention about the reform related to Continuing Medical Education, which will be regulated by law, passed its first parliamentary reading in spring 2015. Hopefully by the end of the year, the medical accreditation system will be applied for every 5 years, instead of current 7-week training programme for each medical specialty, which has a formal character and mentioned in the Law on Medical Care and Services of the Population (henceforth, Law on Medical Care).

7 Health system performance assessment 2009
8 Social snapshot and poverty in Armenia, Integrated Living Conditions Survey of Households, RoA NSS, 2009, http://www.armstat.am/file/article/poverty_2009e_4.pdf
9 http://www.euro.who.int/__data/assets/pdf_file/0007/160864/e96506.pdf

Physical and Human Resources

Armenia inherited an expansive health care system from the Soviet Union with its main focus on specialised care like many other CIS countries. Though the number of hospitals and beds was reduced after health care reforms, the health care system is still considered oversised.

According to the MOH classification, the health care personnel is divided into university-qualified health care personnel (physicians, dentists, pharmacists, biologists, chemists, clinical psychologists and others), intermediate graduate health care personnel (nurses, midwives, physiotherapists, occupational therapists, specialist technicians and others) and auxiliary personnel (technical and special services, maintenance staff and others).

According to the NIH the number of physicians per 10 000 population is 39, which is close to European average stats; among them around 44% of physicians are working in hospitals.

The recent Health System Performance assessment conducted by the NIH in 2014 showed how much the number of medical school graduates exceeds the same number in neighboring countries, EU and CIS countries. Despite that the primary health care (PHC) and health care facilities in rural areas are lacking in human resources.

The Yerevan State Medical University (YSMU) and 2 other private schools provide undergraduate/graduate medical training in Armenia. The National Institute of Health (NIH) and Yerevan State Medical University (YSMU) provide post-graduate education of medical specialists and family physicians.

B) Organisational structures of penitentiary health care

The organisation of the medical assistance and all sanitary-hygienic and medical norms in the penitentiary system are regulated by the **Government decree N825** about "The organisation of the medical, sanitary and preventive care of arrested and convicted people, health care services practice and engagement of appropriate medical personnel for those services".

It states all norms, Medical Service Department roles and responsibilities, health units' staff job description, medical procedures, official medical reporting forms, lists, decision and reporting mechanisms for health units, prison hospital and Penitentiary Health service Department. It was issued in 2006, though the development of this policy document has started in 2001. It contains lots of statements, reporting documentation and lists which are not corresponding to recent development in health care sector.

According to the Government Decree N825, sanitary and hygienic standards in facilities for detainees and prisoners are based on state legislation and regulations in maintaining hygiene as well as hygienic and anti-epidemic measures. The supervision of hygiene and sanitation must be done by Penitentiary Medical Service Department. However, most of the observed prisons, their health units and Prisoners' Hospital as well were totally out of those norms and standards. Moreover, the role of this department is also conducting studies, establishing the committees for identifying causes of diseases and putting preventive interventions.

As a supervising body, the Penitentiary Medical Service Department and Ministry of Justice established the **Medical Working Commission** (MWC) for a 3 – year period, consisting of surgeon, general practitioner, neurologist and others (up to 5 specialists), which is a decisive body for criminal punishment postponing because of a serious illness in detainees/prisoners. The MWC also conducts case studies, approves referrals, organises consultations and diagnostic procedures out of the penitentiary health system. However, the Public Defender's Office (PDO) and National Preventive Mechanism's (NPM) representatives report on undue delays of MWS's and Interdepartmental Medical Commission's decisions due to low frequency of their meetings and visits of concerned prisoners.

The prison health units' work are also regulated by many other civil legislative acts, regulations and laws, such as State Procurement Policy, Law on Medical Care and Assistance, Palliative Care, the Minister of Health Order N 532-A of 2 June 2005 on ratifying "Standards of treatment of narcological diseases in the Republic of Armenia" and Order N 1440-A of 12 December 2006 on ratifying "Clinical guidelines for alternative treatment for opioid dependence" and others. Despite of those laws and regulations, still many gaps are revealed and require immediate amendments or additional solutions. Thus, "a significant gap preventing patients from exercising the right to complain is the lack of a

precise definition of those to whom health-related rights violations should be reported". Article 19 of the Law on Medical Care states that "medical service implementers" bear responsibility for dealing with illegal or improper medical activities, particularly where fault has caused damage to human health. The term "medical service implementers" is unduly vague, leaving patients perpetually uncertain about how and where to file a complaint about improper medical service delivery[10]. Public monitoring group, Ombudsman office reports and CPT reports always refer to the question, as to eventually who is responsible for improving the service delivery, quality of the provided medical care, if every year the same observational notes and reports go to the high level authorities, repeatedly the same issues arise every year without any promise to be changed.

There are twelve penitentiary health units, including hospital, which are responsible for prisoners' health. The overall supervision and management of health care in prison is done by the Penitentiary Medical Service Unit, which is directly supervised by the Penitentiary Department and thus fully dependent from it.

The organisation of health care services is differentiated in the following way: As in civilian health care system, the general practitioners with nurses and feldshers are the frontline medical staff responsible not only for primary medical health care services, but, according to the penitentiary health service regulations, that staff initiates health promotional activities and supervises sanitation and hygiene, including catering.

The current **primary health care** service departments or units, depending on the prison size or number of prisoners, have a head of department, some subdivisions (like for minor surgery or TB subdivisions in Nubarashen with in total 18 doctors), nurses and other personnel or may have one unit with 1-2 general practitioners and several nurses. In the Vanadzor prison, there hasn't been a prison physician for the last four years and all daily medical care has been provided by the five female feldshers with only occasional calling in of a family doctor from the regional primary health care centre. Some of the prisons have dental units; though Government Decree N825 states that it is required, they will have it depending on the institution size, capacity, as well as availability of staff and equipment.

The Prison Hospital in Yerevan is considered as a **secondary level** facility, which has the following departments: therapeutic, surgical, TB with subdivisions (regular TB department and MDR-TB department) with bacteriological laboratory, narcologic and psychiatric departments, infectious diseases department. There is a dental unit, functional diagnosis and physiotherapy department, as well as clinical and biochemical laboratory. However, the hospital is lacking the intensive care unit (ICU), which, according to the Law on Licensing of Health Facilities, is a requirement for all civilian hospitals having surgical department. At the time of the assessment visit only 134 of the 464 beds of the hospital were occupied.

Currently, civil hospitals are widely used for specialised health care services for prisoners. In 2014, two thirds of referrals of prisoners to hospital care were referrals to civilian hospitals. Depending on the case (if it is urgent and require narrow specialists' intervention) or willingness of prisoner to pay for their services, some civil hospitals such as Erebuni Medical Center, Izmirlian Medical Centre and others are used. It seems that the outsourcing of medical services is becoming more frequently used and more attractive for the prisoners too, especially since the prisoners have the right to choose the place of referral if they can afford it. Referral to a civilian hospital is also done in case the prison hospital does not have the specialised services required, particularly as there are vacancies of the specialists in the prison hospital (currently there is a vacancy of a general surgeon post).

In regard to **staffing and vacancies** of health care professionals, out of the 12 penitentiary institutions, 8 units are lacking doctors, nurses and other health staff (18 vacancies in total). The prison hospital has also 10 vacancies, out of which 5 doctors and 5 nurses. Due to vacancies, many health units in penitentiary facilities have only one feldsher on a night duty and a physician is either on call or an emergency ambulance is called if needed. Even in the prison hospital there is only one physician and 1-3 nurses/feldshers on night duty for the whole hospital. The number of security staff in the prison hospital is twice more than the number of nurses. In addition, many specialists are working on a fee-based contract, which creates certain difficulties, first of all having long-term committed specialists, and secondly, providing continuity of care.

The high number of vacancies proves the statement done by many stakeholders and reports, i.e. "penitentiary medical services are not attractive at all for doctors and nurses". The Head of the Medical Service mentions also about

10 http://www.hhrjournal.org/2013/12/06/identifying-the-gaps-armenian-health-care-legislation-and-human-rights-in-patient-care-protections/

low salaries of the medical doctors (from 180,000 AMD to 250,000 AMD) in comparison with civilian doctors. Even if this salary range looks attractive in comparison with Yerevan PHC level doctors' wage (i.e. 100,000-120,000 AMD monthly), "it is pretty far from what doctors earn in Yerevan-based or even regional hospitals" – states the Head of the Medical Service Department. Other reasons are current lack of professional independence in the penitentiary system, challenging working conditions (i.e. medical care for challenging patients in a challenging environment), prohibition of medical work outside prisons for military medical staff, and low professional and social reputation of prison doctors.

For **training and professional development** of the whole staff of the MoJ including the Penitentiary Department staff, the Law Institute (LI) under the MoJ is in charge. In addition to the full-time staff of the LI, 50 professors are invited from outside. One to two-week training courses, both basic training and advanced level training, are held in the training centre in Karbi village. As long as penitentiary staff has been included in the training activities for over 6 years, curricula and syllabuses are to be accredited by the MoJ and consist of physical training and shooting courses and all staff including medical staff have to undergo human rights law, probation and other topics. One of the critical components is staff training and continuing medical education (CME). Health personnel has not passed any training or other CME events, except training on HIV/AIDS prevention and TB control and prevention. Currently there are no specific continuing medical education opportunities for health care providers working in the penitentiary system. Special courses for health care professionals are to be provided in cooperation with the MoH, NIH and the Yerevan State Medical University but are not yet implemented. A new National Center for Disease Surveillance will develop curricula for special medical training.

There is a striking contrast between the reportedly well-staffed LI in charge of training of penitentiary staff and reported lack and urgent need of training as universally expressed by all penitentiary health care staff the assessment team met during its visit.

Summarising the assessment of organisational structures based on the existing laws and government decisions, on interviews with the leadership of penitentiary medical staff and local medical personnel, on observations made in the prisons and Prison Hospital, on meetings with key stakeholders, public monitoring group conducting monitoring in prisons, reports on penitentiary system and services coming from Ombudsman office and CPT report, it must be stated that the whole penitentiary medical service is completely detached from the public health care sector and its ongoing reforms, particularly in regard to legislative regulations, quality control, licensing regulations, complaint mechanisms and professional development.

Recommendations:

- ★ Amendment of the legislative system in regard to penitentiary health care in order to bring it to the same regulatory and professional level as the health services in the community. In particular, provide the same professional supervision mechanisms such as licensing requirements, quality control (protocols and guidelines), medical documentation and reporting obligations for health care professionals in prison as it is in the community. Provide precise definitions of patients' and doctors' complaint procedures. Anchor indisputable medical professional independence and confidentiality as well as the other principles of medical ethics in the Penitentiary Code.
- ★ Rearrange the organisation and management structures of penitentiary health care in line with the recent innovative developments in Public Healthcare in the community by taking up the efforts and expertise of the MoH agencies, such as National Healthcare Agency, State Health Inspectorate, NIH, and Health Implementation Unit (HPIU), in a collaborative endeavour. Most importantly, the prison health care services need to be taken out from the subordination to the Penitentiary Department in order to provide professional medical independence. Professional supervision is to be implemented by professional health authorities such as agencies of the MoH.
- ★ Provide adequate incentives for medical professionals working in prisons in order to improve recruitment.
- ★ Integrate penitentiary health staff in the same qualification and ongoing training requirements (CME crediting) as for health care staff in the community.
- ★ Integrate penitentiary health statistics in the national/international reporting tools as for other health care the institutions in the country.

Part II: Material conditions

The assessment team visited the health units of 6 prisons (Kentron, Nubarashen, Abovyan, Armavir, Vanadzor, Sevan) the Prison Hospital and the civilian Nubarashen psychiatric hospital with the forensic department. The material conditions of these health units were directly visible to the assessment team. Numerous previous reports (from the CoE, CPT, Group of Public Observers and others) supplemented the information on material conditions of health care units of penitentiary institutions not visited during the present assessment visit. Being aware that prisoners' living conditions play a decisive role in maintenance of prisoners' health, the assessment team regrets that due to time constraints assessment of material conditions of prisoners' accommodation was not possible in the frame of this visit.

Buildings: The material conditions of some of the penitentiary health care units are severely impaired by the dilapidated conditions of old prison buildings in need of refurbishment and renovation. Moreover, the medical consultation rooms of most of the medical units were very narrow and lacked adequate space. In Kentron prison, the dentistry chair positioned in the GP's room occupied half of the narrow consultation room. Most medical units lacked waiting space for patients and security staff, thus possibly inducing security staff to stay with the patient in the consultation room. Likewise, the PDO and NPM report that in Yerevan Kentron prison and in Kosh prison, due to lack of space, there are no quarantine units allowing the separation of new prisoners until they have been properly examined. There are no sufficient facilities for physically disabled prisoners such as ramps and suitable toilets.

The prison director from the **Nubarashen prison**, still overcrowded, built in the Soviet times and in Soviet prison style, declared that any renovation work would be in vain because the building is built on "a soil with running water". In addition, the inside of the building is kept careless and dirty, in some places urine smell is worrying and in the gangway to the medical unit (where prisoners would all the times be accompanied by guards) the assessment visit team had to step over a puddle of urine. The patients' rooms of the TB ward (currently 10 patients) were not visited by the assessment team, but they were described as dark with small windows that are not opened in summer due to the heat and there is no ventilation system and no UV devices available.

The walls of the gynecological and dentistry consultation rooms of the closed-regime department of the **Abovyan** female prison are moist and smelly of mold.

A matter of greatest concern is the condition of toilets and shower rooms in the **Prison Hospital** as witnessed in the therapy department: toilet and bathrooms are in a completely dilapidated state, the walls with broken-down painting/plaster and exposed pipes. There is visible and smelly mold, the rooms are dirty and indeed difficult to clean due to the dilapidation. The hygienic condition of these sanitary rooms in hospital amount to an immediate threat to the health of inmate patients! It is noteworthy that already the Ekeid/Arpo report from 2000 recommended closing the Prison Hospital because of the poor sanitary/hygienic conditions! Another remarkable observation in the prison hospital was that several patients' rooms looked like their own private rooms with private furniture and aquarium as they were occupied for a long time by the same persons and not giving at all the impression of hospital patients' rooms. The overall impression from the prison hospital is that neither patients' rooms nor medical procedural rooms, toilets or bathrooms correspond to any norms and standards of hospital care.

In contrast, the new **Armavir prison** complex, designed by a well-known prison architect, will provide spacious and bright living conditions for 1200 prisoners and reduce the overcrowding of the Nubarashen prison. Currently, only two buildings for 200 prisoners each are commissioned. The large medical unit of which only a few rooms are presently used, contains two operation theaters with auxiliary rooms, ample outpatient function rooms as well as stationary treatment wards for 120 patients. This high bed capacity is grounded on the 1:10 relation of treatment beds per number of prisoners from the former soviet prisons as well as on the need to separate convicts from detainees also in the treatment units. Patients' rooms are bright with large barred windows, the floors covered and the walls painted and most of them are still empty. In several rooms there are donated outdated beds with electric positioning. A few rooms for diagnostic procedures are without windows. It is extremely hot; ventilation has been installed only in the rooms without windows but for unknown reasons it doesn't work. For modern functioning of OTs and ICU most probably additional installations (e.g. oxygen pipes) will be necessary, which will most probably bring up the need to open the walls again for these rooms.

Equipment: Primary health care units. In general, the equipment of primary health care units is very basic, pretty old, some is outdated or not calibrated or doesn't function anymore due to lack of spare parts or repair. In the new Armavir prison, the stomatologist carries dental instruments from an outside praxis to the prison health care unit because currently the dentistry equipment in the prison does not go beyond the mere dentistry chair. The list of needed equipment according to the health care professionals in the primary health care units comprises of the following:

Safe(solid and water proof) disposal basket device for contaminated sharp instruments (needles, syringes, blades etc.), dipsticks for urine analysis and glucometers, otoscope, ophthalmoscope, calibrated modern autoclaves, medical fridge for keeping temperature sensitive drugs (e.g. insulin), basic resuscitation equipment (respirator mask and emergency boxes), basic surgical instruments and operating table for minor surgical interventions, dental instruments (extraction sets), dental X-ray. ECG machines, though old, are generally functioning. The Sevan prison health care unit needs a new (digital) X-ray device.

The assessment visit team was provided with a List of Medical Equipment for penitentiary institutions of the Ministry of Justice of the Republic of Armenia consisting of a List of typical equipment necessary for outpatient polyclinic medical services of penitentiary institutions and lists of medical inventory in the prison hospital and the medical units of the prisons stating that, with a few exceptions, all this equipment is "working". As far as the assessment team could judge upon the report of the health professionals, the lists do not correspond well to the experience of the penitentiary health care professionals.

However, in all the prisons visited, when asking the primary health care staff for their needs, all of them prioritised professional training before mentioning equipment needs!

The main problems in equipment assignment for primary health care (PHC) units in prisons are:

1. There is no standardised list of minimal requirements for PHC in penitentiary PHC units in order to be licensed as PHC unit.
2. There hasn't been a special budget line for procurement of medical equipment since 2007.
3. The currently available equipment needs urgent professional controlling (approval/disapproval) by authorised health agencies or technical specialists.

In regard to **specialised (secondary) health care** in the penitentiary system it must be stated that the material conditions as well as the equipment of the prison hospital are completely inadequate to meet the requirements of a hospital. The material conditions of buildings cause severe sanitary/hygienic deficiencies and pose a health threat to patients. The lack of minimal requirements, such as availability of an ICU with monitoring, life supporting and modern resuscitation equipment, preclude the required licensing as hospital with a major surgery department. Non-surgical secondary health care departments should be translocated to newly constructed facilities (such as the large Armavir health care unit) that provide material conditions adequate to hospital care. In addition, the PDO and NPM reported that supply for basic needs for the care of patients such as diapers and oxygen pads in the prison hospital was missing.

Recommendations:

- ★ Renovate and reconstruct those PHC units with deficient material conditions as far as the general building conditions allow and close prisons where this is not possible anymore.
- ★ Draft/adopt a list of minimal requirements of equipment for PHC in line with the requirements in the community in order to be licensed as PHC unit from the MoH.
- ★ Define a special budget for ad hoc and ongoing supplementation of equipment for PHC and procure equipment in cooperation with MoH agencies.
- ★ Install a regular independent supervision mechanism by authorised communal health agencies for quality control of PHC equipment in prisons.
- ★ Close the prison hospital. See for specialised secondary health care provision, particularly major surgical interventions also for male prisoners in civil health care facilities by implementing secured ward units for prisoner patients in these institutions; consider translocating other secondary health care departments to newly constructed facilities

with material conditions appropriate to hospital care.

Medication: For adequate health care it is essential to have not only equipment but medications based on recent evidence-based guidelines and ICD-10. The latter has not been adopted by the penitentiary health system, as Government Decree N 825, containing all important aspects of medical services and their quality hasn't been updated for over 10 years. The medication list is outdated and does not correspond anymore to current developments in practical medicine. Along with that there is another serious limitation, coming from the system, i.e. the medications are acquired via annual aggregated requests coming from the health units. The purchasing is done via State Procurement policy, which requires low price medication. "The latter substantially differs from modern approaches and requirements and very often becomes useless", states one the member of the social monitoring group. The report on "Human rights budgeting in Penitentiary system", prepared by the NGO "Rights without borders" funded by Counterpart International and USAID and published in 2015, discusses provisions and supplies in prisons and their correspondence to the policy regulations in prisons. Inter alia, the report states that the list of essential medication for prisoners does not cover all needs of prisoners taking into account the morbidity structure of prisoners and general recommendations for essential drugs, particularly the supply with antiseptics, pain killers, antibiotics and sedatives.

In addition, there is inadequate storage of medication such as lack of medical fridges for temperature sensitive drugs. In spite of availability of methadone maintenance treatment in prisons, at least in one prison no opioid analgesics were available because of lack of a secured storage facility. Moreover, there is a lack of professional pharmaceutic management of drugs because in many prisons pharmacists are absent – in the Vanadzor prison for the last four years the medication management completely was up to the feldshers because no physician and no pharmacist were present. The assessment team was informed that the prescription of psychotropic drugs in prison is permitted only to psychiatrists but not to GPs. While caution with psychotropic drugs in prison is clearly to be supported, unavailability of psychotropic medication in the absence of the psychiatrist can cause harm in acute cases.

There is no flexibility in funding of the medication and just in case additional medication is needed, the health unit cannot provide funding to purchase it. The assessment visit team has been informed that the procurement of vaccines for the military by the MoH with support of the WHO had been very successful and cost-saving. A similar approach for procurement of medication for the penitentiary system based on thorough analysis of ICD-10 and medication statistics would improve the current situation.

Recommendations:

- ★ Update the list of essential medication for prisoners completely in line with the MoH regulations.
- ★ Base procurement of medication upon regularly collected ICD-10 and medication consumption statistics and involve MoH expertise in the procurement procedure.
- ★ See for adequate storage of medication and use of professional pharmaceutic management of medication – if not present in prison by outside pharmaceutic services.
- ★ Divide the procurement of medication in two phases: 1)purchase of medication as needed based on statistics, and 2) additional purchase of medication on ad-hoc basis, in case of possible need of medications unforeseen, for which certain budgetary funds should be set aside in the general structure of state expenditures on medications.

Part III: Medical service provision assessment

Provision of **primary health care** (PHC) in the six prisons visited differs considerably in regard to staffing of health care professional and qualification of health care providers. In Vanadzor prison, regular PHC was managed for the past four years exclusively by feldshers who only occasionally called in an outside physician or transferred patients to outside health facilities. In Kentron prison, Sevan prison and the present state Armavir prison, there is one general practitioner (GP) physician present. Abovyan prison has two and Nubarashen has six physicians for PHC, however they have only one GP each. In Kentron prison no health professional is present at night at all, in the other five prisons one feldsher is on duty at night and occasionally a physician or an emergency ambulance is called in. In all the six prisons

visited, a dentist's or stomatologist's service is regularly available. However, a psychiatrist's service is provided only in Nubarashen prison. With the exception of Kentron prison, the visited prisons have several rooms with beds designated for in-patient stays if needed.

The majority of penitentiary health care professionals are under military chain of command. Military doctors can decide themselves whether to wear uniform during healthcare work and many of them apparently do not. As a rule, feldshers wear uniform during health care work.

Medical documentation is done by manual non-systematic entering into patients' medical records by physicians or, as has been the case for the last four years in Vanadzor prison, by feldshers. ICD classification of diagnoses or medical interventions is not yet used and the introduction of electronic medical record is not even considered yet. Thus, available nosological statistics are inevitably imprecise and unreliable hampering adequate planning of penitentiary health care budgets, resources, supplies and capacities on an institutional and national level. Likewise, injury statistics as strongly recommended by the CPT in order to control and prevent violence by inmates and security forces are not recorded. Remarkably, the GP in Sevan prison is supporting his own medical documentation by entering data on his own computer.

Reports by PDO and NPM complain about lack of adequate diet availability, particularly for diabetic inmates. Instead, for diabetic patients harmful food supplementations such as additional eggs, butter and oil are provided.

Regrettably, due to time constraints and lack of willingness of the staff to be disposable for the assessment team visit after 6 p.m., the assessment team could not assess properly medical service provision on the **secondary health care** level in the prison hospital. The team could visit only one ward of the hospital which provided negative impression as quoted in the previous chapter on Material Conditions.

Secondary health care for female prisoners in Armenia is provided in civilian health care facilities. The same procedure should be strongly considered also for male prisoners for the following reasons: 1) Long-standing and unacceptable material conditions of sanitary facilities are not compatible with the requirements of a hospital and pose a threat to patients' health.

2) Lack of a well-equipped ICU (Intensive Care Unit) shall not allow getting a license for a hospital intending to perform major surgical interventions.

3) In comparison with civilian hospitals, frequency of major surgical interventions in a prison hospital is much lower leading inevitably to a lower degree of surgical expertise and quality than in civilian hospitals.

4) The number of referrals of prisoner patients to the prison hospital is now already much lower than the number of referrals to civil hospitals (in 2014: 408 vs 708). The occupancy rate of the prison hospital at the time of the visit was as low as 32% (132 patients, capacity 415). Thus, the 76 health care staff posts (out of which 18 posts for doctors) could be used much more efficient in primary health care and/or in pre- and postoperative care in health care units in prisons (thus reducing the time of stay of patients in civil hospitals) and/or in organising out-patient specialist policlinics in prisons.

Having observed these numerous structural weaknesses in penitentiary health care, it must also be stated that many individual health care professionals we met during the visit impressed the assessment team by their apparent commitment and caring attitude towards their patients despite adverse working conditions and low remuneration.

At first glance, the pattern of **prevailing pathologies** in prison and in civilian sector might be regarded as being much the same and this opinion has been expressed also in the meetings with key penitentiary health personnel who quoted cardio-vascular diseases, respiratory infections, gastro-intestinal disorders and oncology diseases as the most prevalent ones also within the prisoner population. However, even the dispenser registration from 2013 and 2014, the only statistical nosological data provided to the assessment team, clearly shows that mental and dependency disorders by far exceed all other disease groups:

				2014	2013
8	Dispenser registration	Total	13	1392 (-13)	1405
		TB	14	126 (-31)	157
		Mental illness	15	238 (+13)	225
		Cardiovascular cases	16	176 (-1)	177
		Gastrointestinal cases	17	155 (-26)	181
		Venereal and dermal cases	18	71 (+20)	51
		Alcoholic and drug addiction cases	19	246 (-22)	268
		Urogenital cases	20	83 (+4)	79
		Endocrine cases	21	90 (+17)	73
		Neurological cases	22	120 (-22)	142
		other	23	87 (+35)	52

This phenomenon is very well known from international penitentiary health experience, i.e. in prisoner population those health disorders are predominant that prevail in impoverished and/or marginalised segments of the communities including mental disorders, infectious diseases concomitant with poverty and substance dependency such as TB and hepatitis C, and HIV disease. As mentioned before, ICD coding in penitentiary health records and statistical recording of ICD classified health disorders would give a much clearer picture than dispenser registration.

According to international surveys up to 70% of the prisoner population suffer from **mental disorders** and some 10% from severe psychotic disorders. In addition, it is well known that in substance dependent patients a high percentage of psychiatric comorbidity must be expected. Given this data, the lack of psychiatric services for identification and treatment of mental disorders in Armenian prisons that was repeatedly complained about also in recent CPT reports is alarming. In line with the CPT standards, a doctor qualified in psychiatry should be attached to the health care service of each prison, and some of the nurses employed there should have had training in this field.

In the CPT report from the visit to the Republic of Armenia in 2002, it was stressed that the cooperation between the Ministry of Justice and the Ministry of Health had led, among other things, to drafting detailed standards for the medical treatment of prisoners and, more specifically, a new programme of psychiatric care in prison. However, up to this date, such programme has not been implemented in practice.

There are different models of organisation of the penitentiary mental health care services for the persons in need of in-patient psychiatric treatment. On the one hand, there is a model with completely separated forensic psychiatric institutions, where the persons who committed crimes and seek in-patient psychiatric treatment, both the ones declared criminally irresponsible after the conviction and the ones who seek psychiatric treatment for different reasons while in prison, are treated in completely separated institutions from the mental health institutions for general population. Usually, the forensic mental health services in this case are under the jurisdiction of the Ministry of Justice.

Further, there is a semi-separated model, meaning that the persons acquitted by the court as criminally irresponsible are compulsory treated with a court measure in civil psychiatric institutions, while the ones who had been sentenced to imprisonment and seek in-patient psychiatric treatment are treated in forensic psychiatric institutions (i.e. prison hospitals). Such model usually includes respective jurisdictions of the two sectors – justice and health.

Next, there is a semi-integrated model which comprises treatment in civil psychiatric institutions for all persons with mental disorders who fall under the category of forensic psychiatric patients, no matter whether they have a measure for compulsory treatment or had been sentenced to imprisonment and seek inpatient psychiatric treatment. Although the treatment of both categories is carried out in institutions for civil psychiatric patients, such model is defined by existence of separate forensic units from the rest of the units for civil patients. In this case, the jurisdiction falls in the domain of the Ministry of Health.

Finally, there is a completely integrated model, where all psychiatric inpatients, no matter whether with forensic or civil legal status, are treated together in same the institutions under jurisdiction of the public health sector. Separate forensic units do not exist in those institutions, and division of the units is made only according to the nature and severity of the psychiatric disorders of the patients, and stratified according to the levels of security.

Regardless of the organisation model of the forensic mental health services, the most important point is that principles of service provision have to be in line with the same internationally accepted principles and standards (see Annex 2, Documents). Above all, the principle of equivalence of care should be observed.

As for the prisoners with less severe and non-psychotic mental health problems who do not seek inpatient psychiatric treatment, but only occasional or continuous pharmacological or psychotherapeutic support, they should also benefit from the provision of mental health services equal to those provided in the community.

The current state of organisation of penitentiary mental health services in the Republic of Armenia is closest to the model described as semi-separated. The persons sentenced to imprisonment in need of inpatient psychiatric care are placed either in the medical units of different prisons or in Yerevan Prison Hospital, whereas Nubarashen Psychiatric Hospital provides mental health care for persons sentenced with a measure for compulsory psychiatric treatment. The first steps for improvement of the penitentiary health care services will be proposed in the respective part in this report, together with other recommendations.

At present, in 5 of the six prisons visited by the assessment team, no regular psychiatric service was available. Psychiatrists are full time employed in Nubarashen prison, the Yerevan Prison Hospital and, understandably, in the Nubarashen Psychiatric Hospital. At the Kentron, Abovyan, Armavir, Vanadzor and Sevan prisons, psychiatrist is only occasionally called in (the assessment team was informed that in these prisons psychiatrist visits on average 6 to 8 times a year), and regularly visits only once in 6 months, in the frames of the visit of the "Medical Working Commission". The assessment team was informed that in inpatient units of Nubarashen, Sevan and Abovyan prisons there were psychiatric patients at the time of its visit. In all 3 prisons prisoners with mental health problems were briefly contacted by the assessment team. Some of these prisoners were obviously seriously mentally disturbed, and they were in need of continuous psychiatric treatment, that could satisfactorily be undertaken only in a psychiatric hospital setting.

The conditions for stay of prisoners with serious mental health problems in inpatients parts of the heath care units of the prisons visited were inappropriate. Apart from the very poor state of repair regarding material conditions (with extreme "visual pollution" in the cells), these persons lacked psychiatrist's frequent visits as required, as well as from some purposeful activities, and above all, from an environment that could be defined as 'positive therapeutic', consisting, first of all, of appropriate options for outdoor activities.

At the psychiatric ward of the Prison Hospital the official number of beds is 42, and at the time of the assessment team visit there were 29 patients. Considering a big number of prisoners with mental disorders in the Armenian prisons, the situation of not using the full capacity of the psychiatric ward in the Yerevan Prison Hospital is unexplainable.

In the Nubarashen Psychiatric Hospital, the separation with the concrete wall from the rest of the hospital created prison-like environment, which could be damaging for the prisoners in need of mental health care. The treatment consists exclusively of pharmacotherapy, any kind of purposeful activities for the mentally disturbed prisoners are lacking, and the outdoor space of the forensic part was far from the needed standards for long-term psychiatric inpatient stay. At the time of the assessment visit there was no patient from the forensic part outside their cells.

On the positive side, certain number of prisoners with mental health problems is also treated in the ordinary wards of the Nubarashen Psychiatric Hospital, apart from the treatment at the forensic part, and they benefit from the required circumstances of a psychiatric inpatient setting.

According to the international standards (The CPT Standards), psychiatric unit should offer material conditions which are conducive to the treatment and welfare of the patients and, in psychiatric terms, a positive therapeutic environment. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hygiene requirements. Provision of accommodation based on small groups is a crucial factor in preserving patients' dignity, and is also a key element in any policy for psychological and social rehabilitation of patients. Such accommoda-

tion also facilitates patient allocation to relevant categories for therapeutic purposes. Such setting should be provided for all prisoners with serious mental health problems who are accommodated in the inpatients units of the visited prisons. The same is valid for the severely mentally disturbed prisoners with a life-time sentence.

In all establishments visited the treatment of prisoners with mental health problems consisted exclusively of pharmacotherapy. The choice of available medication was on a relatively satisfactory level. However, from the medical files of the prisoners who regularly receive psychotropic medication, it could be concluded that there is widespread proneness to use older generation neuroleptics and antidepressants.

The issue of consent to psychiatric treatment is not tackled yet. Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment, regardless of their legal status (e.g. compulsory forensic patients) as well as of their sentence.

Psychologists and social workers should be included in the caring team. The tasks of the psycho-socio-legal service to provide, among other services, psychological assistance to prisoners, have not been really carried out. Only in Kentron and Abovyan prisons there was information about the psychologist regularly seeing prisoners in need of psychological help. However, such activities, obviously based on personal motivation, are far from the required organised and permanent psychological involvement, supported by an adequate number of clinical psychologists in prisons.

The recent rise of suicide cases) points into the same direction (in 2013: 2 cases, in 2014: 4 cases). However, suicide prevention is to be understood as common task of the whole prison community and not as a sole matter of the prison psychologist as was expressed in one of the prisons visited.

In regard to treatment and care of **substance dependent prisoner patients**, the assessment team has been informed that, although the consumption of illegal drugs has been decriminalised by amendment of law, the permitted threshold of illegal drug possession has been defined so low that in practice the number of drug dependent individuals imprisoned now is not less than it was the case before the law amendment. In addition, there still exists the law on compulsory registration and compulsory treatment of substance dependent patients in Armenia (currently 5357 persons registered, the last estimate of a number of substance dependent persons in the country in 2012 was 12700, according to the NIH). In the opinion of the medical experts of the assessment team as well as in the opinion of the large majority of western substance dependence treatment experts, coercive treatment of the dependency syndrome is more than questionable, both for medical and human rights reasons. The express opinion of a narcologist from the prison hospital that group treatment doesn't work with Armenian patients because Armenian people are not open and sincere enough for group treatment, became a matter of concern to the assessment team!

It must be positively acknowledged that harm reduction measures for injecting drug users have been introduced in the Armenian penitentiary system. Methadone substitution maintenance treatment (MMT) programmes have been introduced in the penitentiary system since 2011 and are to be available in all prisons (although in some of the prisons visited there was no MMT because reportedly no opiate dependents were present). MMT is now reportedly well accepted by the security staff and, by cooperation with outside supporting agencies (Global Fund), is continued without interruption after patient's release, according to the NIH Monitoring Center on Drugs and Addiction. A disadvantage to the MMT programmes is that methadone in Armenia is available only as a pill and not as a solution. At present, there are only 143 prison inmates under MMT. A matter of great concern is that in the commission deciding on medical indication of MMT, clearly a sole medical decision, a police officer's presence and opinion is included.

Needle/syringe exchange programmes (NSEP) have also been introduced into the penitentiary system. According to the head of the MSUoPD, the Moldova model, i.e. distribution of injection paraphernalia by peer inmates had been envisaged. In Nubarashen prison injection instruments are now provided to injecting drug users by medical staff. No figures on return rates of contaminated instruments could be given because they are immediately disposed without counting them. There is concern that NSEP is not well accepted by injecting drug users as there is lack of trust in health care professionals due to their dependence from the PD.

Due to well-established and implemented National **Tuberculosis** Control Program and collaboration with Medicines Sans Frontiers, and Global Fund TB program, new TB cases are becoming less, and by May 2015, there were only 36 TB cases in the penitentiary system. Among them 4 are combined with HIV infection. In 2014, out of 35 TB patients

9 were classified as new cases of which 6 were sputum positive and 10 patients were classified as MDR-TB. Giving prisoners access to the same quality and range of health-care services as general public receives from the National Health Service, particularly active case finding by questionnaires and MMR (mass-miniature radiography) upon entry and biannually thereafter definitely has improved the situation. All those suspected after screening undergo sputum smear examination in two TB microscopy laboratory facilities within the penitentiary system, at Nubarashen and the Prison Hospital, where sputum smears are sent for analysis. If required, culture and drug sensitivity testing (DST) is carried out by NRL. Suspected or confirmed cases of TB within all penitentiary institutions are transferred to the Prison Hospital or the TB ward at Nubarashen prison whereas MDR TB patients are treated only in the specialised ward of the prison hospital.

TB infection control (IC) measures in civilian health care facilities conducted according to the "Tuberculosis Epidemiological Control in the Republic of Armenia SR 3.1.-010-08 Sanitary Epidemiological Regulations and Norms" according to Ministry of Health Decree N-21-N of 20 October 2008, which have recently been revised by the national working group on infection control, with technical assistance from invited infection control experts. In 2010, National TB Program developed an Infection Control Activities Organisation Plan for step-by-step implementation of the WHO Policy on TB Infection Control in Health Care Facilities (2009), which was enriched by additional sanitary norms on infection control via support of the United States Agency for International Development (USAID) TB Control Assistance Program (TB CAP). During the assessment visit of the Council of Europe to penitentiary institutions and medical facilities, it was not possible to see whether all these TB infection control measures are adequately applied in the penitentiary system. However, NTP regularly (every three months) monitors TB infection control and treatment practices at the Prison Hospital and Nubarashen and sends a monitoring visit report to the authorities of the Ministry of Justice Criminal Executive Department.

In this sphere there is at least some integration and links between prison health policy with national health policy that would definitely be needed in other areas of health care provision as well. Reportedly, the material conditions (sanitation, ventilation, day light) in the TB wards of the Prison Hospital and the Nubarashen prison are suboptimal for TB infection control and treatment of TB patients. Translocation to newly constructed facilities such as the Armavir prison health care unit should be considered. Likewise, a rapid TB detection and DST device (Xpert MTB/RIF) should be made available to the penitentiary TB laboratory in order to improve early detection, infection control strategies (appropriate separation) and treatment of infectious TB patients.

Similarly, progressive steps toward control of HIV/AIDS prevention have been related to the National Level Health Care Program funded by Global Fund, USAID and other donors implemented by the National AIDS prevention Centre, National TB program and NGOs. Voluntary HIV testing and counselling is reportedly available for detainees/prisoners in all institutions. Antiretroviral therapy is provided by the national Centre for AIDS Prevention (NCAP). Information material on HIV/AIDS is developed by NCAP and distributed in all institutions. Available harm reduction strategies for injecting drug users in prison (MMT, NSEP) have been described above and should be completed by taking up all other strategies as quoted in the UNODC/WHO/UNAIDS Policy Brief: A Comprehensive Package of Interventions in HIV prevention, treatment and care in prisons and other closed settings.[11]Antiretroviral therapy for HIV/AIS patients is also available.[12] In total 27 prisoners with HIV/AIDS, out of which 10 new cases were identified in 2014. No data could be gathered on blood-borne hepatitis B and C. There is no systematic screening for hepatitis B and C and, given the high numbers of injecting drug users in the country and in the penitentiary system, the magnitude of this threatening health disorder for the whole community currently must be suspected but cannot be estimated properly.

Recommendations:

- ★ Provide adequate incentives for medical professionals working in prisons in order to improve recruitment of physicians;
- ★ All physicians involved in primary health care should have a GP qualification;
- ★ All prisons should have regular access to a psychiatrist's service;

11 www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf
12 http://www.euro.who.int/__data/assets/pdf_file/0007/160864/e96506.pdf

- ★ Health care professionals should not wear military uniform when providing health care;
- ★ Introduce ICD coding into the medical file; keep regular nosological statistics in order to adequately plan health care budgets, medical resources, supplies and needed capacities on national and institutional level;
- ★ Keep periodic injury statistics;
- ★ Provide secondary health care for males in secured wards of civilian hospitals; reduce stays in civilian hospitals by organising pre- and postoperative care in infirmaries of health care units in prisons; organise specialist policlinics in prison;
- ★ Mentally disturbed prisoners who require inpatient psychiatric treatment should be promptly transferred to appropriate hospital facilities. Severely mentally disturbed prisoners should not be placed in the in-patient units of prisons, but in appropriate psychiatric facilities which are adequately equipped and possess appropriately trained staff. For the time being, the only institution where such hospitalisation can be carried out is the Yerevan Prison Hospital. Further steps should include two possibilities:
    - Establishment of a penitentiary psychiatric institution with appropriate standards for inpatient mental health care;
    - The possibility to transfer the prisoners in need of inpatient treatment to Nubarashen Psychiatric Hospital or other psychiatric institution[13].
- ★ Intensify psychiatric and clinical-psychological services in the penitentiary system; increase the number of psychiatrists working in prisons; consider engaging clinical psychologists independent from the security staff as part of the caring team;
- ★ The prisoners with less severe and non-psychotic mental health problems who do not seek in-patient psychiatric treatment, but only occasional or continuous pharmacological or psychotherapeutic support, should benefit from the provision of mental health services equal to those provided in the community. For this purpose:
- ★ Psychiatric follow up should be provided on a weekly basis for every such prisoner, and also psychologists and social workers should be included in the caring team, to carry out consultations and psychotherapy.
- ★ With regard to the Nubarashen Psychiatric Hospital:
    - The material conditions in the forensic part of the Hospital should be improved; Patients should be provided with lockable space for their personal belongings and possibility to arrange their rooms with personal items;
    - Apart from the pharmacotherapy, patients should be enabled to benefit from psycho-social rehabilitative activities (additional involvement of psychologists, social workers and occupational therapists is needed);
    - The patients should be encouraged to stay outdoors much more than it is the case at present, and the outdoor space should be arranged so that to offer pleasant and "positive" therapeutic environment.
- ★ Implement inter-professional suicide prevention programs in each penitentiary facility;
- ★ Reconsider the appropriateness of the laws on compulsory treatment of substance dependency;
- ★ Implement modern, evidence-based treatment approaches to substance dependent patients;
- ★ Expand methadone maintenance treatment (MMT) to all inmates for who it is medically indicated and abolish the police presence and influence in decision making bodies on MMT as this is medical treatment and is to be decided exclusively by medical professionals;
- ★ Consider translocating penitentiary TB treatment units to newly constructed facilities with proper material conditions;
- ★ Introduce a rapid TB/DST testing system (XpertTB/RIF) to the central penitentiary TB laboratory;
- ★ Develop legal grounds for HIV/AIDS, blood-borne hepatitis prevention and harm reduction strategies in accordance with international recommendations;
- ★ Gather data on prevalence of blood borne hepatitis B and C in prisons;

13 This option could be the long run perspective and needs legislative prerequisites in the sense of transfer of the jurisdiction to the Ministry of Health for this category of prisoners).

Medical ethics

In regard to medical ethics in penitentiary healthcare, it was striking that all parties interviewed during the assessment visit, i.e. representatives from the MoJ, the PD, the MSUoPD, PDO, NPM, Public Monitoring Group, other NGOs, NIH and all health care professionals met, unanimously emphasised that the lack of **professional medical independence** in the present structure of penitentiary health care as well as in daily health care work with prisoners poses the greatest ethical problem in terms of trust of prisoner patients to health care workers. There seems to be indeed a common will to change these structures accordingly and the assessment team was asked repeatedly to propose alternative health care administration structures in order to improve this deficiency (see below). In practical terms, health care professionals experience on a daily basis that their medical decisions such as on medical documentation, on treatment choices, or on need for medically necessary transfers, were under influence or pressure from the prison government and that health care professionals thus were regarded by their patients as part of the prison regime rather than as independent care providers.

In order to systematically shed light on adherence to internationally accepted principles of medical ethics[14] in Armenian prisons, the assessment team presents thereafter these principles one after the other together with the respective observations:

First, as declared in UN Resolution 37/194 in regard to the **role of the prison physician**, "It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health". This implies that prison HCP should never become involved in medical activities that are not in the interest of the health of their patients. Although the RA legislation does not stipulate the participation of doctors of penitentiaries in the decision making process on disciplinary punishment, the PDO and NPM still report about certifications being issued by doctors about prisoners being fit to undergo disciplinary punishment. Of particular concern is that this is practised reportedly for disciplinary punishment of patients in the prison hospital.

In regard to free **access to health care** for every prisoner, it can be stated that, according to the official documentation and regulations, prisoners' health services are free of charge, without any fee for any interventions or medications. Accessibility to medical care seems to be in place, except for some institutions which are lacking doctors (Vanadzor prison). Detainees primarily receive health care from doctors working for the institution where they are detained. At prison doctor's request, various health specialists from the penitentiary system and, if necessary, from the civilian system, conduct on-site consultations for detainees. In terms of financial accessibility there are some notes coming from the Civil Society Monitoring Group report published in 2013, indicating certain unofficial payment amounts for referrals to the Prison Hospital or to a civilian hospital; there is information about 50 000-60 000 AMD informal monthly payment for accommodation of prisoner in health care units.

In case a prisoner patient is referred to a civil hospital for emergency treatment, these interventions are also free, as there is a state budget for these specialised services. According to the head of MSUoPD, "If the funds are over, the penitentiary department together with the head of medical services apply to MOH for getting additional funding or a waiver". However, as in civilians, these state funds are limited, and prisoners can suffer by staying in a long waiting line until free state-ensured specialised services are funded and being available. Recently, co-payment systems have been introduces both for civilians and prisoners.

However, even if there is free access to medical services, the quality of medical services remains a matter of concern: Quality of care is a multi-factorial domain determining the level of the quality of provided services. One of the most critical components is staff training and continuing medical education (CME). According to MSUoPD administration, health personnel did not pass any training or other CME events except a few Global Fund, NTP and NGO training courses on HIV/AIDS prevention and TB control. Despite the fact that every 3 years all penitentiary staff should pass certain training at the Law Institute of the MoJ, the curriculum of this training does not contain any medical topics or subjects.

14 Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN Resolution 37/194, 1982; The CPT Standards; The Ethical and Organisational Aspects of Health Care in Prison CoE R (98) 7, 1998; CoE Recommendation Rec (2006)2 on the European Prison Rules2006)2; WMA declarations;

Availability of medical specialists, particularly psychiatrists and clinical psychologists, is another top priority issue raised by all stakeholders, administrations, PDO, NPM and NGOs. Readiness to work in prison environment is lacking, due to negative staff attitude, problems with medical confidentiality, professional independence and other ethical issues and low salaries. All these factors are not encouraging to engage staff in penitentiary health care work. In addition, a series of complex bureaucratic requirements not only inhibits Armenian health care providers from claiming their rights to work under more favourable conditions but prevents them from providing quality medical care to their patients. One result of the lack of effective protection and enforcement of providers' rights in Armenia is that lots of experienced medical professionals opt to leave the country and practice elsewhere, frustrated by their low salaries and suboptimal working conditions as well as by the system's failure to defend them in disputes with patients.

The principle of **equivalence** stands for the same level of health care quality in prison as in the community. This can only be achieved by close cooperation and integration of penitentiary health care with community health care and public health in regard to legal regulations, licensing procedures, supervision and control of minimal requirements of equipment and qualifications, common training and staff recruitment procedures and inclusion of prisoners in national health programmes. Beyond its importance as an ethical principle, equivalence and integration of prison and community health care is an indispensable need for Public Health as clearly stated in the WHO Moscow declaration from 2003 and recently has been reemphasised by the WHO/UNODC publication "Good governance for prison health in the 21st century. A policy brief on the organisation of prison health".

Likewise, patients' consent and medical confidentiality are not only a matter of medical ethics but indispensable professional tools of every medical practice. **Patients' consent** requiring thorough information about any proposed medical intervention (informed consent) is well regulated in Armenian laws as well as the exceptions by necessity, i.e. involuntary treatment of mentally incompetent patients. However, the laws on mandatory treatment of substance dependent, mentally competent patients are in conflict with this concept and should be reconsidered. The assessment team was pleased to hear that forced feeding against the will of a mentally competent hunger striker is no longer practiced.

Medical confidentiality is a matter of concern in penitentiary healthcare in Armenia. In spite of the legally guaranteed right to medical privacy and confidentiality (Art 19 (c) of the Law on Medical Care and Art 145 of the Criminal Code), PDO and NPM report having witnessed police officers staying and waiting in the medical examination room during the medical examination of an inmate on entry until the doctor signs the certificate on traces of injuries of the new inmate. In addition to violation of medical confidentiality this practice is supporting ill-treatment and impunity of ill-treatment. The assessment team also observed that there is some uncertainty of medical staff whether the result of the medical examination on admission is part of the personal file of the inmate or confidential medical file. In Abovyan prison, the inmates' medical files are not stored in the medical unit but in the prison administration office. Although Armenian law provides rules on medical confidentiality in the "Law on Medical Assistance and Care", they reportedly are interpreted as being applicable to licensed medical facilities but not to non-licensed penitentiary health care facilities run by military health care staff.

Regarding general **preventive health care** in prisons, the adverse effects of overcrowding in the Nubarashen prison and the deficient hygienic/sanitary conditions, particularly in the Prison Hospital have been already mentioned above and should be urgently bettered. In regard to targeted preventive health care, the successful preventive efforts in TB control and HIV/AIDS harm reduction measures likewise have been described in the previous chapter on health care provision.

In comparison with TB and HIV activities, less attention is paid to primary and secondary prevention of non-communicable diseases in prison, which creates a huge burden for the health care system in Armenia, particularly diabetes, cardio-vascular and neoplastic diseases. National Health Programs including mass screenings with Pap-testing, diabetes and hypertension screenings have been recently introduced at the community PHC level and should definitely include the prisoner population as well. It is particularly important for marginalised segments of the society who have less access to health care and who can reach these services while in prison, thus posing less health burden to the society at a later stage. As a first step, Pap screening by the gynaecologist in the Abovyan prison could be supported.

Humanitarian assistance of health care professionals relates primarily to vulnerable groups within the prisoner population. Whereas the special needs of juveniles and female prisoners, mother/child prisoners are acknowledged

and taken care of, the needs of physically and mentally disabled prisoners are largely disregarded in terms of material conditions (toilets), mobility support equipment and individual care. Implementation of units with adequate facilities and equipment for disabled prisoners should be envisaged.

The required **professional competence** and professional skills of penitentiary health care staff are largely underestimated by the society and even by medical colleagues not working in the penitentiary. In addition to the challenging working conditions and challenging patients, specialised skills in mental health, infectious diseases and infection control, other pathologies prevailing in prisoners and particularly in medical ethics are indispensable in order to meet the requirements of penitentiary health care. These challenges should be compensated by decent remuneration, regular professional development and training (see chapter thereafter), permission to work medically also outside of the penitentiary system and respect of the prison administration including granting indisputable professional independence.

Human Rights

In the last few decades there has been a promulgation of legislation on human rights which consequently affects the rights of the prisoners in need of health care.

Human Rights and Medical Ethics go hand by hand. They are parallel mechanisms, the Human Rights mechanism working at a socio-political level and the Medical Ethics working more on the doctor-patient relationship. Human rights place a duty on the state and on health care providers to comply with minimum standards. Medical ethics place a duty on individual doctors to comply with parallel standards, namely human morality. Human rights and medical ethics are complementary, and use of the two together maximises the protection available to a vulnerable patient.

In the light of widespread human rights violations and discrimination experienced by prisoners, a human rights perspective is essential for the development and quality of health care services in prison. International human rights legal instruments and monitoring and complaints mechanisms are important means of protection, in particular in prison settings. Conventions relate either directly or indirectly to discrimination, quality of access and care, protection against neglect and abuse and safeguards. They develop common rules and standards and also establish international systems for enforcing those standards, *e.g.* specialised monitoring and complaints mechanisms.[15]

Accordingly, all the principles regarding medical ethics already commented above under the respective title, should also be dealt with from the aspect of human rights. For all the inconsistencies in the domain of access to a doctor, equivalence of care, patient's consent and confidentiality, preventive health care, humanitarian assistance, professional independence and professional competence, a systemic approach should be taken. Inconsistencies and shortcomings found in this assessment report in all these areas fall into the domain of state responsibility, namely Republic of Armenia. The above listed principles are of highest interest for human rights protection in the frames of the healthcare provision system in prison. At this point, the Armenian NPM and other monitoring bodies should take the leading role in undertaking the initiatives to make changes in the legislation in accordance with the existing international human rights standards.

In order not to repeat the findings presented under the topic of Medical Ethics, some points should be stressed to make up a clear picture of what represents violation of human rights in this context.

For instance, the inadequate, severely impaired material conditions in the medical units of visited prisons, as well as in the Yerevan Prison hospital and the Nubarashen Psychiatric Hospital represent violation of human rights that amounts to inhuman and degrading treatment. Apart from the international standards, this human right is provided in the Armenian legislation as well[16].

The low number of medical staff and unsatisfactory presence of the medical staff during the night, could also amount to inhuman and degrading treatment.

Systemic breach of confidentiality during medical examinations in prison (that should be performed out of hearing and out of sight of non-medical prison staff), already described above, should be dealt with as an aspect of human rights as

15 By becoming parties to treaties, states assume obligations to implement the treaties within their jurisdiction and ensure that their policies and practices conform to binding human rights law, and this includes the protection of persons with mental disorders.

16 Law of the Republic of Armenia on medical assistance and service to the population, Art.5 (b)

well, placing the duty on the state to comply with international standards, and also with existing national legislation[17].

Concerning the preventive health care, all the findings in this assessment report on social and preventive health care indicate an urgent need for action from the state for significant improvement. The task of prison health care services should not be limited to treating sick patients. They should also be entrusted with responsibility for social and preventive medicine (*hygiene, transmittable diseases, suicide prevention, and prevention of violence, social and family ties)*[18].

There is an absence of complaint procedure in force and it violates prisoners' human rights. This is yet another example where the Republic of Armenia needs to improve the legislation.

From the aspect of Human rights, it is of utmost importance to have healthcare services independent from the prison system. This is a prerequisite for consistent respect of the right to access to health care, as well as for the equivalence of care, the medical confidentiality etc.

Prisoners should be entitled to the same level of medical care as persons living in the community at large. This principle is inherent in the individual's fundamental rights.

Right to healthcare is a fundamental human right. "Law of the Republic of Armenia on medical assistance and service to the population" provides it unequivocally[19]. Accordingly, if the principle of equivalence of healthcare is observed, the right to healthcare of the general population should be undoubtedly applied to prisons/prisoners as well. The findings of the assessment team indicate violations of this fundamental human right. The state should provide the conditions for consistent implementation of the principles for protection of this fundamental human right.

During the assessment visit many national stakeholders – the representatives of the MoJ, PD and MSUoPD, as well as the managers of the visited establishments – pointed out that the lack of financial resources represents the main reason for the unsatisfactory situation of the penitentiary health care. It is important to stress once again one of the basic human rights principles: Prison conditions that infringe prisoners' human rights are not justified by lack of resources[20].

Recommendations:

- ★ Re-structure the penitentiary health care administration and legal provisions in such a way that indisputable professional medical independence of health care workers is guaranteed and respected by non-medical staff of the penitentiary administration;
- ★ Re-inform the prison governments and prison administrations that the sole task of health care professionals in prison is health and well-being of prisoners and that health care professionals must not be involved in medical activities that do not serve this purpose;
- ★ Entitle prisoners to the same level of medical care as persons living in the community at large;
- ★ In addition to the presence of a general practitioner and a dentist in each prison, the availability of a psychiatrist and clinical psychologist as well as other medical specialists if needed should be organised on a regular basis;
- ★ Informal or official co-payment demands from destitute prisoners for needed secondary health care services contradict the principle of free access to health care and must be abolished;
- ★ Undertake every effort to achieve progressive cooperation and integration of penitentiary health care with community health care;
- ★ Reconsider the appropriateness of the laws on compulsory treatment of substance dependency;
- ★ Stop the practice of police officers or other security staff being present at medical examinations and consultations if not expressly demanded by the health care professionals for their own security;
- ★ Keep all patient-related medical information strictly confidential in the medical file and do not allow access to patient-related medical information to non-medical staff;

17 Law of the Republic of Armenia on medical assistance and service to the population, Art.5 (c)
18 CPT/Inf/E (2002) 1 - Rev. 2015 English, Extract from the 3rdGeneral Report [CPT/Inf (93) 12]pp. 38 – 48*;*
19 Law of the Republic of Armenia on medical assistance and service to the population, Art.4
20 Recommendation Rec (2006) 2 of the Committee of Ministers to member states on the European Prison Rules, Appendix, Part I (4)

- ★ Include the prisoner population in Government sponsored National Health Programs;
- ★ Envisage prison units with adequate facilities and equipment for disabled prisoners;
- ★ Support professional competence of health care professionals by defining qualification of competence, regular training and professional development, permission to work also outside of the penitentiary system and granting indisputable professional independence;
- ★ Implement health care complaint procedures to be directed to a state body independent from the Penitentiary Department;

Part IV: Professional development

Training

During the assessment visit, numerous training needs for the medical staff employed in the penitentiary system were recognised and identified by the officials of the Ministry of Justice, the management of the Penitentiary Department, the management of the Medical Services Unit of the Penitentiary Department, as well as by the medical staff of all establishments visited. Likewise, such opinion was supported at the meetings held with several other institutions and organisations, such as, the National Institute of Health, the Law Institute, the Armenian NPM, the WHO office in Armenia, as well as several NGOs met during the visit. It came as a surprise that the Law Institute in charge of the training of penitentiary staff and also of the penitentiary health care staff for 6 years, presented few, if any, suggestions in regard to training of penitentiary health professionals, let alone having training curricula in this regard.

Generally, it was clearly stressed that medical staff employed in prisons, apart from the professional knowledge and skills, need to be additionally and adequately educated and trained in other areas of interest that are closely linked to and necessary for the fulfillment of the demands in everyday working activities with prisoners. In order to adequately face the challenges imposed by the current trends in the field of health care in prison, necessity also arises for more in-depth education and training regarding some growing problems that affect the prison population at present.

For instance, according to the NIH study in 2011 on injection drug use, there were 5,327 registered users in the country, but the estimated real number was 12,700 people. This study shows the importance of an education about the drug use problems and treatment in prison, education and training on drug supply reduction, demand and harm reduction. Methadone programmes have been introduced in Armenia in 2009 and in the penitentiary system in 2011, the current number of prisoners on Methadone maintenance is 143. This reportedly had a very positive influence on supply and demand reduction and drug use in the prisons and positively affected the general health of the prison population. The NIH also informed about the anti-HIV/AIDS project, and the needle provision in its frames carried out in a few prisons. However, for all these issues it was clearly stated that they do not function on a satisfactory level, and that there is a crying need for education and training.

In many other discussions during the assessment visit it was stressed by national authorities, individuals and organisations that a clear policy for administration of Methadone in prisons does not exist. This is another reason to devote part of the training courses to Methadone detoxification and maintenance issues.

Another burning issue identified by the administration of penitentiary services was management of mental health problems. So far, there hasn't been any formal training with regard to mental health issues, and obviously there is a growing need for that.

In the Yerevan Prison Hospital we heard that group psychotherapy of drug addiction is not successful in the country, based on the opinion that there is a common mentality to hide personal addiction problems. It would be good to initiate anti-stigma training for prison healthcare and non-healthcare staff, together with anti-stigma public campaigns and awareness raising regarding mental health problems.

The management of the Medical Services Unit of the Penitentiary Department informed that they signed a training memorandum with the Yerevan State University and they are going to start organised training for the prison doctors. Furthermore, doctors will be sent for education and training abroad. However, the envisaged training is more of strictly professional medical nature. This is definitely needed as witnessed by the assessment team when a GP in Nubarashen

prison expressed his wish for a ECG machine with automatic diagnostic software because he once was able to read ECG but at the moment was completely out of training. Mandatory continuous medical education (CME) for primary healthcare professionals is envisaged for every 5 years, but it is still not in force. A positive step forward represents the application of this provision to prison doctors as well, although the penitentiary healthcare institutions are not under the official licensing provision.

Education and training from the field of Medical Ethics and Human Rights are of utmost importance for the adequate functioning of the health care services in prison. It is necessary for the health care staff to be absolutely aware of their role in the frame of the penitentiary system in order to provide the best possible service to its users – the prisoners in need of health care. The crucial point should be awareness of the necessity for absolute independence from the prison authorities regarding healthcare issues. In this respect, clear boundaries should be defined regarding the mandate of the health care services/health care professionals in order to protect their independent functioning.

It is a welcoming fact that a big number of the recommendations given by the Council of Europe consultants with regard to the training of medical and non-medical staff in prison, corresponded with the suggestions of national bodies and organisations.

The subjects of the future training will be decided based on the assessment report and its findings and recommendations. However, taking into consideration all main elements of the report and given the resources allocated for the medical units in the targeted prisons, the training needs should be very high, if not highest in the list of priorities. The acquisition of "human rights" attitude and human rights awareness, namely change of the mentality with regard to prison healthcare and treatment of prisoners in general, is the most certain basis for the necessary changes in the legislation and consequently, the conditions in the prisons and provision of quality health care, equivalent to the one provided in the public sector.

The following topics should be included in the curricula of future training:

Training for mental health issues for the general practitioners working in prison parallel with same training for the primary healthcare practitioners from the civil sector.

Identification of mental disorders at admission and during detention by medical and non-medical staff as an important part of suicide prevention

Suicide prevention and self-harm for the healthcare and non-healthcare staff

Training for management of infectious diseases

Training for management of vulnerable groups in prison

Training for case management

Training for community alternatives to institutional treatment of mental disorders

Training in Medical Ethics, Human Rights and international standards

Health promotion and Disease Prevention in Prison

Training for drug addiction and drug related health problems, in general and in prison.

Training for stress management

Training on medical examination on admission

Training for proper medical documentation in prison, ICD coding

Violence prevention and Istanbul protocol

Emergency interventions in prison

Aftercare and preparation for release

Recommendations:

- ★ Develop curricula and syllabus on health care, prevention and health promotion for penitentiary healthcare staff and non-medical staff in cooperation with NIH, Medical University and International Organisations;
- ★ Implement cascade training (starting with training of selected trainers) and evaluate efficiency of training by professional evaluation tools;
- ★ Include penitentiary health care staff in the same MoH qualification control and CME requirements as in the civil sector.

Part V: Alternative models of penitentiary health care governance

The CoE assessment team was repeatedly asked by many stakeholders met during the visit to propose alternative models of penitentiary health care structures because of apparent weaknesses of the current structures. The fact that the goal of health care providers in prison, i.e. health of inmates, is completely different from the goals of the security staff and the prison administration, i.e. safety, security, deprivation of liberty and execution of the sentence, explains why this question is currently asked in many countries of Europe. WHO, UNODC and CoE provide an excellent guidance for approaching this question.[21]

At present, penitentiary health care is managed exclusively by the Medical Services Unit of the Penitentiary Department and is accountable exclusively to the Head of the Penitentiary Department who is directly appointed by the President of the Republic of Armenia. However, as far as the parliamentary scrutiny is concerned, the Minister of Justice is the one who appears before the parliament to answer the deputies' questions. Apart from the established national and international penitentiary control mechanisms, i.e. PDO, NPM and CPT, there is no professional health care supervision and support from outside penitentiary system. This implicates the following weaknesses of the present system:

- ★ Penitentiary health care is completely separated from Public Health and community health care structures, although, according to international consensus, "Prison health is part of public health" (WHO Declaration of Moscow 2003);
- ★ This separation precludes the use of common resources, infrastructure, personnel, expertise, training facilities, administration, management, documentation and planning of both community and penitentiary healthcare;
- ★ The separation is also a barrier for inclusion of prisoners in national public health initiatives and for uninterrupted care of prisoners after release from prison;
- ★ Health professionals in prison, particularly military health personnel who are not permitted to medically work outside the penitentiary system, are isolated from the medical professional community and do not benefit from professional experience outside the prison walls and continuing medical education as provided for and required from health care professionals in the community;
- ★ Penitentiary health care professionals, particularly military personnel, face the ethical dilemma of dual loyalty in this structure on a daily basis, i.e. the clinical role conflict between professional duties to their patients and obligations to their non-medical superiors in the penitentiary hierarchy; non-medical superiors can and do misuse their responsibility of supervision by interfering in medical issues. Indeed, the large majority of health professionals met during the visit complained about the lack of professional independence and, as a consequence, lack of prisoners' trust and confidence in the prison health care staff;
- ★ These unpleasant working conditions (in combination with other adverse factors) lead to frustration of penitentiary health care personnel, difficulties in recruitment of health care professionals for the penitentiary system, vacancies and work overload for the rest of the staff.

There are only a few, but very successful examples of fruitful collaboration of Public Health services and the penitentiary system, i.e. trans-mural cooperative endeavors in fighting TB and HIV epidemics as initiated by international agencies including WHO, ICRC, and Global Fund. Lessons learned from these positive experiences should lead to expansion

21 Good governance for prison health in the 21st century. A policy brief on the organization of prison health in the 21st century. WHO and UNODC 2013; Strasbourg Conclusions on Prisons and Health, WHO and CoE 2014

into other areas of prison health care by considering penitentiary health care governance that avoids the weaknesses as quoted above.

Lessons can also be learned from those countries that initiated careful and stepwise integration of prison health care governance from the penitentiary authorities towards health authorities many years ago and have succeeded in this process completely or partially including the UK, Norway, France, Spain, Italy and some Swiss cantons[22][23][24][25][26]. Other countries such as Georgia, Moldova and Azerbaijan, succeeded in making smaller steps in direction of greater independence of health care services from their penitentiary directories.

For Armenia, according to the opinion of the assessment team, as a first step, penitentiary health care services should be taken out from the governance of the penitentiary department and subordinated to a government body under direct scrutiny of the parliament such as the MoJ.

Next, intensive cooperation with the public health authorities MoH, NIH and their agencies National Health Agency, State Health Inspectorate and Health Implementation Unit should, by using their innovative expertise, enable as much as possible cooperation in planning of usage of common resources, regulatory provisions, professional supervision, licensing, medical data documentation, documentation based budgeting, professional development and training of primary health care services at an equivalent level in the community and in the penitentiary system. (It is the opinion of the assessment team that secondary level health care services, particularly major surgery, should be provided in civilian facilities for reasons given above). In order to reach these goals, an inter-ministerial working MoJ/MoH commission with a thoroughly designed long-term action plan should be set up.

After the delineated goals have been achieved, analysis of the results will provide the basis for decisions whether to stay at the achieved level or whether to move on for full integration of penitentiary health care into public health care.

Part VI: Summary of recommendations and proposals

Strive for legal amendments that ensure

- ★ Bringing medical services of correctional institutions under direct subordination of the Ministry of Justice and possibly thereafter under the Ministry of Health;
- ★ Within the time period of preparing the necessary basis for these transfers, consider establishment of an internal complaints mechanism outside the penitentiary, to ensure the impartiality of a body which adjudicates the complaints against the penitentiary employees;
- ★ professional medical independence of health care professionals in the penitentiary system; In case the prison administration decides against a doctor's decision/recommendation, this must be grounded and, according to European Prison Rule 45.2, forwarded to the superior administration in the MoJ; to gradually transform the military health care staff into professionally independent civilian medical staff;
- ★ clear the inconsistency between the Criminal Procedure Code and the Penitentiary Code in regard to early conditional release on ground of the convict's medical condition by giving the convict the right to directly apply to the court and seek his/her release ;
- ★ a comprehensive regulation on keeping patient related medical information confidential;
- ★ assigning sanitary-hygienic supervision and supervision/licensing of health care units in prisons to the state inspection of the Ministry of Health;

22 Iversen JH. Helsedirektoratet [Health Directorate]: prison health reform in Norway. http://www2.ndphs.org/?mtgs,prison_health_public_health.

23 Prison Health and Public Health: The Integration of Prison Health Services. Report from a conference organised by the Department of Health and the International Centre for Prison Studies, London, UK, 2004. International Centre for Prison Studies, King's College London—School of Law; 2004. http://www.kcl.ac.uk/depsta/law/research/icps/downloads/health_service_integration.pdf.

24 Hayton P, Boyington J. Prisons and health reforms in England and Wales.Am J Public Health. 2006;96(10):1730–1733 [PMC free article] [PubMed]

25 Hayton P, Gatherer A, Fraser A. Patient or Prisoner: Does It Matter Which Ministry Is Responsible for the Health of Prisoners? Copenhagen, Denmark: World Health Organization, Regional Office for Europe; 2010

26 Elger BS: Prison medicine, public health policy and ethics: the Geneva experience, Swiss Med Wkly. 2011;141:w13273

- ★ abolishing regulations that inhibit the recruitment of health care personnel in prison and attracting medical personnel to the health care services in the penitentiary system;
- ★ thorough medical examination after every instance of using force by state agents;
- ★ that an independent expert's documentation on body (and/or psychological) injuries must have the same evidentiary value as the investigator's appointed expert's findings;
- ★ abolishing laws with discriminating regulations;
- ★ introduction of independent medical experts whose conclusions will be considered in court when reaching a verdict about precautionary measures for citizens with serious diseases;
- ★ Amendment of the legislative system in regard to penitentiary health care in order to bring it to the same regulatory and professional level as community health services. In particular, providing the same professional supervision mechanisms such as licensing requirements, quality control, medical documentation and reporting obligations for health care professionals in prison as in the community. Provide precise definitions of patients' and doctors' complaint procedures. Anchor indisputable medical professional independence and confidentiality as well as the other principles of medical ethics in the Penitentiary Code.
- ★ Rearrange the organisation and management structures of penitentiary health care in line with the recent innovative developments in Public Healthcare in the community by taking up the efforts and expertise of the MoH agencies, i.e. National Healthcare Agency, State Health Inspectorate, NIH, and Health Implementation Unit (HPIU) in a collaborative endeavour. Most importantly, the prison health care services need to be taken out from the subordination to the Penitentiary Department in order to provide professional medical independence. Professional supervision is to be implemented by professional health authorities such as agencies of the MoH.
- ★ Provide adequate incentives for medical professionals working in prisons in order to improve recruitment.
- ★ Integrate penitentiary health staff in the same qualification and ongoing training requirements (CME crediting) as for health care staff in the community.
- ★ Renovate and reconstruct those PHC units with deficient material conditions as far as the general building conditions allow and close prisons where this is any longer possible..
- ★ Take over the list of minimal requirements of equipment for PHC in order to be licensed as PHC unit from the MoH.
- ★ Define a special budget for ad hoc and ongoing supplementation of equipment for PHC and procure equipment in cooperation with MoH agencies.
- ★ Install a regular independent supervision mechanism by authorised communal health agencies for quality control of PHC equipment in prisons.
- ★ Close the prison hospital; see for specialised secondary health care provision, particularly major surgical interventions also of male prisoners in civil health care facilities by implementing secured ward units for prisoner patients in these institutions ; consider translocation of other secondary health care departments to newly constructed facilities with material conditions appropriate to hospital care.
- ★ Update the list of essential medication for prisoners completely in line with the MoH regulations.
- ★ Base procurement of medication upon regularly collected ICD-10 and medication consumption statistics and involve MoH expertise in the procurement procedure.
- ★ See for adequate storage of medication and use of professional pharmaceutic management of medication – if not present in prison by outside pharmaceutic services.
- ★ Provide adequate incentives for medical professionals working in prisons in order to improve recruitment of physicians;
- ★ All physicians involved in primary health care should have the qualification of a GP;
- ★ All prisons should have regular access to a psychiatrist's service;
- ★ Health care professionals should not wear military uniform when providing health care;
- ★ Introduce ICD coding into the medical file; keep regular nosological statistics in order to adequately plan health care budgets, medical resources, supplies and needed capacities on a national and institutional level;

- ★ Keep periodic injury statistics;
- ★ Provide secondary health care also for males in secured wards of civilian hospitals; reduce stays in civilian hospitals by organising pre- and postoperative care in prisons; organise specialist policlinics in prison;
- ★ Mentally disturbed prisoners who require inpatient psychiatric treatment should be promptly transferred to appropriate hospital facilities. The severely mentally disturbed prisoners should not be placed in in-patient units of the prisons, but in appropriate psychiatric facilities which are adequately equipped and possess appropriately trained staff.
- ★ Intensify psychiatric and clinical-psychological services in the penitentiary system; increase the number of psychiatrists working in prisons; consider engaging clinical psychologists as well as social workers independent from the security staff as part of the caring team;
- ★ The prisoners with less severe and non-psychotic mental health problems who do not seek inpatient psychiatric treatment, but only occasional or continuous pharmacological or psychotherapeutic support, should benefit from provision of mental health services equal to those provided in the community. Psychiatric follow up should be provided on a weekly basis for every such prisoner, and psychologists and social workers should also be included in the caring team, to carry out consultations and psychotherapy.
- ★ Improve the living conditions and treatment options in the forensic part of Nubarashen Psychiatric Hospital (see the recommendations in Chapter III – Medical service provision assessment)
- ★ Implement inter-professional suicide prevention programmes in each penitentiary facility;
- ★ Implement modern, evidenc-based treatment approaches to substance dependent patients;
- ★ Expand methadone maintenance treatment (MMT) to all inmates for who it is medically indicated and abolish police presence and influence in decision-making bodies on MMT as this is medical treatment and is to be decided exclusively by medical professionals;
- ★ Consider translocation of penitentiary TB treatment units to newly constructed facilities with proper material conditions;
- ★ Introduce a rapid TB/DST testing system (XpertTB/RIF) to the central penitentiary TB laboratory;
- ★ Complete HIV/AIDS, blood-borne hepatitis prevention and harm reduction strategies in accordance with international recommendations;
- ★ Gather data on the prevalence of blood borne hepatitis B and C in prisons;
- ★ Re-structure the penitentiary health care administration and legal provisions in such a way that indisputable professional medical independence of health care workers is guaranteed and respected by non-medical staff of the penitentiary administration;
- ★ Re-inform prison governments and prison administrations that the sole task of health care professionals in prison is health and well-being of prisoners and that health care professionals must not be involved in medical activities that do not serve this purpose;
- ★ In addition to the presence of a general practitioner and a dentist in each prison, the availability of a psychiatrist and clinical psychologist as well as other medical specialists if needed should be organised on a regular basis;
- ★ Informal or official co-payment demands from destitute prisoners for needed secondary health care services contradict the principle of free access to health care and must be abolished;
- ★ Undertake every effort to achieve progressive cooperation and integration of penitentiary health care with community health care;
- ★ Reconsider the appropriateness of the laws on compulsory treatment of substance dependency;
- ★ Stop the practice of police officers or other security staff being present at medical examinations and consultations if not expressively demanded by health care professionals for their own security;
- ★ Keep all patient-related medical information strictly confidential in the medical file and do not allow access to patient-related medical information to non-medical staff;
- ★ Include the prisoner population in Government sponsored National Health Programs;

- ★ Envisage prison units with adequate facilities and equipment for disabled prisoners;
- ★ Support professional competence of health care professionals by defining qualification of competence, regular training and professional development, permission to work also outside of the penitentiary system and granting indisputable professional independence.
- ★ Develop curricula and syllabus on health care, prevention and health promotion for penitentiary health care staff and non-medical staff in cooperation with NIH, Medical University and International Organisations;
- ★ Implement cascade training (starting with training of selected trainers) and evaluate efficiency of training by professional evaluation tools;
- ★ Include penitentiary health care staff in the same MoH qualification control and CME requirements as in the civil sector;

ANNEX 1: Agenda of the Assessment Visit.

"Strengthening Health Care and Human Rights Protection in Prisons in Armenia" Project

ASSESSMENT MISSION

Agenda
29 June – 3 July, 2015

Introductory meetings

Day 1, 29 June

09.30 – 10.30 Opening of mission: team meeting and exchange

11.00 – 12.00 Mr Suren Krmoyan, Deputy Minister of Justice

14.00 – 15.00 Mr Arsen Hambartsumyan and Mr Ara Hovhannisyan, Penitentiary unit, Medical Services unit

16.00 – 17.00 Mr Suren Nazinyan, Head of Monitoring Center on Drugs and Addictions of the National Institute of Health of the MoH

17.30 – 18.30 Mrs Genya Petrosyan, Deputy of the Human Rights Defender, Ms Asya Sargizova and Mr Vladimir Hovhannisyan (NPM)

Prison visits

Day 2, 30 June

10.00 – 16.30 Sight visits to Kentron and Nubarashen penitentiaries

17.00 – 18.00 Mr David Amiryan, Deputy Director (OSIAF)

Day 3, 1 July

09.30 – 10.30 Mr Ashot Hayrapetyan, Director of Law Institute of Ministry of Justice

10.30 – 16.00 Sight visits to Abovyan and Armavir penitentiaries

Day 4, 2 July

08.00 – 19.00 Sight visits to Vanadzor and Sevan penitentiaries and to Prison Hospital

Final meetings and round up

Day 5, 3 July

10.00 – 10.30 Mr Tatul Hakobyan, WHO

12.00 – 13.30 Mr Samvel Torosyan, Head of Nubarashen psychiatric hospital

14.00 – 15.30 Meeting with civil society and public monitoring group:

1. Mr Arshak Gasparyan (Social Justice NGO),
2. Mr Mikayel Aramyan and Mrs Kristina Gevorgyan (Foundation Against the Violation of Law NGO),
3. Ms Haykuhi Harutyunyan and Ms Hasmik Harutyunyan (Protection of Rights Without Borders NGO),
4. Mr Arman Danielyan (Civil Society Institute NGO),
5. Mr Ruben Sargsyan (President of Public monitoring group),
6. Mr ArturSakunts (Chairman of Helsinki Citizens' Assembly Vanadzor office),
7. Mr Avetik Ishkhanyan (Chairman of Helsinki Committee of Armenia),
8. Mr Robert Revazyan (member of public monitoring group and lawyer at Helsinki Committee of Armenia)

15.30 – 17.00 Closing of mission: team meeting and exchange

ANNEX 2: Documents

UN Documents

- ★ International Convenant on Civil and Political Rights
- ★ International Convenant on Economic, Social and Cultural Rights
- ★ Standard Minimum Rules for Treatment of Prisoners, 1955
- ★ Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians for the Protection of Detained Persons and Prisoners Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1982
- ★ Body of Principles for the Protection of Persons under Any Form of Detention or Imprisonment, 1989
- ★ Rules for the Protection of Juveniles Deprived of their Liberty. 1990

Council of Europe Documents

- ★ European Convention on Human Rights
- ★ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine 1997 ('European Convention on Human Rights and Biomedicine')
- ★ European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
- ★ European Social Charter 1961 and 1996
- ★ Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and Related Health Problems in Prison. R (93) 6
- ★ Ethical and Organisational Aspects of Health Care in Prison. R (98) 7, 1998.
- ★ The CPT standards CPT/Inf/E(2002) 1-Rev 2010
- ★ Recommendation Rec (2006)2 on the European Prison Rules
- ★ Prison health and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being. A. Lehmets, J. Pont, Council of Europe
- ★ Report of a Council of Europe expert visit to evaluate the prison health services in Armenia May 2000 (The Arpo/Ekeid Report)
- ★ Factors contributing to offending and re-offending in Armenia, Yerevan 2014. Civil Society Institute and Protection of Rights without Borders, supported by the Norwegian Foreign Ministry and the Council of Europe.
- ★ "Effective investigation of ill-treatment". Svanidze E, Guidelines on European Standards 2014
- ★ The handling of complaints about Ill-treatment in the penitentiary system of the Republic of Armenia, December 2013, report by Gerard de Jonge within the Reinforcing the Fight Against Ill-treatment and Impunity Council of Europe and European Union Joint Programme
- ★ CPT reports: CPT/Inf (2010)7, (2010)8, (2011)24, (2011)25, (2012)23, (2012)24, (2015)8, (2015)9, (2015)10, (2015)11
- ★ Report on the training seminar for medical personnel of penitentiary institutions on Effective Documentation of Ill-treatment (Within the Joint Programme between the European Union and the Council of Europe "Reinforcing the fight against ill-treatment and impunity"), Jörg Pont

European Union documents

- ★ Implementation of Armenia's international commitments on torture prevention in penitentiary institutions. European Union Advisory Group to the Republic of Armenia, Policy Paper, Dalia Zukauskiene, 2012

WHO

- ★ Prisons and Health. Stefan Enggist, Lars Møller, GaudenGalea and Caroline Udesen (eds), WHO 2014
- ★ Good governance for prison health in the 21st century. A policy brief on the organisation of prison health. WHO and UNODC, 2013

World Medical Association

- ★ Declaration of Geneva, 1948
- ★ Declaration of Tokyo. Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment. Tokyo 1975, revised Divonee-les-Bains 2005
- ★ Declaration on Hunger Strikers.Malta1991, revised Marbella 1992. Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading treatment, Hamburg 1997.
- ★ Declaration on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases. Edinburgh 2000.
- ★ Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of Which They Are Aware. Helsinki 2003.

OSCE Documents

- ★ Creating a probation service in the Republic of Armenia: Issues and peculiarities. NGO Social Justice
- ★ Penitentiary System of the Ministry Of Justice of the Republic of Armenia. Report of Group of Public Observers Conducting Public Monitoring of Penitentiary Institutions and Bodies of the Ministry of Justice of the Republic Of Armenia, 2008

Armenian Documents

- ★ Criminal Procedure Code of the Republic of Armenia
- ★ Penitentiary Code of the Republic Of Armenia, 2004
- ★ Decree of the Minister of Justice on approving the regulation on organising social and psychological services with detainees and prisoners at Penitentiary Service
- ★ Law on Drugs 1998
- ★ Law on medical assistance and service to the population, 1996
- ★ Law on Narcotic Drugs and Psychotropic Substances
- ★ Law on penitentiary service 2005
- ★ Law on amending and supplementing the law on penitentiary service 2009
- ★ Law on legal status of the penitentiary service of the republic of Armenia
- ★ Law on treatment of arrestees and detainees, 2002
- ★ List of essential medicines of the Republic of Armenia
- ★ Decision on establishing the rules of traffic in narcotic drugs and psychotropic substances and their precursors, 2010
- ★ Legal regulation on sport and penitentiary institutions

Other documents

- ★ The right of persons with mental disorders to liberty, a fair trial and private life in the Armenian law and practice, Yerevan 2014. Civil Society Institute funded by the Norwegian Helsinki Committee, Yerevan 2014

ANNEX 3: Proposals for amendments of laws as elaborated by Roza Babayan and Davit Khachaturyan,

1. LAW OF THE REPUBLIC OF ARMENIA ON TREATMENT OF ARRESTEES AND DETAINEES (Adopted on February 6, 2002)

    1.1. Supplement Article 5 (Use of Correctional Facilities for Keeping Persons under Arrest or Detention) with Para 3 to stipulate as follows:

    "The facility head is obliged to follow a doctor's conclusion unless there is an alternative medical conclusion to the contrary".

    1.2. Amend Para 2 of Article 20 (Living Conditions for Arrestees and Detainees) to stipulate as follows:

    "The maximum number of arrestees and detainees in one cell shall not exceed 6 (or N number) persons."

    1.3. Amend Para 4, Article 21 (Medical-Sanitary Aid to Arrestees and Detainees and their Personal Hygiene, and documentation of their health status) to stipulate as follows:

    "Arrestees and detainees needing specialised medical aid shall be transferred to a specialised or a civilian medical institution. The procedures for rendering medical, including psychological, aid to arrestees and detainees, their stay in medical institutions, as well as the involvement of employees of such institutions in medical services shall be set by the public administration body authorised in the health sphere (the Ministry of Health)."

    1.4. Amend Para 5 of Article 21 to state as follows:

    "If any bodily injury or a trace of psychological violence is detected on arrestees or detainees, the medical personnel of place of arrest or detention shall examine the arrestee or detainee immediately, to which the doctor invited by an arrestee or a detainee may participate. The medical examination shall be conducted outside vision or hearing of the administration of the facility of keeping the arrestees or detainees, unless the opposite would be required by the doctor for the sake of his or her own security. The results of this medical examination shall be recorded in the personal file in accordance with specific procedures and reported to the patient. Based on the results of this medical examination, the administration of the facility shall promptly but no later than within 24 hours appoint forensic or psychological expertise, and at the same time inform the body conducting the criminal proceedings. Besides, the legal representative of the arrestee or detainee shall be authorised to apply to the forensic institution or to a forensic expert or an expert psychologist to conduct forensic or psychological examination in a manner prescribed for under the Criminal Procedure Code. All the state officials and public bodies, as well as specialists mentioned in this paragraph shall take all the necessary measures to secure integrity of the initial data as possible material evidence. Colour photos shall be used, for better reflection of the depth and width of the injuries, and all the medical documentation should not be in hand-writing but by filling in electronic cards.

    The medical examinations mentioned above should be conducted at first entry and afterwards each time when leaving the institution (temporarily or for good) and coming back regardless of the fact of visible absence or presence of bodily injuries or complaints of the arrestee or the detainee.

    The doctors working in a facility where the arrestees or detainees are kept can never be tasked with an assignment to certify the arrestee's or detainee's fitness for investigative or coercive measures. This requirement shall not prevent doctors from obligation to certify unfitness of the arrestee's or detainee's fitness for investigative or coercive measures."

2. CRIMINAL PROCEDURE CODE (1998)

    2.1. Eliminate Para 3 of Article 114, which states that:

    "3. The protocol of {the trial} questioning of an expert cannot substitute the conclusion of an expert."

    2.2. Amend the first sentence of Article 243 (Grounds for appointing and implementation of expert examination) to state as follows:

"Expert examination is implemented based on the decree of the body conducting the investigation, the investigator, the prosecutor, as well as application from the suspect, the accused, the defense counsel, the representative of a victim, or the administration of the facility of keeping the arrestees or detainees when the knowledge of science, technology, arts or crafts, including the knowledge of specialised examination methods, is necessary to reveal circumstances relevant to the criminal case, or to secure possible material evidence. …"

The justification of this proposal has been brought above in relation with changes proposed in Article 21, Para 5 of the RA Law on Treatment of Detainees and Arrestees.

2.3. Remove the provision of Para 1 of Article 432 of the CPC which enables the administration of penitentiary institution -- and not the convict -- with the authority to apply to the court for early release (in the same way as provided under current edition of Para 7 of Article 113 of the Penitentiary Code, see below).

3. LAW ON MEDICAL ASSISTANCE AND SERVICE

3.1. Amend Article 16 (Providing medical assistance and service without a person's consent) to state as follows:

"It shall be allowed to provide medical assistance and service without a person's or his or her legal representative's consent in case of a threat to the person's life, as well as in case of the diseases which pose a danger for the wider public, in the manner prescribed by the legislation of the Republic of Armenia. However, such interference should provide effective safeguards against arbitrariness and ill-treatment."

4. PENITENTIARY CODE

4.1. Amend Article 54 (Provision of material conditions and medical and sanitary care for the convict) to stipulate as follows:

"1. Material conditions and medical and sanitary care of the convict shall be provided in accordance with the standards prescribed by the public administration body authorised in the health sphere (the Ministry of Health).

2. The convict shall be provided with sanitation, hygiene, and anti-epidemiological conditions necessary for protection of health, in accordance with the standards prescribed by the public administration body authorised in the health sphere (the Ministry of Health).

3. Convicts who need inpatient treatment shall be transported, under convoy, to health care institutions defined by the public administration body authorised in the health sphere (the Ministry of Health). Convicts shall be guarded as prescribed by the authorised public administration body (the Ministry if Health)."

4.2. Amend Para 1(8) of Article 68, to state as follows:

"In correctional institutions, the following convicts shall be held separately:… 8) Separation of persons sentenced to a certain term imprisonment and persons sentenced to life imprisonment shall be done only in cases where life prisoner is disciplined for a malicious breach of the procedure for serving the sentence."

4.3. To amend Para 4 of Article 79 (Procedure and conditions for movement outside the correctional institution without convoy or escort) to state as follows:

"It shall not be permitted to take the convicts out of the boundaries of the correctional institution or the detention facility without convoy or escort in cases of particularly dangerous or dangerous recidivism, or for persons sentenced to life imprisonment. Convicts with contagious and parasitic disease dangerous for the surroundings, or those who suffer bacillary tuberculosis, or alcoholism or drug addiction, or have not completed treatment of their sexually-transmitted disease or other contagious or parasitic diseases, which are dangerous for the surrounding, or convicts who are HIV positive, or are present during anti-epidemiological activities carried out in the correctional institution, may be taken out of the boundaries of the correctional institution or the detention facility without convoy or escort if the doctor, psychiatrist, or relevant specialist have given an opinion stating that the convicts in question are not dangerous to the society or themselves, or if such danger is eliminated by means of accompanying them, which should be compensated

by the convict."

4.4. Amend Para 1 of Article 83 (Medical and sanitary care of the convict) to stipulate as follows:

"1. Medical and sanitary care and medical and prophylactic aid for the convict shall be organised in accordance with the healthcare legislation of the Republic of Armenia and as a licensed activity shall conform to all the quantitative and qualitative standards of healthcare services."

4.5. Amend Para 7 of Article 113 (Procedure for releasing from sentence) to stipulate as follows:

"The motion on releasing from the remaining part of the sentence due to mental or other serious disease shall be filed with the court in a manner prescribed by the Criminal Procedure Code".

5. BYLAWS

5.1. Supplement Clause 10 of the RA Government Decision N-860-N (2014) to stress out the following obligations of the forensic experts:

"3. The forensic experts shall be obliged to mention the way the bodily injury has been inflicted, as well as in case of refuting the suggested way of infliction to provide the description of possible injuries which would be caused in that way of infliction, and cases when the person undergoing examination alleges suffering bodily injuries or if those actually exist – to provide explanation on confirmation or refusal of existence of such injuries."

5.2. Amend Decision N-860-N with Chapter "On Procedure of establishment of procedure of evaluation and registration of traces of psychological violence."

5.3. Amend Clause 7 of the RA Government Decision N-825-N (2006) to stress as follows:

"The medical confidentiality shall be guaranteed and protected by the medical personnel. The nature of data constituting medical confidentiality, as well as mechanisms of its preservation and legitimate restriction shall be specified by law."

Taking into account that the human, material and financial resources of the medical unit of the correctional institutions are under supervision of penal system, the normative legal tracking of the order of the treatment and the evaluation of the treatment quality are also under the supervision of the penal system.

Taking into consideration the so-called "dual loyalty", that is the necessity to protect the interests of the governing body of the institution and the correctional system bodies with prejudice to the interests of the detained patients, as well as possible manipulation of the disease and the refusal to provide with the medication in order to produce certain impact we suggest the following legislative initiatives:

5.4. To change the structure of the RA Ministry of Justice which is defined by "B" sub-point of the 2nd point of the RA Government Decision N1917-N made on 28 November, 2002 on "Creating 'The staff of the Ministry of Justice of RA' public administration institution, affirming the legislation and the structure of the staff of the Ministry of Justice" and create a separate subdivision of medical aid and service.

The amendment will ensure the independence of medical services and medical assistance provided to the Penitentiary institutions by removing its structural unit from the Penitentiary Department and transferring it directly to the Minister of Justice as a separate unit.

5.5. Taking into account the above-mentioned, make changes in the following legal acts:

5.5.1. To the RA Government Decision N 1256-N adopted on 24 August, 2006, particularly recognise F sub-point of the 12th point as repealed – "12. The main functions of the department are … f) to take measures to organise the medical-sanitary and preventive care of arrestees and detainees, to ensure the possibility for them to benefit from the health services and given this purpose to initiate activities driven to the involvement of the medical staff in them";

These changes are aimed for removal of the medical services and assistance function from the statutory functions of the Penitentiary Department. The change is directly related to the transfer of the medical services to the Ministry of Justice (this is the first step, afterwards the Ministry of Justice will consider the possibility of moving this function to the Ministry of Health).

5.5.2. To some points of the RA Government Decision N 825-N on "The procedure of organisation of sanitary and preventive medical care for the arrestees and detainees, as well as the involvement of the medical personnel within this purpose" in order to take the medical units out of the supervision of the correctional department and hand them over to direct supervision of the Ministry of Justice (1st phase of reforms). Later on, work out a conceptual document on possible approaches about moving the medical services from the penal institutions to the health system supervision (2nd phase);

6. TO DEVELOP:

6.1. a draft RA Government decree on "**Defining the standard structures of the services providing medical aid and service and the description of the infrastructures which offer medical services";**

The draft will describe the services necessary for provision of medical services in the penitentiary institutions that will enable to establish units with the same structure. The draft will also provide a description of the units.

6.2. a draft Justice Minister Order on **"Defining the volume and the order of providing medical services at correctional institutions";**

The draft will state a procedure and volume of provided medical services in penitentiary institutions, which will allow the provision of medical care according to defined procedures and specified volume.

6.3. a draft legal act on **" Defining the technical and professional qualification requirements and conditions necessary for the medical aid rooms, daytime hospitals and specialised medical activity within the correctional institution";**

The draft will define technical requirements of equipment for offices of medical service provision of penitentiary institutions /equipment, instruments/ or professional activities /human resources/, which will enable us to deliver services with the same standards in all facilities.

6.4. a draft Justice Minister Order on **"Defining the order of affirming, filling in and conducting the forms of medical forms obligatory to be used in correctional institutions";**

6.5. a draft RA Government decision on **"Confirming the order of making medical referrals by doctors of the correctional institution medical units and defining the forms of attendance"**;

The decision will define a procedure of patient referral from penitentiary institution to civil institutions and referral forms.

6.6. a draft RA Government decision on **" Confirming the principles of organisation of the correctional institution doctor's activity and the form of providing information about the activity"**;

The decision will define the main activities and principles of duties of medical doctor in penitentiary institution, the requirements for doctor's professional background, the approaches for prevention, diagnosis, treatment and rehabilitation of most common diseases, the scope of emergency and urgent care provision, and the scope of organisation of medical professional activities (interventions).

6.7. clinical guidebooks and the methods of treating the patients.

6.8. a draft order on **" Confirming the administrative statistical report forms and their filling-in directives about the medical attendance in the correctional institutions of RA**";

The draft is aimed at adoption of unified statistical reporting form and the procedure of its completion, which will ensure the unified collection of statistical data, and analysis of morbidity data at penitentiary institutions.

6.9. reconsider the RA Government Decision N 413-N made on 10 April, 2003 on **"Confirming the average daily ration, the quantity of outfits and terms of their usage, the portion of bedding and hygienic accessories and terms of their usage for the detainees being kept at correctional institutions of the RA Justice Ministry"** defining minimal requirements for dietetic nutrition;

Adoption of the draft will allow to set up the minimum food requirements for persons suffering from chronic diseases, which is lacking at the moment and which results in provision of not sufficient (in terms if diet) food by different institutions.