



PRISON HEALTH: ISSUES AND REFORMS IN THE REPUBLIC OF ARMENIA



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PRISON HEALTH: ISSUES AND REFORMS IN THE REPUBLIC OF ARMENIA

YEREVAN 2018

The present handbook is based on the Concept Paper on “Modernizing medical services in penitentiary institutions of the Republic of Armenia”, adopted by the Government of the Republic of Armenia on 19 January 2017 and developed by a working group established with the use of funds of the joint European Union – Council of Europe project “Strengthening health care and human rights protection in prisons in Armenia” under the auspices of the Council of Europe/European Union Partnership for Good Governance for Eastern Partnership Countries.

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The views expressed herein can in no way be taken to reflect the official opinion of the European Union or the Council of Europe

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ACRONYMS

RoA	Republic of Armenia
UN	The United Nations Organization
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CoE	Council of Europe
PI	Penitentiary institution
CJSC	Closed joint-stock company
CPD	Continuing professional development
ICD	International Classification of Diseases
WHO	World Health Organization
HIV	Human immunodeficiency virus
AIDS	Acquired immunodeficiency syndrome

INTRODUCTION

Prison health is an element of public health. The right to health is guaranteed to the vulnerable members of the society through the state's commitments towards the international community, as well as the domestic legislation, with the resulting right of the person to claim certain positive obligations to be fulfilled by the relevant state bodies. The core international treaties in this field provide that health policy in prisons shall be integrated into, and compatible with, national health policy.¹ Furthermore, prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.²

Under Article 3 of the Constitution of the Republic of Armenia, the human being, his dignity, fundamental rights and freedoms are supreme values. The state shall ensure the protection of fundamental rights and freedoms of the human being and citizen in accordance with the principles and norms of international law. The right to health is an integral part of fundamental human rights. It is a primary and fundamental human right. The rights of persons in closed institutions are more vulnerable; hence, special attention should be paid to the protection of the right to health of inmates.

The shortcomings of the institutional system of prison health, the inadequate quality of services, the prevalence among inmates of HIV/AIDS, tuberculosis, hepatitis, and mental health issues indicate that the prison health policies and legislation need to be reviewed. In the Republic of Armenia, health and the provision of medical care and services in the penitentiary system are regulated by the general health sector legislation, as well as the legislation on the rights of inmates (the "penitentiary legislation"). This paper addresses the legal regulation of medical service provision in penitentiary institutions, the analysis of the institutional system, and the problems in the sector, taking into account also the international commitments undertaken by the Republic of Armenia and the standards enshrined in the international instruments on the regulation of medical services in penitentiary institutions. The main objective of this paper is to present the possible solutions aimed at modernizing medical services in the penitentiary institutions, based upon the international standards, which will enable safeguarding the rights of persons held in penitentiary institutions of the Republic of Armenia in the delivery of medical services.

¹ Council of Europe, European Prison Rules, Rule 40.2.
http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

² UN, Basic Principles for the Treatment of Prisoners, para. 9.
<http://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx>

CHAPTER 1. MEDICAL SERVICES PROVIDED TO PERSONS IN PENITENTIARY INSTITUTIONS

§1. Scope and Overview of Services

Under Paragraph 9 of the UN Basic Principles for the Treatment of Prisoners,³ prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

Under Paragraph 22 of the UN Standard Minimum Rules for the Treatment of Prisoners,⁴ “at every institution there shall be available the services of at least one qualified medical officer ... Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers. The services of a qualified dental officer shall be available to every prisoner.”

Under Paragraph 40.2 of the Council of Europe’s European Prison Rules,⁵ health policy in prisons shall be integrated into, and compatible with, national health policy.

The analysis of all of the aforementioned provisions shows that inmates must have access to quality health services insofar as they are accessible to each member of society irrespective of legal status.

In the Republic of Armenia, health and the provision of medical care and services in the penitentiary system are regulated by the general health sector legislation, as well as the legislation on the rights of inmates. Article 12 of the RoA Law on Population Medical Care and Services provides: “Arrested persons, detained persons, and persons serving a sentence in places of deprivation of liberty shall have the right to receive medical care under the procedure stipulated by the RoA legislation.” Article 12 of the Penitentiary Code specifies, among the listed rights of the prisoners, the right to healthcare, including the right to receive sufficient food and medical care. Article 83 of the Penitentiary Code provides: “... The RoA Government shall prescribe the procedure of organizing medical-sanitary and medical-preventive care for prisoners, prisoners’ using the medical institutions of the healthcare authorities, and engaging the staff of such institutions for such purposes. To provide effective medical-sanitary and medical-preventive care to prisoners, a medical correctional institution shall be organized.”

Various aspects of the medical care and services delivery for detained persons and persons serving a sentence in places of deprivation of liberty are regulated mostly by the Penitentiary Code and the RoA Government Decree 825-N dated 26 May 2006 “On Approving the Procedure of Organizing Medical-Sanitary and Medical-Preventive Care for Prisoners, Prisoners’ Using the Medical Institutions of the Health Care Authorities, and Engaging the Staff of Such Institutions for Such Purposes” (hereinafter, “Decree 825-N”). Under Paragraph 3 of the said Decree, the organization and provision of the necessary medical care to detainees and sentenced persons is a core task of the medical services unit. The functions of such units are not limited only to providing medical care, but include also

³ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx>

⁴ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

⁵ http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

disease prevention, monitoring of the sanitary conditions, hygiene, food safety and security, and healthy lifestyle promotion functions.

Legal acts do not clearly define the specific types and scope of medical care and services provided to a person within the penitentiary system under the requirements of RoA Government Decree 276-N dated 27 March 2008 “On Approving the List of Types of Medical Care and Services Provided in the Republic of Armenia.” Nevertheless, Chapter 1 of the Procedure approved under Decree 825 defines the main tasks of a medical unit within the penitentiary system, and the analysis of such tasks provides an understanding of the general nature of the services provided.

Primary healthcare units operate in all penitentiary institutions. Certain penitentiary institutions also have hospital (in-patient) units or in-patient daycare services. The medical units, depending on the size of and number of people in the penitentiary institution, shall have doctors (as a rule, a general practice doctor) and nurses, and in some cases—also heads of wards or heads of groups.

Unlike the public (civil) healthcare system, the analysis of activities of the primary healthcare units in the penitentiary system shows that legislative reform, as well as material-technical and human resource reforms are necessary in order to improve the quality of health care services provided. Hence, RoA Government Decree 1936-N dated 5 December 2002 “On Approving the Requirements and Conditions for Technical and Professional Qualification Necessary to Provide Medical Care and Services in Polyclinics (mixed, adults’, and children’s), Separate Specialized Rooms, Offices of Family Doctors, Medical Ambulatories, Rural Health Centers, Nurse-Midwife Care Stations, Women’s Counseling Offices, and Hospital (Specialized) Care and Services” (hereinafter, “Decree 1936-N”) regulates, among other issues, the requirements and conditions on the technical and human resource capacities necessary to provide medical care and services. Under the existing legislation, these regulations do not apply to primary healthcare units of penitentiary institutions, because the medical services of penitentiary institutions are not subject to licensing. Therefore, there is no legal basis for ensuring consistent minimum conditions of medical care in all of the penitentiary institutions. The absence of such regulations impedes the sound and consistent functioning of medical units of penitentiary institutions.

A similar problem arises in relation to the scope of medical care and services provided in a penitentiary institution. Decree 825-N refers only to the main functions of the medical services unit: Paragraph 3 of the Decree, in particular, defines the following as the main functions of the unit:

- a) organizing and providing the necessary medical care to detainees and sentenced persons;
- b) ensuring medical surveillance over the detainees’ and sentenced persons’ health through regular medical checks and examinations, and whenever possible, the implementation of medical recovery activities;
- c) complying with the requirements of the sanitary legislation of the Republic of Armenia in penitentiary institutions;
- d) raising medical and hygiene awareness of, and healthy lifestyle promotion among, detainees and sentenced persons;

- e) regular analysis of, and development of measures to prevent, morbidity and loss of work ability among detainees and sentenced persons;
- f) applying medical surveillance over sentenced persons in need of sentence serving postponement due to a grave illness; and
- g) planning and implementation of medical-preventive measures in penitentiary institutions.

However, the aforementioned decree does not regulate the scope of medical services (including the ones provided by narrow specialists) provided by the medical care units of penitentiary institutions. Thus, the scope and general profile of medical care and services offered in a penitentiary institution are not defined.

No legal act defines the requirements concerning the premises of medical care units of penitentiary institutions. Though Armenia still uses the construction norms and rules, as well as sanitary norms and hygiene rules adopted as legal acts back in the Soviet years, regulating certain aspects related to the premises of civil medical institutions, even these rules are in practice not applicable to the penitentiary institutions.

In addition to the issues related to the legal foundation, the primary healthcare units in penitentiary institutions also face logistics and human resources issues. To address these issues it is necessary to renovate the rooms allocated for the medical care and to modernize the medical equipment.

In general, almost all the equipment available at the primary healthcare units in penitentiary institutions is subject to replacement, as it is impossible to provide quality medical care using the equipment, which is worn out. According to the assessment report prepared by experts under the joint CoE-EU project Strengthening the Health Care and Human Rights Protection in Prisons in Armenia, certain equipment necessary for the provision of primary healthcare services is totally absent. Due to logistics and human resources issues, the medical services provided in penitentiary institutions are not consistent with the level of primary healthcare services available in the country.

The issue of logistic support to primary healthcare units in penitentiary institutions was raised in the reports⁶ prepared after the CPT's visits to Armenia.

As to the availability of human resources for the relevant medical units, it is worth mentioning that, depending on the size of the penitentiary institutions and number of inmates held therein, the number of doctors and nurses varies considerably between penitentiary institutions. For many years, routine medical care in several penitentiary institutions was provided by nurses and, upon necessity, a family doctor was invited from the district primary healthcare center, even though Paragraph 22 of the UN Standard Minimum Rules for the Treatment of Prisoners⁷ provides that "at every institution there shall be available the services of at least one qualified medical officer ..."

A similar requirement is contained in Rule 41.1 of Recommendation R(2006)2 on the European Prison Rules adopted by the Council of Europe Committee of Ministers on January

⁶ See, for example, the CPT report on the regular visit to Armenia from 6 to 17 October 2002 (CPT/Inf (2004) 25), paras. 106-113, the CPT report on the regular visit to Armenia from 2 to 12 April 2006 (CPT/Inf (2007) 47), paragraph 82, the CPT report on the regular visit to Armenia from 10 to 21 April 2010 (CPT/Inf (2011) 24), paragraph 103.

⁷ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

11, 2006, according to which “every prison shall have the services of at least one qualified general medical practitioner.”⁸

Moreover, the importance of human resource availability in the respective healthcare units of penitentiary institutions was also emphasized in reports prepared after the CPT’s visits to Armenia.⁹

Therefore, ensuring the presence of at least one qualified general doctor in the primary healthcare unit of each penitentiary institution becomes another priority to be addressed in the sector.

The Republic of Armenia legislation contains virtually no requirements on human resource availability in the medical units of penitentiary institutions. Minimum requirements for human resources are not defined and requirements on the qualification of the medical personnel are not prescribed.

Ensuring a number of medical services of narrow specialization, which according to the international standards shall be available in penitentiary institutions, is also challenging. For example, in accordance with Paragraph 22 of the UN Standard Minimum Rules for the Treatment of Prisoners,¹⁰ “... the services of a qualified dental officer shall be available to every prisoner.”

A similar requirement is contained in the CPT standards: according to the CPT standards, each prisoner shall have access to the services of a highly-qualified dentist¹¹.

Consequently, access to dental services is the right of inmates. However, not all penitentiary institutions in Armenia offer this service (in particular, the Yerevan-Kentron, Vanadzor, Hrazdan, and Kosh, penitentiary institutions do not cover the staff position of a dentist). This problem is stated also in reports prepared on the basis of the CPT’s visits to Armenia¹².

Therefore, ensuring the availability of this service in all penitentiary institutions is another priority that needs to be addressed; the provision of dental services can be arranged by means of engaging a dentist on a contractual basis.

Alongside physical diseases, mental health issues have the second highest prevalence in penitentiary institutions. Paragraph 1 of Article 12 of the UN International Covenant on Economic, Social and Cultural Rights¹³ provides the “right of everyone to the enjoyment of the highest attainable standard of ... mental health.” Paragraph 22 of the UN Standard Minimum Rules for the Treatment of Prisoners¹⁴ provides that “the [prison] medical services shall include a psychiatric service for the diagnosis and ... treatment of mental abnormality.”

A similar requirement is contained in Rule 47.2 of Recommendation R(2006)2 on the European Prison Rules adopted by the Council of Europe Committee of Ministers on January

⁸ http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

⁹ See, for example, the CPT report on the regular visit to Armenia from 6 to 17 October 2002 (CPT/Inf (2004) 25), paras. 106-113, and the CPT report on the regular visit to Armenia from 10 to 21 April 2010 (CPT/Inf (2011) 24), paras. 98-102.

¹⁰ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

¹¹ <http://www.cpt.coe.int/lang/arm/arm-standards.pdf>, para. 35, p. 59

¹² See, for example, the CPT report on the regular visit to Armenia from 10 to 21 April 2010 (CPT/Inf (2011) 24), paragraph 102, and the CPT report on the *ad hoc* visit to Armenia from 5 to 7 December 2011 (CPT/Inf (2012) 23), paras. 17 and 20.

¹³ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

¹⁴ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

11, 2006, according to which “the prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment...”¹⁵.

According to 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 training in this field.¹⁶

The present state of mental health care in Armenia’s penitentiary system gives reason for concern. The problem has also been raised in reports prepared on the basis of the CPT’s visits to Armenia.¹⁷

Access to a psychiatric service is challenging in all penitentiary institutions. Considering the specific nature of a penitentiary institution and the fact that frequent mental health issues are often found among inmates, primary healthcare in a penitentiary institution should necessarily provide services of a psychiatrist. The valid position of a psychiatrist is currently available in the Nubarashen, Artik, and Prison Hospital penitentiary institutions.

Inmates with less severe mental health issues and non-psychotic issues, which do not need inpatient psychiatric care, but need non-permanent or continuous medicational or psychotherapeutic care, should enjoy access to regular mental healthcare services, which should be equivalent to the ones available to the general public.

To sum up the foregoing, the following reforms need to be implemented in order to improve the medical services provided to persons in penitentiary institutions:

- Based on Decree 1936-N, elaborate technical and human resources requirements and conditions for medical care and services in the primary healthcare units of penitentiary institutions, taking into consideration the peculiarities of the penitentiary institutions;
- Based on Decree 1936-N, elaborate the description of medical care and services provided in a penitentiary institution, as well as the procedure of organizing the activities of a general practice doctor in a penitentiary institution; and
- Ensure the availability of the necessary human resources, including at least one general practice doctor and nurses, a dentist, and a psychiatrist in each penitentiary institution, including access to the doctors during working days and hours, and access to the nurses on a 24-7 basis.

§2. Hospital Medical Care and Services in Penitentiary Institutions

In the penitentiary system of the Republic of Armenia, secondary medical care is provided at the Prison Hospital, which is the only institution of its kind in Armenia’s penitentiary system. The hospital admits only males, and female and juveniles inmates are treated in civil hospitals. The hospital has 415 beds. The beds are distributed in the following

¹⁵ http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

¹⁶ <http://www.cpt.coe.int/lang/arm/arm-standards.pdf>, paragraph 41, p. 61

¹⁷ CPT report on the results of the regular visit to Armenia from October 6 to 17, 2002 (CPT/Inf (2004) 25), paragraph 111, CPT report on the results of the regular visit to Armenia from April 2 to 12, 2006 (CPT/Inf (2007) 47), paragraph 89, CPT report on the results of the regular visit to Armenia from April 10 to 21, 2010 (CPT/Inf (2011) 24), paragraphs 109-111, CPT report on the results of the regular visit to Armenia from December 5 to 7, 2011 (CPT/Inf (2012) 23), paragraphs 17 and 20.

units and wards: therapeutic, surgical, psychiatric, tuberculosis, narcological and infectious diseases. There are other wards, too, such as the dental, X-ray, laboratory, and functional diagnosis wards.

The hospital is in dire need of logistic support and additional human resources. The hospital lacks an intensive care unit (ICU)—something that is a must for an institution providing secondary medical services. Quality medical services cannot be delivered in such substandard conditions.

In its report, the CPT has repeatedly addressed the issue of logistic and human resource support to the Prison Hospital, including the need to improve the condition of its buildings.¹⁸

One of the problems related to the Prison Hospital is its location, namely its proximity to residential buildings. The Prison Hospital holds, among others, detainees and sentenced persons that have infectious diseases, which may pose a threat to the health of neighborhood residents. This, together with the fact that the building was constructed in the early-20th century and is in a poor state, subject to the risk of collapsing, is worrisome and requires urgent solution. In this respect, it is worth discussing the possibility of building a new Prison Hospital: This can be achieved by selling the current building and attached land, and using the proceeds (which will certainly be sufficient) to build or reconstruct a new hospital in the territory of the Abovyan penitentiary institution. The land attached to the Abovyan penitentiary institution is nearly 30 hectares and carries one- or two-floor buildings that are not in use, but are technically in a satisfactory condition. According to information received from the Penitentiary Department of the RoA Ministry of Justice, these buildings can be reconstructed with minimum financing and adjusted for medical use. Moreover, it is important to consider that the Abovyan penitentiary institution site already has the relevant engineering and technical infrastructure for protection (functioning guard posts, means of communication, alarms, etc.).

Hospital-type medical care and services are provided also in the Nubarashen penitentiary institution. The necessary conditions exist in the Armavir penitentiary institution, as well.

However, it should be noted that Decree 1936-N defines the technical and professional qualification requirements and conditions necessary for hospital (specialized) medical care and services. In reality, these requirements and conditions are not complied with in either the Prison Hospital or the Armavir and Nubarashen penitentiary institutions.

The provision of hospital-type psychiatric care is another one of the issues related to secondary medical care. Although the Prison Hospital has a psychiatric ward where patients with mental health issues transferred from other PIs receive care, the conditions are not sufficient to organize the treatment of persons with severe issues of mental health. Inmates with mental disorders who need in-patient care are transferred to the respective hospital institution: more specifically, inmates with severe mental disorders are transferred not to the in-patient wards of penitentiary institutions, but rather to the respective psychiatric institutions in which the relevant equipment and staff with proper qualifications are available.

¹⁸ CPT report on the results of the regular visit to Armenia from October 6 to 17, 2002 (CPT/Inf (2004) 25), paragraphs 131-143, CPT report on the results of the regular visit to Armenia from April 10 to 21, 2010 (CPT/Inf (2011) 24), paragraphs 112-116.

The reality, however, is such that inmates with severe mental disorders are often not transferred to the respective psychiatric institutions and do not receive adequate professional services.

Two options of reform can be considered in the context of improving the quality of hospital-type medical care and services. The first option is that secondary specialized medical care is provided to inmates only in civil hospitals, entering into service delivery contracts with civil hospitals selected according to the geographic location and complying with the respective security criteria, and close down the Prison Hospital. Under this option, it is necessary to elaborate also security criteria related to the organization of medical care of detainees and sentenced persons in civil medical institutions.

A second possible option is to refurbish the Prison Hospital and to convert it to an institution providing medical care and services (including psychiatric, narcological, rehabilitation, and care) in some specialized hospital form, and to organize the complicated cases of specialized medical care in civil hospitals. Non-surgical specialized wards of secondary healthcare and services could be placed also within the Armavir penitentiary institution.

A possible third option could be the following: to sell the Prison Hospital administrative building and the attached land plot and use the proceeds to build (or to reconstruct) a new hospital in the administrative area of the Abovyan penitentiary institution. (The total land plot attached to the Abovyan penitentiary institution is around 30 hectares, which is completely sufficient for implementing the project)..

§3. Prison Health Models in other countries

An overview of the international experience shows that there are broadly two models of penitentiary health systems—(i) standalone, and (ii) integrated within the general healthcare system. A mixed model can sometimes be encountered. In **France**, for instance, starting from 1994, the penitentiary health services were integrated within the public healthcare system. A nearby hospital is assigned to each penitentiary institution and provides all the necessary healthcare services, including primary healthcare and hospital medical care. In case of hospitalization, inmates are held in separate rooms, and security is provided by the penitentiary officers. Unlike France, in **the United Kingdom**, each penitentiary institution has a medical unit set up to provide primary healthcare, which employs general practice doctors. As a rule, these medical units provide 24-hour service. If necessary, inmates may be transferred to specialized hospitals. **In Estonia**, too, each penitentiary institution has a medical unit set up to provide primary healthcare: these medical units comply with the requirements of the Health Services Organization Act¹⁹ regulating the relations connected with primary healthcare. However, unlike **the UK**, in Estonia, when hospitalization is necessary, the inmate is not transferred to a specialized hospital, but to the medical unit of the penitentiary institution of Tallinn, which provides in-patient medical care, too. In **Slovenia**, the model is the same as in **Estonia**.

¹⁹ https://www.riigiteataja.ee/en/compare_original?id=512122013005

The analysis of the prison healthcare system in **the UK** and in **Estonia** shows that, in general, the functions of primary healthcare units in penitentiary institutions include organization of emergency care, disease prevention and early detection, diagnosis, treatment and rehabilitation, management of chronic cases, early detection of non-infectious diseases, referral of patients to hospitals and other institutions for specialized care, post-hospital care and rehabilitation, solving mental health problems, taking other preventive actions such as immunization, and ensuring access to and providing sufficient medical equipment, orthopedic and other necessary supplies, medical examinations, and necessary medications.

For the effective organization of healthcare services in penitentiary institutions, in international practice, requirements are set and standards are defined with respect to the premises, furnishing, and equipment condition and fitness (also testing) of medical units of penitentiary institutions.

In the United Kingdom, medical equipment undergoes accreditation by the UK Accreditation Service (UKAS) national authority, which has a number of healthcare bodies and organizations as its members. The Ministry of Health of Slovenia defines standards for medical rooms in penitentiary institutions and their furnishing, in line with the general healthcare regulations.

§4. Medical Records, Medical Statistics, and Documenting Health Issues

Requirements concerning medical documents, their compilation, content, forms, and record-keeping, as well as on statistics and confidentiality in the public healthcare sector are prescribed in detail in a number of legal acts: Article 34 of the RoA Constitution, in particular, regulates the right to personal data protection, prescribing as follows:

“1. Everyone shall have the right to protection of data concerning him or her.

2. The processing of personal data shall be carried out in good faith, for the purpose prescribed by law, with the consent of the person concerned or without such consent in case there exists another legitimate ground prescribed by law.

3. Everyone shall have the right to get familiar with the data concerning him or her collected at state and local self-government bodies and the right to request correction of any inaccurate data concerning him or her, as well as elimination of data obtained illegally or no longer having legal grounds.

4. The right to get familiar with personal data may be restricted only by law, for the purpose of state security, economic welfare of the country, preventing or disclosing crimes, protecting public order, health and morals or the basic rights and freedoms of others.”

The aforementioned constitutional provisions are spelled out in greater detail in various pieces of the RoA sector legislation, including medical care and services. Paragraph (c) of Article 5 of the RoA Law on Population Medical Care and Services provides that, when seeking medical care and while receiving medical care and services, everyone shall have the right “to demand confidentiality of the fact of seeking a doctor’s help and of information

related to his health condition and information established during examinations, diagnosis, and treatment, except for cases provided by the RoA legislation.”

The aforementioned right of a person seeking medical care and receiving medical care and services logically triggers a corresponding obligation for the providers of medical care and services. Paragraph (e) of Article 19 of the RoA Law on Population Medical Care and Services requires providers of medical care and services “to ensure confidentiality of the fact of seeking a doctor’s help and of information related to his health condition and information established during examinations, diagnosis, and treatment, except for cases provided by the RoA legislation.” Paragraph 2 of the same Article provides that persons failing to honor the said obligation shall be held liable under the procedure provided by the RoA legislation. Under the RoA legislation, this may entail, among other types of liability, criminal liability.

Article 145 of the RoA Criminal Code prescribes liability for providers of medical care and services that disclose, without professional or official necessity, information on a person’s illness or the results of a medical examination.

Thus, information containing medical confidential information may be provided only when demanded by a court (judge) or the prosecution, pre-trial investigation, or inquest authorities and other competent authorities, in cases and under the procedures provided by law. For these purposes, “disclosure” means making third parties aware of such information in any form (orally, in writing, and so on).

The subjective element of the crime in question requires direct intent. Whenever a patient has consented to disclosure of information on his illness or on the results of a medical examination, the *corpus delicti* of the crime is absent.

The more dangerous form of this crime is proscribed by Paragraph 2 of Article 145 of the RoA Criminal Code (“... the acts proscribed by Paragraph 1 of this Article, which by neglect have given rise to grave consequences”). In both cases, under Paragraphs 1 and 2 of the RoA Criminal Code, disclosure of the defined data happens with direct intent, and the sanction depends on the consequences, rather than the disclosure. Hence, it is necessary to establish not only the offender’s guilt in neglect, but also the causal link between the offence and the grave consequences that ensued.

Certain other legal acts address this issue, as well: Article 10 of the RoA Law on the Prevention of the Disease Caused by the Human Immunodeficiency Virus, HIV lab testing shall be voluntary and anonymous, except for cases provided by Article 11 of this Law (Article 11 concerns mandatory medical examinations). Paragraph “f” of Article 14 of the same Law safeguards the right to medical secrecy of HIV-positive persons. Article 13 of the RoA Law on Psychiatric Care safeguards the confidentiality of information concerning a person’s mental health. In cases provided by the RoA legislation, such information shall be provided to the patient and his lawful representative when demanded by them.

A mandatory requirement to compile medical records is prescribed by the RoA Law on Population Medical Care and Services. Paragraph 13 of Article 1 of the Law defines “medical records” as “documents compiled (filled out) by a member of the medical personnel and paper or electronic reporting or accounting documents of a form approved under the procedure provided by the RoA legislation, which contain necessary medical and non-medical data on the patient’s health, medical care and services received, consent thereto or refusal to give such consent, and protection of the patient’s health or prevention of an illness”. Moreover, Article 19.3 of the same Law provides that medical personnel shall be

obliged to fill out, compile, and circulate medical documents under the procedure provided by the RoA legislation, as well as register medical interventions.

Article 19 of the Law obliges medical personnel, among others, to present statistical and other information under the procedure provided by the RoA legislation. A similar requirement is contained in RoA Government Decree 1936-N dated 5 December 2002 for business entities providing medical care and services (“each one shall keep patient records and compile medical statistics and shall present a statistical report to the relevant unit of the RoA Ministry of Health”). A number of regulatory decrees of the RoA Minister of Health have approved the annual administrative statistical reporting forms, according to which health sector organizations present statistical reports.

The aforementioned rules, however, do not apply to penitentiary sector medical records and their compilation and management, as well as statistics and confidentiality. The respective regulations are prescribed by the penitentiary legislation. Provisions on any data related to the health of inmates held in the RoA penitentiary institutions and on the registration of all actions (examinations, tests) performed by a doctor, compilation of records, statistics, and confidentiality are enshrined in the procedure approved under Government Decree 825-N (Paragraphs 4, 7, 28, 37, 38, 40, 51, 53, 85, and 92). Some general provisions are contained in the RoA Penitentiary Code and the RoA Law on Holding Arrested and Detained Persons.

According to the record-keeping provisions of Decree 825-N, separate medical cards shall be compiled for every person held in a penitentiary institution, and such cards shall contain data on the results of the person’s medical examination, past and present illnesses, injuries, surgeries, and other health-related issues. The person’s history of disease shall be compiled separately, as well. The forms of medical cards and patient histories compiled in the penitentiary system, as well as the procedures of filling them out are not approved under any legal act.

The RoA Minister of Health Decree 35-N dated 3 July 2013 approved a number of forms of medical documents (including continuous surveillance cards) used in the RoA. The RoA Minister of Health Decree 1752-N dated 26 November 2007 approved the form of the outpatient (ambulatory) medical card. However, the requirements prescribed in those binding decrees practically do not apply to the penitentiary institutions, and the forms approved under the decrees are not used in the penitentiary system. Penitentiary institutions also compile ward surveillance cards that are kept in a special database by months, depending on the visit time scheduled by the doctor. In addition to the individual documents, registers are compiled, as well (for various medical examinations, sanitary-epidemiological surveillance, medications and other supplies records, etc.), and the forms of the registers, unlike the aforementioned medical card and disease history forms, are approved under Decree 825-N. The legal regulations indicate that the forms of medical documents, namely the medical card and the disease history, among others, are not approved. As a result, medical data is registered inconsistently and, consequently, there is no consistent practice of filling out medical documents. The analysis of the legal rules and the results of practical visits show that all the data is registered manually on paper. No electronic system is used for recording.

The compilation of medical documents is closely related to the confidentiality of medical care and services, which must be safeguarded and secured in the penitentiary, as well as in general. Articles 19 and 19.3 of the RoA Law on Population Medical Care and Services stipulate that providers of medical care and services “to ensure confidentiality of the

fact of seeking a doctor's help and of information related to his health condition and information established during examinations, diagnosis, and treatment, and medical personnel shall ... keep medical secrets... except for cases provided by the RoA legislation.”

According to the procedure approved under Decree 825-N, medical secrets shall be safeguarded and protected by the medical personnel. The medical card and the disease history compiled for each inpatient patient shall be deemed as documents containing medical secrecy and shall not be handed over to detainees or sentenced persons. They shall be kept with the medical personnel of the penitentiary institution, in a fire-proof safe box, and the person responsible for the institution's medical services shall be responsible for registering and keeping them. In order to become familiar with information contained therein, an excerpt may be issued to the detainee or sentenced person or a person indicated by the detainee or the sentenced person in the form of written consent. In case of sending to other medical institutions, the medical card shall be marked with the words “Medical Secret,” placed in a sealed envelope, and handed over to the escorting official.

Thus, despite the prescription in legislation of requirements on medical secrecy, there are some gaps, namely limitations related to the provision of the records to inmates, the unclear definition of the third parties to which the records may be provided, the record provision procedure, and the obligations of the medical personnel in respect of maintaining confidentiality.

The next important issue is the injury detection, examination, recording, and compilation of statistics on injuries. According to Paragraph 37 of the Procedure approved under Decree 825-N, “the documenting of the medical examination of a detainee or a sentenced person shall include ... the complete picture of all statements made by the examined person (including the description of his health condition and any allegation of ill-treatment) ... If a bodily injury discovered as a result of the medical examination or a complaint regarding the health condition is, according to the statement of the detainee or sentenced person, a consequence of any act committed in relation to him, which contains elements of a crime, the person performing the medical examination shall inform the administration of the place of holding detainees or the administration of the correctional institution thereof.” The administration shall then “immediately inform law-enforcement agencies thereof. The results of any medical examination and the statements and doctor's conclusions shall be accessible to the detainee or sentenced person and to a person authorized by the detainee or sentenced person.” Paragraph 34 of the same Procedure provides: “...the institution warden shall give written notice of cases of injuries and intoxication that caused grave consequences or death to the head of the health services unit of the Penitentiary Department, as well as the respective institutions of the public administration body authorized by the RoA Government in the field of health.” Article 21 of the RoA Law on Holding Arrested and Detained Persons provides that a member of the medical personnel shall, in case of discovering a bodily injury, immediately carry out a medical examination in which a doctor chosen by the arrested or detained person may participate. The medical examination shall be performed out of the penitentiary administration officer's hearing, and unless the doctor demands otherwise, also out of his sight. The results of the medical examination shall be registered in the personal file, and the patient and the body conducting the criminal proceedings shall be informed thereof.” Clearly, the legislation fails to prescribe a requirement to compile statistics on injuries.

Proper documenting of medical data is important for proper organization of medical care, as well as compiling statistics and in the context of safeguarding the rights of patients. Article 19 of the RoA Law on Population Medical Care and Services provides: “Medical care and service providers shall: ... (f) present statistical and other information in the procedure provided by the RoA legislation...” Decree 1936-N provides that polyclinics, hospitals, and other providers of medical care and services shall compile medical statistics and present a statistical report to the relevant unit in the RoA Ministry of Health. A number of binding decrees of the RoA Minister of Health have approved annual administrative statistical reporting forms, according to which health sector organizations present statistical reports. In the penitentiary system, regulations on statistics are contained only in Paragraph 4 of the Procedure approved under Decree 825-N, which provides: “Based on administrative statistics and reporting, data on medical care and services and on the health condition of detainees and sentenced persons shall be consolidated and analyzed, and the results shall serve as a basis for planning the work in future years.” This provision is very generic. Moreover, the statistical forms and requirements on compiling statistics are not approved. The aforementioned provisions, which are about public health care and services, are not applicable to penitentiary institutions in all cases. Administrative statistics forms have not been approved for penitentiary institutions. In practice, the Penitentiary Department and penitentiary institutions do not present statistical reports to the RoA Ministry of Health, hence the penitentiary is actually not covered in the health statistics.

Observations at the RoA penitentiary institutions prove that the healthcare documents and medical records often are freely available to everyone; in certain cases, there are records of discriminatory nature in them. Medical records by doctors are taken manually but not systematically. The International Classification of Diseases (ICD) is not applied. Despite the legally-enshrined requirement, statistical data of diseases is not registered; from the partially made records, it becomes evident that they are not reliable and accurate, which impedes the proper planning of the budget, resources, supplies, and capacity of the penitentiary institution. Statistics of injuries are not compiled, either, which does not enable overseeing and preventing possible violence by the inmates and the staff. Perhaps, a system of electronic data registration and processing will enable solving many of the aforementioned problems, as a uniform electronic database is a more reliable means of ensuring information confidentiality and conducting analysis.

As to the international legal regulations of medical records and medical secrecy, they clearly define standards related to the documentation of examination results and their confidentiality. Rule 15.1 of the Council of Europe’s European Prison Rules provides:²⁰ “At admission the following details shall be recorded immediately concerning each prisoner (...) subject to the requirements of medical secrecy, any information about the prisoner’s health that is relevant to the physical and mental well-being of the prisoner or others.”

Paragraph 4 of the UN Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment provides:²¹ “Alleged victims of torture or ill-treatment and their legal representatives shall be informed of, and have access to, any hearing, as well as to all information relevant to the investigation, and shall be entitled to present other evidence.”

²⁰ http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

²¹ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/EffectiveInvestigationAndDocumentationOfTorture.aspx>

Paragraphs 82 and 83 of the UN Istanbul protocol²² (dated 2004) provides: “In cases of torture, medical experts shall quickly prepare a clear report in writing, which should include information about the time, day, venue of examination and other things, details of examination, detailed information about revelations about physical and mental situation, recommendations for necessary examinations or treatment, etc.”

Rule 18 of the Council of Europe R(98)7 Recommendation provides:²³ “All transfers to other prisons should be accompanied by full medical records. The records should be transferred under conditions ensuring their confidentiality. Prisoners should be informed that their medical record will be transferred.”

In all of the countries studied, information about the health condition of inmates is mainly kept in electronic form, consistent with the International Classification of Diseases (ICD). An electronic database of statistical data is compiled, too. There are, however, some differences: in France, for example, a working group of healthcare and penitentiary authorities develops a joint document that regulates the exchange of information.

In the United Kingdom, a summary of prison healthcare information is provided for research purposes. Public Health England (PHE), which is a unit of the executive branch of government, addresses in its analyses the infectious disease prevalence in prisons. Cases of death in prison are registered in the Ministry of Justice.

Estonia has a database that contains various types of personal data about inmates, including data pertaining to the health condition and to the necessary treatment. It is for internal use only. The Ministry of Justice regularly monitors the database and its usage and draws the attention of prisons to the gaps in the documents or in the database.

In Georgia, the penitentiary medical authority has a special records unit that maintains the inmates' personal files and stores them. Once every six months, requests and complaints are analyzed and sent to the Minister.

In Romania, in case of torture or inhuman treatment, the doctor is obliged to record the examination results and to provide them to the prosecutor. In such cases, the inmate may demand a forensic doctor, whose conclusion shall be attached to the inmate's medical documents.

The international regulations and the experience of the countries studied can be summed up as follows: from the moment of admission, all personal data pertaining to the inmate, including data on physical and mental health, treatment, and medical examinations is recorded in detail, mostly in electronic form. The data is securely kept and managed. Strict confidentiality of medical records and data is maintained. They are accessible to the inmates and only to the medical personnel, and in certain cases defined by law, also to other persons. In case of transfer to another place, the inmate must be informed, and in certain cases, the inmate's consent is required, too. General information on inmates' health and disability, as well as information on infections and epidemics or the threat thereof is also entered into the relevant database.

Having analyzed the present situation in Armenia's penitentiary institution, the relevant legal regulations of Armenia, and the international experience, reform measures in this field should encompass the following:

²² <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

²³ [http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+\(98\)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095](http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+(98)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095)

- Review the forms of medical documents used in public health institutions and, taking into account the peculiarities of penitentiary institutions, develop legislative amendments approving the list of medical documents that a penitentiary institution is obliged to maintain, the rules for keeping such documents, the requirements thereon, and the forms of such documents, including the form of medical cards compiled in penitentiary institutions. Medical cards should contain detailed information on the person's health state, all the actions performed by the doctor, all information pertaining to their place and date, and if possible, attached photos confirming the health state.
- Based on requirements approved in public health, draft a legal act approving the list of statistical data (including data pertaining to injuries, infectious disease, drug users, and others in penitentiary institutions), requirements on their registration and compilation, reports, and the relevant forms. Prescribe a binding requirement to present statistical data to the RoA Ministry of Justice and the RoA Ministry of Health and to approve the presentation form.
- In the RoA Penitentiary Service, implement an electronic database that will be integrated with the public health system. The electronic database will contain all medical records, including medical cards and statistical data. It is necessary to digitize the existing resources, too, and thereafter, to compile only electronic documents.
- Review the existing regulations on the confidentiality of medical services provided in penitentiary institutions. Develop legislative amendments that will clearly define the doctors' obligations with respect to confidentiality, the scope of third parties to which confidential data may be provided, the provision procedure and conditions, and the right of the person to access information concerning himself without any restrictions.
- In order to document the health state in line with the international best practices, and taking into account that the standards of the Istanbul Protocol are currently being implemented in the country, adapt the special form for medical examinations on the basis of the Istanbul Protocol and approve it as a binding form for medical examinations performed in penitentiary institutions.

CHAPTER 2. LICENSING AND SUPERVISION OF HEALTH CARE SERVICES, AND REQUIREMENTS ON MEDICATIONS IN PENITENTIARY INSTITUTIONS

§1. Licensing of Health Care Services Provided in Penitentiary Institutions

The penitentiary institutions of the Republic of Armenia provide medical care and services within the frameworks of the Procedure of organizing medical-sanitary and medical-preventive care for detainees and sentenced persons, their use of medical institutions of the health care authorities, and engaging the staff of such Institutions for such purposes (as

approved under RoA Government Decree 825-N dated 2006). However, the quality of the medical services provided by the correctional institutions is seriously undermined as such institutions do not comply with the requirements prescribed in the legislation for providing medical care and services. Article 43 of the RoA Law on Licensing provides that the activity of “medical care and services” is subject to licensing: the license is issued under the “complex” procedure, for the medical care types and service types defined by RoA Government Decree 276-N of 2008, and subject to compliance with the requirements and conditions prescribed by RoA Government Decree 1936-N (dated 2002) for offices and services providing medical care. These requirements concern the availability of equipment, as well as appropriately qualified human resources. The license-issuing authority is the RoA Ministry of Health. For the year in which the license is issued and for each successive year of operations, a stamp duty is collected under the RoA Law on Stamp Duties.

The requirement to receive qualified and safe medical care and services is prescribed by Article 19 of the RoA Law on Population Medical Care and Services (“providers of medical care and services shall ensure the conformity with the established standards of the quantitative and qualitative aspects of the provided medical care and services”).

Moreover, Article 3 of the RoA Law on Licensing provides that a license is an official permission confirming the right to engage in a type of activity that is subject to licensing, as well as the official document confirming such right, and licensing is a process related to license issuance, extension, restatement, suspension, and termination.

Article 1 of the RoA Law on Population Medical Care and Services provides that “a provider of medical care and services is a sole entrepreneur or legal entity, or a state institution or municipal institution that is not a body of state government or municipal local self-government, which is licensed under the procedure provided by the RoA legislation and provides a certain type (types) of medical care and services.”

The analysis of the aforementioned provisions shows that there is a legal inconsistency between the RoA Law on Licensing and the RoA Law on Population Medical Care and Services: the RoA Law on Licensing requires licensing of organizations and sole entrepreneurs, while the RoA Law on Population Medical Care and Services requires licensing of sole entrepreneurs or legal entities or a state institution or municipal institution that is not a body of state government or municipal local self-government.

As noted above, under RoA Government Decree 825-N dated 2006, medical services within the Penitentiary Service shall be provided by the medical services units of the Penitentiary Service. Those units are a part of the Penitentiary Service's system and are not subject to licensing for purposes of Article 43 of the RoA Law on Licensing, but subject to licensing under Article 1 of the RoA Law on Population Medical Care and Services, because Article 1 of the latter applies also to a state institution or municipal institution that is not a body of state government or municipal local self-government. The licensing legislation is currently not applied in practice to the medical services units of the Penitentiary Service in part due to the aforementioned legal inconsistencies.

Furthermore, the legislation does not prescribe requirements on the medical equipment and human resource availability in the aforementioned medical units.

As noted above, a stamp duty is collected for a license (50,000 Armenian drams annually). However, when issuing a license to the medical services units of the Penitentiary Service, the source paying the stamp duty would be unclear, because the state budget

funding for the Penitentiary Service does not cover the payment of stamp duties for licensing of medical services.

Another problem relates to the presentation of documents pertaining to the licensing. Article 28 of the RoA Law on Licensing prescribes the documents necessary for obtaining a license. Paragraph 6 of the Procedure of Licensing Medical Care and Services Provided in the Republic of Armenia by Organizations or Sole Entrepreneurs (approved under RoA Government Decree 867-N dated 29 June 2002 on Approving the Licensing Procedures and License Forms for the Drug Production, Pharmacy Activities, Medical Care and Services, and Vocational and Higher Medical Education Activities Carried out in the Republic of Armenia) regulates the list of documents necessary for obtaining a license for providing medical care and services, and concerns only sole entrepreneurs and legal entities, but not state institutions. Another problem is related to how a number of confidential documents (such as the ownership certificate of a penitentiary institution) can be presented.

In other countries, the penitentiary health service is subject to licensing or accreditation, which is mostly carried out under the licensing procedure for public health services. The licensing authorities are ministries of health or social issues, and in some cases—independent agencies. In Georgia, for example, penitentiary health services are licensed by the State Regulating Agency for Medical Activities (which is under the Ministry of Labor, Health, and Social Issues). In Estonia, as well, there is a mandatory licensing requirement for penitentiary health services: the licensing authority is the Healthcare Council. In contrast, health service providers in the United Kingdom are accredited by a private company called Quality Health Advisor (QHA) Trent Accreditation. In France, medical institutions and doctors are certified by the Supreme Health Authority (HAS), which is an independent scientific public body, the management of which is appointed by the country's President and Parliament. International experience of licensing penitentiary health services shows that a model does exist, which implies licensing by state authorities and checking of compliance with the standards by independent bodies.

Thus, taking into consideration the aforementioned international experience and Armenia's domestic legal framework, penitentiary health services can be reformed through the following alternatives to the existing system:

- For the units providing medical care in penitentiary institutions, it is necessary to prescribe requirements concerning premises, human resources, and equipment availability based on the respective standards applicable in the public health system and taking into consideration the peculiarities of the penitentiary sector. Compliance with the prescribed requirements can be checked by a commission created by the RoA Ministry of Justice, which could comprise representatives of the RoA Ministry of Justice and the RoA Ministry of Health.

- As a second option, one may consider the licensing of units providing medical care and services based on the binding minimum requirements and conditions established for medical care and services in the penitentiary, based on Article 43 of the RoA Law on Licensing. In this context, the Law on Licensing would need to be amended in order to eliminate the differentiating language on state institutions (one type of which is penitentiary institutions). As a result, penitentiary institutions in the RoA will be required to obtain a license in order to carry out medical care and service activities. The licensing authority will, similar to public health, be the RoA Ministry of Health.

§2. Status, Qualification, and Social Safeguards for the Medical Personnel of Penitentiary Institutions

Article 19.1 of the RoA Law on Population Medical Care and Services provides: "Medical personnel shall be divided into groups according to the level of education and activity carried out in the health sector and shall be accordingly called senior, middle, and junior medical workers." A senior medical worker is a natural person carrying out certain professional activity in the health sector, who has the relevant higher education, qualification, and specialization, and has, under the procedure provided by the RoA legislation, received professional activity and continuing professional development (CPD) certificates. A middle medical worker is a natural person carrying out certain professional activity in the health sector, who has secondary vocational or preliminary vocational (crafts) education and qualification and has, under the procedure provided by the RoA legislation, received professional activity and continuing professional development (CPD) certificates.

The legislation defines a junior medical worker as a natural person carrying out non-professional, i.e. support activity in the health sector, of whom, depending on the medical care and service type, the RoA legislation or the medical care and service provider may require certain knowledge and skills.

The analysis of the Article cited above shows that, to carry out professional activity, senior and middle medical workers need, in addition to the respective education, also to receive professional activity and continuing professional development (CPD) certificates. A CPD certificate is a permission for the medical worker to continue his/her independent professional activity, which is granted in case of collecting CPD credits and having at least three years' professional work experience in the last five years. The CPD process is delivered in a five-year cycle based on professional activity carried out during the five years and the assessment of knowledge and professional skills acquired, for which CPD credits are awarded.

Although the aforementioned legislative requirements should be applied also to penitentiary medical personnel, they are in practice not applied. As mentioned above, under Decree 825-N, the medical services unit of the Penitentiary Service, including its personnel, is a structural unit of the Penitentiary Department, which has its divisions and subdivisions. Article 2 of the RoA Law on Penitentiary Service provides that penitentiary service is a special type of public service, and citizens serving in penitentiary service are public servants. The Law prescribes no exception for the medical personnel.

Penitentiary service staff, including medical personnel, takes part in courses at the Law Institute of the RoA Ministry of Justice, but they are not professional health care courses.

Furthermore, the medical service personnel of the Penitentiary Service operate as a part of public service, and the doctors are subject to the same requirements as the other staff, including the requirement (under Paragraph 4 of Article 14 of the RoA Law on Penitentiary Service) whereby a person applying to work in the Penitentiary Service shall be below 30 years of age at the time of applying. Thus, it is a requirement that applies, among others, to the doctors. Representatives of the Penitentiary Service have stated that this problem could be solved by reviewing the age restriction for doctors and setting the threshold

at 45 and the cap at 65 years of age. The same Law provides that they may not perform other paid work. This provision should also be amended so that doctors can undertake professional activity outside the penitentiary system.

As to the remuneration of medical personnel, it is consistent with the wages of public servants, which is quite low compared to wages in private medical organizations. Under the RoA Government Decree 712-N (dated 3 July 2014, “On Establishing the Cases of Providing Bonuses, Their Amounts, and Payment Procedure, Due to Specificities of Service in the Armed Forces, National Security Bodies, the Police of the Republic of Armenia, the Penitentiary Service, and the Rescue Service”), medical service personnel receive wage bonuses when certain conditions are present, in view of the specificities of penitentiary service.

To sum up the legal framework of the Republic of Armenia concerning the qualification of medical personnel in the penitentiary system, it can be noted that the age restrictions, the prohibition of performing other work, low wages, the peculiar conditions of work, and the absence of professional training considerably reduce the potential to attract qualified medical personnel to the medical units of the penitentiary system, which in turn negatively affects the quality and scope of the medical services provided.

As to the international standards on the qualification of medical personnel in the penitentiary, Paragraph 22 of the UN Standard Minimum Rules for the Treatment of Prisoners²⁴ provides: “At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry.”

According to Rule 41.1 of Recommendation R(2006)2 on the European Prison Rules adopted by the Council of Europe Committee of Ministers on January 11, 2006,²⁵ “every prison shall have the services of at least one qualified general medical practitioner.” According to Rule 41.4, “every prison shall have the services of at least one qualified general medical practitioner”, and according to Rule 81.4, “the training of all staff shall include instruction in ... human rights instruments and standards, especially the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, as well as in the application of the European Prison Rules.”

According to Rule 10 of the Council of Europe Recommendation R(98)7²⁶, “prison doctors should be able to call upon specialists.” According to Rule 20, “health care personnel should operate with complete independence within the bounds of their qualifications and competence”.

The overview of the international experience shows that the licensing or accreditation of doctors, and in some cases also of nurses, is a mandatory requirement for being able to provide services. There are different approaches in the international practice with respect to the improvement of the qualification of doctors. **France, the United Kingdom, and Georgia** apply the continuing professional development model that has replaced the lifelong learning requirement that is applied in **Slovenia**. Unlike the lifelong learning model, the continuing professional development model includes not only participation in professional theoretical

²⁴ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

²⁵ http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

²⁶ [http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+\(98\)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095](http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+(98)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095)

courses, but also the acquisition of professional experience. In the **United Kingdom**, it is mandatory to register prison doctors in the Chief Medical Council, and testing once every 5 years is also mandatory.

The present situation in the penitentiary system of Armenia shows that the medical personnel needs development, and in some cases, also specialization. Based on the foregoing, the following options have been considered for addressing the identified problems:

- Amend the legislation appropriately and separate the medical personnel from the penitentiary service system. A possible solution could be the granting of civilian employee status to the medical personnel of the penitentiary institutions.

- Define requirements on the professional activity and specialization of doctors, as well as their professional training, revising the current age restriction, remuneration amounts, and requirements peculiar to penitentiary service.

- Apply the continuing professional development requirements of the RoA Law on Population Medical Care and Services also to doctors working in the penitentiary system, taking into account whenever necessary the peculiarities of the penitentiary.

§ 3. Oversight of Health Care Services of the Penitentiary Institutions

Two types of oversight should be discussed in the context of protecting human health in penitentiary institutions: firstly, oversight of the quality and effectiveness of the medical care and services provided in penitentiary institutions, and secondly, the safety of the medical care and services, especially in relation to state surveillance of hygiene and epidemiology.

The service safety standards, namely the standards set for the government-guaranteed free-of-charge medical care organized in the form of outpatient, obstetrician-gynecological, dispensary, hospital, children's, and other services, provide to some extent the ground and the tools for the oversight of the organization and set the scope for the provision of medical care services by the institutions.

As to state surveillance of sanitation and hygiene, Article 4 of the RoA Law on Ensuring the Sanitary-Epidemiological Safety of the RoA Population provides that sanitary rules and hygiene standards (sanitary rules) define the criteria for safety and harmlessness of the environment for the population and requirements to ensure favorable conditions for human activity. Complying with the sanitary rules is mandatory for all state bodies, enterprises, institutions, organizations, as well as officials and citizens. The procedure of elaborating, approving, revising, and enforcing the sanitary rules is defined by the RoA Government. Sanitary rules and hygiene standards are defined in a number of binding decrees of the RoA Minister of Health, which address hygiene requirements concerning drinking water, air and noise, the organization and implementation of the immune-prevention process in the RoA, epidemiological surveillance of tuberculosis, combined epidemiological surveillance of viral Hepatitis B and Hepatitis C, the location, structure, furnishing, operation, employee workplace protection, and individual hygiene of dental medical care and service providing organizations, the sanitary and anti-epidemiological regime, the recycling of

medical waste, and disinfectants, insecticides, and rodenticides. The State Health Inspectorate of the RoA Ministry of Health is the body authorized to oversee compliance with the aforementioned standards. However, in practice, it does not oversee the work of the penitentiary institutions.

Article 83 of the RoA Penitentiary Code regulates the medical-sanitary care of prisoners. Paragraph 1 of Article 83 provides: “The medical-sanitary and medical-preventive care for prisoners shall be organized in accordance with the Republic of Armenia health sector legislation. The RoA Government shall prescribe the procedure of organizing medical-sanitary and medical-preventive care for prisoners, prisoners’ using the medical institutions of the healthcare authorities, and engaging the staff of such institutions for such purposes.” The same regulation is prescribed for detainees in Article 21 of the RoA Law on Holding Arrested and Detained Persons. Under Paragraph 1 of the Procedure approved under Decree 825-N, “Medical-sanitary and medical-preventive care for detainees and sentenced persons shall be organized in accordance with the legislation on population medical care and services, the sanitary legislation, this Procedure, and other legal acts.”

The medical services unit of the penitentiary institution is responsible for the oversight and supervision of compliance with medical-sanitary and medical-preventive activities, sanitary, food storage, food preparation, hygiene, and anti-epidemiological requirements. Under Paragraph 4 of the Procedure, for purposes of properly carrying out the medical-sanitary and medical-preventive activities, the medical services units of the penitentiary institutions should present semiannual and annual reports on activities carried out by them. Under Paragraph 34 of the Procedure, in case of outbreaks of infectious diseases or epidemics, poisoning, food poisoning, and poisoning that inflicted grave consequences or death, the institution warden shall inform in writing the head of the medical services division of the Penitentiary Administration, as well as the relevant institutions of the RoA Ministry of Health.

It flows from the foregoing that these rules are very generic, and clear procedures and obligations are not prescribed. The real situation in the penitentiary institutions shows that sanitary and hygiene surveillance is not properly performed: within the penitentiary system, there is no clear definition of either the official overseeing compliance with medical-sanitary and medical-epidemiological rules or the duties of such official. The penitentiary institutions lack specialists having knowledge and qualifications to oversee compliance with sanitary rules and hygiene standards. Moreover, the relevant specialized body does not check the regular oversight and conformity to the requirements.

The international experience shows that there are bodies of different types and different subordinations, which perform health oversight in penitentiary institutions. In France, for example, each penitentiary institution has its assessment board, which consists of judges, prosecutors, lawyers, and social workers, and it conducts food and sanitary-epidemiological supervision. In the United Kingdom, such supervision is conducted by Her Majesty’s inspection, which is independent and reports to the government. In Georgia, the medical department of the penitentiary system conducts sanitary and anti-epidemiological supervision. The experience of the countries studied shows that integration of prison healthcare in the public healthcare system increases the quality and availability of the services.

In view of the sanitary-hygiene oversight situation in the penitentiary sector and the international experience, the following options have been considered: (i) delegate sanitary-

hygiene oversight to the RoA Ministry of Health in the same way as in the public health system, or (ii) under public procurements, conclude contracts with organizations providing the relevant services, and delegate responsibility for direct oversight in the institutions to the medical service personnel thereof. As to the definition of sanitary rules and hygiene standards, it is proposed either to apply all of the public health system rules or to elaborate separate sanitary rules and hygiene standards for the penitentiary institutions, taking into account the peculiarities of the penitentiary sector.

§4. Requirements and Procedures Pertaining to Supplying Medications

Decree 17-N of the RoA Minister of Health (dated 9 September 2010, “On Approving the Procedure of Transportation, Storage, and Keeping of Medications”) prescribes the requirements concerning the storage, keeping, and transportation, including wholesale selling, of medications. Paragraph 64 of the Procedure approved by Decree 825-N provides: “Medications and medical supplies shall be kept in the institution's administrative building, in an area that is equipped with an alarm system, in a fire-proof safe box. They shall be dispensed in strict accordance with medical instructions.” However, this regulation is insufficient for proper keeping of medications. Moreover, visits to the penitentiary institutions have made it clear that the necessary conditions for keeping medications (for example, refrigerators for temperature-sensitive medications) are often missing.

As to the distribution of medications, Paragraph 99 of the Procedure approved by Decree 825-N provides that medications and medical supplies shall be distributed between the medical units of the penitentiary institutions by the Head of the medical services division of the Penitentiary Administration through the Center for Distribution of Medications and Medical Supplies of the Penitentiary Service, which operates within the medical correctional institution. Paragraph 103 of the same Procedure provides that the registration, storage, and use of medications and medical supplies in the Center for Distribution of Medications and Medical Supplies shall be supervised under the procedure provided by the RoA legislation. The reality here, too, is far from being satisfactory: in practice, no health authority oversees either how demand for medications used in the penitentiary institutions is formed, or medications quality, efficacy, and safety.

The legislation on the circulation of medications requires licensing of activities related to such circulation, as well as the availability of buildings, technologies, and human resources for the circulation of medications, but these requirements do not apply to the penitentiary institutions. An additional requirement is prescribed for sellers and/or dispensers of narcotics or medications containing psychotropic substances: they are required to have a bunker for storing narcotics and psychotropic substances, or a fire-proof safe box attached to the ground. The warehouse must have a humidometer and be equipped with an alarm system, whereby the sound or light signal shall be connected to the guard station or affixed on the outside of the building. The alarm equipment electricity supply system shall have a backup source of electricity supply.

To ensure the temperature mode necessary for storage of medications, the pharmacy warehouse and the pharmacy kiosk warehouse (if present) shall be equipped with closed cupboards, have separate cupboards and a humidometer for bandage supplies and rubber products. Technical and technological means shall ensure the temperature mode necessary for storing medications.

A special requirement is prescribed also for the specialist working in the pharmacy or pharmacy kiosk, who shall be a pharmacist and/or pharmacologist who is a graduate of the relevant education institution, qualified under the procedure provided by law, and who has undergone professional training in the last five years under the procedure defined by the authorized body.

To provide proper medical care and services, it is necessary, in addition to high-quality personnel and equipment, to have also requirements on the list and storage of medications. No list of essential medications has been approved for the penitentiary institutions of Armenia. There are no criteria for selecting the medications. The medications are purchased on the basis of a general annual request that is presented by the penitentiary institution. The procurement is made through public procurements, where the main criterion is the low price. If additional medication is needed, which is not included in the annual lists, it cannot be purchased due to the absence of funding and procedures. Penitentiary institutions often lack the essential medications, such as antiseptics, painkillers, antibiotics, and tranquilizers: the problem is more acute in light of the health state of inmates. This is confirmed by the 2015 Annual Report of the RoA Human Rights Defender,²⁷ which documented problems of the scarce quantity and selection of medications provided by the penitentiary institutions, as well as the availability of medications in the dental cabinets.

The scarcity of the quantity and selection of medications provided by the penitentiary institutions was highlighted also by the CPT in the course of its visits to Armenia. The CTP addressed the problem on a number of occasions.²⁸

The international experience in this area shows that only qualified medical personnel can dispense the medications, and the medications should be managed by such personnel. Financing of medications in foreign penitentiary systems is provided mainly from the state budget. In Romania, medications are supplied through the National Health Insurance Foundation. Inmates may pay to purchase other medications. In Slovenia, medications are supplied by the pharmacies located in the territory of the penitentiary institutions.

Taking into consideration that the list of medications and the procurement and supply regulations are flawed, it is proposed to address the aforementioned problems by approving the list of medications and medical supplies necessary in penitentiary institutions and reviewing the legal regulations on the procurement of medications and medical supplies. Medications and medical supplies should be procured through the public procurement procedure on the basis of annual requests prepared by the medical personnel, which in turn will be based on the preceding year's statistics, the more prevalent health issues among prisoners, and the medications required to treat them. It is proposed that the annual budget

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http://www.ombuds.am/storage/files/library/pdf_5949209102_arm_Tarekan_haghordum_2016_Ombudsman.pdf

²⁸ For example, CPT report on the results of the regular visit to Armenia from October 6 to 17, 2002 (CPT/Inf (2004) 25), paragraph 113, CPT report on the results of the regular visit to Armenia from April 2 to 12, 2006 (CPT/Inf (2007) 47), paragraph 82, and CPT report on the results of the regular visit to Armenia from April 10 to 21, 2010 (CPT/Inf (2011) 24), paragraph 105.

should contemplate funding for procuring medications and medical supplies on the basis of additional requests when such needs come up. Another option to address the problem would be, in addition to government resources, to allow inmates to pay to purchase appropriate medications based on a doctor's prescription. The international experience could be taken into consideration for devising the alternative of delegating oversight of the circulation of medications to the health care authorities.

CHAPTER 3. HEALTH RIGHTS OF PERSONS DEPRIVED OF LIBERTY

When seeking medical care and services, persons deprived of liberty should have the same rights as those in freedom, except for special defined cases. This is confirmed by Paragraph 9 of the UN Standard Minimum Rules for the Treatment of Prisoners²⁹ ("prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation") and Rule 40.2 of the European Prison Rules³⁰ ("health policy in prisons shall be integrated into, and compatible with, national health policy"). The analysis of the RoA legislation shows that, for inmates, a number of rights pertaining to medical care and services are enshrined in the general public health legislation, as well as in the penitentiary legislation.

Paragraph 1 of Article 85 of the RoA Constitution provides: "Everyone shall, in accordance with law, have the right to health care." The Constitution also prescribes the right of persons to deprived of liberty to proper treatment in Article 26, which provides: "No one may be subjected to torture, inhuman or degrading treatment or punishment. Corporal punishments shall be prohibited. Persons deprived of liberty shall have the right to humane treatment." Article 6 of the RoA Penitentiary Code prescribes the principle of humanism: "Sentence execution ... shall not be accompanied with physical violence in relation to the person..." Paragraph 3 of Article 123 of the RoA Penitentiary Code provides: "It shall be prohibited to subject a prisoner to medical or scientific or other experiments irrespective of his consent."

Chapter 2 of the RoA Law on Population Medical Care and Services is dedicated to human rights in the field of medical care and services. One of those rights is **the right to receive medical care and services** irrespective of nationality, race, sex, language, faith, age, health condition, political or other views, social origin, property status, or other status. "Other status" may include also the fact of being in a place of deprivation of liberty. Article 12 of the same Law provides: "Arrested persons, detained persons, and persons serving a sentence in places of deprivation of liberty shall have the right to receive medical care under the procedure stipulated by the RoA legislation." Article 12 of the Penitentiary Code specifies, among the listed rights of prisoners, "the right to healthcare, including the right to receive sufficient food and medical care." Paragraphs 5 and 6 of the Procedure approved under

²⁹ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

³⁰ http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

Decree 825-N prescribe the right to access medical care and medical counseling at any time and without obstacles.

An important safeguard for persons held in places of deprivation of liberty is prescribed in Paragraph 2 of Article 4 of the RoA Law on Population Medical Care and Services: “Everyone shall have the right to receive medical care and services free of charge or on concessional terms in the framework of targeted state health programs guaranteed by the state.” Arrested, detained and sentenced persons are specified in Paragraph 19 of the List of Socially-Vulnerable and Special (Specific) Groups of the Population Entitled to State-Guaranteed Medical Care Free of Charge or on Concessional Terms (approved under RoA Government Decree 318-N dated 4 March 2004 adopted in execution of the aforementioned Paragraph 2 of Article 4 of the Law on Population Medical Care and Services). Article 5 of the Law enshrines human rights while receiving medical care and services: “When seeking medical care and while receiving medical care and services, everyone shall have the right:

- a) To select the provider of medical care and services;
- b) To receive medical care and services in conditions complying with the requirements of hygiene;
- c) To demand confidentiality of the fact of seeking a doctor’s help and of information related to his health condition and information established during examinations, diagnosis, and treatment, except for cases provided by the RoA legislation;
- d) To be informed of his illness and to give consent to medical intervention;
- e) To refuse the medical intervention, except for cases provided by this Law; and
- f) To receive respectful treatment from the providers of medical care and services.”

The RoA legislation prescribes also **the right to receive compensation for damage inflicted upon health**. Article 5 of the RoA Law on Population Medical Care and Services provides: “Everyone shall have the right to receive compensation, in accordance with the procedure provided by the legislation of the Republic of Armenia, for damage inflicted upon his health during the organization and provision of medical care and services.”

The right to receive information about the state of health is regulated in further detail in Article 7 of the RoA Law on Population Medical Care and Services provides: “Everyone shall have the right to receive information in understandable form about his health state, results of tests, the diagnosis and treatment methods, the related risk, the possible options of medical intervention, consequences, and treatment results.” As logical continuation, Articles 8 and 17 of the same Law prescribe **the person’s right to consent and refusal for medical intervention**. For persons deprived of liberty, those rights are provided in Paragraph 8 of the Procedure approved under Decree 825-N: “Detained and sentenced persons shall receive prior explanation of any laboratory and instrumental test, and give consent to the doctor with respect thereto, except for cases provided by the legislation, when the detained person’s or sentenced person’s state does not allow expressing his will.” Moreover, Paragraph 5 of Article 49 of the RoA Law on Narcotics and Psychotropic (Psychoactive) Substances (concerning medical care provided to drug addicts) provides: “... in respect of persons convicted for a crime and needing treatment, compulsory treatment measures may be ordered by court decision.” Compulsory treatment limits the right of the person, including person deprived of liberty, to give consent. Nevertheless, the procedures for receiving information and giving consent are not fully and duly regulated for persons held in places of deprivation of liberty. Detained and sentenced persons —as a

vulnerable group—need definition of additional mechanisms and safeguards for the exercise of these rights.

The right to medical secrecy, too, is regulated by the RoA Law on Population Medical Care and Services, Article 5 of which provides that “...everyone shall have the right to demand confidentiality of the fact of seeking a doctor’s help and of information related to his health condition and information established during examinations, diagnosis, and treatment...” Paragraph 37(2) of the Procedure approved under Decree 825-N provides: “All medical examinations shall be performed out of hearing and sight of penitentiary or other officers.”

The right to select the provider of medical care and services, which is provided by Article 5 of the RoA Law on Population Medical Care and Services, has not been analogously regulated for persons deprived of liberty. However, Paragraph 9 of the Procedure approved under Decree 825-N provides that detained and sentenced persons may pay for and use the services of other doctor-specialists of their choice. Article 13 of the RoA Law on Holding Arrested and Detained Persons provides: “An arrested or detained person shall have the right ... to be examined by a doctor of his choosing at his own expense.” Proper mechanisms need to be prescribed in the penitentiary legislation in order to guarantee this right. It should be specifically mentioned how a sentenced person should apply to receive medical care at his expense, and the cases in which such application may be rejected.

Another important right of persons deprived of liberty is **the right to be released from the sentence due to a grave illness obstructing the serving of the sentence**. This process is regulated by Decree 825-N and the RoA Government Decree 1636-N dated 4 December 2002 “On Approving the Procedure of Creating Inter-Agency Medical Commissions.” The list of grave illnesses obstructing the serving of the sentence is approved under Decree 825-N.

The analysis of the RoA legislation leads to the conclusion that the rights of inmates to medical care and services are mostly regulated in the legal framework. However, there are some gaps that limit their rights. The process of releasing from the sentence is complicated, as it consists of several communication links (treating doctor to medical working commission to inter-agency commission to finally the court); the working methodology of the inter-agency commission and its decision-making procedure are unclear: a prisoner may not personally and directly apply to the inter-agency commission or to court on this basis. The list of grave illnesses obstructing the serving of the sentence was approved in 2006 and never revised since then: presently, it is not consistent with the standards of the International Classification of Diseases (ICD).

The next key question related to health rights is the existence of provisions for compulsory treatment of narcotics addiction. As noted above, the person has the right to give consent to treatment, but this right is limited due to the existence of provisions on compulsory treatment.

Another problem is the absence of legal provisions regulating the rights of hunger-strikers. There is no provision requiring medical personnel to carry out regular checks of hunger-strikers, and the cases in which force-feeding is permitted are not defined. As to force-feeding, it is necessary to distinguish between the right to immunity of person and the right to life: when there is a threat to the right to life, the state should be guided by the positive obligation to save the person’s life through force-feeding. Hunger strikes should be

managed by doctors in a normal therapeutic doctor/patient relationship and should respect medical independence.

Having safeguards of **appeals** is essential in the context of protecting the rights of the person. The penitentiary legislation does not prescribe special mechanisms of appeal or provisions on compensation of damage inflicted upon health during medical care and services. The RoA Law on Administration and the Foundations of Administration are applicable in those cases. Article 70 of the Law provides that an administrative appeal may be lodged with the administrative authority that adopted the act or to its superior administrative authority.

The actual situation in the penitentiary institutions of Armenia shows that despite the existence of legislative provisions, not all of the rights are duly respected. For example, during medical examinations, officers of the penitentiary institution, besides the doctor, are present, which violates the right to medical secrecy; moreover, documents pertaining to a patient's personal and health status are provided to the penitentiary institution warden or other members of the administration. The procedure of release from the sentence due to a grave illness is not effectively applied. The state funding is often insufficient for providing the proper quality and volume of medical care and services.

As to the international legal norms related to patient rights, the European Charter of Patients' Rights³¹ defines the 14 human rights in healthcare. Among others, the right to protection of health is mentioned as a fundamental right. The mentioned 14 rights are the rights to preventive measures, access, information, consent, free choice, confidentiality, respect of patient's time, observance of quality standards, safety, innovation, avoiding unnecessary suffering and pain, personalized treatment, complain, and compensation.

According to Rule 2 of the Council of Europe's European Prison Rules,³² "persons deprived of their liberty retain all rights that are not lawfully taken away by the decision sentencing them or remanding them in custody."

In accordance with Paragraph 13 of Council of Europe recommendation R(98)7,³³ "medical confidentiality should be guaranteed and respected with the same rigor as in the population as a whole."

In accordance with Paragraph 10 of Council of Europe recommendation R(98)7,³⁴ prisoners shall always be entitled "to give the doctor their informed consent before any physical examination", except in cases provided for by the law. The reasons for each examination, as well as treatment and its possible consequences should be clearly explained to, and understood by, the inmates.

In accordance with Paragraph 62 of Council of Europe recommendation R(98)7,³⁵ "hunger strikers should be given an objective explanation of the harmful effects of their action upon their physical well-being, so that they understand the dangers of prolonged hunger striking". In accordance with Principle 2 of the Declaration of Malta on Hunger Strikers,³⁶

³¹ http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf

³² http://www.coe.int/t/dgji/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

³³ [http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+\(98\)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095](http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+(98)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095)

³⁴ Ibid.

³⁵ Ibid.

³⁶ <http://www.wma.net/en/30publications/10policies/h31/>

“hunger strikers should not be forcibly given treatment they refuse.” In accordance with Principles 12-13 of the same declaration, “artificial feeding can be ethically appropriate if competent hunger strikers agree to it. Forced feeding is never ethically acceptable.” The same approach should be applied in case of refusing treatment.

In accordance with Principle 22 of the UN “Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment”,³⁷ “no detained or imprisoned person shall, even if with his consent, be subjected to any medical or scientific experimentation which may be detrimental to his health.” In accordance with Rule 48 of the Council of Europe’s European Prison Rules,³⁸ “experiments involving prisoners that may result in physical injury, mental distress or other damage to health shall be prohibited.”

On page 69 of the UN WHO Health in Prisons, WHO Guide to the essentials in prison health,³⁹ it is said that “prisoners who enter the later stages of chronic or terminal illnesses require specialized end-of-life care. Prisons – even in high-income countries – are ill equipped to provide such care.”

For these reasons, many prison systems have introduced release programmes to allow prisoners to lengthen their lives as a result of receiving care in the community.” In accordance with Part 51 of Council of Europe Recommendation R(98)7,⁴⁰ “the possibility of a pardon for medical reasons or early release should be examined”.

The experience of the countries studied shows that the aforementioned international approaches and norms are also included in their domestic legislation. There are certain peculiarities, though, which are presented below.

In **France**, inmates have the right to benefit from the services of the doctor of their choice, provided that his qualification is checked. **Georgia’s** experience is somewhat different: the administration of the prison has the right to limit the inmate’s right to choose the healthcare service provider, however such decision may be challenged in court.

In **France**, boxes are installed in a place close and accessible to the inmates, where they can easily drop their messages about the prison healthcare services. The boxes are opened almost every day, and only by the medical personnel.

In **the United Kingdom**, the Ombudsman, as the person responsible for the rights of inmates, receives complaints about healthcare. In **Slovenia**, inmates, as well as those in liberty, to protect their healthcare rights, can benefit from the mediation services of the special representative under the Law on the Protection of the Sick. Unlike the aforementioned, **Estonia** has no special law on the protection of patients’ rights, including patients in prison. There are norms in other legal acts, which generally reflect the international principles in this field. Virtually all of the countries studied apply the procedure of early release due to a serious health condition, except for Romania, where there are no legal regulations for early release. The criminal code provides an opportunity to postpone or stop the serving of the term if certain conditions are met.

To combine the international experience and the legal framework of the Republic of Armenia, the legal regulations of medical care and services for persons deprived of liberty

³⁷ <http://www.un.org/documents/ga/res/43/a43r173.htm>

³⁸ http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

³⁹ http://www.euro.who.int/_data/assets/pdf_file/0009/99018/E90174.pdf

⁴⁰ [http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+\(98\)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095](http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+(98)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095)

need to be revised in light of the protection of the rights of persons deprived of liberty; the provision of the same volume and quality of services to them should be prescribed as is prescribed for persons in liberty, taking into consideration the peculiarities caused by the status of persons deprived of liberty, and without unnecessarily limiting their rights. Moreover, it is necessary:

- To develop a sound arrangement for free-of-charge delivery of medical care and services, with the possibility of financing the shortage of the penitentiary institution budget, and to develop a procedure for inmates paying to use the services of other doctor-specialists or medical institutions of their choice.

- To revise the legal regulation of the procedure of release from the sentence due to a grave illness, so that based on a conclusion of the penitentiary institution doctor or an application of the sick inmate (or his representative), the matter is presented directly to the inter-agency commission for review. Clear regulations and standards need to be developed for the decision making by the inter-agency commission. A procedure for appealing the commission's decisions should be developed. The list of grave illnesses obstructing the serving of the sentence approved under Decree 825-N should be revised and brought into line with the standards of the International Classification of Diseases (ICD).

- To revise the legislation regulating the compulsory treatment of inmates that have drug addiction.

- To introduce in penitentiary institutions, legal procedures on appeals related to medical care and services, which will provide the possibility of appealing to an independent body.

- To elaborate a legal act that will regulate the medical care and services for hunger-strikers, taking into consideration the international standards, especially force feeding and compulsory treatment.

- To adopt provisions in the legislation to prescribe the right of inmates in penitentiary institutions to receive palliative care and to put in place the appropriate arrangements.

- To prescribe, in line with the international standards, special mechanisms for the realization of patient rights in penitentiary institutions, taking into consideration the peculiarities of the penitentiary.

CHAPTER 4. PROVISION OF MEDICAL CARE AND SERVICES TO VULNERABLE GROUPS IN PENITENTIARY INSTITUTIONS

§ 1. Provision of Medical Care and Services to Vulnerable Groups in the Penitentiary Institutions of the Republic of Armenia

Humanitarian assistance by medical professionals is related primarily to vulnerable groups in the prison community. While the special needs of juvenile and female inmates, as

well as mother/child inmates are established and receive attention, the needs of inmates with physical or mental disability are largely neglected in terms of physical conditions (toilets), mobility aids, and individual care. Units with appropriate conditions and equipment should be planned for inmates with limited abilities.

The public health legislation regulates and provides legal safeguards for all groups of the population, and special legal acts regulate the peculiarities and special safeguards for persons that belong to socially-vulnerable and special groups of the population. Such regulations exist in the RoA Penitentiary Code, as well as the sub-legislative acts. Article 68 of the Penitentiary Code clearly prescribes the cases in which prisoners must be separated (**men and women** should be kept separately, and **adults and juveniles** should be separate). Taking into account the special needs of vulnerable groups, Paragraph 3 of Article 76 of the Penitentiary Code provides that a prisoner who is pregnant, a breastfeeding mother, a juvenile, or sick, shall receive **additional food**, the portions of which shall be approved by the Government of the Republic of Armenia. In order to provide more favorable living conditions for juveniles, Paragraph 4 of Article 56 of the Penitentiary Code provides that prisoners shall have the right to at least one hour of outdoor exercise every day, and juvenile prisoners to at least **two hours**. Paragraph 3 of Article 80 of the Penitentiary Code provides: “A prisoner who suffers from a mental illness that does not amount to criminal insanity, or a prisoner who has first- or second-degree disability, and needs constant care due to his health, as well as a juvenile prisoner shall be granted a short-term leave only when escorted by a next-of-kin or another person.”

Paragraph 3 of Article 121 of the Code is aimed at facilitating the living of **elderly** prisoners or prisoners with **disability**, which are released from the sentence: “A prisoner who has reached pension age or has first- or second-degree disability shall, if they so request and if they are so nominated by the staff of the institution executing the sentence, be sent by the social security authorities to institutions envisaged for persons with disability or for the elderly (homes for the elderly).”

Provisions on vulnerable groups exist also in Decree 825-N, Paragraph 41 of which provides: “Medical-preventive examinations shall be performed at least once a year and shall be performed with the consent of the prisoner, and in case of a juvenile—the consent of his lawful representative.” Paragraph 107 of Decree 825-N provides: “Detained or sentenced persons that have infectious disease, including active form of tuberculosis, women who are in the third trimester of pregnancy, women who have children between the ages of one month and two years, and persons that have mental or other grave illness shall be transported in isolation from all other detained or sentences persons”.

With regards to the health of women and juveniles, the prevalence of mental health problems is particularly important to address, as the Abovyan penitentiary institution does not have a staff position for a clinical psychiatrist: as a result, persons suffering from mental problems do not receive gender- and age-specific specialized attention.

When discussing the health care issues of vulnerable groups, it is important to address also **persons with disabilities**, for whom all penitentiary institutions should have accessible infrastructure (ramps), various medical aids (hearing, orthopedic, and others), as well as possibilities for specialized care and diagnosis.

Life prisoners are also be viewed as a vulnerable group, because an extended period of stay in a penitentiary institution negatively affects family and social ties, which in turn leads to numerous health, including mental health problems. There are around 98 life prisoners in

Armenia, the vast majority of who were initially convicted to the death penalty, but in 2003, after the adoption of the new Criminal Code and the abolition of the death penalty, their death penalty was replaced with life imprisonment by a decree of the President of the Republic. Special needs of life prisoners include continuous social and psychological activities and regular engagement of life prisoners in screening programs. Taking into consideration the issues found among long-term prisoners, Paragraph 13 of the Council of Europe Committee of Ministers Resolution (76)2 on the Treatment of Long-Term Prisoners,⁴¹ it is necessary to improve the training of prison staff of all ranks with reference to the special problems of long-term prisoners and provide staff adequate to ensure deeper understanding, personal contacts and continuity in the treatment of prisoners.

As to other vulnerable groups, such as **religious, sexual, and ethnic minorities**, a problem sometimes encountered is discriminatory attitudes in the provision of health care services; hence, it is necessary to take appropriate measures to preclude these discriminatory attitudes. A possible solution is the engagement of staff members of penitentiary institutions in the prevention of discrimination risk, which should be preceded by training courses on ethical issues.

To sum up the foregoing, the following reform options can be considered for improving medical services provided to vulnerable groups in penitentiary institutions by means of ensuring the availability of the minimum necessary medical equipment and the relevant medical personnel in penitentiary institution (to provide medical care to women):

- To ensure that detained and sentenced persons are covered by **screening programs** carried out in the field of public health;
- To ensure appropriate accessibility **inmates with physical disabilities** in all the penitentiary institutions, including ramps and appropriate toilets, as well as the necessary care;
- To organize ethics **training courses** for the staff of penitentiary institutions on precluding discriminatory attitudes towards vulnerable groups; and
- Taking into consideration that lack of language skills can obstruct the delivery of medical services, it is necessary to consider the engagement of interpreters for persons that do not speak Armenian.

§ 2. International Experience of Providing Medical Care and Services to Vulnerable Groups in Penitentiary Institutions

Based on the needs of vulnerable groups, special regulations are also stipulated by a number of **international documents** for each of the groups. In accordance with Paragraph 23 of the Standard Minimum Rules for the Treatment of Prisoners,⁴² “in women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in

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<https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016804f238>

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⁴² <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx>

the birth certificate. Where nursing infants are allowed to remain in the institution, provision shall be made for a nursery staffed by qualified persons.”

Paragraph 6 of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders⁴³ provides that women prisoners shall have access to comprehensive mental health-care and rehabilitation programs.

It flows from the analysis of Articles 2 and 25 of the UN’s Universal Declaration of Human Rights⁴⁴ that minors shall benefit from the same rights as adults.

Under Article 25 of the UN Convention on the Rights of Persons with Disabilities,⁴⁵ “states Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.” Under Article 13 of the same Convention, “in order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.”

A number of countries have, based on international regulations, enshrined in their domestic legislation a number of specificities related to vulnerable groups. In the **United Kingdom**, at every penitentiary institution, a person is appointed as responsible for disability issues and tasked to help persons with disabilities to take part in prison events, to provide counseling, and to inform the prison staff about the needs of persons with disabilities. In **Slovenia**, psychological and therapeutic programs developed specifically for minors are implemented.

CHAPTER 5. THE INSTITUTIONAL SETUP OF PENITENTIARY HEALTH

§ 1. Institutional Setup of Prison Health in Armenia, the Sector Problems, and Possible Solutions

The health of detained and sentenced persons is protected and recovered by the medical services units of the Penitentiary Service under the Ministry of Justice of the Republic of Armenia. The medical unit of the Penitentiary Department is directly subordinate to the Head of the Penitentiary Department, and the medical units of the penitentiary institutions are directly subordinate to the head of the respective penitentiary institution. The medical units of the penitentiary institutions are in professional terms subordinate also to the medical care division of the Penitentiary Department.

The main problem arising out of the institutional setup of penitentiary health is the ethical dilemma caused by the subordination of the medical personnel—the clash between professional duties and liability towards non-medical superiors within the penitentiary

⁴³ <http://www.ohchr.org/Documents/ProfessionalInterest/BangkokRules.pdf>

⁴⁴ http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

⁴⁵ <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

hierarchy. The problem is the partial lack of professional independence, which results in the lack of confidence of inmates towards the medical personnel of the penitentiary institution. These unfavorable circumstances lead to difficulties in recruiting medical personnel for the penitentiary system, vacancies, and subsequently, heavy workload of the existing personnel. The vacancies of doctors' positions indirectly deprive inmates of access to timely and quality medical care. In the Vanadzor penitentiary institution, for example, the doctor's position has been vacant for four years now, and nurses perform the first medical examination upon admission to the penitentiary institution.

As mentioned above, the penitentiary health service is a part of the penitentiary system. The current legislation indicates that the administration of a penitentiary institution may impose disciplinary sanctions upon doctors or in practice refuse to approve their purely medical conclusions. These and many similar circumstances, which are due to the absence of professional independence, negatively affect the quality of the medical services provided. The professional conclusions of the medical personnel on purely medical matters are unprofessionally revised by the administration of the penitentiary institution, which is impermissible, unless there are fact-based professional conclusions proving the opposite. Moreover, the medical personnel should not have to discuss the results of professional examinations with the administration of the penitentiary institution.

One option for reforming the institutional setup of penitentiary health and safeguarding medical professional independence could be removal of the penitentiary medical service from subordination under the Penitentiary Administration and transferring it to the RoA Ministry of Justice. Safeguarding the practical independence of doctors working in the penitentiary institutions would help to reduce corruption risks in this area and put in place a strong foundation for protection of the health rights of inmates.

A reform option proposed by the Penitentiary Department of the RoA Ministry of Justice for reform of the penitentiary health institutional setup is to consider making the penitentiary institution doctors directly subordinate to the Head of the Medical Services Division of the Penitentiary Administration (as opposed to the current subordination to the warden of the penitentiary institution). However, this option is vulnerable in terms of safeguarding medical professional independence and is also not consistent with the international standards and regulations.

The analysis of legal acts and practical visits indicates that penitentiary health care is completely separate from public health and the public health care organizations, even though the international regulations, namely the World Health Organization's 2003 Moscow Declaration,⁴⁶ provide that "prison health is part of public health." This fact negatively affects the experience and training conditions for the medical personnel of the penitentiary system, because they do not benefit from programs implemented in the public health system, and are as a result isolated from the medical professional community and do not benefit from any professional and CPD opportunities outside the penitentiary, which is prescribed and required for all medical personnel working in the public health care system. However, there are also success stories of effective partnership and cooperation between the public health services and the penitentiary system, such as the joint experience of combating tuberculosis and HIV epidemics. Such cooperation should be encouraged in other areas of health care, as well.

⁴⁶ http://www.euro.who.int/data/assets/pdf_file/0007/98971/E94242.pdf?ua=1

As mentioned above, another problem of the penitentiary health system is the recruitment and professional development of the medical personnel. Therefore, it is necessary to abolish the regulations that hinder the recruitment of medical personnel for penitentiary institutions, to propose solutions that will make the penitentiary health service attractive for doctor-specialists, and to gradually convert the penitentiary health care personnel into professionally-independent civil medical personnel.

To sum up the foregoing, the following **reforms** need to be implemented for improving the institutional setup of penitentiary health:

- One option for reforming the institutional setup of penitentiary health could be to develop legislative amendments that will remove the penitentiary medical service from subordination under the Penitentiary Administration and transfer it to the RoA Ministry of Justice. Such amendments will safeguard the professional independence of the medical personnel, which in turn will facilitate the provision of services of proper quality.
- Reforms of the institutional setup should include appropriate measures aimed at ensuring continuous cooperation between the penitentiary health system and the public health system, including measures to cover inmates by national health programs financed by the government and to include penitentiary medical personnel in regular training courses.
- As a long-run solution, it is necessary to consider the possibility of integrating the penitentiary health care service within the public health care system.

§ 2. International Experience of the Institutional Setup of Prison Health

As to the institutional setup of prison health, it is important to address the **criteria enshrined in the international documents and the experience of other countries.**

Under Paragraphs 21 and 22 of the Council of Europe's Rec (98) 7E 08 Recommendation on Ethical and Organizational Aspects of Health Care in Prison (dated 1998),⁴⁷ “a prisoner’s healthcare needs shall be the doctor’s primary concern. Clinical decisions and other assessments about the prisoners’ health shall be based solely on medical criteria. Medical personnel shall act in full independence, within the boundaries of their qualifications and powers.”

Under Paragraph 23 of the same Recommendation, “the remuneration of medical staff should not be lower than that which would be used in other sectors of public health.”

Under Paragraph 12 of the Council of Europe's Recommendation R(98)7,⁴⁸ “a clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries.”

In international practice, there are three main models of penitentiary healthcare services. There are countries in which penitentiary healthcare services are under the healthcare authorities (France, the United Kingdom, some states of Spain, and Sweden). In another group of countries, they are under the Ministry of Justice (Georgia, Romania); and

⁴⁷ [http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+\(98\)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095](http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+(98)+7+concerning+health+care+in+prisons.pdf/16c64309-1794-4210-9d88-c4f435730095)

⁴⁸ Ibid.

there are countries in which transition is being made from the Justice Ministry to the healthcare authorities (Slovenia and Estonia). In some countries, penitentiary healthcare operates under the penitentiary service (the Republic of Armenia, the Russian Federation, the majority of the CIS countries, Asia, and some European countries, such as Ireland and Albania). There are also cases in which the penitentiary healthcare service is managed by various agencies based on the specificity of their functions; to differentiate the scope of powers clearly, relevant contracts are sometimes concluded. There are bodies of various types and subordination, which carry out supervision. This is a type of “extra-agency” model, in which medical care is provided by outside organizations (from within the commercial or civil healthcare system), i.e. the care is delivered by medical institutions that are not under the penitentiary system. Financing may be organized through various schemes: the closer the scope of the medical services to the national standards, the more it exceeds the similar expenses of the civil healthcare system. This model works successfully in Norway, England, France, and Australia. Spain and Scotland are in a transitional stage. The existence of such a system creates conditions for improving the quality of the medical-sanitary care provided to prisoners; opportunities emerge for further development and improvement of the system for safeguarding the prisoners’ right to quality health care.

Under this model, prisoners have the same status as all other citizens of the country. Medical personnel cooperate with the administration of the penitentiary institutions, but are independent of them. Under this model, better quality medical-sanitary services are provided in penitentiary institutions, and continuity of medical care is ensured for released prisoners. One of the shortcomings of this system is that its management is complicated.

In **France**, medical personnel are completely independent from the administration of the penitentiary institution: since 1994, the healthcare system of penitentiary institutions has been transferred from the Justice Ministry to the Health Ministry. In **Romania**, judges have offices right in the penitentiary institutions, where they examine the complaints on-site. In most of the countries, complaints related to healthcare services are examined by bodies that are independent of the penitentiary service.

The mixed model, which is used in the USA, combines organizational components of the aforementioned two systems. Federal penitentiary institutions are financed from the government budget, and their medical personnel are subordinate to the federal executive authority (such as the Department of Justice); they are public servants and have relevant ranks, which safeguards their strong social protection. In some states (districts), medical services to prisoners in penitentiary institutions are organized the same way as on the federal level, but the financing comes from the budget of the respective state. Medical care is delivered by commercial organizations, which have undertaken to deliver medical services within the limits of the allocated resources.

It is stated in the international universal principles that penitentiary healthcare services need to be independent and need to integrate within the public/national healthcare system.

Lessons can be learnt also from countries that have, for many years now, been implementing the cautious and phased integration of the penitentiary healthcare management system into the public healthcare system, and have achieved in this process complete or partial success, such as the UK, Norway, France, Spain, Italy, and some cantons of Switzerland. Other countries, such as Georgia and Moldova, have succeeded in certain small steps taken towards making the medical care services more independent of their penitentiary administrations.